

Behavioral Sciences Regulatory Board

2025 Survey of Professional Counselors

Final Report

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Introduction and Methodology

This report is part of a series of reports studying survey results in 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 and behavioral health professionals, including the professional counseling profession. As of February 2025, Kansas offers two levels of permanent licensure for the professional counseling profession: (1) an independent level of license called a Licensed Clinical Professional Counselor (LCPC) license and (2) a non-independent Licensed Professional Counselor (LPC) license. LPCs must practice under supervision or direction of a supervisor in Kansas. To assist the work of the Board, the BSRB utilizes seven subcommittees, called "Advisory Committees," which are comprised of the Board member for the profession (serving as Chair), a public Board member, and between three and ten other individuals, usually licensees for that profession.

In the fall of 2024, members of the Professional Counseling Advisory Committee for the BSRB requested the creation of a survey of professional counseling licensees. 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 professional counseling workforce in Kansas. The members of the Advisory Committee worked with the Executive Director of the BSRB to draft potential questions for a survey, while BSRB Advisory Committees for other professions developed similar questions for surveys for licensees in their professions. While the final survey included a few unique questions per profession, efforts were made to create uniformity for most topics between the professions, so both a profession-specific report and an overall summary report comparing professions could be created.

As of January 13, 2025, the total number of professional counselors with a permanent license in Kansas totaled 2,695, including practitioners with a Licensed Professional Counselor (LPC) license (1,209) and practitioners with a Licensed Clinical Professional Counselor (LCPC) license (1,486). From January 24, 2025, to February 23, 2025, all licensed professional counselors 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, 716 professional counselors completed the survey, for an overall response rate of 26.6 percent. For the LPC level of license, 274 individuals completed the survey, for a response rate of 22.7 percent, and for the LCPC level of license, 442 individuals completed the survey, for a response rate of 29.7 percent.

Note: While the results of the 2025 survey are included on the following pages, most specific language is found in the appendices. Identical responses were grouped, edits were made for spelling and grammar, 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 Professional Counselors by the Kansas Behavioral Sciences Regulatory Board revealed helpful findings about workforce trends and other information related to licensure. Over the 31 days the survey was open for responses, a combined total of 716 professional counselors completed the survey, including 274 practitioners holding a non-independent Licensed Professional Counselor (LPC) license and 442 practitioners holding an independent Licensed Clinical Professional Counselor (LCPC) license.

Practice Location by County – A significant number of professional counselors reported practicing in multiple counties, however the most common responses showed that practitioners were likely to practice in heavily populated cities, primarily (in order of popularity) Johnson County, Sedgwick County, Wyandotte County, and Shawnee County. Both LPCs and LCPCs showed similar trends in terms of most popular counties for practice.

Practice Location by Urban, Rural, or Frontier Areas – The vast majority of survey respondents reported practicing in urban areas (65 percent for LPCs and 72 percent for LCPCs), while less than 25 percent of both LPCs and LCPCs reported practicing in rural areas (24 percent for LPCs and 19 percent for LCPCs).

Practice Area by Setting – Concerning practice area by setting (public practice, private practice, educational setting, or all other settings), 49 percent of LPCs and 69 percent of LCPCs reported working in private practice. The second most common response for both groups of licensees was working in public practice, though that was more common for LPCs (29 percent) than for LCPCs (16 percent). The number of professional counselors working in an educational setting was similar (9 percent for LPCs and 8 percent for LCPCs), while respondents selecting a category including all other settings followed close behind (9 percent for LPCs and 7 percent for LCPCs).

Length of Career Practicing Professional Counseling – For LPCs, the most common response for survey respondents was between two years to five years (32 percent), while 19 percent reported between one to two years of practice, 20 percent reported five to 10 years of practice, 18 percent reported over 10 years of practice, and 11 percent of LPCs practiced less than one year. The vast majority of LCPCs reported practicing professional counseling over 10 years (69 percent), while nearly 23 percent provided professional counseling services between 5 years to 10 years, and 8 percent practiced professional counseling less than 5 years.

Professional Counseling Licenses Held in Multiple States – For LPCs, the overwhelming majority of respondents were licensed in one state (87 percent), 11 percent reported being licensed in two states, and almost no survey respondents were licensed in three or more states (less than 3 percent combined). For LCPCs, a combined 82 percent of survey respondents reported holding a professional counseling license in either one state (46 percent) or two states (36 percent). Much less common were individuals holding a license in between three to five states (15 percent).

Professional Counseling Licenses Active, but Not Currently Being Used – Professional counselors were asked if they maintain an active license but no longer provide professional counseling services. For both LPCs and LCPCs, the most common response (nearly half of both groups of licensees) was from practitioners that maintain an active license and continue to use it to provide services. For individuals maintaining an active license but not providing services, the most common responses from LPCs noted individuals working in administrative roles, taking breaks for personal reasons, or professional burnout. LCPCs in this category were individuals holding administrative roles or provided supervision.

Professional Counseling Services: In-Person Services Per Week – Both LPCs (36 percent) and LCPCs (34 percent) primarily reported providing between 20 hours and 40 hours of in-person services each week. For LPCs, the second most common response was between five to 10 hours per week (23 percent), followed by less than five hours per week (21 percent), then between 10 hours and 20 hours per week (8 percent), and individuals providing in-person services over 40 hours per week (6 percent). For LCPCs, the second most common response was between 10 hours and 20 hours each week (28 percent), followed by less than five hours (22 percent), then practitioners working between five to 10 hours (10 percent), and individuals providing in-person services over 40 hours per week (4 percent). *Note:* a definition for “*in-person services*” was not provided in the survey, so there may be some level of subjective interpretation from survey respondents when answering this questions, that could be clarified more fully in future surveys.

Professional Counseling Services: Telehealth/Remote Services Per Week – Popularity of providing telehealth/remote services to clients per week was similar between both professional counseling license types. Both LPCs (72 percent) and LCPCs (48 percent) primarily reported providing less than five hours of telehealth/remote services to clients each week, followed by providing between five hours and 10 hours per week (15 percent for LPCs and 23 percent for LCPCs), then between 10 hours to 20 hours per week (6 percent for LPCs and 15 percent for LCPCs), and between 20 hours and 40 hours per week (3 percent for LPCs and 12 percent for LCPCs).

Professional Counseling Services: Supervising, Managing, or Overseeing Work of Others – LCPCs were asked the number of hours they supervised, managed, or oversaw the work of others, and the overwhelming answer was less than five hours per week (66 percent). Responses for all other categories were each under 10 percent each.

Reasons Why LPCs are not Working Towards a LCPC License – The majority of LPCs responding to the survey reported they are working towards a clinical license (about 60 percent), but some respondents that were not working towards a LCPC license attributed their responses to satisfaction with their current employment that did not require a LCPC license, plans to retire in the future, concerns about the number of hours to reach clinical licensure, or difficulty passing the clinical licensing examination.

Professional Counselors Anticipating Retirement in Next Five Years – The vast majority of both LPCs (84 percent) and LCPCs (77 percent) do not anticipate retiring in the next five years, though some respondents were unsure whether they would retire in the next five years (7 percent for LPCs 12 percent for LCPCs). A small number of professional counselors noted they planned to retire in the next five years (6 percent for LPCs 10 percent for LCPCs).

Familiarity with Professional Counseling Advisory Committee – Despite the BSRB Board utilizing a Professional Counseling Advisory Committee and broadcasting these meetings on the agency’s YouTube channel, the vast majority of both LPCs (70 percent) and LCPCs (62 percent) and were not familiar with the Advisory Committee, with a small percent of both license types reporting only being somewhat familiar with the work of the Advisory Committee (18 percent for LPCs and 21 percent for LCPCs).

Negative Practice-Related Issues Observed by Licensees – When asked whether professional counselors had observed practice-related negative issues or situations where practitioners needed more education or training in a certain area over the past two years, some LPCs and LCPCs responded “no” (34 percent of LPCs 21 percent of LCPCs). LPCs noting issues mentioned a need for improved reimbursement rates from insurance providers, collaborative efforts among state on licensure requirements, enhanced training in trauma-informed care, challenges in billing processes, cultural and social competency. Less frequently mentioned by LPCs were a desire for more education on telehealth services, ethical implications of using artificial intelligence in practice, mandatory reporting requirements, dual relationships in small communities, and boundaries. Other LPCs expressed a desire for additional training in documentation practices, diagnosis, addiction treatment, supervision, business management, and strategies for collaborating with the medical community. LCPCs noting issues highlighted ethical concerns concerning social media, treatment of children and families within the legal system, issues related to insurance billing and reimbursement, and documentation and treatment planning. Less frequently referenced by LCPCs included a need for more education on boundaries, self-care for practitioners, telehealth, supervision, addiction care, and suicide prevention.

Negative Telehealth Issues Observed by Licensees – Both LPCs and LCPCs overwhelmingly expressed support for the positive aspects of telehealth, as the largest group of respondents at each license level noted they have neither experienced negative issues nor observed negative issues concerning telehealth of other practitioners (50 percent of LPCs and 60 percent of LCPCs). LPCs noting concerns focused on challenges of following requirements in different states when providing remote services across state lines and difficulty connecting with clients by screen. Less frequently mentioned by LPCs were concerns about client confidentiality and concerns about insurance reimbursement. LCPCs that did note concerns referenced technology being unreliable and some clients lacked suitable environments for telehealth. Less frequently mentioned by LCPCs were frustrations at adhering to laws in other states when practicing across state lines and the quality of therapy by screen.

Number of Individuals Supervised by LCPCs – When asked the number of individuals LCPCs are currently supervising, for LCPCs providing supervision, the most common response was one supervisee (18 percent), followed by between three and five supervisees (12 percent), then two supervisees (6 percent), and between six to 10 supervisees (8 percent). Less than five percent of respondents reported providing supervising more than 10 supervisees. (*Note:* the most frequent response for LCPCs was the option “prefer not to answer,” however due to a survey drafting issue, respondents were unable to select “zero” as an option.)

Negative Supervision Issues Experienced by Licensees – When asked if respondents had experienced any negative issues involving supervision over the past two years, both a significant number of LPCs (67 percent) and LCPCs (65 percent) reported they had not experienced negative issues involving supervision, though some individuals reported not providing supervision currently. LPCs noting concerns commonly referenced lack of availability of board-approved LCPC supervisors and cost of supervision. Less frequently mentioned by LPCs were concerns about the Board-approved supervisor list, the possibility of other professions providing supervision, and the overall quality of the supervision they were receiving. Concerns noted most commonly by LCPCs included costs associated with maintaining continuing education requirements for supervision, availability of supervisors, and supervisors who only provided group supervision. Less commonly noted by LCPCs were concerns related to some supervisors supervising too many licensees and documentation challenges.

Utilization of Artificial Intelligence in Practice – The largest groups of respondents (62 percent of LPCs and 62 percent of LCPCs) reported not using artificial intelligence in practice, though several of these respondents expressed interest in its potential application while others expressed concern. For LPCs using artificial intelligence in practice, note-taking and transcribing notes were the most frequent uses, while others used the technology in similar ways to LCPCs. For LCPCs using artificial intelligence in practice, they reported using it primarily for note-taking and transcribing notes, while others utilized the technology to enhance grammar, develop treatment plans, and to support business functions, such as marketing and research.

Additional Ways the BSRB Could Protect and Serve Consumers of Services – When asked, based on their experience, if LCPCs and LPCs had recommendations on additional ways the BSRB could protect and serve consumers of services offered by BSRB licensees, the most frequent survey response for both levels of licensure was “no” (56 percent of LPCs and 53 percent of LCPCs). Several respondents reported they were happy with their experiences with the BSRB. LPCs who made recommendations requested more licensure information and more responsiveness to inquiries. Less frequently mentioned by LPCs were requests for more communication on upcoming changes and resources, online applications, regulation of private practice, and more regulations on testing. LCPCs providing recommendations noted it would be helpful to have recommendations on artificial intelligence and telehealth along with more information and support regarding the complaint process. Other LCPCs mentioned less frequently a desire for increased communication from the BSRB to licensees, a request to conduct background checks of license

applicants, offering free continuing education classes, and establishing an impaired provider program.

Additional Comments and Feedback – When offered the opportunity to provide other comments and feedback, most survey respondents did not have additional comments (56 percent of LPCs and 36 percent of LCPCs). Several professional counselors noted they were satisfied with the work of the Board and others expressed appreciation for the opportunity to provide feedback through the survey. LPCs providing feedback requested more clarity on navigating the application process and allowing supervision from other professions, improvements to the BSRB website, and including more job positions in clinical training plans. Less frequently mentioned by LPCs included recommendations to improve telehealth guidelines, increased pathways to clinical licensure, and addressing the shortage of professional counselors in rural communities. LCPCs providing feedback recommended clearer and more uniform guidelines for telehealth services, more information about the professional counseling multi-state compact, detailed information on the application process, and recommendations to increase awareness about the work of the Advisory Committee. Less frequently mentioned by LCPCs were suggestions for dual licensure and clearer information on reciprocity regulations and continuing education.

Survey Questions and Summary of Responses

Question 1 (LPC and LCPC). In what county/counties do you practice the profession of professional counseling?

LPC Responses

269 LPCs answered question 1. Full responses are included in Appendix 1 on page 29.

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

- Johnson (84 responses);
- Sedgwick (34 responses);
- Wyandotte (13 responses); and
- Shawnee (10 responses).

LCPC Responses

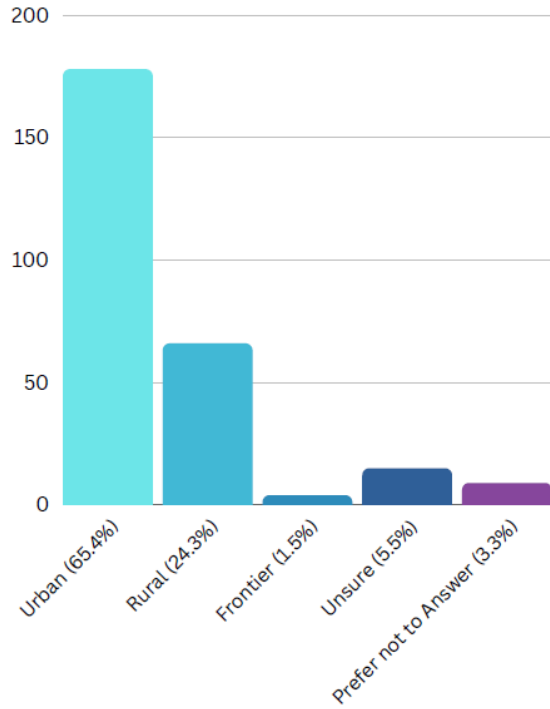
431 LCPCs answered question 1. Full responses are included in Appendix 2 on page 31.

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

- Johnson (139 responses);
- Sedgewick (43 responses);
- Wyandotte (9 responses); and
- Shawnee (7 responses).

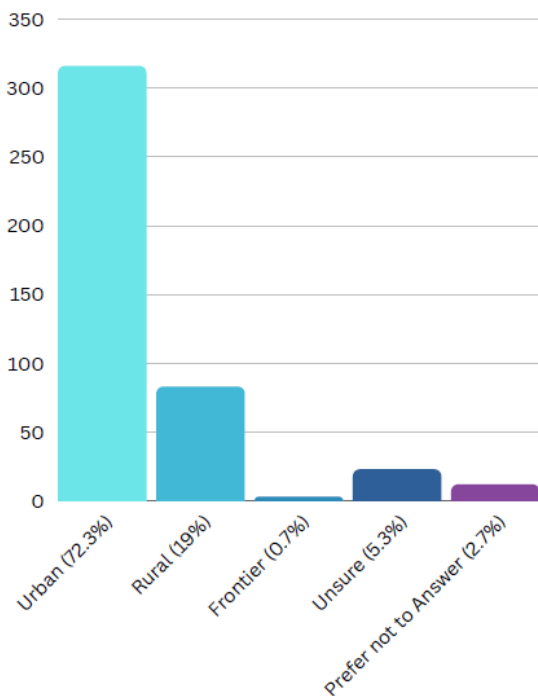
Question 2 (LPC and LCPC). Do you practice in a predominantly urban area, rural area, or frontier area?

LPC Responses



Of the 272 LPCs that answered question 2, about two-thirds (65 percent) reported living in an urban area and about one quarter (24 percent) reported living in a rural area. All other responses were less than 6 percent. According to the 2020 US Census, about 57 percent of Kansans live in urban counties, and trends show an increase in residents moving to urban areas, so the results from the survey are consistent with demographics from the most recent census.

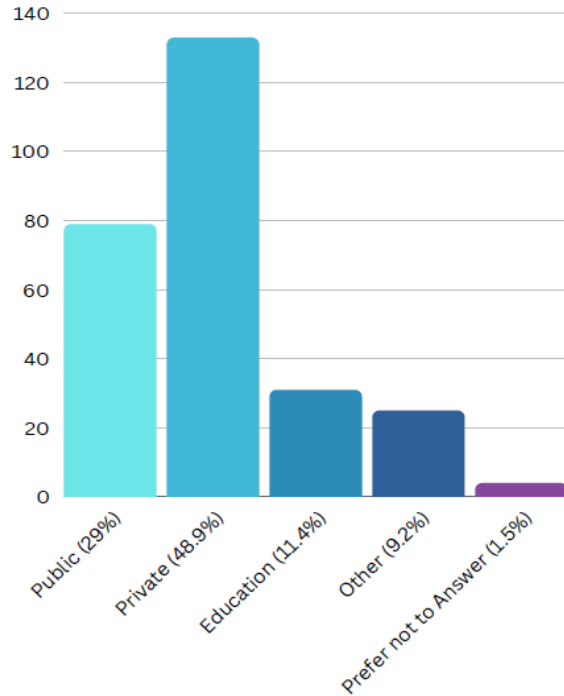
LCPC Responses



Of the 437 LCPCs that answered question 2, about 72 percent reported living in an urban area and about 19 percent reported living in a rural area. According to the 2020 US Census, about 57 percent of Kansas live in urban counties, so the results of the survey reflect that a higher percentage of LCPCs live in urban areas compared to the overall census and compared to the survey results for LPCs (65 percent).

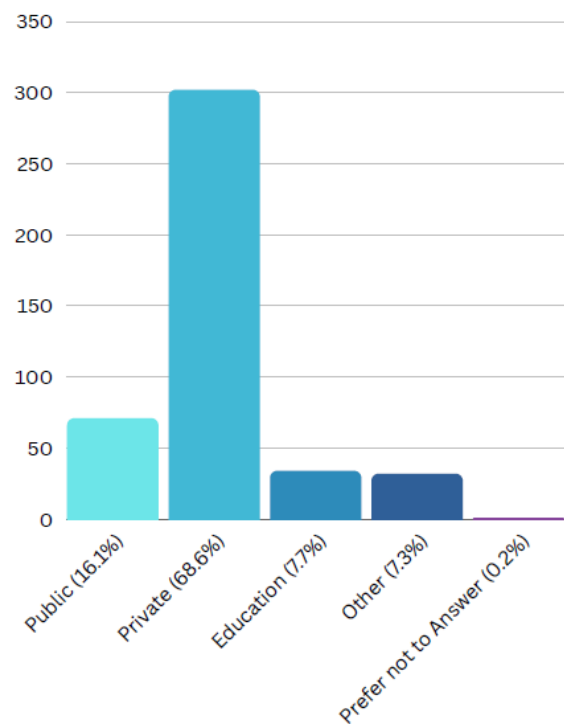
Question 3 (LPC and LCPC). Do you primarily work in a public practice, private practice, educational setting, or another setting?

LPC Responses



Of the 272 LPCs that answered question 3, about half of the respondents (49 percent) report working in private practice, followed by public practice (29 percent), then education (11 percent). All other responses were under 10 percent.

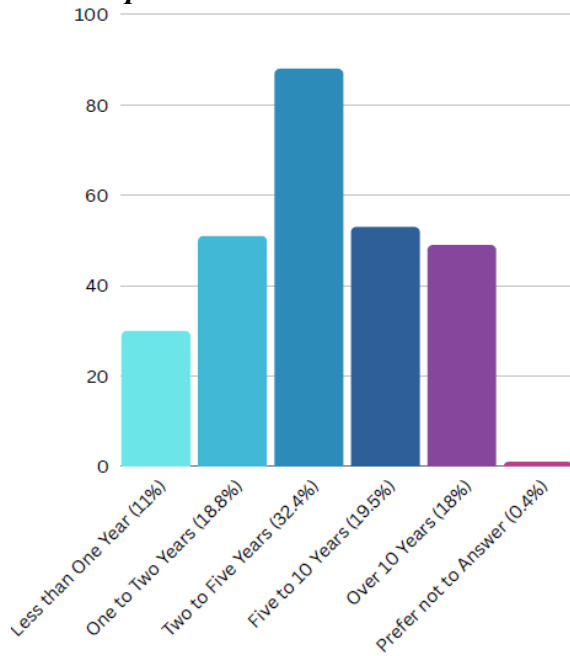
LCPC Responses



Of the 440 LCPCs that answered question 3, it is notable that the most popular response, by far (69 percent), was individuals working in private practice and second most popular response was public practice (16 percent). All other responses were under 8 percent.

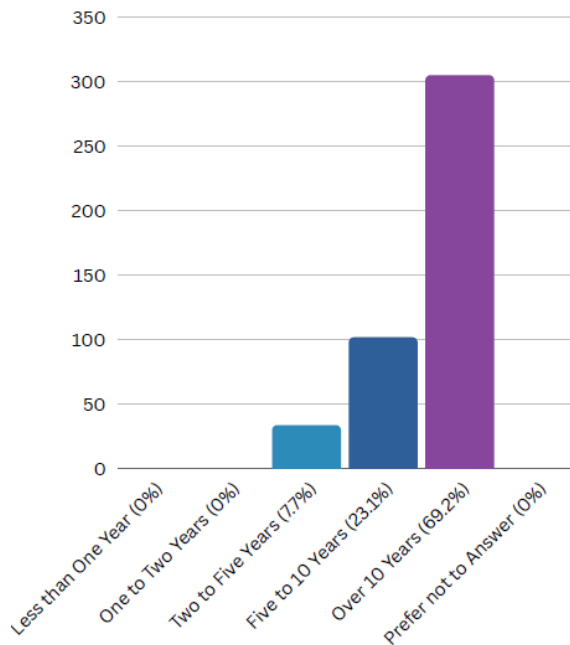
Question 4 (LPC and LCPC). How many years have you practiced professional counseling (if applicable, you may include years practicing professional counseling in other states)?

LPC Responses



Of the 272 LPCs that answered question 4, when asked how many years they had been practicing professional counseling, the most popular response was between two to five years (32 percent). The second, third, and fourth most popular groupings were all very close, between five to 10 years (19 percent), between one to two years (19 percent), and over 10 years (18 percent).

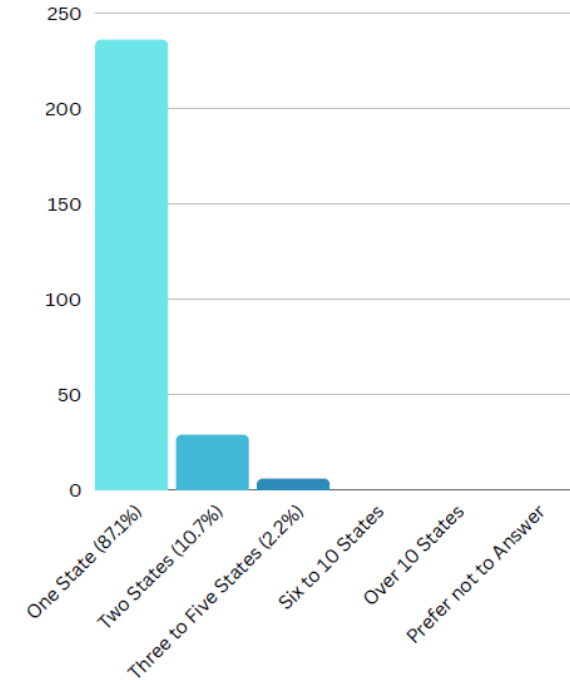
LCPC Responses



Of the 441 LCPCs who answered question 4, the biggest group of respondents (69 percent) reported practicing professional counseling over ten years, followed by individuals practicing five to 10 years (23 percent). All other responses were under 8 percent. This data shows that the vast majority of LCPCs are long-time practitioners.

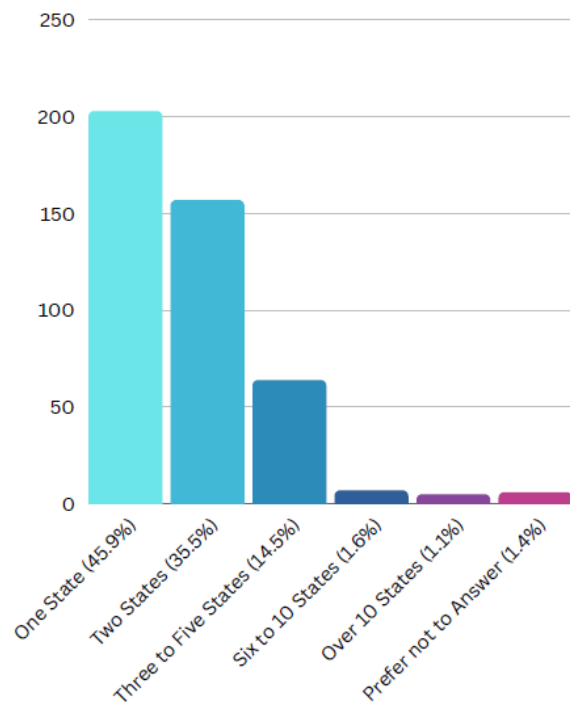
Question 5 (LPC and LCPC). Including Kansas, in how many states are you licensed as a professional counselor?

LPC Responses



Of the 271 LPCs who answered question 5, the vast majority of licensees (87 percent) report being licensed to practice professional counseling in only one state, though a small number of licensees report being licensed in two states (11 percent). All other responses were under 3 percent.

LCPC Responses



Of the 442 LCPCs who answered question 5, the most popular response was from individuals only licensed to practice professional counseling in one state (46 percent), however it was somewhat closely followed by individuals who are licensed to practice professional counseling in two states (36 percent), then three to five states (14.5 percent). All other responses were under 2 percent.

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

LPC Responses

One hundred and seventy-three Licensed Professional Counselors answered this question. (Responses for all licensees can be found in Appendix 3 on page 35)

The most frequent survey response (123 responses) was “no.” Respondents noted they were licensed and providing services.

Among the respondents who were not currently providing services, they fell into a few different categories. The majority were on a break due to family or health reasons, while others were in administrative roles. A few indicated that they were not providing services because of burnout. Many of the respondents were working within the school system as counselors.

LCPC Responses

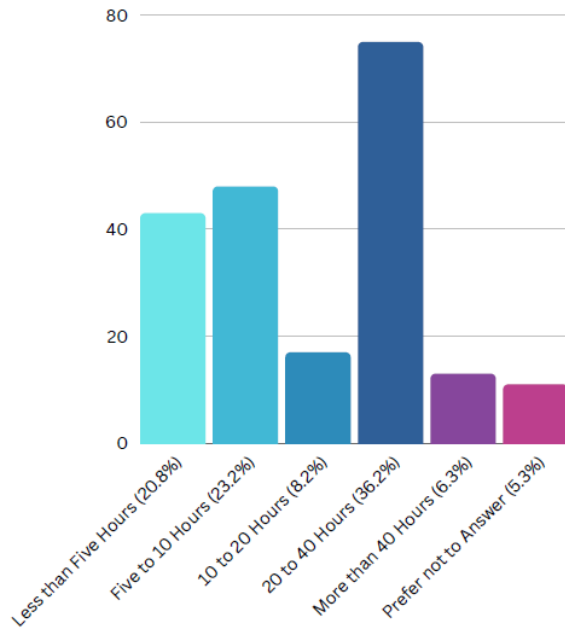
Two hundred and sixty-nine Licensed Clinical Professional Counselors answered this question and identified a variety of issues. (Responses for all licensees can be found in Appendix 4 on page 37)

The most frequent survey response (129 responses) was “no.” Respondents indicated they were licensed and providing services.

Among the respondents who were not providing services, most held administrative roles or were focused solely on supervision. A few mentioned that they had retired or were working as consultants. Additionally, two respondents indicated that they were currently employed in the school system—one as a teacher and the other as a counselor.

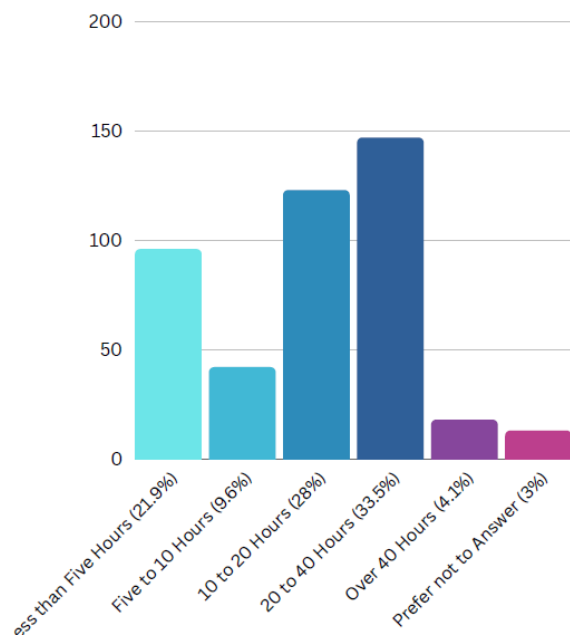
Question 7 (LPC and LCPC). In a typical week, how many hours do you provide in-person services to clients?

LPC Responses



Of the 271 LPCs who answered question 7, the most popular response was between 20 to 40 hours (36 percent), followed by between five to 10 hours (23 percent), then less than five hours (21 percent). All other responses were under 9 percent.

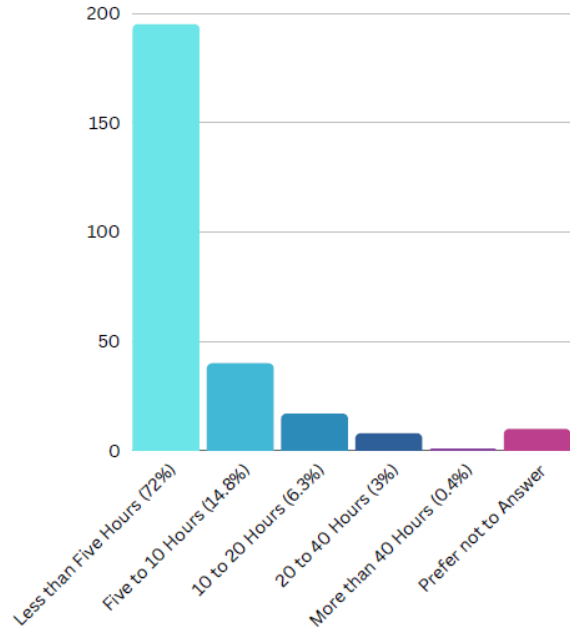
LCPC Responses



Of the 439 LCPCs who answered question 7, the most popular response was between 20 to 40 hours (34 percent), followed by between 10 hours and 20 hours (28 percent), then less than five hours (22 percent). All other responses were lower than 10 percent.

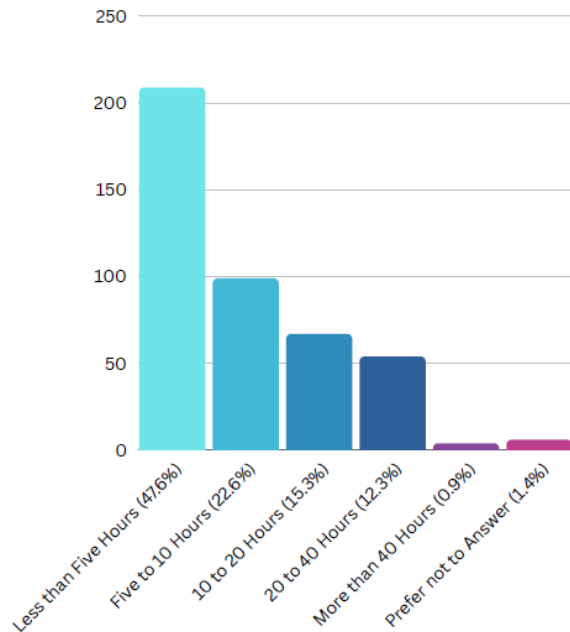
Question 8 (LPC and LCPC). In a typical week, how many hours do you provide telehealth/ remote services to clients?

LPC Responses



Of the 271 LPCs who answered question 8, the most common response by far was less than five hours per week (72 percent), followed by five to 10 hours per week (15 percent). All other responses were less than 7 percent.

LCPC Responses



Of the 439 LCPCs who answered question 8, the most common response was less than five hours per week (48 percent), followed by five to 10 hours per week (23 percent), then 10 to 20 hours per week (15 percent), and 20 to 40 hours per week (12 percent). All other responses were less than 2 percent.

Question 9 (LPC). Are you currently working towards attaining a Licensed Clinical Professional Counselor (LCPC) license in Kansas? If you are not taking steps to receive an LCPC license, please explain why you have made that decision.

LPC Responses

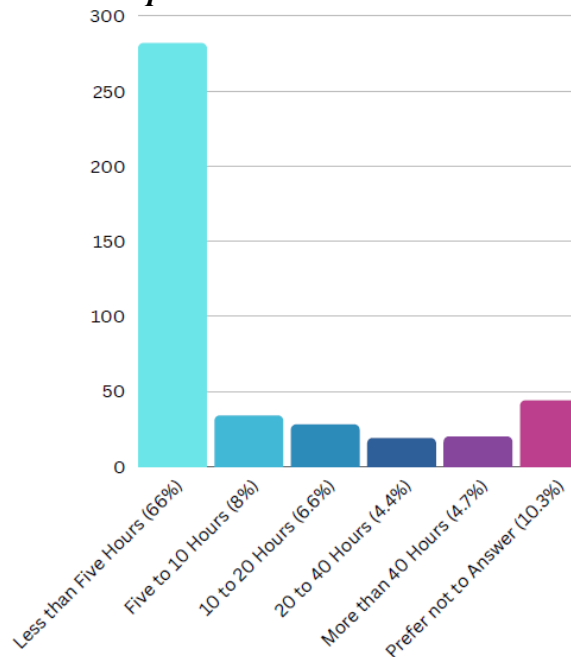
Two hundred and sixty-two LPCs answered this question. (Responses for all licensees can be found in Appendix 5 on page 39).

The most popular response was “yes” (157 times), and some licensees noted recent progress towards a clinical license or their reasons for pursuing clinical licensure, such as wanting to work independently or opening their own practice.

Some licensees responded “no” (46 times), and some of the comments that followed these responses noted satisfaction with their current employment that does not require a clinical license or the lack of desire to seek a clinical level license at this point in their careers, some noted that they were nearing retirement, concern about the number of hours needed to reach the independent level, or difficulty passing the clinical licensing examination.

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

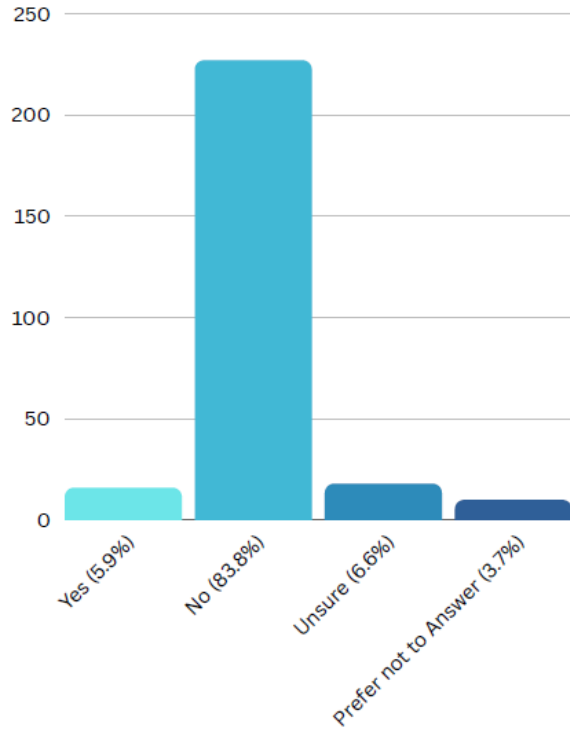
LCPC Responses



Of the 427 LCPCs who answered question 9, the vast majority of responses were less than five hours per week (66 percent), followed by respondents marking that they preferred not to answer the question (10 percent). All other responses were less than 10 percent.

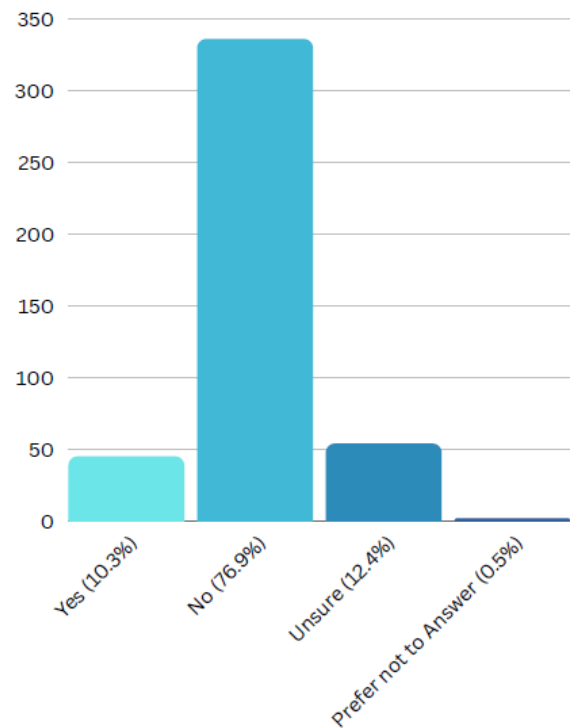
Question 10 (LPC and LCPC). Do you anticipate retiring from the professional counseling profession in the next five years?

LPC Responses



Of the 271 LPCs who answered question 10, the most common response was “no” (84 percent). All other responses were under 7 percent.

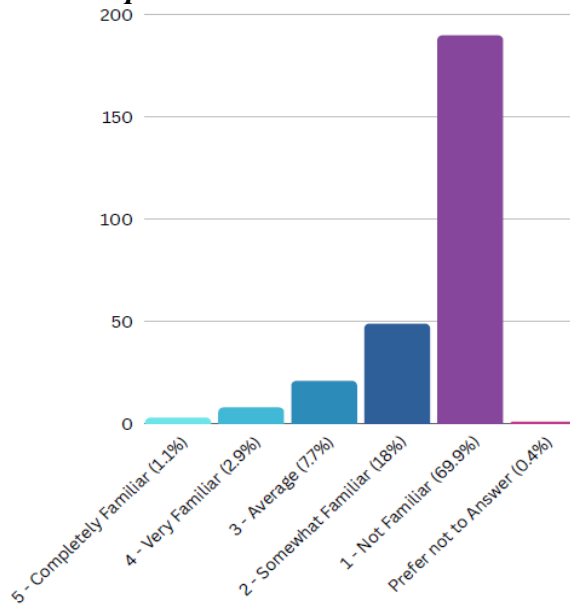
LCPC Responses



Of the 437 LCPCs who answered question 10, the most common response was “no” (77 percent), followed by licensees answering “unsure” (12 percent), then “yes” (10.3 percent). All other responses were under 1 percent.

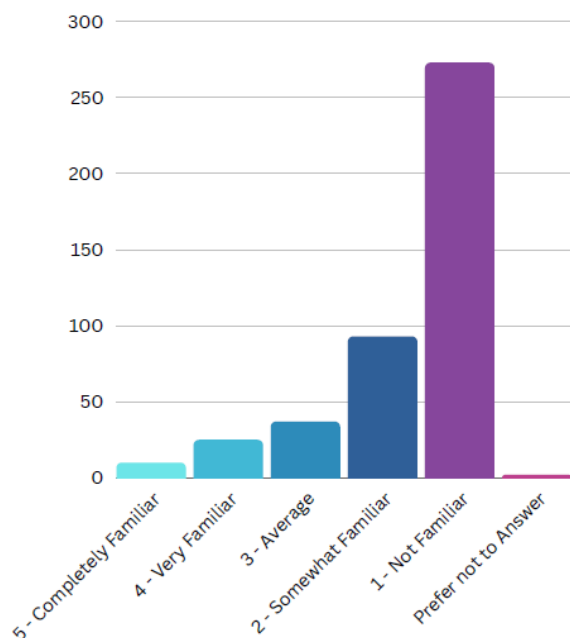
Question 11 (LPC and LCPC). To assist the work of the Board, the BSRB has seven standing Advisory Committees (one for each profession regulated by the Board), which are primarily composed of licensees in each of the seven professions. Advisory Committees discuss topics relevant to the work of the Board 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 Professional Counseling Advisory Committee?

LPC Responses



Of the 272 LPCs who answered question 11, the vast majority of licensees reported they were not familiar with the Professional Counseling Advisory Committee of the Board (70 percent), followed by licensees saying they were somewhat familiar with the Advisory Committee (18 percent). All other responses were less than 10 percent.

LCPC Responses



Of the 440 LCPCs who answered question 11, the vast majority of licensees reported they were not familiar with the Professional Counseling Advisory Committee of the Board (62 percent), followed by licensees being somewhat familiar with the Advisory Committee (21 percent). All other responses were less than 10 percent.

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

LPC Responses

A total of 212 LPCs participated in the survey, providing insights into a range of issues they perceive as negative aspects of their practice. For more comprehensive responses from all licensees, refer to Appendix 6 on page 45.

The most frequent survey response (71 responses) was “no,” indicating that they did not recognize any significant practice-related challenges that necessitated additional continuing education or training for practitioners. Several respondents who answered “no” went on to express the need for improved reimbursement rates from insurance providers and collaborative efforts among states on licensure requirements.

Among the negative issues identified, a significant number of respondents voiced the need for enhanced training in trauma-informed care, underscoring the growing recognition of trauma’s impact on mental health. Additionally, many counselors highlighted challenges in billing processes, particularly those related to Medicaid and Medicare, which can complicate financial transactions and impact service delivery to clients.

Cultural and social competency emerged as another common theme, with counselors stressing the importance of being equipped to address diverse backgrounds and communities. Respondents noted that personal and political biases could hinder their ability to provide unbiased care.

While less frequently mentioned, some counselors raised ethical concerns regarding their practice, expressing a desire for more comprehensive guidelines on telehealth, the ethical implications of artificial intelligence in therapy, regulations surrounding mandatory reporting and, the complexities of managing dual relationships in smaller communities, with a strong interest in receiving additional training on maintaining appropriate boundaries

Furthermore, a considerable number of survey participants articulated the need for training in several specific areas, such as documentation practices, diagnosis, and addiction treatment, including the use of addiction medications.

The need for improved supervision training was also noted. Additionally, respondents identified a growing need for training in areas such as suicide prevention, business management practices, and strategies for more efficient collaboration with the medical community.

LCPC Responses

Three hundred and thirty-seven Licensed Clinical Professional Counselors answered this question and identified a variety of issues. (Responses for all licensees can be found in Appendix 7 on page 52)

The most frequent survey response (69 responses) was “no.” Several respondents reported that there needed to be more continuing education on ethics.

The negative comments from respondents were ethical concerns. Respondents provided feedback about issues related to the ethics of social media and the importance of understanding ethical codes. There were also significant concerns regarding the treatment of children and families within the legal system, as well as issues related to insurance billing and reimbursement. Additionally, respondents expressed common worries about documentation and treatment planning.

Respondents expressed a need for more continuing education on boundaries, particularly regarding self-care for practitioners. They also requested additional resources for telehealth, supervision, addiction care, and suicide prevention.

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

LPC Responses

Three-hundred and thirty-six Licensed Professional Counselors answered this question, identifying a wide variety of comments on Telehealth. (Responses for all licensees can be found in Appendix 8 on page 66).

The most frequent response (167 responses) was "no," and they did not recognize any practice-related challenges associated with telehealth. Some responses that mentioned no went on to highlight some areas of concern, such as state policies and technological reliability.

One of the most significant concerns mentioned was the complexity of practicing telehealth across state lines. Respondents highlighted the challenges of adhering to the varying telehealth regulations established in different states, particularly when patients are located in or traveling to those jurisdictions. Practitioners must navigate this legal landscape carefully to ensure compliance with telehealth laws.

Additionally, respondents expressed difficulties in connecting with clients through telehealth platforms. Less frequently mentioned were concerns about client confidentiality and ensuring patient safety during telehealth sessions. Another issue noted was related to insurance reimbursement for telehealth services.

LCPC Responses

Three hundred and thirty-six Licensed Clinical Professional Counselors answered this question and identified a variety of issues. (Responses for all licensees can be found in Appendix 9 on page 70.)

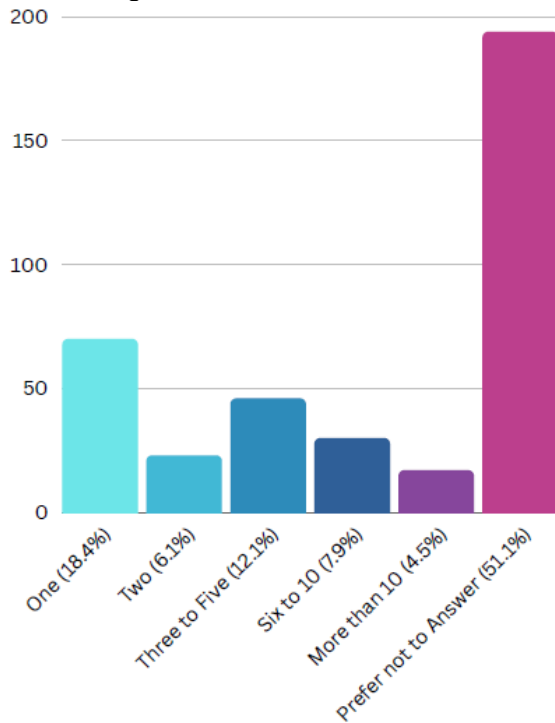
The most frequent survey response (199 responses) was “no”; Several respondents reported experiencing technical difficulties.

The licensee's most common concern was related to technical issues and the overall unreliability of technology. Furthermore, several respondents expressed concerns about client safety, specifically noting that clients and licensees often lacked suitable environments in which to conduct therapy sessions. These distractions raised concerns about the focus necessary for effective therapy and potential violations of HIPAA regulations.

Less frequently mentioned were comments showing frustrations with adhering to differing state laws, particularly regarding clients traveling across state lines, as well as concerns regarding the quality of therapy delivered via telehealth platforms.

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

LCPC Responses



Of the 380 LCPCs who answered question 14, the most popular answer was that licensees preferred not to answer the question (51 percent), followed by “one” (18 percent), then “three to five” (12.1 percent). All other responses were less than 10 percent.

The responses appear to show that licensees providing supervision do not appear to be providing supervision to too many licensees.

Note: the survey did not include an option for licensees to report providing supervision to zero individuals, so this is likely the reason that so many respondents marked that they preferred not to answer the question. However, while this construction error was unfortunately, it still shows that most respondents were not providing supervision to individuals.

Question 14 (LPC)/Question 15 (LCPC). Over the past two years, have you experienced any negative issues involving supervision? If so, please explain.

LPC Responses

Two hundred and twenty-seven Licensed Professional Counselors answered this question and identified a variety of issues. (Responses for all licensees can be found in Appendix 10 on page 77.)

The most frequent survey response (151 responses) was “no”; Several respondents reported that they were happy with the supervision services that they are receiving.

Survey respondents frequently expressed concerns regarding the availability and accessibility of supervision services from board-approved LCPCs. Additionally, the cost of these supervision services emerged as a common issue among the participants.

Less commonly, respondents highlighted concerns about the board-approved supervisor list, the possibility of allowing other clinical professions to provide supervision, and the overall quality of the supervision they were receiving.

LCPC Responses

Three hundred and forty-four Licensed Clinical Professional Counselors answered this question, identified a variety of issues. (Responses for all licensees can be found in Appendix 11 on page 81.)

The most frequent survey response (222 responses) was “No,” that individuals did not identify any supervision related negative issues. Survey respondents highlighted that they were not offering supervision.

Key concerns regarding supervision included the additional costs associated with maintaining Continuing Education Units (CEUs) for supervision, the availability of supervisors, and supervisors who provide only group supervision.

Additionally, some licensees reported less common issues, such as supervisors managing too many supervisees, challenges related to documentation, and problems with the supervisor list.

Question 15 (LPC)/Question 16 (LCPC). Do you currently use artificial intelligence (AI) in your practice? If you do, in what areas do you use AI?

LPC Responses

Two hundred and seventy-four Licensed Professional Counselors answered this question and identified a variety of issues. (Responses for all licensees can be found in Appendix 12 on Page 87.)

The most frequent survey response (171 responses) was “no.” Some respondents indicated that the use of AI is not permitted in their practice, while others expressed interest in its potential applications despite not currently utilizing it.

Among those who reported using AI, many employed it primarily for note-taking and transcribing notes. Additionally, other respondents utilized AI for tasks such as enhancing grammar, developing treatment plans, and supporting business functions like marketing and research.

LCPC Responses

Four hundred and forty-two Licensed Clinical Professional Counselors answered this question and identified a variety of issues. (Responses for all licensees can be found in Appendix 13 on page 90.)

The most frequent survey response (274 responses) was “no.”; Several respondents reported that they are still unsure of AI.

Among those who reported using AI, many employed it primarily for note-taking and transcribing notes. Additionally, other respondents utilized AI for tasks such as enhancing grammar, developing treatment plans, and supporting business functions like marketing and research.

Question 16 (LPC)/Question 17 (LCPC). 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?

LPC Responses

One hundred and ninety-eight Licensed Professional Counselors answered this question and identified a variety of issues. (Responses for all licensees can be found in Appendix 14 on Page 94)

The most frequent survey response (110 responses) was “no.” Several respondents reported that they are happy with the services of the Board.

Respondents commonly recommended that the BSRB provide more licensure information and be more responsive to inquiries.

Although not frequently mentioned, there were suggestions for the Board to enhance communication with licensees by informing them about upcoming changes and the resources available through the Board. In addition to online applications, there should be more regulations regarding private practice and LPC testing.

LCPC Responses

Three hundred and one Licensed Clinical Professional Counselors answered this question and identified a variety of issues. (Responses for all licensees can be found in Appendix 15 on Page 99.)

The most frequent survey response (160 responses) was “no.” Several respondents reported that they are happy with their experience with the Board

Among the respondents, the most common recommendation was to have regulations on AI and telehealth, along with more information and support regarding the complaint process.

Although less mentioned, there are suggestions for increased communication from the board to licensees, conducting background checks, offering free CEUs, and establishing impaired programs.

Question 17 (LPC)/Question 18 (LCPC). 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 professional counseling profession?

LPC Responses

One hundred and eighty-four Licensed Professional Counselors answered this question and identified a variety of issues. (Responses for all licensees can be found in Appendix 16 on page 108.)

The most frequent survey response (103 responses) was “no.” Some respondents indicated that they were pleased with the committee's work and appreciated the opportunity to complete the survey.

Many respondents suggested changes, with the most common recommendation being to improve the navigation of the licensing process and to allow for supervision from other professions.

Additionally, some participants responded with concerns about the website, stating that it did not provide the information they needed. They also advocated for incorporating more job positions into clinical training plans.

While not as recommended, some responses noted a desire for improved telehealth guidelines, increased pathways to LCPC, and addressing the shortage of LPCs in rural communities.

LCPC Responses

Four hundred and forty-two Licensed Clinical Professional Counselors answered this question and identified a variety of issues. (Responses for all licensees can be found in Appendix 17 on page 114.)

The most frequent survey response (159 responses) was “no.” Several respondents reported being satisfied with the Board's work.

The respondents recommended the need for clearer and more uniform guidelines for telehealth services. Additionally, there were calls for more information regarding the counseling compact.

Many suggested that providing detailed information on licensure would help guide applicants through the application process. There was also a recommendation to increase the awareness of the advisory committee.

Although there were fewer response recommendations, there were still suggestions for dual licensure and clearer information on reciprocity regulations and CEU provider status.

LPC Q1. In what Kansas county/counties do you practice the profession of professional counseling? (269 responses)
All (telehealth)
Atchison
Barber and Pawnee
Barton
Butler (4 responses)
Cass
Cheyenne, Sherman, Thomas, Rawlins, Wallace, Neosho
Coffey (2 responses)
Concordia
Cowley (2 responses)
Chautauqua, Cowley, Elk, Montgomery, Wilson
Crawford (4 responses)
Currently not practicing in KS. I'm under clinical supervision in MO but have my LPC in KS and wish I could practice in KS at same time
Douglas (8 responses)
Douglas and Johnson (2 responses)
Douglass
Ellis (4 responses)
Finney (4 responses)
Ford (2 responses)
Franklin (2 responses)
Franklin, Douglas, Miami
Geary Osage Shawnee
Geary/Riley
Harvey (3 responses)
Harvey, McPherson, Marion
I do not currently practice.
I just started a new position with the new MCO Healthy Blue Kansas, so I am uncertain Which counties I will be covering. Primarily I will be working with members who live in Lyon County and also the surrounding counties.
I practice in Missouri at this time.
I reside in Cowley and see clients virtually from various counties
Johnson (84 responses)
Johnson (primary) (2 responses)
Johnson and Shawnee
Johnson and Wyandotte (7 responses)
Johnson, Wyandotte, Shawnee
Kansas City
Kingman and Sedgwick
KS (2 responses)
Leavenworth (2 responses)
Leavenworth, Wyandotte, Johnson
Lyon (6 responses)
Marion Co

McPherson
Miami and Franklin
Miami and Johnson (2 responses)
Mitchell
Montgomery
N/a
Neosho
Non practicing sedg when working
None (3 responses)
None currently, working in Missouri
Norton (3 responses)
Ottawa
Pratt
Reno (3 responses)
Retired
Rice
Riley (4 responses)
Riley and pott
Riley, telehealth throughout the state
Rylie
Saline (4 responses)
Saline, Shawnee, Dickenson, Geary
Sedgwick (34 responses)
Sedgwick, Johnson, and Wyandotte
Seward
Shawnee (10 responses)
Shawnee and Wyandotte
Shawnee, Johnson, Wyandotte, Jackson
Shawnee, Pottawatomie, Wabaunsee, Jackson, Jefferson, Brown, Riley, Douglass, Johnson
State-wide telehealth practice
Stevens, Kiowa
Wabaunsee, Lyon
Wichita
Wilson and Sedgwick
Wyandotte (13 responses)
Wyandotte and Johnson
Wyandotte, Leavenworth, Johnson

LCPC Q1. In what Kansas county/counties do you practice the profession of psychology? (431 responses)
(All counties - telehealth)
All - telehealth
All - telehealth only
All (8 responses)
All by Telehealth in person I'm located in MO
All counties (5 responses)
All counties because I am telehealth. My physical location is Miami County
All potentially, as I practice telehealth
All via telehealth
All virtually (licensed in ks)
Any
Any, I do virtual work.
Any/all, but mostly Johnson, Miami, and Wyandotte
Atchison (2 responses)
Barton
Barton, Pawnee, Stafford, Rice
Bourbon (2 responses)
Butler (4 responses)
Butler, Sedgwick
Clay
Client is in Lawrence
Closest to Johnson, but practice located in Missouri
Could be all counties through tele therapy.
Crawford (4 responses)
Crawford, Bourbon
Currently living in illinois
Currently Missouri but eventually will be Shawnee area as well
Dickinson
Doniphan
Doniphan, Atchison, Leavenworth, Wyandotte and Johnson
Douglas & Riley
Douglas (14 responses)
Douglas and Johnson (2 responses)
Douglas Shawnee
Douglas, Johnson,
Douglas, Johnson, Leavenworth, Miami, and Wyandotte
Edwards, Kiowa, Comanche, Clark
Ellis (3 responses)
Ellis, Thomas, Sherman
Ellis/Thomas/Sherman
Ellsworth, Saline, Lincoln
Finney (2 responses)
Finney and Seward
Ford (2 responses)
Ford, Hodgeman, Finney

Ft. Riley
Geary
Geary/Riley
Gove
Harvey
Harvey, Sedgwick, Shawnee, Johnson
Haskell, Seward, Meade, Stevens
I actually live in FL now but see clients via televideo in KS.
I do all telehealth.
I do Zoom counseling in many counties in Kansas
I only do telehealth in Kansas, so wherever necessary
I see clients in different counties, virtually, from Missouri.
I work in OK now
I'm in KC Mo
Jackson County Missouri
Jackson, wyandotte, sedgwick
Johnson in KS and Platt. in Missouri
Johnson & Wyandotte (2 responses)
Johnson (139 responses)
Johnson ,Wyandotte , Franklin
Johnson and Douglas (2 responses)
Johnson and Franklin
Johnson and Leavenworth (2 responses)
Johnson and Miami (2 responses)
Johnson and virtual throughout the state of Kansas to be able to serve small towns
Johnson and Wyandotte (4 responses)
Johnson County (which is a SUBURB --neither urban, rural, frontier)
Johnson County, KS
Johnson, Douglas
Johnson, Miami
Johnson, Riley
Johnson, Sedgwick, Wyandotte
Johnson, Wyandotte (3 responses)
Johnson, Wyandotte, Douglas (2 responses)
Johnson, Wyandotte, Douglas and Salune
Johnson, Wyandotte, leavenworth
Johnson, Wyandotte, Miami
Johnson, Wyandotte, Miami, Leavenworth, Shawnee
Johnson/Wyandotte
Kiowa
Labette County
Lansing and Wyandotte
Leavenworth (9 responses)
Leavenworth Riley Atchison and Potawatomi
Leavenworth, Atchison, Jefferson
Leavenworth, Atchison, Oskalooga
Linn County, Johnson County

Lyon (4 responses)
Lyon, Chase, Coffee
Lyon, Chase, Wabaunsee, Osage, Coffey, Greenwood, Morris
lyon, johnson
Lyon, Neosho, Shawnee, Morris
Marion, Harvey
Marion, Sedgwick
Mcpherson
McPherson and Marion
Miami and Franklin
Missouri (2 responses)
Multiple
Multiple - Telehealth
My office is in Johnson County, however I offer telehealth to the entire state of Kansas.
My practice is in Sedgwick. I serve Sedgwick, Butler, Cowley and Sumner County residents.
N/A (4 responses)
ND
Nemaha
None - practice virtually from MO
None (3 responses)
None at this time. I practice in KCMO.
None currently. I practice in Missouri.
None yet
None, I live out of state
None, right now. Previous clients were in McPherson Co and Johnson Co
None--I reside in Minnesota
Norton (2 responses)
Not sure - not many of them, just occasional telehealth clients.
Overland Park (2 responses)
Pottawatomie
Primarily in the KS metro, although I do telehealth statewide
Reno (3 responses)
Riley (9 responses)
Riley County/Pottawatomie
Riley, Barton
Riley, Dickinson, Pottawatomie, Geary, Morris, Mitchell, Barton, Marshall, Washington, Clay, Ottawa, Saline
Riley, Pottawatomie
Riley, Pottawatomie, Cloud, Clay, and others
Rooks, Ellis, Phillips
Saline & Sedgwick
Saline (3 responses)
Saline, Dickinson, Ottawa, Lincoln, Ellsworth
Saline, Ellsworth, Lincoln, Ottawa,
Saline, Geary-online as well
Saline/Ellsworth

Sedgwick (43 responses)
Sedgwick and Johnson
Sedgwick/telehealth/ BU/CO/etc.
Seward (2 responses)
Shawnee (7 responses)
Shawnee and telehealth statewide
Statewide
Telehealth
Telehealth, so all
Telehealth, statewide
Thomas, Sherman, Wallace, Cheyenne county
Various (2 responses)
Was all across Kansas...this year I have not practiced in Kansas. Hopefully will return soon.
We have not launched our practice in KS yet.
Wichita
Wyandotte (9 responses)
Wyandotte and Johnson (3 responses)

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

Active license and practicing
Active license, active counseling work
Actively providing counseling services to individuals.
Burnout was the initial reason. Currently seeking a place to practice.
company I work for is not providing mental health services.
Currently in administrator role
Currently working in a school setting providing mental health crisis intervention
Currently working in Missouri.
Due to a health condition that has left me with a disability, I no longer see clients, but choose to maintain my LPC license because it's very important to me.
Hard to find supervision
I am active and practice.
I am an active therapist
I am currently working as a professional counselor
I am in a supervisory role now.
I am required to have an LPC per the requirements of the MCO for this role.
I am still a practicing counselor.
I currently work as a LPC, LMAC.
I do not currently see patients but manage a children's therapy program.
I experience severe burnout and transitioned into another helping role that did not require on call/emergency hours.
I have an active license and work as LPC
I have an active license and work in the field.
I have an active license but work in child welfare. It's too difficult to find an LCPC to supervise hours to get clinical hours
I have been dealing with health issues and paused in providing services
I maintain a professional license because I want to hold myself to professional standards while in an educational setting. Just because I'm free for students doesn't mean I am not providing a professional service.
I maintain an active license but I am employed as a school counselor. I only provide school counseling services.
I maintain an active LPC license but am under supervision in MO. If I could also count hours towards my supervision in MO, I'd love to work under the direction of someone in KS as well. I love the work I'm doing in MO and wish the states would work more reciprocally when it comes to hours/supervision.
I work as a Licensed Behavioral Health Case Manager for a Medicaid provider and need this license for this position
I work as a school counselor
I'm only practicing as a school counselor not as an LPC.
I'm taking a break from providing counseling services.
I'm working in. A professional position requiring licensure but not formal counseling.
Maintain for work at private psychiatric hospital
No (113 responses)
No, I am still providing services

No, I have 2 licenses
No, I maintain an active license and am providing services.
No, I maintain an active license and practice.
No, I work in school setting and private practice
No, license is active and currently practicing
No, still working as counselor
Not in counseling role at current organization- only providing psycho education.
Retired
Retired professor
School counselor
Still working in this capacity
Taking time off after having a baby.
When I got my licensure, there were several hours that had to be supervised, and I wasn't in a job where I got supervision. I tried to do some private practice with a hired supervisor, but I couldn't afford to try to keep the business open, so that got me out of the practice altogether. I now work for the state of Kansas and vocational rehabilitation services. I was a VR counselor and now I'm a trainer. It was the amount of hours and the fact that I had to pay for supervision that kept me from being able to move forward. I was a single parent, and I just couldn't afford that.
Work in administration
Yes (2 responses)
Yes, because I've retired.
Yes, extended maternity leave.
Yes, helping with our family owned business. Also, supervision is too much for LCPC licensure.
Yes, I maintain an active license and work with kids in foster care (4-6 kids).
yes, serve as a counselor educator in Kansas, also as a supervisor in other states where I have the supervisor credential.
Yes. Currently staying home with children
yes. currently, family members with medical needs have taken priority. I hope to return to actively working in professional counseling.
Yes. I did not submit my supervision plan to the board during COVID. I would have had my hours if I did. Starting over and not being paid well doesn't sound appealing. So I haven't been in practice due to that.
Yes. I maintain an active License in KS.
Yes. I started a nonprofit 8 years ago which provides services for underserved communities. We provide holistic care including professional counseling, life coaching, equine therapy, faith-based counseling, health and nutrition and meditation through art.
Yes. I work in education and have for most of my career. I continue to keep my license as it was a credential I worked hard for in Oklahoma in the 1990s and in Kansas when I relocated in 1995. The professional development is interesting and I informally counsel kids all the time.

LCPC Q6. Do you maintain an active license, but no longer work as professional counselor? If so, please explain why you are not providing services currently. (269 responses)

Active and practicing

Active license (2 responses)

Active license and currently working as a LCPC

Active license, still practicing

Currently provide therapeutic services in KS, and working on credentialing with insurance companies in MO

Currently working as an LCPC.

I am a full time professor.

I am actively using my license

I am an LCPC working in Quality Improvement now. Very little direct services to clients.

I am dually licensed as an LCPC and a professional school counselor. I am currently practicing in the schools as a school counselor and do not currently see any clients outside of the school environment.

I am practicing.

I am primarily in administration at a CCBHC but provide care as needed.

I am working.

I have a professional and active license as a school counselor, but do not use it. I also have an active license for LCPC and have my private practice

I have an active license and practice

I have retired. I was a school counselor. I practiced both in Kansas and Missouri. I worked as an elementary and middle school counselor.

I maintain an active license

I maintain an office in Wichita, but my client numbers have dropped considerably and I am evaluating whether or not to continue it. I love what I do.

I maintain my license

I provide clinical supervision and trainings. I see no clients at this time.

I work as a LCPC

I work as an LCPC in Kansas, but retired my license in Arizona when I moved here. I could have done both, but the licensing fees for Arizona are more than double here, so I decided to focus locally.

I work for an insurance company.

I work here in Kansas, but all of my clients are in Arizona.

I work in counselor education. I provide supervision.

I'm often asked to give "consulting-opinions" to educators informally to educators in others states.

Maintain an active license and continue to work as a counselor.

Maintain and active

Maintain and active license and currently working in private practice

My license is active and I still counsel.

N/A- I am still counseling

No - I still work as a professional counselor

No (129 responses)

No, actively practicing.

No, I am employed full time as a counselor
No, I hold an active license and work in the field.
No, I'm still in practice.
No, I'm active with my license
No. I have an active license and I continue to work as a professional counselor.
No. I do work as a professional counselor.
No. I have an active license and regularly practice.
No. I work as a professional counselor.
No. I work providing services.
Retired and doing some occasional consulting.
Still practicing. Limited Private Practice.
Still work as a LCPC
Working
Yes I work in child welfare and Medicaid, maintain a license but do not active practice
Yes, currently I am teaching full time. I do see a couple counseling clients, but mostly just supervise.
Yes, I've been working in managed care and at the leadership level.
Yes, N/A.
Yes, prn practice
Yes. Administrative role
Yes. I am a school counselor so I have a school counseling license and maintain my LCPC.
Yes. I work in Utilization Management and a license is required.

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

"Working towards" in the loosest sense ... I've printed off the paperwork, I have not lined up my supervisors. I've heard the payments for supervisors is very expensive and I don't have any professional benefit for doing it. Seems like I'm just paying LCPCs so I can be an LCPC and then charge LPCs.

Already obtained.

At this time I work as a school counselor and I do not use my LPC. I am planning on starting to use my LPC outside of the school setting in 2025.

Building case load first

Can't afford supervision

Currently working towards attaining an LCPC license, but the only struggle with that is thinking about taking another comprehensive exam again which is always a lot to prepare for while trying to work and meet other responsibilities. It seems too much after taking the NCE already.

I am coming up with a plan and hope to start within the next month.

I am currently in the process of my clinical licensure in order to eventually move into a private practice setting

I am not currently working toward attaining the LCPC license as I just obtained the LPC and have recently started a new job with that license and I don't want to add anything else to my plate right now. I do plan to eventually attain the LCPC license.

I am not currently working towards a LCPC license. I have thought about it but it will take me too many years to get the supervision hours due to my current job. Also finding a LCPC in my area is difficult, most are LSCSW's

I am not. I have worked in many capacities over my 30 year career. Some in other states, once I returned to Kansas I was told I would have to complete a contract and contact hours again. Frankly it's not worth it. Funny my Clinical level license in Texas is good but to return to Kansas after all of my years training I would be required to start over as a new grad. No thank you.

I am retired.

I am waiting on my employer to fill out their part of the paperwork.

I am working on the application and other steps to work toward this.

I am working towards a license in MO. I'm a resident of MO, and it will help me participate in the interstate compact.

I am working towards clinical licensure.

I am, except that my professional counseling work is on hiatus due to family needs

I do not plan to seek my LCPC in Kansas because I'm waiting for reciprocity in Missouri.

I have already submitted my application and passed the exam. Just waiting on the official word.

I have completed all my requirements for my LCPC and am studying for my LCPC exam

I have completed my supervision hours, and have sat for the NCMHCE exam twice. I am about to take it a third time. If I realized what this exam was going to be like, I would not have spent all this money to become a LCPC. I have a high reading comprehension, but slow reading speed. I have not finished the exam in the allotted time yet. It feels like I am being tested for my reading speed, not my mental health clinical skills!! There has to be a better way to assess qualification for a clinical license. Many of the other Kansas disciplines (LP, LMFT) do not have to take a second exam, or it is a similar exam to the first. The NCE and NCMHCE are vastly different. In Nebraska, the candidate can choose which exam to take to get their LPC, and then they must see a minimum number of specific diagnoses during their supervision to obtain the clinical level license. I have spent hundreds of dollars on exam prep materials, online classes and coaching. I am prepared, but none of these improve reading speed. This is a terrible process! Respectfully, and thank you for listening.

I have currently applied for my independent license in AZ and will try to get reciprocity in KS. Kansas did not recognize my program and made it difficult for me to get the LPC license as I had to work remotely with patients in another state to gain my experience.

I have had my license for 22 years approximately and don't feel like going under supervision after all these years let alone take another national exam.

I have had my LPC in Missouri for 12 years and LPC in Kansas for probably 10. I would like my LCPC but don't feel the need to be under supervision again to get a LCPC.

I haven't felt the need to do so in order to advance my career.

I need to find a supervisor.

I plan on applying for reciprocity instead

I see no purpose in having this license when I can do the job I want with the LPC.

I want to but it's hard to connect with supervisors with similar experience and with whom I feel aligned in values.

I want to; however, the fees that are being charged by the supervisors make this impossible for me to afford. I am the sole provider for my family; consequently, I am unable to get my C. It is taking advantage of new therapist to charge over 150 and hour to do supervision for any reason and should be regulated better.

I wanted to be the best and at the highest licensure available

I was but have not since 2022 when my last child was born.

I work in a hospital, everyone here and many other places are LCSWs and it's difficult to find an LCPC let alone one that can supervise

I would have liked to, but in my previous answer, I explained about the amount of hours of supervision, and I just wasn't in jobs that could give me what I needed. It's disappointing to spend the time to do the degree but then not be able to use What I've learned. Now it's been several years since I've been out of college, and I just don't know if it would even be an option anymore.

I would like to work toward this, but I have not been able to locate a supervisor who is an LPC. I wonder if I could have a MFT or other type of license for a supervisor.

I would like to work towards this but I need opportunities for clinical hours outside my employment
I would love to but there is never an LCPC on staff who can provide supervision, who has room for another, and I cannot afford to pay out of pocket.
I'm in the process of looking for a supervisor to begin my hours towards my LCPC.
I've had my hours years ago but haven't pursued licensure. I've taken the test once and did not pass. I'm considering taking it in the fall. We have over 30 professionals. It takes a great deal of time. I primarily provide faith-based counseling through my ordination. However, I love learning more about mental health so I value my license.
It's on my 2025 plan to submit application for it.
Need to get paperwork signed
No - I work as a school counselor. That extra credential isn't needed or cost/time effective.
No - it's still a goal but there have been barriers obtaining a clinical supervisor
No (7 responses)
No- as an LPC, I am able to provide competent care with research-based modalities for my clients' issues. I don't have a pressing need for a LCPC
No I am currently working as supervisor in the child welfare system.
No, because my job does not offer opportunities to meet the requirements for LCPC. I have been working around 60 hours weekly and caring for my elderly mother, so I do not have any time to pursue this option although I wish I could.
No, do not need it for my current employment.
No, do not want to pursue clinical licensure.
No, I do not currently need it in my role as a manager for a CMHC.
no, I do not intend to serve as a counselor, but would like to be able to serve as a supervisor in Kansas, as I do in other states where I earned the supervisor credential
No, lacking time to dedicate to it.
No, nearing retirement
No, not practicing in Kansas
no, short answer- procrastination, longer answer- more complex
No, the hours required are way too high.
No. I attempted the test 3 times and failed by 5 points, then 3 points, and then 1 point. For my own self-esteem/mental health, I decided I need to stop. During that time I was going through perimenopause, which makes it difficult for some to recall information.
No. I've been reducing the number of kids I see because I'm burned out on how the federal and state manage Medicaid, so I planning on getting totally out of private practice counseling. It's too big of a headache to only work with 4-6 kids.
No. Challenges with finding a reliable supervisor.
No. Counseling is not my full-time job.
No. Current position does not require it and does not leave time in my life to focus on LCPC
No. I cannot take the time away from my profession to get the required hours.

No. I have not obtained enough consistent clients to start working towards my LCPC licensure.
No. I might change that decision later.
No. I see no need at this point in my career. Adding a C does not impact my ability to provide quality work. I've been in the field for 30 years and have gone beyond the requirements needed to receive my C however was on maternity leave when the opportunity to be grandfathered in came along. Thankfully my reputation and client care are excellent therefore the need to start the process over is unnecessary.
No. I'm ok with a LPC only.
No. I'm predominantly seeing clients in Missouri and anticipate becoming fully licensed there, then filing for reciprocity in Kansas.
No. Not needed
No. Not worth it
No. The amount of time and cost over supervision over that time did not seem worth it.
No. The requirement for the NCMHCE in order to receive an LCPC license in Kansas is a bridge too far, especially since most other states don't require it. I would understand if it was an optional cert like play therapy or art therapy but the board's standpoint is that in order to practice independently at all it's a hard and fast requirement. The average compensation in this state makes that a poor ROI when I can base here and practice elsewhere for better compensation with requirements I've already met.
No. There have been family issues that have kept me from this.
No. Working under clinical supervision in MO because that is where I found someone I felt comfortable with and trusted to oversee my supervision. I've had a number of potential job opportunities come up in KS but I feel limited in my ability to take work in KS because I want to maintain my current supervision in MO yet I live in KS so it would be ideal if I could also work in KS and count those hours towards the 3000 I need for clinical in MO and then apply for my LCPC in KS as well.....
Not at this time, the cost is too much for me in this economy
Not at this time. Wasn't needed at former position
Not required for my current role
Not this year due to my current position in education. Looking at logistics to begin this soon, but supervision costs are prohibitive
Not yet but I would like to
Not yet but will shortly in the future.
Not yet, however awaiting an answer from my company on when supervision can start.
not yet. I have a full time job and provide counseling on a part-time basis. When I switch to providing counseling full-time, then it will become a goal.
Open private practice one day
Opportunity
Past retirement age and don't think it would be utilized at my age
Prefer not to have two clinical supervisors and working on submitting my LSCSW plan for approval.

See #6.
Soon
Suspended the process due to relocation but resuming in the summer
That is a goal, but finding a place to practice comes first in my mind.
The comparison of work to obtain LCPC is comorable to doctorate in my opinion.
The cost and the availability of supervisors. Also the discrepancy of transcript requirements despite attending a cacrep accredited 60 master's program and having licenses in other states.
The supervision expense is a strong factor.
Too difficult to find someone to supervise the hours
Trying to find an affordable supervisor. So far in my career I have been able to offer services under a licensed practitioner.
Unfortunately, it has been 27 years since I did my academic work to get my degree in counseling. I don't know how well I would do with the examination.
When I initially tried, I was turned down because I didn't have a LCPC but a LMLP so I never tried back. Now I'm close to retirement.
Will be soon
Years ago when I was working towards a LCPC, I was laid off from work due to the recession. After that I worked at various types of counseling facilities. I didn't want to restart my efforts and get laid off again. Instead I got certified for drug and alcohol counseling license. I used that in addition to my LPC license and worked at a variety of counseling facilities until I was told additional credits were needed to renew my certification for Drug & Alcohol. At that time the BSRB decided to change the requirements for the certification. I could have been grandfathered in but I didn't want to go through it all over again. I was burnt out from all the hoops I had to jump through just to keep my D&A certification . It's been all about the money and I don't have much. Kansas is the worst state to be a LPC or anything else but some sort of Social Worker. As an LPC in Kansas there is little respect for anything unless you are a Social Worker.
Yes (133 responses)
Yes because I wanted the support of a clinical supervisor and want to be available for more insurance panels with LCPC.
Yes because once clinically licensed I can accept more insurances and don't have to pay for supervision the rest of my career.
Yes I am currently working towards my LCPC (7 responses)
Yes just took my test and passed
Yes So I can advance the practice and array of services.
Yes, but slowly
Yes, cost of supervision is a deterrent to pursuing for so long
Yes, I am actively working towards my LCPC hours. My goal is to be completed with those hours by next March.
Yes, I failed the test twice
Yes, I finished my hours while living in a different state (dad had cancer) and struggling to get LCPC due to non-licensure in current state.

Yes, just have the testing to do.
Yes, once supervision plan is approved.
Yes, so that I can open my own practice.
Yes, through reciprocity
Yes. I am working on revising my supervision plan so I can resubmit for approval after losing my previous supervisor. I have 20 hours left before I can test.
Yes. I want to be able to practice independently if I want to. I also want to be the best counselor I can be.
Yes. I would like the opportunity to work independent.
Yes-waiting patiently for my supervision plan to be approved. :)
You make reciprocity to difficult and onerous.

LPC Q12. Over the past two years, based on your observations and experience practicing in the professional counseling profession, could you share information on any practice-related negative issues you have seen, such as areas where practitioners appeared to need more continuing education or training in a certain area? (212 responses)

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A need for more trauma-informed care in the CMHC setting
Addiction
As an African American working in Kansas, I experience several practitioners who lack cultural competence.
As an African American, I believe we need more counselors who are sensitive to the black experience.
As I work alongside mostly social workers (as an LPC), it appears that many of them lack a wealth of knowledge that should be known coming out of their graduate program, this includes how to assist clients with medication management, diagnosis, therapeutic interventions.
ASD and ADHD in women
Assessments like FSIQ and MMPI should be more accessible and Kansas is not on par with the country in allowing Professional Counselors to do them, even when coming from a CACREP background.
Autism, ADHD, and LGBTQ+
Billing for private practice.
Clinical judgement in diagnosis.
Potential overdiagnosis of psychiatric meds.
Billing insurance and the credentialing process.
Boundaries and burnout prevention.
Burnout
Charging Medicaid recipients missed session fees and other administrative fees.
Client confidentiality - continually see oversharing online or hear stories from counselors where they have not properly de-identified a client's story. I also think there is concern that many providers don't know how to identify their own lack of competence and continue to provide care to populations that they aren't suited for and seem not to have an ethical decision making process for discerning when referrals should take place.
Continued education around Social media, ethics, and the rise of AI
Continued education in understanding specific populations including LGBTQ+
Counselors must be aware of the importance of cultural competence when working with clients from different backgrounds.
Counselors not getting their own counseling. Also, in public business settings, the ethics are questionable.
Court room testimony and court report documentation preparation
Differences between professions / views on therapy
Credentialing, billing, areas of focus to pass the clinical exam
cultural awareness, ethics
Developmental trauma disorder, child abuse, and domestic violence
Diagnosing

Diagnosis
Addiction
Differential diagnosis
Documentation
Dual relationship as a billing person and provider
Ethical concerns when practicing over telehealth, working with multiple diagnosis, and working with kids at 10-12 (not kids but not yet teens).
Ethics
ethics
Ethics, especially when it comes to client contact or boundaries
Evidence based practices, best practices, and episodes of care.
For-profit providers are not making superior salaries when compared to non-profit providers. And they are serving in a under-served domain. For profit providers need to be considered for loan forgiveness programs. 2 master degrees can easily coast ~100K
How the first year of gaining your license can look like in different settings. I've noticed expectations are very high and clinicians feeling dejected early on. Also a mandatory class on business practice models would be helpful. This will ensure clinicians going into private practice are staying ethical.
How to manage their self care, and have less experiences that could lead to burnout
How to properly do an initial assessment, diagnosing personality disorders, and differentiating between substance induced disorders verses bipolar or schizophrenia type disorders
I am seeing (personally and as a supervisor) that counselors are coming out of their schooling with little to no training on note writing. Especially LPC's that are coming from school counseling to professional counseling.
I believe that addiction counselors should be required to take courses in trauma and somatic therapies.
I believe we need more practice in implement theory into practice. I felt that alot of what I learn was more on the job than in school.
I can't share in the last two years as an LPC but as a professional school counselor for many years I feel there is a need for CEU support with children specific related DSM-5 diagnosis'. There is some out there but much of it hits adults with only a little bit of children material. I'm thankful for the growing amount of user friendly CEU outlets.
I currently work in a rural area where there aren't many counselors practicing, so I am counseling many clients who know one another which can be hard to manage and keep track of. So maybe more education for counselors in rural areas?
I found out while in graduate school that the professors are out of touch with the real world of counseling. Real skills need to be taught instead of throwing graduates out into the world and not preparing them for being a LPC.
I got a position at the local mental health center but resigned after learning how much time is spent on paperwork with minimal time on counseling
I have not been aware of any negative issues where practitioners need more CE or training.

I hear that prospective clients don't receive returned calls when seeking services. I've witnessed this as well and return all voicemails/texts within 48 hr business hours as a result.

I honestly can't think of any. It might be good to require training specific to your population if you are servicing children-- ie, maybe mandated reporter refresher, ethics when working with families/dual relationships. Maybe something with counseling notes/case notes.

I practice within a group setting, and the practitioners I have been associated with have all been highly professional.

I see a need for more continuing education on Kansas specific laws regarding ethics or potential ethical situations and diagnosis scope of practice for LPC and LCPC in Kansas.

I see that counselors need a lot of help to remain unbiased when it comes to political views, ethics, the use of technology (and AI) ethically, as well as documentation.

I think counselors need more training in documentation and managing the business/administration end of a counseling practice.

I think it should be a requirement that LPCs immediately start working toward their clinical license. In an agency setting, it is easy to put this off without a BSRB requirement. This would, I think, increase the competence through supervision and training early on in a new counselor's career.

I think that working with LGBTQ and POC clients needs more training. I also think it would be beneficial to know what modalities are currently accepted and which are not yet valid

I think there is a need for more/better trauma training with the increase of awareness of the general population (I.E. Clients that present with "needing to fix years of trauma")

I think we need more continuing education in the area of practical interventions to specifically address specific issues we are dealing with the clients and more online interventions with younger clients who have a short attention span.

I was the only big city girl working with and for women who grew up together. They intentionally made my life a living hell

I work in a school but many of my students receive mental health services from a myriad of providers. Most of them are LMSW's but very few of them work with the clients to develop skills to deal with their problems alone. Meaning if you are having a panic attack how to regulate and calm your self down so that you can continue to function. In my training we were always taught that the goal of therapy is to get the client to where they no longer need you, so you would teach them skills or coping strategies to start working on themselves while you are helping them and hopefully the client improves and does not need you anymore. When I ask about this, some of the younger therapist look at me like I am crazy or making something up

I would have liked and needed more training on trauma in classes at ESU. I had one trauma class, all online, all book based. I learned about ACE at a Montessori conference as I was a teacher before becoming a therapist. I learned much about trauma and trauma informed care at my internship at Safehome in Johnson County. And, I have learned much with my own reading and consultation as well in supervision.

I would like to see more trainings on telehealth and best practices of setting up private practice using this format.

I'd love more information about working as a part of a treatment team with nurses, doctors, and expressive therapists.
IFS, trauma, and somatic
I'm not sure if this is the question, but I have noticed therapists indicating that they are "informed" on topics vs. trained or certified. I'm not sure if there is way to monitor this, but as I've been trained in SE, EMDR and Gottman post grad, I've noticed practitioners saying they were "somatically informed" or "EMDR informed" without any formal training.
I'm not sure.
Income stream issues- economic issues impacting clients ability to afford services (even with or without insurance) affecting business income sustainability. Manageability and (lack of) clarity in insurance paneling and reimbursements rates/contract issues/communication with insurance reps, etc. adding undue stress and burden and lower income revenue to practitioners. Continued need for greater training in multicultural humility and competency, especially regarding understanding and working with systemic factors (social, racial, political, economic, etc.) on client populations and client wellness.
Increased training on Community relations, specifically with medication providers. There is a lack of coordination and receiving of the LPC work with clients.
Insurance being easier to take.
Insurance rates and restrictions. Dealing with other providers who are not trauma informed. Working with a system that is not preventative based. Struggling to find affordable supervision.
It would be helpful to have a handout or resource detailing the Telehealth rules by state for when clients travel outside of Kansas and want to meet via Telehealth. Each state seems to have different requirements. I recognize this is outside of the BSRB's scope, but it would be extremely helpful for practitioners.
It's become a lot harder to tell whether someone is a counselor or a realtor. They schmooze a lot, they say they care and they're on your side, but they seem to just really want money. I want more counselors who are obviously in it for the love, not the paycheck.
Just the shortage on counselors.
Ketamine/drug induced therapy needs to be heavily observed with required on going continuing education. I have heard of individuals taking one course and thinking they are competent/certified to do this therapy.
Lack of needed resources/providers for families and lack of funding to provide for resources or lack of providers to refer to for additional support.
Lack of professional boundaries
LPC licensed professionals should be able to practice independently, as was in the past. We have such a need, and LPC licensure level is should be qualified.
LPC's know minimal about treating clients with addiction, general DBT/CBT/ACT training, self care, how to stay organized when overwhelmed
Market level salary too low, unavailable CEU's at a reasonable cost.
More education and training for supervisors on how to supervise ethically and understanding their biases.

More opportunities for continuing education are always beneficial, especially low cost. Also, training opportunities to expand a clinician's professional knowledge will help them reach a wider audience
More training in addictions would be helpful for others. I also believe social workers have too much power in the state and they lack clinical counseling experience.
More training regarding Kansas law would be nice!
More trauma informed training
More trauma informed trainings to provide adequate care for individuals with mild to severe trauma.
Multicultural counseling
Multicultural counseling
My only issue/concern is with the BSRB licensing process. It took over 6 months to receive my license in the last 3 months, they did not need any additional information from me.
No (71 times)
Navigating ethics, best practices and parties related to clients in the court/legal setting. I work often with children and parents going through divorce or custody litigation proceedings. I've had to learn and I'm still learning the in's and out's of working with the court, guardian ad litem, court appointed co-parenting counselors, attorneys and DCF caseworkers.
Navigating political climate
Need more training in SUD; observed many newly licensed individuals join private practices and reporting specialties in a broad range of topics and diagnosis, yet have minimal experience.
Neurodivergence in assigned female at birth clients, working with teens/family systems, advocating for clients in school systems, minimum legal knowledge by state.
No other than the states collectively working together on licensure requirements etc
No, clinicians need higher reimbursements and less required supervision.
No, other licensed professions are doing well. I believe non licensed professionals need the additional support
No, therapists that I have worked with are competent and do well in their area.
Not applicable.
Notes are available to too many people in an office.
Personal maturity and character. Professional development. Self care, and ethical care of clients who hold traditional religious beliefs and practice. AI.
Policies around telehealth
Poor supervisory skills
Possibly more training with providing telehealth services being a need.
Practitioners in my area, unaware of the ethical guidelines. I believe that this should be a part of continuing education. Specifically where military populations are large.
Practitioners need to know suicide assessment.
Regulations on how LPC can work independently. Requirements LPC must meet when they decide to go into practice by themselves.
Regulations on when to contact an individual's doctor or primary care provider. Nuances of owning a business for tax purposes and being able to be credentialed by insurance carriers especially with a LPC versus LCPC.

Research in the field of counseling. We see so many clients, but little research is completed.
Sexual abuse and trauma
Social workers practicing as therapists struggle with boundaries, and lack knowledge related to diagnoses, clinical interventions, and struggle with countertransference.
Sorry, no.
Standards need to be higher to graduate with a master's degree. It is appalling that some of my classmates graduated and are now licensed Professional counselors because they barely went to class and did their assignments yet still were pushed through.
Suicide
Suicide prevention and supporting communities after a suicide. Living in a small town where everyone is connected these losses are very hard and impact everyone even the counselors
Supervision
Supervision when not going for lpcp, but not licensed, Supervision of students, contractors vs w2,
Technology, multiple diagnosis, and addictions
The first thing I can think of is in the reporting of abuse and neglect. Too many times there is no reporting when there should be, people who also report things that are not abuse just to cover themselves. What a waste of time and resources. Penalties are not effective incentives for fixing this. I would like to see more education both ongoing and for licensure to begin with. Or some kind of 24 hr information line. It's just a thought
The state of Kansas switching from Aetna to Healthy Blue. I've been trying to get into Healthy Blue network for 6 weeks and have received no correspondence; yet I have 2 kids I see that I can't bill on but there is medical necessity there, so I continue to see them for free.
the use of computer programs such as simple practice...would have been nice as a college class-the business side of it
The use of technology in counseling (telehealth, texting/emailing clients, AI, etc). Confidentiality and its limits (when to report something to DCF, what parents should/shouldn't be told when counseling their child), how to navigate dual relationships in rural communities.
Therapists need to be trauma-informed and if planning to work with rural communities, have some training on the differences in community and culture.
There is a great need for substance use practices
There is very little awareness of the differentiation between LPC's and other licensures such as LMSW.
There's is a need, but there is not enough support for newly licensed practitioners.
To many private practice owners are withholding pay or outright stealing pay from 1099 contracted therapist and misclassifying therapist; however, they are getting away with it because there is little to no accountability for their actions from the BSRB. More education on the misconduct in this area and the consequences as well as advocacy for self on behalf of victims would be beneficial; therefore, there is less turnover within practices and less disruption of care for clients changing providers.

Training around ethical documentation, working with insurance companies would be helpful upon entry to the field.
Trainings for children with adhd and other childhood disorders would be very helpful. I am blessed to have a great private practice group where we get a lot of extra training but it would be nice to have that for others.
Transgender Issues
Trauma and autism
Trauma and dissociative disorders
Trauma informed care
Treating psychosis, treating children with oppositional defiant disorder and working with families to support children
Truly, I cannot come up with anything in particular. I've been witness to my colleagues and peers practicing and upholding the ACA code of ethics as well as seeking consultation when questions arise. Burnout prevention, connection points for practitioners to have community.
Uncertain if current short term training programs such as those promoted to nonprofits go through a BSRB approval system.
Unsure
Unsure
Very little prep and support in guiding new clinicians in master's programs
We are all trained very differently.
We need more LCPCs that can supervise and is willing to do it for free, Cost is a barrier for professional advancement
When there are supervisors/ceos/upper management who do not have any licensure and do not understand why certain things like documentation or CPS/APS reports
While graduate schools definitely vary, treatment planning and other documentation is something that may be beneficial to provide training or continuing education on.
Yes
Yes 1) Working with invisible disabilities 2) working with neurodivergent adults.
Yes, a group practice I was previously in the own/supervisor did not provide adequate supervision to other LSWs. Observed by me see notes and talking to other clinicians.

LCPC Q12. Over the past two years, based on your observations and experience practicing in the professional counseling profession, could you share information on any practice-related negative issues you have seen, such as areas where practitioners appeared to need more continuing education or training in a certain area? (337 responses)

1) Do we need both parent's consent to treat a child?
2) Could use more knowledge around treating children who come from divorced families. If one parent consents to therapy but the other does not, what is a practitioner supposed to do?

1. Student loan is way too much.
2. LCPC/LPC is not in demand the way LCSW is.
3. We need to be able to bill Medicare.

A major area of concern is lack of supervision for LPCs in community settings (ie guidance centers) and school settings. If the board is going to continue to require LPCs to be supervised by only LCPC-S then we need to figure out how to advertise supervision programs and to also pay supervisors well enough so that they can persist in their role.

A recurring conversation in one of my consultation groups has been the topic of self-diagnosis by clients and how to encourage clients to reflect on pop psychology terms promoted on social media. This is a continuously evolving area that will continue to need more attention as counselors work with clients in the age of self-diagnosis and AI.

Ability to give resources for needs

Ability to problem solve when client is in crisis.

ACEs seem on the exponential rise!

Addiction, medications for addiction and all psychotropic medications,

AI (2 times)

All of the specifiers of this question are confusing.

An area of training I wish the BRSB would provide is demystifying the process for counselors if or when someone contacts the BRSB with a complaint.

Areas where I've sought out additional continuing education include diagnosis, pharmacotherapy, and ethics.

Around 90% of my clients are LGBTQ+, so the negative issues that I do hear about are mostly around lack of cultural competence regarding those issues, as well as therapists being uncomfortable writing letters of recommendation for gender affirming treatment.

ASD in adults

Assessment and diagnosis for clinicians is beneficial. I've seen many professionals who have been way less detailed in their assessments than would be preferred (from old co-workers, as I have no supervisees)

Attachment theory

Autism spectrum disorder

Autism, supports for parents parenting children with autism , self injury, insurance requirements

Based on my own observation, increasing telehealth training for clinicians would be greatly beneficial. How to have a productive and successful experience in therapy via telehealth. How to maintain engagement, things to address with clients and/or family members, environmental considerations, etc. This combined with tangible resources to engage with clients during a session would be beneficial for positive therapeutic outcomes.
Being able to practice telehealth in states you are not licensed in.
Boundaries with clients, self-care of practitioners, reporting abuse/neglect
Boundaries, texting with clients for reasons beyond appt confirmation, etc.
Burn out and self care, telehealth services and ethics
Can always use more trauma related and substance use disorder related
CEU that are easily affordable
Child and family therapy, documentation practices
Clear diagnosis CEU's
Clearly understanding their role in working with children in divorce / child custody situations. Understanding ethics & best practice based on research.
Clinical notes, diagnosis
Clinical supervision face to face CEU training
Coercive control, betrayal trauma
Conceptualization and Treatment Planning, Therapeutic Relationship and Countertransference/Transference Issues
Continued areas for improvement would include LPC or LMSW attempting to general practice in a clinic setting and feel they are equipped to treat substance abuse. At most they had two classes in school and lack the knowledge. More education is needed.
Crisis Counseling
Crisis situations
Cultural bias about assessing mental health services
cultural competency
Cultural Trainings Suicide Trainings
Customer satisfaction. 90% of the people that I talk to about trying to find counseling services report that they've called numerous therapists and do not ever hear back. Also, appropriate self-disclosure and ethical behavior.
Dealing with insurance companies
Dealing with the area of family law - how to take court notes vs. case notes and my obligations of communication (i.e. to divorced parents or when parents cannot communicate with each other due to DV and a restraining order against one parent) - any topics related to our communication with legal obligations in messy family/parental situations.
Dealing with unrealistic caseloads
Debriefing Suicide for Clinicians who may have lost clients to suicide.

Despite our services being viewed by the insurance industry in the same manner as other health care professionals, there still seems to be a perception that therapy is not on par with medical care and therefore mental health practitioners fees should be significantly less than medical practitioners. This puts practitioners in a difficult position and perpetuates the idea that therapy is pseudo-science vs. a valid healthcare treatment.

Diagnoses and treatment of DSM diagnosis

Diagnosis and treatment of neurodevelopmental disorders, credentialing processes for insurance companies, treatment planning and session documentation, treating trauma-related disorders, connecting to community resources

Diagnostics

diversity and inclusion, addiction, loneliness

diversity and inclusion, self care for therapists, neurodivergent clients, helping our supervisees navigate the exam

Divorced family. My target population is children but parents often try to manipulate the kids to take their side and handling the legal situation (custody battle at court etc.) add another complication.

Do not have much contact with other practitioners. Three in my office do a good job.

domestic violence safety planning and responsiveness vs reactivity regarding suicidality and parasuicidality. Suicide risk assessment

Eating disorders

EMDR and trauma-informed care

Ethics

Ethics

Ethics and boundaries with clients. How to conduct a private practice when you may have dual relationships in small towns and cities that are interconnected. Understanding transference and countertransference and how to work with it rather than get into enactments.

Ethics and Diversity

Ethics around pricing, timely documentation, and consultation practices could use attention.

Ethics issues or getting too close to clients

Ethics regarding telemed services

Private practice time management and paperwork efficiency

Ethics that guide informed consent with clients.

ETHICS!!!!

I see so many issues with ethics.

Ethics, mandated reporting

Experience is by far the best teacher.

Extremely high direct service requirements by agencies that result in burnout and decline in client care.

Faith/Spirituality integration

Clear ethics and treatment options for gender dysphoria

Family Therapy

For those who are licensed by reciprocity, there is a need for education about Kansas ethics, standards, professional development and updates on changes in laws.

Formulaic counseling

General lack of Hx of counseling, techniques. vs theory based practice. Lack of awareness of their own bias
Given the current political climate, I have seen politics enter into the therapeutic relationship and it concerns me a great deal. As clinicians we need to be culturally competent regardless of our political beliefs.
Good ceu is too expensive.
Government/contractor counselors - require an excess of additional training!
Health issues that cause mental health issues - like thyroid, other hormone, mold illness, vitamin deficiency. I think counselors should have training to screen patients for this stuff.
Helping those with Narcissistic traits. Helping young adults who "fail to launch." Disconnecting from electronics. Challenging sexual amorality with scientific data and long-term efficacy studies.
How to deal with insurance companies such as progress notes, credentialing, audits, and how to file tax with private practice
How to set up a private practice, credentialing and how to deal with insurance companies
how to start a PP/business, politics and holding space for all sides, addiction from children to adults, insurance, AI
I am a solo practitioner.
I am not aware
I am often alarmed with the amount of counselors on helping pages such as Facebook groups that do not seem to know, ethical practice, HIPAA procedures, and supervisory practices per licensure. I have had people report to me that a practitioner will claim that they are let's say trained in LGBTQ populations, but are not or have harmful biases that they are putting onto the patient. There are practicing clinicians who are deterring work from themselves based on their beliefs instead of scope/practice. I've even seen posts of clinicians "yelling" at their patients about politics.
I believe provider burnout/compassion fatigue, as well as insurance reimbursement rates as two large threats to the provider community.
I believe the knowledge and confidence to counsel children is lacking in educational programs. I have supervised many interns and they come to me without prior knowledge.
I believe we can all benefit from continuing education and training.
I can't think of anything specific.
I don't know of anything.
I feel practioners need more CE i DBT, CBT, mindfulness, and coping skills.
I feel that practitioners need more training on insurance billing and proper documentation when they first graduate a masters program.
I have had no opportunity to assess this need.
I have not experienced any issues related to practitioners needing more CEU or training.
I have not experienced this.
I have not noted anything specifically.
I have not observed any negative issues.

I have seen group practices that are unethical and appear to be committing financial fraud towards therapists, private practice family counselors who are very unethical and are supervisors. It's concerning that the state ethics do not match the ACA ethical standards and can cause harm to clients.

I have seen lack of professional and clinical training in more acute/high-risk areas and specialties including high-conflict couples and families, substance abuse, and domestic abuse (emotional/mental/physical). These high-risk/acute issues do not discriminate and I have found it difficult to have referrals for people or professional connections to consult with on them.

I have serious concerns about the number of people "coaching" who have zero training in graduate counseling programs and are just hanging a sign and taking money. I've had clients come in with additional damage done to their lives because of pastors and coaches providing counseling without the proper ethical behavior or license.

I am concerned about the number of graduates that enter the counseling field every year, particularly from universities that use their counseling programs for general income, such as MNU. It saturated the field and creates lower standards of care because there are so many new professionals marketing themselves and clients cannot tell the difference. I really think BSRB needs to make place boundaries and limitations on the number of students a program can enroll.. or something else that balances the market and ethical considerations - both with new counselors AND with coaches who are really providing mental health care without licenses.

I haven't observed too much of that.

I hear from clients, very frequently, that a previous therapist overshared personal information, acted like they were friends, or did things like paint their nails in session. I also hear, very frequently, that I'm the 18th therapist they've reached out to and the first to return their call. I think both are appalling.

I only work with a few other mental health professionals all of whom I believe to be competent and well-trained.

I provide counseling for quite a few therapist in the public sector. I would encourage agencies to provide more training related to self-care practices as their work in crisis is so demanding.

I regularly interact with LCPs who do not know the limits of their licenses. For example, they mistakenly believe that they can practice independently. New counselors need more training in professional writing, diagnosis, and appropriate record security.

I see individuals with little to no training in couples and family therapy seeing couples and families. This occurs in all of the states where I am licensed.

I see very few negative issues that could be resolved with CEs.

I specialize in treating sex, porn, love and fantasy addiction and infidelity in couples. I see many counselors practicing in these areas with no training. I'd like to see the LCAC license cover all addictions and require training for them all to help prevent this.

I think ethics of communication and dual relationships. It's something I need to be mindful of consistently since I work with police and fire depts and often work alongside people in multiple capacities

I think most of the practitioners I am familiar with are doing well with most things. I think ethics (especially with documentation requirements) and suicidality are always areas we can learn more.

I think social media influences our profession probably more than we would like to admit. I have found practitioners sometimes get a large source of the "continuing education" from influencers rather than research and quality education. I'm not sure what the cure for this is, but making sure we base diagnostic and treatment decisions on the available research is extremely important. I'm not sure Tiktok has helped our clients or our clinicians in the long run.

I think this is improving yet feel many therapists don't have an understanding of betrayal trauma.

I wish we could work in more than one state.

I would encourage new graduates to work with an agency before starting a private practice. It supports a strong clinical foundation and diversity in clients.

I would love to see providers working with adoptive families to have more training in adoption competent counseling. Family therapy involving adoptions has unique complications that requires an understanding of trauma, development and family dynamics.

I would say some folks don't understand the implications of social media.

I've noticed that graduate school equips counselors with basic evidence based interventions, but does not provide adequate training in attachment theory or other models that can help clinicians conceptualize how/why symptoms developed. In practice, educating clients about neurodevelopment and their psychological/social needs helps lower shame around symptoms and identify a path to health in the present.

Illinois did not offer reciprocity with Kansas. I had to take 3 graduate level classes and sit for the NBCC clinical exam before I could be licensed.

I'm not sure

In supervising clients, there is a need to train better on documentation, diagnosis and treatment planning. Also, understanding credentialing. Treatment provision seems to be ok.

In the area of diagnosis, I occasionally see licensed therapists (they are not all LCPC or LPCs) with differing information on a licensed therapist's ability to diagnose certain disorders, especially ADHD. For example, some therapists state that only medical providers or psychologists who complete a psychological evaluation can diagnose ADHD; others state that clinical level therapists are able to diagnose ADHD.

Increased visibility and availability of board approved supervisors. Having an active database of board approved supervisors with contact info and availability would be a good resource for newer clinicians wanting to obtain clinical licensure.

Infant mental health is a huge need and most training is for 5 years and over.

Insurance Billing Codes/Payments

Insurance, assessing for personality disorders, personal discloses

Issues related to response from COVID.

It is a problem that while under supervision, I was not given a warning for my first ethics violation. I did not know it would lead to so many problems and neither did my supervisors. It shouldn't be a surprise what happens to us when we break a rule, yet it was a surprise to me, my supervisors, and the lawyer (United Health forced me to discharge all of my clients who are insured with them).
It is always nice to have more options for the required CEUs like Ethics, Suicide and Diagnosis.
It is of my opinion that most providers tend to not understand key measurements to progress nor do I think most providers are using science based measurements to track the progress of their clients
It seems as though there are many clinicians that need more ethical training. I believe that more clinicians need more relational training with clients.
It seems, generally, that many provisionally licensed professionals are entering the field with unrealistic expectations about how to practice ethically and professionally. I have seen a significant decline in providers ability to provide quality services pertaining to documentation expectations, treatment planning, and diagnostics. It's a huge concern! As a supervisor, I am shocked at how unprepared new providers are at providing the basic building blocks in therapy.
It would be nice for there to be way to be more informed about each insurance option and reimbursements for clients.
It's shocking that not all counselors are LGBTQ+ affirming and oriented to racial justice.
I've seen, overall as a profession, the inability to remove personal bias from professional social media posts and wonder how much of that gets into therapy.
Just the need for more clinicians in our area.
Knowing when to refer for substance use treatment and what resources are available.
Lack of knowledge about Art Therapy, when to refer to an Art Therapist, and how to stay within scope of practice when utilizing expressive and experiential elements in practice.
Lacking areas in treatment planning and ethical issues.
Learning to adhere to regulations/laws of practice and remove self opinions from current political and social stances.
Legal and ethical issues as they pertain to the counseling profession.
Legal issues related to documentation (session notes, couples, etc) and seeing minors of divorced parents
Legislation
Less training easier lcpc license less tests lower passing scores
LGBTQ+ issues (nonpathologizing gender or sexual identity), sexuality (nonpathologizing pleasure, sexual trauma, level of sexual interest), religious inclusion (creating space for those of any faith practice or lack of faith practice, and for religious trauma), political inclusion (creating space without pathologizing any political party membership or participation)
LGBTQ+ terminology
LGBTQia
Managing transference/countertransference
Mandated reporting

Mandated reporting, crisis intervention
Mandatory reporting guidelines, specifically when responsibility is and is not at play.
Many new clinicians enter with little practice in developing necessary rapport, problem solving, and abstract reasoning/cognition necessary for clinical work.
Microskills, appropriate paperwork/documentation language.
More continuing education with both Telehealth and AI.
More continuing education!!
More continuing education. More supervision.
More training in Clinical work for LCPC's
More training in trauma related care would be helpful.
More training is needed around weight stigma in the therapy room.
More training on psychosis work in private practice and more training on addressing co-occurring substance use
More training on recognition of transference/countertransference in session; how to effectively and responsibly diagnose (not over pathologize or diagnose non-remittable disorders without clear evidence that criteria is met); and how/what is counselor impairment - when is it appropriate and responsible to take a step back to care for self rather than risk harm to clients by being unreliable or inconsistent. Lastly, training for clinicians that are supervising interns, in practice for 2+ years but that do not have their clinical license or other supervision experience - most clinicians in this role have no clue what they are doing.
More training to become a supervisor would be helpful. I have had a hard time finding any in person trainings for this and do not wish to re-enroll in school.
My immediate family members have sought treatment 1 hour away because they do not trust the privacy/confidentiality in a small town. There is only 1 INN provider within a 30 mile radius. Also, BSRB made it extremely difficult for me to become licensed in Kansas despite having licensure in 2 other states for 15 years. If Kansas needs providers, specifically in rural areas, it seems the reciprocity process would be more reasonable.
Navigating insurance coverage is always a challenge. Seeking grant funded opportunities to create easier access to care would require training and would be a great help to disenfranchised folks.
Navigating the licensure process. Self-confidence in the field. Boundary setting.
Need more assistance in understanding AI and the impact on the counseling profession Opportunities to explore the challenges of the Trump administration and his restrictions on DEI and training in diversity
Need more support and connection of professional counselors. With high rate of world changing events, including the pandemic, there is more burnout with more pressure.
New graduates getting their licenses
New individuals coming into the could utilize more support around DEIA and Suicidal Ideation.
New supervisees seem to have less focus on self development than helpful for growth as a counselor. In a sense they are less introspective and open to exploring personal growth as part of counselor development. Unsure if this is a trend/related to their education or individual traits with two of my supervisees.

New therapists - more training in diagnosis, documentation, treatment planning, crisis situations, substance use disorders
No (69 times)
No I have not. I have enjoyed the effort that the board has made to make licensing easier. I am also glad to see Kansas being willing to participate in the interstate compact.
No. I feel that the practitioners I know do a good job of finding appropriate continuing education.
None are coming to mind right now - I will reach out should something come to mind
Not really, but I've noticed some practitioners still work outside their competency (i.e. jack of all trades, master of none).
Nothing observed amongst my colleagues or referrals.
Obtaining and maintaining credentialing with Medicaid, Medicare, and insurance companies.
Office politics between colleagues can be problematic for some organizations.
Oh man, what a loaded question. Let's start with social workers practicing counseling... Every. single. social worker I've ever met, and ESPECIALLY the ones right out of school, are honestly dangers to this profession. They have zero idea what they are doing. Their own words. I digress. In regard to counselors, I would say that there needs to be an awareness comprehension and baseline therapeutic modality established for counselors. My degree was so eclectic, and while I'm grateful, it didn't allow me to master anything or harness the power of something to grow from. With more people growing more neurodivergent more than ever, we need to provide some structure to bounce off of coming from grad school. The eclectic/disorganized structure doesn't allow for mastery in the field. In regard to negative issues, the shock and awe I have surrounding older professionals having such burnout, negative-mindset, and judgmentalness toward clients is absolutely disgusting, disheartening, and downright awful toward the ability to move forward in this profession.
On referring patients to other providers and resources if a person can't see them at the initial or during their treatment
Only observed via GKC Facebook group some shifts in providers' practices that I'm not sure are in the best interest of clients - cannot confirm these things did occur: Therapists offering "intensives" for multiple hours long sessions The use of AI for notes concerns me for the growing expectations on providers' documentation
Outside of requirements pertaining to CEUs, other training requirements have been unclear (e.g. annual sexual harassment training, anti-discrimination training, etc.) What is required in the State of Kansas vs. what is strongly recommended
Over the past 2 years, more and more people are going into private practice immediately after graduating, as opposed to working in a public setting. Going directly into private practice before gaining more work experience may be leaving a gap in new graduate's work and clinical experience.

Overall, the professional counselors I interact with seem to be well trained in a variety of issues. I primarily see difficulties with social workers in lack of training (group therapy, family systems). I think an area we are always needing increased training in is diversity, working with marginalized communities, and understanding suicide/crisis more effectively.
Particularly in the last two years, I have been disappointed in the ability/quality/education of the young people I have been in contact with, and only some of those are counselors.
Perhaps just reminders of rules and necessary tasks, such as coordination of care with parents or PCP's.
Practitioners are being pushed to normalize a certain political agenda as an "ethical responsibility" and are getting threats by other therapists that they should be reported to the board and have their licenses taken away, if they do not agree
Practitioners could use more information about neuroscience
Practitioners need clear and updated information about the changes the Board makes and how they are implemented. Newsletters, emails, and other means of disseminating Board meeting notes for greater transparency would ensure clinicians are upholding the most up-to-date requirements and policies. Clinicians are more than capable of managing their needs in practice related issues - there are more opportunities for online training than ever.
Practitioners need more training informed by latest research and practice of trauma. Graduate programs need to offer/require more training in trauma-informed technics
Primarily in the areas of compassion fatigue and/or vicarious trauma that tend to affect attitudes and foster some boundary issues; particularly, within the context of attempting to 'fix & rescue' clients.
Professional Ethics.
Psychedelics, cannabis, and other substances are becoming ubiquitous. It feels important folks are trained in this.
respect for MA level counselors
Risk management/assessment and documentation
Safety planning
Self safety siyes for therapy sessions.
Self-care
Sharing info about clients to other clinicians that do not need to know
Shortage of providers trained to treat children and adolescents with problematic sexual behaviors. And, providers not having appropriate knowledge/training in assessments specifically for children and teenagers. Providers using adult assessment tools.
Since I am required to be supervised, I don't have much contact with other therapists.
Somewhat
Staying up to date on new theoretical approaches and research
Students coming into the field are not able to pass licensing exams. This is very concerning and hits many areas.

Suicidal thinking and Self-Harm seems to be the new go-to when individuals (SM, Spouses, Kids) get stressed out. So, more education on suicide prevention, for example, CAMS, and training on the difference between suicidal ideations/attempts and Self-Harm.

Suicide prevention

Suicide prevention, telehealth best practices

Supervision training. I recently became an LMFT supervisor and their training is much more robust. LPC should catch up.

Supervision. Ethics ai

Supervisor, play therapy, dual relationships, collaboration, telehealth

supervisors are allowed to have too many supervisees and not in line with other states. supervisees often have NOT had good support or training when they transfer to me

Supporting each other - giving support to other professionals.

Telehealth

Telehealth guidelines

Telehealth Ethics

That's a great question. I've noticed that the older generation of therapists could benefit from sessions on basic helping skills. They often lean heavily on CBT and may not fully appreciate the importance of attachment in their work. On the other hand, the younger generation could use more guidance on conducting appropriate research to validate their methods and on continuing to grow their skills.

I also think it would be beneficial across the board to implement more thorough intake processes. While it's time-consuming and expensive, it's essential for therapists to have a fuller understanding of what they're working with so they can create clear, actionable goals for treatment.

Additionally, I believe therapists would greatly benefit from better partnerships with psychiatrists. It could be valuable for therapists to take basic classes on medication to better understand how to appropriately assist clients who are on medications and coordinate care effectively. Incorporating AI into their Practice will also be important here
real soon!

The counselors that work on my team would like additional training in the areas of domestic violence, substance abuse, and diagnosing PSMI. I also believe we need substantial training in AI and it's ramifications.

The dangers and challenges of using AI and venture capital backed companies

the lack of professionalism is unreal. Too many counselors disclose personal information to clients that detracts from the therapeutic session. The standard for CEU's that are provided by other LCPC's needs to be raised and monitored by the board

The lack of protection when there is a physical threat to safety by a client or prospective client and the lack of support through the complaint process. The trauma of retaliation is a heavy load to carry on addition to the job itself.

The only issue I have seen that can be challenging at times is contacting BSRB (availability). When I am able to make contact- they are super helpful and informative...but sometimes getting ahold of the right person can be challenging. I imagine they are very busy so it doesn't make sense.
The politicization of counseling—it seems we're moving away from the ACA Code of Ethics.
The potential of utilizing AI. It would be difficult since it's new but I wonder how there could be oversight in this area and assure client safety and HIPPA compliance.
The statutes and regulations around telehealth, including who can offer remote counseling and where their clients need to be located during sessions.
The turnover in practitioners due to the lower pay. There is constant churn of personnel and higher case loads.
therapists that are not clinically licensed going into private practice without supervision - I am VERY concerned as I have seen this happening more and more - they don't take board rules seriously and don't see the ethical issue
Therapy overwhelm. Plenty of clients - with big issues - but poor pay and high self-employment tax.
There appears to be some drama surrounding the issue of notifying parents when mandated reports are made. Social Workers in my district notify parents, but as a counselor, I have always been told that it is unethical and dangerous to notify even non-abusing parents when filing reports because we never really know what the relationship status is between the adults in the child's life. Could be setting up the child for further abuse. I am not a licensed supervisor.
There is a lot of change over in staffing at the residential settings I work at. Often it's due to overwhelm, budget changes, etc. Training helps but in my opinion more resources for the administration to hire or put more staff on shifts would help the most.
There is always ways to improve therapeutic relationship, skills and education. I think there is sometimes negative feedback about other therapist from client but I think it difficult to determine the basis of issues and to manage because the client/therapist relationship may not have been established or trusted.
There needs to be more training on identifying pathological personalities that impact the therapy session when counseling couples and families.
There seems to be a loop-hole between LPC and LCPC. People think they can practice as a LPC without having a supervisor as long as they aren't working towards LCPC AND they can practice as a LPC without providing a name of a supervisor. THIS NEEDS TO BE FIXED!
They need a greater understanding of the core responsibilities of a counselor, administrative especially.
Training in ethics and professionalism in regards to not incorporating the practitioner's values in client sessions.
Training in trauma, substance use disorder, diagnosing
Trauma
Trauma informed care, OCD, sexual disorders, and agoraphobia coupled with anxiety/depression with individuals in their twenties.
Treatment planning and documentation
Treatment planning is an area of concern for supervisees. Boundaries and ethical considerations regarding telehealth, and AI continue to pose challenges.

Unethical practices and no consequences when it was reported. Disturbing trend of unqualified and inexperienced professionals being in supervisory positions who don't understand the ethics of actually practicing in the field of counseling.
Unfortunately, violation (not just crossing) client boundaries occurs more often than it should.
Use of AI in professional counseling practice.
Varies by practitioner
Wait lists making access to care difficult
We need have extra training on different on how to handle the fluctuating political environment. Also, more and more people are experiencing trauma. Trauma training would be helpful.
We need more trauma specialists in Western Kansas - training for EMDR or equivalent treatments.
What accepting insurance actually means/looks like.
More trauma training.
When receiving transfer clients, I am often discouraged by the note taking and documentation practices of other providers. Intake and process notes are often plagued with limited information and grammatical errors. This may be linked with lower writing and literacy skills in general. I'd like to see more training support for practicum and internship sites so that we can support counselors and therapists in writing skill development.
While under the supervision of former employer I was manipulated into a sexual affair. The employer has since gone on to allegedly make other females uncomfortable working for him to the point of a University allegedly refusing to provide him female interns. The board has not taken issue to his pattern of unethical conduct. So the importance of appropriate supervisory conduct and information about how to best report misconduct.
Wholistic health activities that could be paired with therapy such as being out in nature, social connections, exercise, etc.
With in this time frame, the only negative issues clients have brought to their work with me concern Christian counseling and in this modality of counseling the clients who had a negative experience felt judged, and overall left because they felt worse than before they came to counseling.
With telehealth counseling being in such demand easier access to knowing each states rules. Navigating health insurance for cts and easier access to getting mental health services.
Work with individuals of all ages with developmental and/or intellectual disabilities; work providing family therapy
Working towards bringing cultural acknowledgments and humility into the therapeutic space in terms of theoretical orientations and the use of certain modalities can cause more harm to marginalized populations.
Working with commercial insurance companies has become increasingly difficult over the past decade. Having more support from the BSRB, in the form of both resources and advocacy, would be amazing.
Working with ethical dilemmas
Working with minority groups

Yes

Yes, I have noticed that since people are living longer, geriatrics training for LCPS'S does not adequately meet the needs of septuagenarian's & octogenarians.

Yes, I have observed there needing to be more training in licensing exam preparation and support; family therapy modalities; treatment for neurodevelopmental and developmental diagnoses; and the responsibility of credential holding in the mental health profession (the importance of continuing education, maintaining active licensure, scope of practice, multidisciplinary collaboration, etc). The use of self disclosure, issues with countertransference, cultural competence matters, crisis intervention as well.

Yes, language used around clients such as calling a client "schizophrenic" rather than "client that has schizophrenia."

Yes. Professional boundaries courses targeting specific behaviors such as discussing personal life with clients, letting personal judgments negatively impact client's treatment, emotion management, canceling client appointments without enough notice due to difficulty managing emotions. Overall greater accountability and vetting process needed for clinicians to ensure they are not addicted to substances, are not abusing/neglecting their own children, have healthy view of relationships, and do not struggle with a mental illness at levels that affect their functioning to be a competent therapist.

Diagnosis training.

Knowing how to build a treatment map based on knowledge of diagnosis and interventions.

LPC Q13. Over the past two years, have you experienced any issues concerning telehealth, either through professional practice or observations of other practitioners? (224 responses)

Ability for some rural/frontier clients to connect (high speed internet)

Counselors not using secure methods

AI integration

Although it makes services more accessible for clients I believe clients aren't as accountable as they are face-to-face. But many of our clients lack transportation so it is a benefit.

An LMSW had a family member walk through the background during our session

Appropriateness of telehealth for couples

Because the College was closed during the pandemic, we used completely virtual counseling. When we came back to in-person, I could clearly see the difference. There were things that I couldn't observe online that were very visible in-person, i.e. students who visibly shook because of their extreme anxiety. I wasn't able to see that online. I definitely prefer in-person counseling for the increased ability to observe.

Being in a county on the state line (and being a Missouri resident) causes challenges in who can be seen where and when.

Better help is questionable.

Concerns only on the part of the client. Sometimes they do not appear to be as engaged as if the service was face to face. As a counselor you cannot read body language when you can't see their entire body online.

Confidentiality and HIPAA related issues

confusion around the pandemic and practicing over state lines (in Kansas City)

From my observation, insurance panels may sometimes pay clinicians less for telehealth session versus in person session which is a significant barrier for clinicians.

I always worry about security, and clients are not always tech savvy.

I do not use telehealth very often, usually if a client is sick and wants a session. Sometimes I use it for intakes with parents of a client if it is easier for them. I have not noticed any issues.

I have known practitioners to work with clients living in KcMO when that practitioner is only licensed in KS

I have no concerns with Telehealth. That said, I practice EMDR for trauma treatment and feel that Telehealth is not a good setting for EMDR treatment. A patient could emotionally flood and Telehealth would be problematic with helping the patient recover.

I have not experienced any personal issues with telehealth and have not observed any issues with other practitioners.

I have not noticed negative issues.

I have noticed it is more difficult to connect with people through telehealth and forming a therapeutic relationship.

I have noticed many practitioners confused about differing state laws pertaining to the location of the client and if people are allowed to receive services while traveling.

I haven't personally had any issues with these.

I learned about my responsibilities regarding BAA & implemented them to the best of my knowledge (assisted by my clinical supervisor).
I work 100% in telehealth, 10 hrs a day. 4 days a week. I find the client is more comfortable and relaxed than when I worked in office. zoom goes out from time to time... that's frustrating. My employer wants us scheduling back to back so there is no time to recompose after a difficult or intense session. IN person sessions you have a moment or two between, possibly walking the client out or pausing between sessions.
I'm not offering telehealth at this point.
I'm not a fan of telehealth. During the COVID pandemic when we were supposed to be isolated, it became a way to get the counseling accomplished. Today, I feel it's a lazy way to do counseling. Too impersonal and no guarantee of security and confidentiality.
In rural mental health centers where my employment takes me, I still see positions unfilled, overworked therapists and largely therapists with less experience
It is difficult as a KS LPC only clinician who is not licensed in MO to work with clients who reside in MO and need telehealth sessions at times.
I've had wonderful experiences with telehealth. The clients who live in distant counties in Kansas where there is no counselors available, especially, have expressed how thankful they are to be able to work with a counselor via telehealth, since they wouldn't have the ability to seek counseling services, otherwise.
Lack of personal connection has people wanting in office visits more.
learning curve on how to interact with the client and get things signed by the client. too much detachment.
Living in Kansas and having several clients in Missouri can sometimes make it challenging to maintain adherence to state law, especially when clients and patients are mobile before the session starts.
Losing connection at key moments
Mainly with speed of insurance reimbursement and rate stagnation.
Major issue was when the state of MO. changed the statute for any practitioner in the state of KS. to no longer be able to provide any Telehealth services with zero advanced notice for options to either begin the application process to do the PLPC in MO. Lots of issues arose like prevention of client abandonment, staying in compliance is always something I've witnessed each practitioner have hypervigilance on and the way the MO board communicated, handled inquiries, and further discussion was greatly discouraging. For example, when we called the representative on the phone call said "if you are practicing under a clinical supervisor that is licensed in the state of MO you are covered by your clinical supervisor's license to continue offering Telehealth services. Then when asked for it in email from customer service another representative gave different feedback. Then when asked more inquiries there was never any resolve regarding how to proceed forward. Resulting in clients having to drive 2+ hours to their providers for in-person sessions so the provider stays in compliance with licensure. These types of situations bring a lot of anxiety to providers
More legislation needs to be passed to ease the barriers for telehealth across state lines
My CMHC does not allow telehealth

My only issue with this is not being able to provide counseling when a client is out of state. As an LPC, not being able to obtain reciprication in a bordering state limits my ability to care for my clients.
No - telehealth has been a wonderful option for clients and clinicians alike!
No (150 times)
no issues, I use Telehealth for my supervision practice since I am an LPC-S in another state and my supervisees are in that state
No issues, just lack of clarity knowing which states allow you to provide Telehealth services if a client is traveling. It potentially limits my ability to serve clients as I say no to Telehealth sessions when I'm unsure.
No issues.
No longer covered by insurance after covid
No major ones for me. Just challenges with get technology to consistent work.
No, I am impressed with how much training came during covid and I feel the access to mental health services in rural Kansas has grown because of it.
No. I only offer telehealth for clients that have to drive a long distance.
No. I have only observed people having technical difficulties such as getting both audio and video to work.
No. Telehealth is an incredible resource
None. Telehealth has proven to be a useful medium to accommodate my clients, with great efficacy.
I wish insurance companies would value this as so, with equal reimbursement rates.
Not being able to work with clients when they are out of state is very challenging for their care. I work with lots of college students and this is very disruptive to the quality of care I can provide.
Not enough counselors (independent) to go around. Being required to work foe 2 years in a clinic before private is difficult.
Not from a professional standpoint.
Not that I can think of
Only attempts to do telehealth for young children.
Only in the area of technical issues.
Personally, no. It's important to have clear expectations with clients regarding telehealth sessions.
Some insurance plans, such as Blue Cross Blue Shield of KS, do not cover telehealth services on certain plans the same way they would cover in person services. This means that sometimes even though a provider is in network to provide in person services, they are not eligible to be compensated for providing the same services over telehealth. This is an unnecessary restriction on care and creates further barriers for clients who need telehealth to access services in their area or around their work schedule.
Sometimes technology is glitchy.
Telehealth is a great avenue for certain clients. I have not had any issues but I do not see many people via telehealth.
Telehealth is growing and needed.
Telehealth is looked down upon, despite 50+ years of research supporting its efficacy. I suspect this board looks down upon it.

Telehealth rules are somewhat vague. I wish there was more definitive language. I have asked multiple therapists who have been in the field and even they don't understand completely.

The biggest issue is initial documentation (i.e., professional disclosure/informed consent) - securing it with the clients as some do not complete it.

The only issue has been connection issues at times and having to reschedule. Not really sure what the rule is when college students that are clients leave the state for school. Are we allowed to continue seeing them if they are in another state for college if we are not licensed in that state. In the past I have told clients I cannot continue seeing them until the return home.

The rules have changed a lot over the past two years and there has not been easy access to find the information unless one has time to call the BSRB. A newsletter or required meeting quarterly would help.

There have been several times where I have experienced technical issues with using telehealth in my practice but not many other issues.

Valley Hope is cooperating with BCBS in a worldwide insurance fraud scheme. They fired me, and I immediately began to publicize the fraud. Only the FBI can fix this white-collar crime.

yes - patients who travel are not allowed to receive care from their mental health provider due to license restrictions (requiring a license in the state/location the patient is physically located at the time of the session)

Yes it can be difficult when a client moves to a different state or when the client is temporarily in another state to understand how to navigate this in accordance with board statues and regulations.

Yes, a positive 'issue' in being able to offer services to those in rural and remote areas or where cost of fuel and transportation prohibits client from access

Yes, I think it opens the door for lesser-effeciency by providers.

Yes.

Yes. I have terminated staff for lacking professional boundaries.

LCPC Q13. Over the past two years, have you experienced any issues concerning telehealth, either through professional practice or observations of other practitioners? (336 responses)

A small number of clients have expressed confusion when trying to schedule an appointment with other therapists and poor communication of technology use and accessibility. In general, many clients report failure of other therapists to follow through on the initial inquiry call when seeking services.

As a CMHC, since approx 2022, telehealth has pretty much been confined to involuntary screens and some prescriber appts. On occasion, other staff will utilize telehealth.

As a provider who spent his first 12 years of practice face-to-face, I've been primarily working in telehealth since 2020. I haven't found many issues, if any. I find it to be a really useful and efficient way to work, as do my clients. I don't anticipate working face-to-face again unless something changes.

Aside from the technical aspect not working well at times, I find virtual to be excellent.

Clinicians are often uncomfortable with enforcing the requirements necessary when offering telehealth services out of fear that it will harm the therapeutic rapport. However, allowing clients to engage in areas that are not private or while doing other activities is ineffective and irresponsible.

Clinicians need more freedom to therapy/counsel clients without worrying if sessions would get paid or not.

Concerns around some practitioners not trained on HIPAA and issues around informed consent, telehealth across state lines, and telehealth exceptions during the pandemic that may no longer apply.

Connection issues, increased comfort as client can be in their safe place, etc

Connectivity issues

Connectivity issues.

Difficult to know standards for VPN or other HIPPA concerns

difficulties with interruptions in connection during telehealth sessions

Documentation of telehealth sessions-

Frustration by clients and providers with buffering/technical issues

Have been providing education to supervisees on best practices. Some have training on the ethics and special considerations, others do not.

I am a resident of Texas and live on the Gulf coast. July 9th, 2024, our area was hit by Hurricane Beryl which caused a lot of damage in the area. There were many trees and powerlines down and we were without power for nearly three weeks. Fortunately, I was able to run off of a generator with cellular Wi-Fi and could continue providing telehealth services. However, the challenges many of my clients faced was that they did not have access to a generator or other sources of power to have the session. Especially during a period when they were under extreme stress and loss.

I am grateful that telehealth creates increased access for patients. However, telehealth can at times seem not as quality as in-person therapy.

I did run into the problem that phones/watches are listening. This is a major issue that violates HIPAA and needs to be regulated profession-wide. Phones need to be locked up ASAP if we want to protect client info.

I feel telehealth becoming normalized has allowed me to treat clients who I would not been available to. There are way more pros then cons in my opinion.
I have clients who will request telehealth appointments when traveling for work - these are clients who would like to have access to counseling and are established clients living in Kansas but who travel frequently which disrupts their access to therapy. It would be nice to have the ability to support established clients, residents of KS, who have high-travel work.
I have concerns regarding the encryption method for some platforms. I don't believe agencies and professionals are fully aware of the drawbacks and legal requirements to accommodate the confidential practice for the client.
I have heard negative comments and experiences provided through Better Help - the most recent one was a client who reported their Better Help therapist was only visible by chin and nose and appeared to be doing their laundry during the therapy session.
I have heard people may still be practicing across state lines and not following the "other" state's protocol or guidelines as it relates to tele heath (e.g., a MO client is first seen in office in KS but then wants to move to telehealth and counselors do it).
I have no concerns with Telehealth being effective. I have had at times situations that creates other aspects, ex. having a domestic violence situation where I am having to also create wellness checks while on call or someone being under the influence.
I have not experienced any and have not heard of any issues.
I have not experienced any issues related to telehealth.
I have not experienced this personally, but I have heard on LinkedIn and on other counselor forums that clients receiving counseling services on some of the large internet-based platforms have had their counselor leave without notice/sessions terminated without notice or resources for transfer. I further understand this is not related to the therapist but to the internet platforms who remove therapists without notice.
I have not used telehealth.
I have not, directly, but I have heard some horror stories - including a client that masturbated during his session and a client that was intentionally using telehealth to proposition therapists, inappropriately.
I have not.
I have significant concern over how KS and other states will implement the Counseling Compact, specifically how they will make it a slow, tedious and expensive process with 50 different sets of hoops to jump, making it essentially useless.
I haven't, or not that I can recall.
I heard antidotal accounts of negative experiences, both from clients and providers, on large national Telehealth businesses like Better Help
I know of counselors/therapists providing Telehealth in states they are not licensed in and have not received exceptions in. When discussed with them, they stated their attorney said they are allowed to.
I love tele health. I think it is a wonderful tool.
I prefer not to practice this way. It is too limiting, and there are often many technical challenges. I make exceptions for illness if the client would rather not reschedule.
I really enjoy telehealth. The only issue has to do with the technology not working effectively at times.
I see a lot of people that wouldn't or can't come otherwise.

I still still somewhat surprised at how many clinicians are unaware of state regulations and ethical considerations regarding Telehealth.
I think telehealth has some unique challenges that come with it (such as needing to find the correct emergency services number for clients in different locations), but I haven't noticed anything that can't be managed by the therapist.
In my opinion telehealth is NECESSARY to reach those areas which are remote and those clients who will not drive to see a therapist due to their negative feelings about "going to a counselor".
Insurances not paying for telehealth services
Internet can be slow
Irregular signal strength between some is locations and me
Issues, not really, out in western Kansas it is definitely a service that has been beneficial, but internet often is an issue. Otherwise, our telehealth services have dramatically increased, now fearful insurance will stop reimbursing.
It has been such a wonderful addition to my practice. My patients really appreciate the option. No issues at all!
It was not really a concern, but it appears to be more challenging to assess and support a client over telehealth especially when you are concerned about SI or NSSI.
its a love/hate relationship
It's more difficult to maintain/ensure confidentiality.
It's not as intimate, but is still appropriately effective.
I've had good experiences with telehealth. The only downside can be if client has spotty connection with their internet can be difficult.
Just issues with telehealth programs themselves, such as issues with Doxy not working effectively.
Lack of awareness around laws & regulations providing telehealth services
Lack of compassion
Love it
Many people access telehealth services. I worry about people utilizing AI, but we will see how that plays out in the future.
More so reminding some patients that they need a private space for confidentiality and that they can't be driving during sessions. Most people are great at remembering that but there is a small number that are not.
Mostly just a general move in the direction of distance care vs. in person care. My preference will always be face to face with virtual being a resource for occasions of illness, difficulty with transportation, etc.
Mostly technology issues that impede with staying in the moment.
My biggest concern is the lack of reliability of the connection. Nothing is as fool-proof as meeting in person. Most clients I have worked with navigate technical challenges fine, but it can be very disruptive and affect the efficacy of the session.
No -- it's been a very valuable option to be able to provide to my clients.
No (199 times)
no but I do not have any clients choosing to do telehealth
No concerns.
No concerns. I will share allowing Teletherapy platforms for clinical supervision has expanded opportunities for both supervisor and Supervisees.

No issues, most clients prefer it.
No not within my observation.
No real challenges- just making sure that patients tuning in are located in the State of Kansas. Working in KC (near State Line)- with Patients from both KS and MO...it requires due diligence and good communication skills for exclusions.
No specific issues regarding telehealth.
No telehealth services needs to be increased to meet needs of rural patients
No, I have had positive experiences.
No, I love telehealth and wish I could do more of it.
No, I personally utilize a Telehealth system through my secure electronic based system that keeps every thing secure.
No, most people love it and think it makes counseling much more accessible.
No, not in my direct observation. I've been conducting telehealth for several years now with success.
No, telehealth continues to be a great resource.
No, telehealth has been a surprisingly good way of offering quality care and quality mental health services.
No, telehealth seems equally effective as in-person counseling for many clients
No, the current platforms available such as zoom workplace are secure and effective.
No. For the rural/Frontier population who have to drive 45+mins to get to a location to see a therapist, it has been a great option to be able to do therapy. Otherwise they won't be able to as missing too much school or work.
No. I have seen that telehealth has made counseling much more accessible to clients. My clients are more able to attend in a more regular basis and my treatment efficacy has improved with the telehealth option. This observation is congruent with research. I do think it is important for counselors who do telehealth to have training in the ethics of telehealth and telehealth in general.
No. There are great ethical CEU's out there for telehealth practices.
No; once clients and providers became used to it during covid, it's now a seamless part of my practice.
no; Re questions 9 and 14, I do not supervise anyone, and I am a solo practitioner, but the responses offered do not allow me to say that directly.
none. I'm not a licensed supervisor.
none. telehealth is a lifesaver and convenience with access to treatment/services for both practitioner and client.
Not really related to telehealth
not that I'm aware of. I personally don't like using Telehealth though. So I might not be the best person to ask. Although I have been frustrated when I can't treat people out of state through Telehealth. It would be nice to be able to practice across borders.
Not using telehealth at all in current job. All contact is in person.
Observing co-workers walking around the office providing services by phone or tablet on speaker mode for anyone in the office to hear
Occasionally, there are clients who have others in the room (not visible to the camera) when they say they're alone. I always remind the client of the need for confidentiality.
Once or twice -I was concerned about privacy of my client when utilizing telehealth (a minor client)

One thing I wish were different would be the ability to provide telehealth services to clients across state lines, particularly if a relationship is already established. (i.e., if an established client moves to another state)
Only that it takes a little more energy to run an telehealth session.
Only the need for more creative interventions that don't require hands on activities or finding ways to augment hands on activities for tele health.
platforms are not stable, frequent technical issues
Practice limitations based on state when the client resides.
primarily only connectivity issues. other issues are boundary related such as a clients choice of location (e.g. car, shared dorm room etc.) causing interruptions and limitations of the actual therapeutic process to fully work
Privacy can be an issue at times with clients logging in when out in public.
Providers continuing to use telephone (audio only) services.
Setting clear guidelines and expectations for clients who are using telehealth, such as having a private space, good internet connection, and limiting interruptions and distractions. These things are not always within our control, but it is within our control to communicate our expectations for using telehealth ethically and effectiely.
Some clients are not suitable for telehealth and would be better served in person.
Some clients are not truthful and without the whole body shot, it is sometimes difficult to see "tells" of dishonesty
Some clients misuse it...lazy way to get in a session...but no commitment to process. I limit my telehealth presently to a very select few .
Some states require you to be licensed in that state to practice .!
Sometimes technical issues but otherwise I have found it more useful than problematic.
Standards and professional practices in telehealth (no interruptions, know where your client is, appropriate background, etc)
statutes changing post covid about state limitations, frustration with the compact care law not passing
technical connection issues, decreased attunement/ missed cues
Tele Health has allowed many many people that would not otherwise continue to get mental health services. it is not the greatest for children, but it is better than nothing at all, which is what a lot of them would receive.
Telehealth for me does not seem as effective as in person
Telehealth has been an absolutely wonderful option for myself as a clinician and the clients I serve. I am grateful that COVID encouraged new opportunities and acceptance in this realm of treatment.

Telehealth has been great for my clients, until they move (or are deployed in military service or training) or spend time out-of-state due to work or family care. If they are not in a state where I am licensed, I cannot see them at all. It's not just KS laws that impact this, but the laws of the state where they are. I understand the need for state regulation of the profession and I am not against it, but would like to have clear processes for seeing clients on a limited basis when they are in another state. The lack of clear carve-outs disproportionately impact military couples and families, families who work in a travel/transportation industry or have a member who travels regularly for work, and families who need to leave an area for their safety or economic reasons.

Telehealth has been wonderful when it has been needed for providing more accessibility to clients. I have not seen any issues for the clients who enjoy the telehealth option.

Telehealth has grown incredibly important and should not go away. We see increased access and lower no show rates.

Telehealth has it's pros and cons. It makes so many things more convenient-being able to see clients who are further away and who do not want to change therapists, easier to have meetings, etc. However, it does make it easier to not be fully present in conversations or sessions at times.

Telehealth is a great platform. The changing rules of where the client is or where the practitioner is has been confusing since COVID.

Telehealth is not really therapy. It's a conversation. It can be more beneficial if you already have an established in person relationship with them.

Telehealth makes it difficult to read body language and develop a healthy connection for treatment in most of the cases I've experienced or heard from others about.

Telehealth practitioners who do not reside in the Midwest counseling clients in Kansas does not bring a positive outcome for the clients.

The biggest concerns I find are on setting boundaries and limits with clients around what they are doing during therapy. I have had many experiences where clients are running errands around town during session or are not in a private space for individual therapy. I have found many clients struggle to turn cameras on during group therapy held via telehealth, despite shaping by group leaders, which can make facilitating group dynamics more challenging and it is unclear if clients are in a private space or paying attention to material presented which brings up several ethical concerns (again, privacy but also, is it ethical to bill a client I'm not seeing, not being sure if the client is even present during therapy, etc).

The concern I raised, as well as other clinicians, is that telehealth services eliminate several factors that help build rapport and bridge connection with the client. It is difficult to work with certain populations via telehealth due to the additional distractions you have to navigate (especially with younger populations).

The concern is fraud by not documenting accurate time for how long sessions actually are.

The only issue I have experienced is WiFi failure but the technicians typically have it up and running before I start with clients.

The vast majority of my practice has been telehealth. It has grown dramatically since COVID/2020. This has really been a gift to the rural communities and individuals with limited means to receive professional services.

The worst aspect is having to be licensed in the state you are in as a provider and the state your client is in.
There should be a way to see clients from other states. It was allowed during covid but then revoked.
Too many clinicians not understanding confidentiality for telemedicine.
Uncertainty about where clients/providers can be physically located.
Venture capitalist backed companies and "billing services" have concerning and increasingly unethical business practiced
When the technology does work it can be frustrating, but most of my clients make the same progress telehealth as they would with face to face counseling.
With licensure in the state where the client is located. I have heard about some not paying attention to this.
Yes (3 times)
Yes, educating clients about limits and boundaries have been challenging. Clients wish to engage in session in public environments or lack privacy in their homes, have wanted to participate in therapy while driving, or want to continue gaming during sessions.
Yes, not making client priority such as walking dog or cooking during sessions.
Yes. Needing to discontinue working with a client because they move to another state.

LPC Q14. Over the past two years, have you experienced any negative issues involving supervision? If so, please explain. (227 responses)

A reoccurring issue I see is the lack of ability to be provided supervision by someone outside of one's license despite their qualifications and their proximity to the supervisee (I.e., working within the same practice/building).

All the supervisors I have had have been great and very helpful.

As mentioned above, if someone is under supervision in MO or in KS it would be great if they could see clients in either state and count towards supervision hours in the state they are receiving supervision. Who does it hurt if they are just wanting to reach and help as many people as possible?

Communicating with the board to find an available supervisor was a nightmare experience. It took me over a year and a half to even begin my training plan because I could not find a supervisor that met all the requirements and I could afford and see when needed. The spreadsheet of supervisors that is given out by the board is outdated and inaccurate as most of the counselors listed do not offer supervision anymore.

Cost and availability

Couldn't have supervision hours remotely while in the process relocating

Have not been able to locate LCPC to supervise hours

I am seeking supervision for my clinical license; however, supervision is difficult to find and when found the fees are insanely high due to no regulation; consequently, many LPC wanting to become LCPC are unable to complete the process.

I did not have a positive experience with my internship site and wish that these supervisors needed to have additional training

I have not experienced any negative issues involving supervision.

I have not noticed negative issues.

I have not. My supervision has been helpful.

I LOVE my supervision time! My supervisor is a wealth of resources, thinks outside the box, and is creative. She is excellent about ethical concerns, particularly helpful with questions about mandated reports. She doesn't hesitate to call me out on something- well that is a bit strong. Rather, she's straight forward and points out concerns I need to see in a nonjudgemental manner. Honestly, the wealth of the sessions are a small part of my procrastination in starting work for LCPC. I just spoke with my supervisor this week about it, she suggested moving into a consultation role after I have earned the LCPC.

I moved from Illinois to Kansas and I have had a very difficult time finding a supervisor. In Illinois, more often than not, the employer provides supervision for the employee. For Kansas, that has not been the case.

I struggle with the notion that only LCPCs can offer supervision. I'm in an environment where I have PhD and PsyD clinicians/psychologists who are willing to provide free supervision. However, finding LCPC clinicians to work at a state inpatient psychiatric hospital is not easy and therefore I'm having to pay for supervision out of pocket. It's frustrating.

I think the hardest part of being in a school setting being pulled in many directions and feeling limited on time.

I wish that supervision was more directive and instructive

I'm not in supervision yet.

I've had 3 supervisors & all of them have provided the same, mundane experience. Despite finishing my hours months ago, it's annoying to have to be on the supervision plan for minimum 2 years, although I understand why. I'm sure I'd feel differently if I got something out of supervision. The cost of supervision is also a drag.
In a prior work environment supervisors/management tried to keep licensed mandated reporters from reporting.
It is incredibly difficult to find a supervisor who is qualified to do the amount of work required. Furthermore, keeping somebody as a supervisor is a balancing act that requires constant PR.
It was difficult for me to find a supervisor to supervise me for my LCPC.
It's been difficult to maintain consistent support and supervision.
It's just so expensive. I understand it but it can be really hard as a new therapist
I've never had the option for clinical supervision but this is my first job as an LPC and my supervisor (LCSW) is amazing. We need more supervisors like him that are solution focused
Lack of availability, needing to be LCPCs,
Micromanaging from my supervisor in critical situations where crucial decisions need to be made quickly but are restricted.
My supervisor is fantastic. Sometimes I just have questions on how close of oversight she should have over my management of clients (review progress notes and treatment plan?)
My supervisor started telling VHA leadership that I had mental problems. My supervisor, in a dept.-wide conf. call said we could share information with patients. My Supervisor didn't take responsibility and I was given a review that included any complaint I had over the 12 years I worked there. My Supervisor had been fired at one time for having sex with a patient. She was rehired. Her Supervisor never reported this crime to licensing. My website is: stolenhealthcarebenefits.com I need to update it.
No (151 times)
No my supervision Hollie Foley exceeded my expectations.
No my supervisor is great
No negative issues
No, Christie Kelly is the best. Her knowledge is extraordinary and her compassion and understanding is the benchmark we all strive to be.
No, I left my job with a not great supervisor. She and I had different values and I felt she overstepped when she would rewrite my documentation without telling me.
No, it is just hard to find a supervisor that is reasonably priced! Then to have our supervision ours increase from every 15 hours to 20 hours, made it more costly.
No, I've had positive supervision experiences
No, my supervision experience (group and individual) has been professional and educational.
No, my supervisor, Jennifer Agee, is great, and has always been available for any questions that may come up, as well as covering topics preemptively.
No, really the only challenge is the cost, but I have had amazing supervisors
No, the supervision plan was approved quickly by BSRB and I have had incredible experiencing with both of my supervisors.
No. I have a wonderful supervisor.

No. My group and individual supervision has been fantastic. I feel very supported and challenged.
No. My supervision has been great.
None other than may be a possibility of having the supervisor have at least 5 supervisees not less.
Not all supervisors are created equal. It would be helpful to have a set program for training clinical supervisors so quality of supervision is consistent.
Not in KS
Not personally, luckily. I have observed several friend-colleagues have significant issues with supervisors who "power trip," hold signing off on hours "hostage" based on unreasonable (and unprofessional) demands of the supervisee, and conduct supervision based on the supervisors personal unhealthy behavior and/or unethical business or therapeutic practices. This is not uncommon.
Personal conflict.
See prior comments
Sometimes not enough and other times too much!
Stated previously, it's the lack of ability to get or afford to get supervision for me.
Students having lower value in a private practice setting
Supervisor of non lcpc pursuing new therapist not taking time when supervisee had questions because she didn't have to according to her.
Supervisors are hard to find in my rural area.
That is was difficult to find a supervisor and the list was not easy to get or even know who to get it from.
The cost of supervision for the supervisee is a struggle while the supervisee is working in positions that are underpaid
The only negative to working with a supervisor is the cost of doing so.
The only questions have been who is supervising. We have a lot of social workers out here operating under the supervision of someone, somewhere. It is not always clear if they are not with an agency.
The State requirements of supervision hours before obtaining LCPC seems a little extensive.
Yes but with my former employer.
Yes- the only supervisor available to me at my agency is someone that does not specialize (or even work with) the age ranges that I work with.
I could benefit from being able to use ANY licensed professional (not just an LPC).
Yes with my first/previous supervisor but I do not feel comfortable with explaining further.
Yes, but will not express it today.
Yes, I'm not sure there's a structure to it that could be followed to help aid in growth, but I have not yet had a supervisor that follows one.
yes, lack of knowledge of biases
Yes, personal bias
Yes, poor preparation & ethical decision making.
Yes, supervisors that were too busy to provide thorough supervision. Or ones that were not equipped to speak to the populations I serve.
Yes, too many hours. Also, should be allowed to utilize any licensed helping professional. It's so limiting to choose from a list. Especially in rural communities.

Yes. I had one who was inconsistent and reassured me my hours would be ok. They were not.

Yes. For some reason there is an idea among the board that those with PhDs in psychology somehow have vastly different backgrounds than those of us with Master's degrees. This led to me not getting my supervision plan approved for months and not being able to have the supervisor that I wanted. The idea that LPC's can only be supervised by LCPC's is frankly ridiculous, and should be changed immediately.

Yes. I had a complaint filed against me that was dismissed by the BSRB, my supervisor has told me she refuses to take clinical responsibility over a client of mine that I was in a very fragile state, the client was able to get to the right resources and supports through my relationship with other community providers, I was supported by other clinical supervisors during that process. Present day, I finished all of my post graduate clinical hours and am in the process of submitting my application to sit for the LCPC exam.

Yes. I had issues with finding the right supervisor on the list provided by the Board because there is no section listing specialities or emphasis. Additionally, several supervisors that I had contacted were concerned about how I obtained their phone numbers and or email addresses. I believe the list needs to be updated and include supervisors' business phone numbers and business email accounts. I had one supervisor show interest in taking me on as a supervisee, and then suddenly stopped all communication with me. I had another one who I signed a contract with and started services, only to be frustrated with his unprofessional comments about past colleagues. I finally found one who is amazing, and I am highly satisfied with her services (Jennifer Agee).

Yes. My supervisor was new to supervision. I was already in the field a few years before starting supervision. I was excited to start supervision, but I got very little out of supervision.

Yes. Poor guidance and favoritism.

Yes. Sometimes I feel like my supervisor is unsure in decision making and she can get too personal at times

LCPC Q15. Over the past two years, have you experienced any negative issues involving supervision? If so, please explain. (344 responses)

A supervisee's personal mental health and trauma history interfering with work with clients and relationships with colleagues

Additional CEUs and license to supervise. Additional expenses above and beyond keeping license current!

Bad supervisors who don't care

clarity around fees

Clinicians who are not on a training plan frequently ask about requirements for supervision. It would be nice to have more direction and oversight over those clinicians who are not on a training plan.

Cost of certificate to supervise.

Documentation overload

Getting treatment plans approved.

Getting responses from certain people at the BSRB

How to provide group supervision-

I am finding that supervisors do not want to sign off on hours at the end of the supervision period and have not informed the supervisee of any concerns about their skills until time to sign off on hours. I have also had supervisees whose supervisor made them pay the supervisor their hourly rate in order to receive their signed hours. This did not happen in KS, but I am seeing it more often with supervisees in other locations.

I am not a licensed supervisor, currently an LCPC but would greatly appreciate clarity on how to become a certified supervisor. It's quite ambiguous to someone working outside of the state.

I am not a supervisor (15 times)

I am not a supervisor. Why do these questions assume I'm a supervisor?

I am not providing or under supervision . At work , my direct supervisor is generally only available via email.

I am not supervising anyone.

I can be difficult when my Supervisee's are not able to finish their notes in a timely manner.

I chose the answer one on question 14 because there is no zero. I am not providing supervision to anyone nor have I provided supervision to anyone in the past 2 years.

I do not currently provide supervision

I do not currently supervise anyone

I do not provide clinical supervision to the providers I see, but am their administrative supervisor in the setting I work. I primarily supervise social workers and 1 LMLP. I've had quite a few difficulties navigating defensive team members who do not take feedback well and have difficulty developing insight into their behaviors. I work on a team setting, so there has also been a lot of enmeshment in our therapy team that I've had to address and shape which has been challenging, but a good growth opportunity for all involved. I've done supervising of practicum students in a counseling MS program in the past and had minimal issues there, both times the students were very open to learning and receptive to feedback.

I do not supervise anyone, nor am I under supervision

I don't provide clinical supervision at this time.
I don't provide supervision -- There isn't an option on this survey to say I don't.
I don't supervise licensees. I supervise professionals in the agency practice only.
I find the format of logging hours to be confusing
I had a horrible and unethical supervisor two years ago that resulted in me leaving that organization (despite loving the work.)
I have not conducted clinical supervision virtually (through telehealth). Only direct in person supervision when doing so.
I have not provided supervision in over ten years. Note: Item number 14 (see above) has no option listed for no supervision.
I have not supervised anyone. I have colleagues I meet with regularly to discuss cases.
I haven't experienced any negative issues involving supervision in the past two years, but I also don't provide supervision, in case the question was for those providing supervision.
I like that supervisors need to have supervisory CEU's but I think the requirement is too much.
I no longer supervise, however I did not have a good experience with the student intern. She was underprepared and lacked self-awareness.
I only supervise support staff
I provide more informal oversight of positions and have had no issues
i would like more practice testing materials for supervisors for us to help our supervisees navigate the exam. Besides the one practice test that can be ordered
I'm not a supervisor, and my supervision was fine
I'm not supervising anyone
I'm not a supervisor. I haven't yet had my "C" for 2 years.
Imposter syndrome reported by supervisees, feeling like a failure in the counseling room.
it has been extremely difficult to find the appropriate supervision courses and become a board approved supervisor
It is difficult to keep straight the differing requirements between states & how/where to find requirements of each state. Things evolve & my supervisees (and I) sometimes feel behind on figuring out those requirements.
It's not that I prefer not to answer; I'm not supervising anyone.
I've just become a supervisor for the BSRB and just moved into a director's position with the company I work for. I have a really good supervisor so this has helped me a lot to move into becoming one myself.
Lack of available approved supervisors was an issue when I needed it.
Lack of basic counseling skills.

<p>Many new graduates do not understand what the state requires to practice independently. I supervise a postgraduate who has been waiting over a year to receive notification from the board of the results from a complaint filed against them.</p> <p>One of my postgraduates has gotten incorrect information from another supervisor.</p> <p>Many school counselors in Wichita appear to be using their work with students at school as clinical contact hours. They appear to be doing so in spite of the fact that they don't diagnose and treat using DSM-5TR. They do not provide mental health therapy and appear to be doing so without informing the parents that they are practicing under supervision.</p>
<p>My concerns are with supervisors who are unethical and therefore could be teaching others to be unethical thus damaging the future of the profession regardless of licensure.</p>
<p>N/A - I have not yet taken on any supervisees</p>
<p>New practitioners not clear on risks of communicating with clients outside of sessions</p>
<p>No (222 times)</p>
<p>No because I don't supervise.</p>
<p>No concerns.</p>
<p>no negative issues</p>
<p>No other than the need for mor CEU's that pertain to post grad supervision.</p>
<p>No, I have been blessed with highly conscientious, mature supervisees starting a second career.</p>
<p>No. I do not provide supervision to anyone.</p>
<p>No. Lucky so far</p>
<p>None at all. I had except Supervisors. I'll be excited to be one in a couple of years. I do wish I could offer supervision sooner.</p>
<p>none involving the individuals I supervise.</p>
<p>none, I appreciate the updates you did to the required hours of supervision for counselors to be in line with social workers and other similar licenses.</p>
<p>None. Currently not in supervision, but will be starting as I finish up my certification in Play Therapy in the next 6 months</p>
<p>North Dakota did not accept all supervision hours from KS</p>
<p>Not a current supervisor; only been an LCPC for 1 year</p>
<p>Not any issues that aren't remedied through some informative coaching and collaborative discussions. I supervise clinical and non-clinical staff in a residential MH/SUD setting, so issues that arise are very much 'in the moment' and readily addressed.</p>
<p>Not at this time.</p>
<p>Not currently supervising anyone.</p>
<p>Not having a way to market my availability or connect with potential supervises.</p>
<p>Not in the past two years.</p>
<p>Not supervising at this time</p>
<p>Not that I can think of</p>

<p>Noted above and copied here: new supervisees seem to have less focus on self development than helpful for growth as a counselor. In a sense they are less introspective and open to exploring personal growth as part of counselor development. Unsure if this is a trend/related to their education or <u>individual traits with two of my supervisees.</u></p>
<p>Oh, yes. My first supervisor fired me because I could not keep up with her constant schedule change, she falsely accused me of not being compliant. Since then, I struggled with trust and finding a good supervisor and it took 7 years to do so. Supervisors think they have so much authorities and power, at some point they treat supervisees unfairly. I am so <u>glad I am over now.</u></p>
<p>One of my supervisees that is in private practice struggles to be consistent coming to supervision</p>
<p>Only one Art Therapy graduate from Emporia State University under my supervision has remained in the state of Kansas to continue working after completing supervision. All the others have sought work in Missouri due to <u>accessibility of licensure.</u></p>
<p>Only when an employee engages in unprofessional conduct and/or has performance <u>issues.</u></p>
<p>Personality differences, struggles with staff continuing to make the same mistakes repeatedly to the point of needing formal right-ups</p>
<p>Providing clinical supervision is getting more difficult and seems like too high-risk for liability. The online university candidates seem to lack in clinical areas that should be covered at university such as clinical writing, treatment planning, assessment and <u>diagnosing.</u></p>
<p>Recently started supervising again.</p>
<p>Some Supervisors are pressured to schedule their clinicians 24.5 and higher clinical hours or more. <u>Burn out with high need clients.</u></p>
<p>Sometimes the ending/licensure application piece for full licensure is cumbersome, and the person has to continue under supervision at full speed, even though they've completed their hours and application process. A suggestion within this would be a different type of monitoring, adherence, where the person does not have to see their supervisor necessarily weekly/pay for supervision the full-time while they're waiting on their licensure application to go through. While I have to adhere to the rules, this is something I've mentioned in passing <u>to others in discussion of the same topic.</u></p>
<p>Struggling to get paperwork confirmed.</p>
<p>Students who's course work was during COVID struggle with the application piece in the workforce.</p>
<p>Supervisee's often don't want to improve and go through the "motions". I had some leave due to supervision conflict and didn't want to "do the work"; they moved to supervisors that checked the boxes. Additionally, I notified the board of my termination of those relationships; not sure what happens and if that's an appropriate response, but I wouldn't <u>have recommended them for clinical licensure.</u></p>
<p>Supervisees often seek me out after having bad experiences - supervisors with too many supervisees, some supervisors are running groups but not individual or are not taking <u>responsibility for EVERY client a supervisee has seriously</u></p>
<p>Supervisors that take on post grad supervisees without the adequate time or training to support the new clinician.</p>

Telehealth has provided an increased benefit to those supervisees who cannot travel to a supervisor. The reasons for this might be busy schedule, remote distance or their own life situations. I actually travel to their offices several times during the clinical supervision experience. I can get a better idea about their practice by doing that than if they travel to mine. So I think a combination of in-person and virtual supervision is NECESSARY!

The BSRB making changes and not implementing them. For example: The vote to change the 1:15 ratio language happened and I have followed up many times for clarification and told it's not moved any further. How are supervisors supposed to be up to date and accurately informing supervisees when there are multiple conflicting pieces of information?

The only negative experience I am aware of is the limited option for supervisors to supervise via telehealth. I am not sure if that is correlated to BSRB regulations or more of a University preference.

The only negative I would share would be the board helping supervisors and Supervisees connect with a central location/platform.

Therapists, like most people, are expressing difficulties managing social situations, accountability, hard conversations, etc. I have supervised therapists resistant to receiving feedback and requiring much more oversight and direct instruction in the last two years, as compared to early supervision experiences. Although this has been a problem off and on through the years and I have adjusted my expectations, learned how to lean into hard conversations, and gotten more practiced at putting in performance improvement plans ... I don't understand the descent from what the profession once seemed to be. I am even more appalled that there is not consistency across disciplines. It seems like LPC's have much more strict oversight than MFTs or LMSW's. Some disciplines don't even have supervisors sign off on their progress notes!

There are online trainings, but not many in person.

(1) There does not seem to be any follow-up on insuring that supervisors are getting the required bi-annual CEs.

(2) A current list of Board Approved Supervisors would be VERY helpful to those looking for supervisors and help with the notion that there aren't enough LCPC supervisors in the state.

(3) There are some supervisors who are allowed to JUST provide group supervision (and make BIG money at it) and therefore don't feel like they are liable for the supervisees' full case load, instead putting the burden of it on the individual supervisors. This needs to be clarified as to who has the primary responsibility when there are multiple supervisors.

(4) It also needs to be clarified that if you are related to a supervisee or have a close relationship with that person you should not provide supervision. (I can't believe this is being allowed to happen and there is no question about it on the forms).

There seems to be some confusion around what the requirements are to measure the supervisee's progress. A clear rubric and description of what it means to meet the rubric could be helpful.

unfair cost for value when I was being supervised

We are supposed to be gatekeepers. However, I see Cluster B personality disordered people being graduated through the system. We are not that desperate for counselors. More care needs to be given when it comes to identifying those who are disordered and could damage others who trust them.

when a supervisee is reported, why isn't the supervisor brought in?

When I supervised or taught at WSU, I frequently found that dissatisfaction with course requirements, etc., were expressed not to me but to the person above me. I interpreted that to the low self esteem and the lack of assertiveness training. I eventually left that environment.

When trying to be transparent about countertransference with a client, I was shut down pretty quickly and felt shame rather than met with openness. Counselors need places they can go and be completely vulnerable and honest about how they struggle with certain clients.

Yes

Yes, but not with the state of Kansas, with another state.

Yes, I had to report a counselor I supervised for ethical violation.

Yes, I have noticed that the geriatric training for counseling septuagenarians & octogenarians is inadequate to meet their present & varied life-styles.

Yes, my supervisee struggled to keep up with the admin demands of private practice (progress and psychotherapy notes, billing, etc)

Yes, not seeking consistency in supervision. Very few ppl seek supervision or consultation in Ks consistently

Yes, one supervisee reported inappropriate behavior from a colleague at an agency that created ethical challenges for her internship.

Yes, staff not following the assigned protocols.

yes, supervisees not communicating with supervisor and not following policies and procedures because they have their own idea. Not wanting to work hard, not being compliant with notes and not using clinical language because they "want to say it like the client speaks" even when not quoting.

Yes, unethical practice by a licensed psychologist. Has been reported to BSRB and is undergoing investigation.

You do not have 0 as the answer - I am not currently supervising anyone

LPC Q15. Do you currently use artificial intelligence (AI) in your practice? If you do, in what areas do you use AI? (274 responses)

Absolutely not. Ai is deeply unethical.

Assistance with treatment planning.

Chat GBT for marketing suggestions

composing generic messages for emails or web pages

Developing treatment plans

Grammarly to check my sentences.

Have used for notes on a limited basis

Heidi Health for transcribing notes

Help me reword sentences for notes to make more sense.

Helping to conceptualize cases, research, to increase general knowledge.

I have begun researching the topic and benefits/challenges, but not implemented any use within my practice.

I have used AI to assist in writing generic note templates in the past as a means of trying out the technology, but I do not currently use AI in my practice.

I have used AI to help write my bio for our website and construct blogs for our website.

I have used AI to look up resources.

I have used ChatGPT for my website, to help with wordsmith.

I use AI to generate ideas for supporting clients.

I use AI to help provide examples of goals related to desired outcomes and then personalize the goal with the individual

I use it for ideas sometimes with sessions.

I use it to assist me with conceptualizing my notes.

I would if I had to deal with Cigna.

In writing reports

I've used it only once to generate an initial structure for a group therapy offering- after the initial basic structure was generated, the group structure was then adjusted, developed, and created to completion without AI.

Just starting to and I am very distrustful of this type of software.

No (171)

No AI is not used in my practice.

No, but I am going to schedule a training.

no, but I am interested in using AI in my documentation.

No, but I really want to but could use some training on how to do it well, and ethically.

No, but I'm interested in implementing AI in my note taking.

No, I have never used AI in my practice.

No, I'm old-school, and prefer to write my own notes.

no, not allowed

No. But I'm interested in using it for assisting with my session notes.

No. I am concerned about the use of AI in practice.

No. I believe it is unethical.

No. I wrote all of my own chart notes and only utilize Grammarly for cleaning up emails and providing an accurate tone. Otherwise I keep everything in alignment worn how I was trained. I do think AI can be a really helpful tool in helping with charts and keeping everything streamlined.
Not applicable
Not at this time.
Not currently.
Not personally
Not that I am aware of
Not yet, but we are going to soon.
Not yet, but will be this year.
Not yet, currently being vetted by employer
Not yet, our community health center is working on adding this
Note taking
Occasionally to change wording for court reports. Very minimal use of AI overall.
Rarely. I've tried it to make a chart note more professional but found it lacking.
Sometimes to aid in creating a tx plan
Sometimes to get help brainstorming interventions
Sometimes. I only use it to help session plan if I am on a time crunch or need some new ideas for patients that are not receptive to traditional therapy.
Starting to
Strategies and treatment plans
Used ai one time for a test case conceptualization using a fabricated client. Has potential but question the ethics of using real information without disclosure, even if personally identifying information is not used.
We are about to roll out AI technology for clients via an app.
Yes - we use eleos to help document progress notes
Yes for drafting communications to clients and stakeholders
Yes in helping with notes, treatment plans and ideas to help a client. I use my own words but it helps to give me an idea on how I set it up.
Yes, composing notes or documents without client specific details.
Yes, documentation
yes, for notes
Yes, I use a HIPAA compliant program that records sessions and uses AI to generate soap notes. Life-changing and clients are properly informed/consents are signed.
Yes, I use AI to help with writing letters, reports, and notes.
Yes, I use it as a tool to help create policies and procedure documents, termination letter templates, and business related letters. I occasionally use it to create handouts for coping skills and self-care. The accounting program my business uses will be implementing AI technology. My professional email has AI built in to summarize, set a tone, and correct grammar. I use it to ensure my tone is professional yet friendly, and my grammar is correct.
Yes, in helping me with documentation and some interventions
Yes, it comes with the EHR I use.
Yes, note-taking.

Yes, with client informed consent, to help write intake and progress notes.
Yes, writing outlines for treatment plans and worksheets.
Yes. Emails. Assistance with treatment planning and just began using HIPPA compliant notes assistance.
Yes. I use AI to record sessions and transcribe my notes.
Yes. I use Blueprint for transcribing notes for insurance
Yes. I utilize a service called Upheal to help me with my notes.
Yes. In Research and indirect services
Yes. Note writing it is mandatory here

LCPC Q16. Do you currently use artificial intelligence (AI) in your practice? If you do, in what areas do you use AI? (442 responses)

A little. I just sometimes ask Chat GPT a question.

Absolutely not as it is a violation to use any type or form of recording in session or to enter clinical information into such an unregulated and easily accessible system to the masses.

Absolutely not.

After I have drafted an email I will ask ChatGpt to polish the email for me.

Assist with documentation

Charting

Do not use

Do not use AI.

for documentation only

For progress notes dictation.

Goblin Tools for ADHD and ASD clients

Have just begun using HIPPA secure AI it for some documentation. Clients PHI is withheld.

I do not, but I am interested in how it can help or how it can undercut current practice.

I am in the process of researching AI for note taking, but do not currently use any AI in my practice.

I am not employing AI at this time.

I do not

I do not currently use AI

I do not, but I know others who do. I use AI in other areas of my life, but not in my counseling practice. I'm on the fence on whether it can be helpful.

I do not. I would like to, but I worry about HIPAA risks. If the BSRB had a program which recognized approved AI programs for progress notes, that would be so helpful.

I don't use AI in my practice at this point, but have used it in other areas and find it useful. However, I have some severe concerns about how AI might soon be used to summarize therapeutic conversations and turn them into the body of a note. From my experience as a supervisor, it's important for the provider to consider the therapeutic conversation within the context of theoretical orientation, client development, etc. and AI likely can't make those connections. I think it's important for the provider's note to be an accurate statement of the interaction while remaining in context and AI will be a threat to that balance.

I have not yet, but it is an area I intend to research for assistance with note taking.

I have used it to create content for my website. I have not engaged with it in my client notes.

I have used it to help me outline a blog for our website content.

I tested it. I don't have enough clients to make it worth it to pay for it right now. But it was pretty amazing when I tried the free trial and I hope to use it soon.

I use a confidential based program for transcribing sessions.

I use a specific AI software for notes as long as the client signed the AI informed consent document.

I use AI for assistance with clinical writing and at times for ideas for interventions.

I use AI to support my dictation for summary notes. I always reread as the AI does not always hear what I've stated correctly.

I use it in TherapyNotes for clinical summaries for intake notes. I also sometimes use it for treatment plans
I utilize online forms that enter information into my computer system.
I work with an organization that is using AI to generate clinical notes after a session. This has proven beneficial so far but still familiarizing myself with the technology.
I'm sure I do but other than spell check, the parts of the electronic record that my company uses and my iPhone I'm not really sure.
Just started for note-taking- so far, not a fan.
My agency is exploring it's use as part of a wellness app as well as an audit tool for our clinical charts.
My employer plans to implement it soon. I do not wish to use it.
No (274 times)
No -- but am seriously looking into AI options for note taking, progress note writing, treatment plan writing.
No - this is a great concern of mine! To be transparent I am a millennial :) I am intimately aware of the many pros of advancing technology, and still maintain a high level of hesitancy to incorporate these advancements due to the overwhelming impact of potential cons.
No but I am interested in doing so - concerns and curiosity
No I don't. I've thought about researching more into it, but if I were to use it, there are AI based notes programs and AI based treatment planning options out there.
No I'm not comfortable with it
No, and I do not believe AI has any place or purpose in our profession.
No, and I have no intent to do so.
No, and will avoid using if possible
no, but I am interested to learn more about this.
No, but we here at my agency are all aware and interested in better understanding it's applications and ethical considerations.
No, I have major concerns about issues with data security and what AI is doing with the information of clients. I don't have any plans of using it in the near future.
No, I have not seen any need or benefit.
No, I'm using AI in my practice.
No. I believe it's invasive and unethical.
No. I do not use AI. I think most of my clients would be uncomfortable with AI, or any of the products available that could generate case notes. I do not use AI at all.
No. I have used AI services to help find specific research documents on the web, so that then I can actually go in and find those particular journals in my institutions library. It does make the process much easier.
No. That is ridiculous. AI is lazy and invalidates anything therapy related.
None related to therapy, occasionally for setting up letters or emails.
Nor currently but looking in to how to integrate effectively
Not currently but I have been looking into note taking AI
Not currently, but actively looking into the matter
Not directly, but I realize that AI is being integrated into many of the apps we all use.
Not for anything other than revising emails
Not in Leavenworth yet.

Not in private practice. Some is used on platforms I am a provider on, but it has to be reviewed and at least one edit made.
Not using A.I.
Not yet
Note taking, Berries
Note using twofold
Note writing. Nabla
Notes (2 responses)
Notewriting
NoY
Occasionally to help with professional languaging (careful to never provide any confidential information or details about clients).
Occasionally, I will allow AI to draft an email response, but most the time I end up changing the majority of it.
Only as a starting point to help with creating new worksheets or email templates.
Periodically use AI to assist in writing letters, reports, etc.
Progress note documentation
Rarely. Have tried to apply it to progress notes with limited success.
Researching
Summaries of books I'm considering buying. Overviews of topics. Research summaries of sub-topics related to mental health. Creation of memes and artwork related to counseling.
Supervision notes
The company I work for uses Augmented Intelligence (AI) for therapy progress note writing.
There are several areas of AI integration utilized. Profile summaries in our client files, AI transcripts during intakes, intensive sessions, couples, and family sessions, etc. AI has also been beneficial in treatment summaries for various reports that are needed.
This program is pending at this time.
Treatment plan writing
creation, design of marketing materials
We are just testing that as a tool; we are exploring UpHeal and Blueprint.
we do not but do plan to implement for notes
Yes
Yes - I use AI for notes
Yes - the agency I work with has contracted with a company called ELEOS to that uses "augmented intelligence" to help write progress notes. It is embedded in our EHR and we have a box in our offices that we turn on during session that serves as a "voice to text" to our EHR and provides suggestions of what to write in the progress note.
Yes Document writing
Yes to assist in writing progress notes
Yes to help with notes
yes, at times to gather information quickly in a session I might use it.
yes, both notes and sessions
Yes, for documentation purpose only.
Yes, for writing collection letters, responding to text & emails.

Yes, I use Zoom Pro with the business associate agreement to provide end to end encrypted video calls to conduct remote therapy. In this product there is now AI Companion. I use this to record sessions. I then go into the meeting summary and pull form this to reduce documentation time by bring more or less of the summary into my notes as is appropriate to provide insurance carriers with enough information to approve submitted claims. This AI produce is also HIPAA complaint.

yes, letter writing, personal notes, emails

yes, marketing, content development

yes, note generation

Yes, progress note documentation

Yes, we have some providers who have processing disorders and spend hours on documentation. We have allowed them to use AI to assist, while also designating supervision time to teaching strategies from streamlining and organizing relevant information for the purpose of high standard charts - so its a "both-and" situation that allows flexibility for learning and keeping up with documentation timelines and expectations.

Yes, we use AI for notetaking purposes. It helps with audits being more proficient and compliance.

Yes, we use Eleos for progress note assistance.

Yes, website development.

Yes. Eleos for progress notes.

Yes. Help with wording sometimes.

Yes. Updating required regulatory documentation.

Yes. Help with editing progress notes.

Yes. I use Google's Gemini AI through which I also have a business associates agreement in order to be compliant with HIPPA. I provide the ai deidentified case information to help me write reports.

Yes. I use it to assist in creating worksheets, journal prompts, and other similar tools.

Yes. I use it to assist with case conceptualization and diagnostics. I do not use AI for anything with protected health info (PHI).

Yes. It helps to write a progress note. The AI will formulate note based on the bullet points note that we create.

Yes. To help draft emails or occasionally to find better wording for notes.

Yes. To provide summaries of meetings.

LPC Q16. 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? (198 responses)

- .
- Advocate for payer sources to recognized the legitimacy of LPC's working within a practice just as much as LCPC's. Also, that clinicians be required to work within a practice such as a CCBHC or other treatment center for 2 years prior to going into private practice.
- Advocate for us related to service provision to minorities, immigrants, LGTBQIA+ clients
- Advocating for vulnerable groups, helping connect different multi-disciplinary teams so counselors can make solid referrals and have an easier time practicing within scope
- Allow an LPC to work independently again.
- Be mindful of life events and offer the same grace and care we offer our clients.
- BSRB experiences has always been smooth for me.
- Change the LPC test. Change the LPC test
- Check in more often to see if we need assistance or at least provide a bulletin email to let us know of updates
- Consistent correspondence. I've had to reach out to BSRB to confirm they have made necessary changes to my information due to a lack of response.
- Ease and access to services
- Encourage the growth of telehealth options.
- Encouraging licensees to serve where they feel most comfortable. Some go into urban communities and are quick to diagnose people through their own lenses.
- Enforce consequences for private practice owners taking advantage of therapist and stealing pay.
- Help to educate the public about the ways board licensure of a professional by the state protects them. People are very confused about the differences between professional counseling & coaching.
- Help us know what "being competent" means when learning new modalities. Do clinicians have to be certified in DBT, EMDR, TF-CBT, etc to use them? How measure when someone is ready to start using it?
- Higher standards for education
- Honestly, the Board should consider becoming a state that requires degrees with approval from CACREP or an equivalent. It was a major contributing factor when I was obtaining my degree because many states require it and there is less hassle when obtaining multiple licenses with other states. I also felt that it provided a level of excellency within my field, as ethics is a large part of program requirements. I also felt that it was just challenging enough to "weed out" certain individuals that probably would not be a good fit for the field, thus protecting consumers.

How can you break through the lifelong old-buddy system of rural communities that have been honored for generations?
I am still learning what is out there that the BSRB provides.
I believe I mentioned everything above
I can't think of any right now.
I do not have any additional recommendations. My experience with the BSRB has been entirely positive and I cannot think of any other ways that the BSRB could help to protect consumers.
I had no idea the advisory board had a YouTube channel until I took this survey so the BSRB could do a better job of informing people about resources the BSRB provides and ways to get involved.
I have no recommendations at this time.
I know other states don't require a test for the next level such as LCPC. This costs more time and money over areas I will never specialize in. I wish there was no test for Kansas. I bet it keeps others from pursuing LCPC.
I think clients could greatly benefit from a therapeutic decision tree of sorts that directs them to the appropriate level of care and possibly evidenced based therapeutic modality options for their needs. Clients are often unsure what kind of therapy/counseling can help them.
I wish that the steps to obtain licensure were understood prior to graduating.
I wonder about the thinking of blocking supervision or how to obtain that credential if I do not earn the LCPC?
I would really love if the BSRB did not only communicate through email. Being able to talk to someone friendly while navigating through the challenges of licensure would be so helpful.
I'm looking forward to when the counseling compact goes through. It seems like more people could be served.
Implement the Counseling Compact privilege to practice. Kansas was one of the first states to pass laws supporting the compact but there is still no way for a Kansas LPC to request privilege to practice elsewhere nor for someone licensed in another counseling compact state to request privilege to practice in Kansas.
Improve communication between licensees and staff going through the licensing process and or responding to questions. Additionally the website could use improvements to be more user friendly. Currently it's cluttered and confusing- not easy to find what you need.
Increase standards of those entering private practice and what identifies someone as a specialist in certain areas of care.
It is extremely challenging to get ahold of people at the BSRB. The process to get licensed feels confusing and overwhelming. Also, it would be beneficial to be able to do all of it online instead of paper.
It would be amazing if we opened up our licenses to be able to provide services to individuals in other states.

It would be helpful if there was a CE course on how to create a practice. There is a ton of information but not in an easy to access location and nothing that is complete without paying quite a bit of money for.
It would be helpful if there were more reminders about impending licensing renewal, potentially at least one reminder that's further in advance of the renewal than the two month reminder currently.
Just maybe keep helping us stay abreast of protections offered and how to access them.
Just mentioned above
Limit caseloads to manageable numbers.
Limit the scope that social workers have clinically.
Lobby for higher respect which would then lead to higher wages. The salary and the education requirements are mismatched very badly
LPC's working toward hours for clinical licensing should not have to also worry about obtaining CEU's.
Make AI optional and not mandatory for our level of professionalism.
Make it easier to obtain supervision in rural communities.
Make it easier to practice in other states.
Make reciprocity easier.
make supervision more affordable
Mandatory CEUs covering boundaries
Maybe this already exists, but some sort of online resource that outlines what clients can expect if they report a clinician. I think some serious errors have been made at times and clients feel that when they report, clinicians only get a slap on the hand and then no true accountability. Some sort of consumer friendly explanation of how the clinician is evaluated post-report and what kind of education they have to complete (at the least) would be reassuring and encourage more reporting (which keeps our clients and our profession safe).
More efficient and transparent licensing process.
More ethical trainings
More open lines of communication or better streamlined process to submit application for licensure and supervision. Was frustrated by the time it took for me to hear confirmation that my application for either was even received.
more training on documentation, norms are more limited on details and pressures to write notes catered towards insurance reimbursement
More update and information as changes are made to statutes. I personally took the LCPC test failed by 2 points. Learned I must wait six months. In the intermitted time the test has changed. Very frustrating. I am starting all over again.

Nah, it's a tough job. It's hard to know what someone is doing behind closed doors and hard to measure their effectiveness. I don't think additional layers would add anything beneficial.

I guess maybe more advertising on how to report your counselor? Or what an ethical counselor behaves like? "Ted Lasso" inadvertently brought up this discussion because I noticed a lot of people on Reddit think marriage counselors can soon start dating their ex-clients. And "Shrinking" also raised a lot of ethical concerns ... but people who are watching don't know what behaviors are NOT ethical, and it's not up to entertainers to educate us. So maybe BSRB would be best served educating the PUBLIC so the public becomes reporters.

No (110 times)

No, seems like the BSRB is on top of everything.

No. BSRB is doing a great job.

not at this time - beyond allowing telehealth for residents of Kansas not currently in Kansas (traveling)

Not sure (to new to the field)

Nothing specific I can think of right now.

Offer a standardized language to add into consent form.

Offer CEU courses that qualify for renewal of licensure.

Offer more information about licensing requirements. The information online is confusing and the process to obtain answers is not helpful.

Protecting young therapists more with requirements for meeting with supervisors so they aren't taken advantage of by supervisors and can focus on client care.

Provide more free CEU

Providing education to consumers on the differences between licenses, LPC, LCPC, LCSW, etc. so clients can be more informed on the training each license has acquired.

Providing educational or supportive materials for testing for licensees wanting to get their LCPC.

Quality of care for consumer of providers in independent or small group practice. And turn over rates in community based practices (CMHC).

Refer to comment on assessment services above.

regulations on employers which inhibit or slow their abuse of therapists. Perhaps guidelines on how many clients to be seen in a day to avoid burnout for therapists. With no cap employers are free to overwhelm therapists with their expectations and requirements. There is no way clients get the best care with a therapist that is exhausted.

Responding to questions asked, via email and phone calls, sometimes wait multiple days/weeks for a response, having identified person for each area/license so we know who to reach out to

See above for training.

See answer to #12
See below
Since I am new to the field I don't have any recommendations right now but that may change with more experience and knowledge I gain from working in the field.
The KSBSRB is extremely helpful
The Ladies at the BSRB are wonderful. It seems that they are overworked. Email responses can take up to 2 weeks. I would like to see an email pool where others can check the emails if someone is out sick.
The process going from LPC-T to LPC was more difficult than I thought it needed to be. With the change of not taking the NCE until after I graduated (I went to Avila who is not CACREP approved), I thought it was an extra unnecessary step. I earned at MSCP, and met all the requirements for licensure. I felt I should be able to take the NCE prior. Additionally, my license number changed from the LPC-T, to the LPC and I had to change all documentation with a different license number (NPI, Malpractice insurance, etc).
Too many roadblocks in licensure
Unsure (2 times)
Updates on ethical practices (like telehealth) going to licensed clinicians being mailed, emailed, or informed through a meeting.
We have one of the most undeserved states in the country because there is a shortage of us which directly relates to the boards strict rules and being one of the lower paying states. I think this has been a growing problem now for the last 5 years.
While I am being selfish in asking, I have been practicing a long time and very few opportunities presented themselves to allow me to achieve a clinical license. Could there be a way for providers like myself to receive clinical license through duration if in good standing...In the future?
Work to get the counseling compact operationalized. I believe Kansas has some of the best counselors in the nation and we could be leading the pack in this area.
Work with the state to make transitioning to different insurance companies (Medicaid) easier and quicker.

LCPC 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? (301 responses)

A more easy & seamless process for licensure that more closely matches other states/similar licensed professions. It's tricky to feel like I know everything I need to guide my supervisees with full and accurate licensure information.

A team of designated therapists to support other therapists dealing with board complaints to help with the stress and trauma of pending investigation and the need reduce time, effort, energy and money they goes into having to defend our licenses.

Acceptance of complaints filed by other providers rather than directly from the clientele - many times clients or their families aren't aware they are being taken advantage of due to the relationship at play or the power differential

Additional free CEUs- when you decide to be in this field of work, its not for the money. CEUs can often be expensive so any ways to help support licensees, would be beneficial

Address non-licensed therapists who provide "counseling"

Admittedly, I don't pay enough attention to issues outside of the individuals I serve.

Advocate for protection of licensees against legislative changes seeking to limit mental health access or that criminalizes good mental health practice

Allow partitioners licensed in other states to conduct telehealth with Kansas residents.

Always more communication

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

Become knowledgeable about the Art Therapy profession. It is not just a modality. Art Therapists are trained in a broad array of counseling knowledge, not just art techniques. This includes counseling theories, group theories, and group process as well as all the same graduate course requirements as that of a counselor. Protecting and serving consumers of mental health services in Kansas should include support of the licensure bill for Art Therapists and BSRB licensed counselors who also provide Art Therapy within their scope of practice.

Believe BSRB does a great job

Better communication.

BOARD IS doing a good satisfying job now

BSRB needs to get ahead of AI in therapy. AI is not licensed as a LCPC in Kansas, does not carry malpractice insurance, and cannot be held legally liable (per Section 230 of the Communications Decency Act of 1996). Until AI meets these requirements, it should not be used in direct 1:1 therapy with clients. Also all KS mental health licensees should receive required training in the appropriate use of AI in therapy.

Changing when someone can become a supervisor. I was able to supervise in MO but took longer to get my LCPC in Kansas so I was unable to provide supervision there but had my Kansas LPC longer then my MO LPC
Check criminal backgrounds more closely.
Client and therapist safety and confidentiality should always be top of mind when considering constant technology updates and threats to confidential information, especially based on who is in charge of the way information is shared and withheld in our current systems.
Clinical supervision ceu's
Collaborate more with other state offices, in particular the Department of Children and Family Services
Complete investigations and make decisions related to complaints within 6 or fewer months. I know of at least three counselors who have had complaints submitted against them who have had to wait over seven months. Three of these counselors were deeply impacted personally and professionally only to have the complaints determined to be nuisance complaints.
concerns with compact and the requirements to hold a compact license; does the requirement meet the same standards of current licensees
Continually working on making licensing across state lines easier. Excited about the counseling compact but it has been slow moving. Living in a city that is in both Kansas and Missouri, there are areas in both states that could benefit from access to telehealth therapists.
Continued education that is not so expensive and more expansive not just general.
Continued Weekly supervision for LPC's
Create a state license for Registered Art Therapists to protect clients from risk of harm from people claiming to do art therapy that do not have any formalized or adequate training in the modality
Creating a website of services in KS
Degrees that are offered from entirely online schools need additional ways of judging competency in direct service other than a practicum . Non clinically licensed counselors should not be allowed to be in private practice; it is prevalent in the community where I reside and someone just signs off on their notes who isn't present in their clinic (has an affiliation with that clinic at an entirely different location)Students don't appear to come out of school equipped to go directly to private practice
Do everything you can to keep telehealth as an option
Encourage more education in assessments
Establish regulations around telehealth to ensure proper training and notifications of education in this area. Continue ensuring clinical supervision is provided by counselors. Move misconduct regulation updates more quickly through the process to stay aligned with existing ethical expectations.
except inexperienced clinicians do not seem to be aware of ethical decision making or how systems work together(maybe that is a Social work area)

Expanding telehealth coverage
Extend licensing period.
From client reports, I have been told that medications are frequently prescribed by intake as a first option of treatment. Informed consent with cautions of side effects does not seem to be a serious concern.
Furnish samples of notes and other criteria that reflect the standard(s) upon which audits are based. If these are already on the KSBSRB website, please make them prominent.
get new clinicians licensed sooner
Greater accountability for non-clinically licensed therapists in private practice. Most states don't allow someone at that level to open their own practice and I am not sure why Kansas is allowing it, especially with no oversight and accountability
Have MO applicants who are seeking clinical reciprocity take the NCMHCE before getting a KS LCPC.
Have the supervisor review the supervisee's notes for a 3 month minimum.
Help advocate for insurance companies to better support their clients.
Help support us with protecting client information from government officers who would use client PHI information to place our clients into extremely traumatizing camps and detention facilities. This includes both my undocumented clients and my LGBTQ clients. I fear for their safety from the people who are scapegoating them.
Honestly, I've found through personal experience, as well as conversation with numerous other professionals, several of the employees at the KSBRB are rude and uptight when responding to questions or concerns. I would encourage individuals at the BSRB not to immediately dismiss that feedback and consider a more compassionate and friendly approach to their work. Additionally, I was told when setting up my practice that a lower level license practitioner could not own an LLC and had to be a sole proprietor. I was told this multiple times and was not the only practitioner to be told this by the BSRB. Not only does this leave practitioners open to personal liability unnecessarily, it's predicated on nothing logical. Changing to an LLC once clinically licensed caused massive issues in my practice. This is NOT advice the BSRB should be giving practitioners. Professional liability insurance (ex. HPSO) is not enough. A regulatory board doesn't need to give advice on the structure of one's business.
I am not sure this would actually be possible, but perhaps it would be helpful for the BSRB to offer licensure verification and status (active/inactive) on the insurance carriers' websites where the BSRB professional is credentialed.
I am unable to think of anything.
I do not

I encourage new grads to work with other clinicians. If new grads are practicing in private practice under supervision, encourage no cost consultation in the profession.

I feel supported by the board and am proud that our licensure is as extensive as it is

I have no specific recommendations other than knowing the best ways to provide feedback and suggestions when they occur to me.

I service on crisis management is always helpful at all levels in education.

I think consumers may be concerned about AI. I think having a policy in AI, especially in terms of informed consent or allowing clients to opt out of AI, would help people feel more comfortable. I also think telehealth is an invaluable tool for counselors to be able to use and should be protected.

I think continuing to work towards the counseling compact could be helpful - clients should be able to continue seeking therapy services when traveling or etc

I think it would be incredibly valuable to the public for the BSRB to provide a database of licensees, specialties, etc. to make it easier for people to find clinicians.

I think self care trainings and retreats could be advertised, facilitated, or provided.

I think the BSRB does a good job of considering the impact on consumers. I serve many rural Kansas clients who can sometimes suffer from limited internet speed and outages. The board might consider supporting continued statewide improvements in internet access and infrastructure.

I think the BSRB does a good job.

I think the system in place works well as it is.

I will echo comments from the LCAC survey, which are that the BSRB tends to do a much better job of helping consumers than the agencies that tend to exert influence over clinicians and the consumers served.

I would require real-world experience, work in a state or not for profit in the human services field before a person is licensed in private practice. At age 21 going from school into private practice is a disservice to the practitioner and client.

I would take a "wait and see" attitude on allowing the widespread use of AI.

I'm not aware of anything specifically.

I've been very appreciative of the support and responsiveness of the Board

If possible, it would be beneficial to include a resource page to help navigate specific concerns or provide consistent education information for therapists, interns, and consumers (e.g. website links for ethical guidelines to increase consumer awareness, AI usage, intern rights/ responsibilities, etc.)

I'm not sure if this is relevant, but I struggle to look-up licenses. For whatever reason, the search engine can never yield results (even though I know certain licenses are valid or invalid).

I'm not sure, so far I haven't seen any Kansas clients.

I'm not sure.

Increase requirements for becoming an approved supervisor
Increased advocacy to protect gender affirming care.
It seems like there has been a shift to protecting the clients and not the therapist.
It would be nice to advocate for equal standing with clinical social workers.
I've had good experiences with BSRB since I became an LPC. I've worked up to an LCPC and then got approved for a certified supervisor. Between the website and being able to call and reach a live person when needed I'm not sure if there was anything else that would have been helpful.
Just continuing up to date CEUs is always good
Less lcpc requirements end second test for lcpc automatic give lcac upon completion of lcpc end lcac continuing education requirement
Limit and monitor out of state practitioners very closely.
Lobby for more money/reimbursements; quicker credentialing.
Lobbying around health care/insurance related issues so that more folks can have access/adequate coverage for mental health care.
Lock up phones. Soundproof boxes, or turned off. They are a serious hazard to privacy and protected health info. One session, a client talked about her endometriosis. I don't have that at all, and the next day my phone showed me ads about it for days until I told it to stop showing me ads for it. This happens with many different topics and it's so scary.
Make sure they're working within their scope of practice. Not everyone can do trauma work without training in the treatment of trauma
Make the process for approved supervisor in a way we can check the prices. and have a list of approved supervisor online.
more clarity in the licensure - LPC is the highest level of licensure in our neighboring state - and Lowest here - this confuses the public - also, Ks supervision requirements are less per month, allow more autonomy and can result in too many supervisees per supervisor for good transfer of support and knowledge
More education and support to the counselors as this would result in better services.
More efforts toward multistate compacts would be great. It's tedious managing so many multiple licenses, and not being able to connect with clients when they're travelling outside of my licensed states is frustrating.
more LCPC focused CEU workshops, clearer standards for LCPC supervision
More training and experience in supervision
Much faster turn around time on complaint processing - this would be extremely beneficial to both the client and clinician.
Requiring clinicians send surveys to their clients to track satisfaction and the surveys be automatically directed to the board. It being made clear in the survey that the therapist will not be seeing the survey results.
No (160 times)

New measures to ensure practitioners familiarity with matters related to cultural competence and suicide prevention/crisis intervention.
No suggestions but I must note that your office staff are wonderful.
No, I appreciate what you do.
No, I think the BSRB does a great job protecting consumers.
No. I think that the BSRB does an exemplary job.
Not at this time, but I'll keep thinking.
Ns
Nursing professional licensing agencies have ways to report impaired nurses. The reporting often is for drug diversion or other such impairments. The goal is for restoration, treatment, and to rehabilitate. That does not exist for counselors outside filing complaints. As an administrator and supervisor I don't have a mechanism to report concerns about a therapists performance or concerns for their wellbeing without filing a complaint against their license. We need a system that can remain confidential and address potential safety risks to the community.
Offer less expensive liability insurance for the licensee.
opportunities to discuss the social-political challenges to the mental health profession
Others have mentioned difficulty receiving services from the board in a timely manner.
Overall, nothing specific comes to mind. One thing I am eager to receive guidance on, and continue to check in with the ACA, surrounds the recent legislature on anti-gender affirming care, which is antithetical to our code of ethics and values as counselors. I would like some guidance on how we as professionals navigate protecting our clients these laws impact, following our ethics, and protect ourselves as providers from potential legal consequences.
People should be practicing in the field for at least 10 years before they consider them to be in a supervisory position at an agency.
Perhaps a background check might be a good idea although I know it adds an additional burden and cost
Perhaps more and better websites and other means to inform consumers of the availability of behavioral health services.
Please align with the ethics of nation wide organizations such as the ACA because currently the ethics are outdated when it comes to inclusion and protection from doing harm against clients who are culturally different from the therapists.
Please consider creating clear carve-outs for limited services to clients who are working temporarily out-of-state, are out of state for family care, or are regular business travelers.
Please limit the universities, and please go after the coaches who have violated ethical and legal boundaries. They are after money, emotional power, social title and meeting their own emotional needs with client feedback loops, but have no idea the damage it does.

Please maintain the standards for individuals entering the profession, including CE credits
PLEASE TRACK LPC's supervisors (who aren't working towards LCPC) and clarify what kind of supervision that they need. (I would suggest weekly, regardless of the number of clients they are seeing.)
Pre-certification for CEU providers is currently only available to LSCSW licenses, this should be available to other professionals (counselors, psychologists, mfts) offering CEUs.
Provide more information and better access to counselors in rural communities.
Providing a list of trustworthy cyber security insurance?
Public education on the importance of licensure and understanding the training and education that goes into being a licensed professional and how this benefits them
Quick telephonic response. Greater perception of being willing to hear out licensees instead of adhering without discussion to the rules.
Quicker turnarounds for licenses.
Reciprocity hoped for!
require training and/or licensure in treating all addictions - not just for substance use
Return to when masters level graduates had to practice under the supervision of a clinically licensed person in the same practice or at a Community Mental Health Center for a minimum of 2 years. This was the case in the early 2000s. It yields more prepared independent clinicians.
Since I shepherded the licensure movement, finalized by Gov. Graves, I have found BSRB helpful and respectful of my service and I am grateful to have licensure.
Some type of newsletter or email would be appreciated as to significant, important or interesting topics the BSRB is involved in. I think this could help foster involvement from the professional community.
Somehow be more available- OI don't know if that means hiring more BSRB employees (which may not be possible due to budgeting). I know they do their best, and they are certainly competent.
Specific ketamine training when used in conjunction with counseling.
Standardizing expectations across counseling professions and auditing supervisors/supervisees. Reducing costs for new providers who are working to get started while also increasing accountability to fidelity of the profession.
Stop taking 2 months to license new counselors as this can cause a lapse in care.
Thank you for everything you do! You all have a thankless, difficult job. I'm extremely grateful to you for working so hard on our behalf even though we may never know all of the things you do for us.
The BSRB can issue protections against the use of AI.

The BSRB could set up a CEU system OR CEUs that was less costly than the marketplace and gave some of the LCPCs in practice the opportunity to use their knowledge and skill in additional ways (teaching/presenting)

The NBCC has a board certification for telehealth and there are some other programs that provide telehealth training. Perhaps state requirements for telehealth would help ensure a better quality of telehealth?

Additionally, this is not your area per se, but I was a Kansas Medicaid provider. When I moved out of the 50-mile border area, I understood that I could no longer provide services to Medicaid clients. I would be willing to continue to do so, if it was okay that I'm not in the border zone but offer my services via telehealth. Eliminating that requirement might possibly increase the pool of counselors available to Kansas Medicaid recipients.

As I have heard nightmare stories about previous therapists clients have worked with, I've asked why they did not report the therapist. Many times they did not know they could. I include the information on my informed consent. I wonder if the BSRB provided a standardized paragraph of information that was required to be provided in paperwork, and perhaps on the clinician's website, if this would help clients report therapists who are practicing questionably. If so, I would include a list of possible valid reasons for a client to report a therapist.

Therapy should be done in person. You could supplement the periodic phone call/telehealth but that should never be the primary therapy modality. Businesses like "Better Help" are scams.

There are a few inconveniences that I felt that the BSRB should be more supportive for me

There are increasing numbers of therapists who are strictly private pay or only credentialed with one or two insurance companies as there are many things that are problematic with the current health insurance system. This limits the number of therapist available to consumers. I would recommend the BSRB continue to advocate for legislation, better reimbursement rates for mental health services, improving the credentialing process, etc. Also, insurance companies should not be allowed to pay therapist with a debit card (rather than a check or electronic deposit) that results in the therapist being charged a fee to get the payment.

There are people who are not licensed who market themselves as counselors - they are unqualified - seems like something should be done about that to protect the public

There do need to be new rules and guidance on the use of AI and also providing services through national telehealth programs like Better Help

There needs to be more BIPOC representation on the board and committee.

This helps

To be honest, I think consumers can be protected by counselors. Feeling a little more protected. It feels like professional counselors don't have an advocate. I understand it is the role of the regulatory board to protect the consumer and I absolutely think that's necessary and wonderful. I wish there was more support for the counselor.

Train therapists that diversity means toward everyone and that it is not okay to criticize ANY group for beliefs that you do not understand or agree with. We are not the moral police, we are to help people develop healthy habits within the scope of their lives.

Unsure.

Webinar lectures provided to universities which describe the process of licensure. This could be expanded to virtual free ethical decision making training.

Where are we w/ cross-state compact?

While ongoing supervision training is helpful, I'm not sure the current amount expected each two years is absolutely necessary. Could that be keeping some approved supervisors from taking on supervisees?

Would like network opportunities

Yes, as I stated in mt other survey for my addiction license, make reciprocity truly reciprocity.

Yes, I have some concerns in the area of Christian counselors. I began one training with a group and the very initial statement made by the trainer was, "Since we are not licensed the board doesn't care what we do so long as we don't diagnose." She went on to say some things I found concerning. The room had approximately 30 persons participating, licensed, unlicensed, and faith based. She stated there were over 100 participants on line that morning as well.

Yes. Please continue to see telehealth as an important need to Kansas citizens as the state is made of rural areas. Allow supervision to be conducted through telehealth; it is very difficult for rural providers to find supervisors in their local area. Travel time can be enormous and costly for restricted license therapists in rural areas.

LPC Q17. 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 professional counseling profession? (184 responses)

Again, efficient licensing process, shouldn't take 6 months to get issued a license.

Again, just having someone who is kind and patient to help us navigate through all of the different licensure questions we might have. For example, I am applying for LCPC soon and I have so many questions regarding the requirements I need due to a lot of my hours being in two different states. I am hesitant to reach out to BSRB due to my past experience of being answered only by email and the answers not being thorough enough.

Allow counselors to share their faith in sessions if clients ask or want to know more.

Allowing other licenses to provide clinical supervision.

Allowing supervision from other licensed professionals.

All paperwork/licensure done online and not through paper/mail.

Anne Warner is amazing at quick communication and so kind and patient.

As a new licensee I have a hard time navigating CEUs and what qualifies/how to track and report/etc.

As far as changes to the statutes and regulations, no. However, I would suggest having a more user-friendly way to access important information for licensees, such as a webpage with common questions like how many hours of continuing education are required per year and their breakdown, how many hours are required for full licensure, etc.

At least extend the time for LCPC renewals to 5 years or more since these processes take a lot including completing CEU's that people spend money on (may be providing free CEU's...), renewal fees and make the process easier for practioners... including the length of waiting for all the paperwork to be approved. Maybe set a standard rate of pay for practitioners to help those being underpaid but carrying a lot of loads. Consider removing the requirement for comprehensive exams after LPC supervision hours before getting an LCPC since practitioners still do CEU's and do a variety of trainings that covers treatment plans, diagnosis, and ethics.

Ban the term "Christian Counselor" as misleading to consumers. At present, anyone may identify as a "Christian Counselor" while avoiding any training, oversight, or ethics requirements. If anyone insists on using this term, it should at least be someone who is actually trained and falls under the regulatory authority of this body.

Change the LPC test

Change the regulations around who is allowed to Supervise LPCs. It is antiquated and backwards to think that PhDs or even Social Workers cannot provide supervision to LPCs.

Concern over who provides supervision is expressed in my area of the state as many believe it should remain within the PC sector and not other psychological fields due to differences in education and training

<p>Consider widening the requirements for clinical supervision hours based on job description. I would say ANY direct services qualify as meeting the requirements over traditional long form or short form therapy engagements. Mastery of case planning, treatment planning can be shown a variety of ways.</p>
<p>Could the Committee consider another way for people to obtain LCPC after they have been LPC for several years, especially in multiple states.</p>
<p>Counseling Session Note Writing course that teaches how to write for a variety of counseling types. How to write appropriately for court reports, Mental Health Evaluations and Psychosocial Evaluations.</p>
<p>Everything mentioned above. Please reach out if you have questions.</p>
<p>First of all, kick out the ineligible Insurance Commissioner and bring in an eligible person who cares for the lives of Kansans.</p> <p>I'm still working to do what I can. If you give my feedback any attention, you'll be the first.</p>
<p>Flexibility regarding courses and supervisors when approving the LCPC training plans. Especially for those that have been successfully practicing for 5 or more years.</p>
<p>Get a general counsel for legal questions. I called your offices and was told that the BSRB doesn't offer interpretation of the laws (which you are tasked with enforcing) and only investigates after a complaint is received. The justification for this was not having legal counsel on staff. I was told to consult with other LPCs or old supervisors. I literally asked the government entity tasked with enforcing the laws governing my profession if I was within the legal limits and was told to go ask other people who don't work for the government. That's ridiculous.</p>
<p>Good luck!</p>
<p>Have a cheap statewide telehealth service that is HIPPA compliant that providers can use. It would be a win-win for both sides. Maybe it'd host the practioner \$.50/session or something like that.</p>
<p>I am currently at my wit's end with the BSRB. In October of 2023, a previous employer supervisor filed a complaint against me with the BSRB, and 14 months later, it has still not been resolved. This is a complete failure of this agency to serve this member, as for 14 months, I have been living under the threat of penalties or suspension, which I find unlikely, given the complaint. However, I have no respect or regard for the judgment or competence of this board. If I could file a complaint against the board, I would. If there is any interest in improving any conditions for those whom you presumably serve, this will be resolved. Of course, I expect that, given this feedback, it will be done negatively towards me, but so be it. DO WHAT YOU'RE GOING TO DO.</p>
<p>I am still learning what is out there that the BSRB provides.</p>
<p>I am very excited to utilize CE Broker to obtain my CEUs. This option will be so helpful as my income is limited.</p>
<p>I believe it would be beneficial to remove barriers of requiring an LCPC to provide clinical supervision towards a supervision plan. (Allow similar licensees such as LSCSW, LCP, etc) Decrease number of hours required for a clinical supervision plan, like social work licensees</p>

I can't think of any.
I can't think of anything at the moment
I do not have any other comments or feedback except to say that I appreciate all of my positive interactions with the BSRB, prompt responses, and helpful and direct information.
I feel this profession is greatly understaffed. I have had many quality interns in the office for internship and they have chose to get licensed in Missouri rather than Kansas because they can't afford the added expense of supervision and thing to obtain their LCPC. This is sad.
I have come across medication providers and LMSW's that look down on my licensure. It would be nice to have more creditability with other professionals in the field.
I have seen almost no increase or even a decline in client inquiries since I started practicing almost 3 years ago. It has caused some concern for me and has made getting hours for my LCPC training difficult. However, I am unsure how the Advisory Committee can help with this. I do not have any recommendations at this time.
I recently applied for LCPC licensure and was denied due to the lack of formal approval for my Supervisory Training Plan. Unfortunately, I failed to notice that I never received confirmation from the BSRB granting that approval, and I take full responsibility for that oversight. I do not fault anyone but myself, and I respect the importance of adhering to regulations.
At the same time, I find myself struggling with this outcome. I followed my plan under the guidance of an experienced supervisor, met every requirement, and went above and beyond what was asked of me. I invested significant time, effort, and financial resources into this process, only to find that my work does not count toward licensure due to an administrative technicality. While I have worked hard to accept this decision, it remains difficult to reconcile with the broader goal of ensuring well-qualified professionals can serve our communities effectively.
I appreciate the work you and the board do to uphold the integrity of our profession, and I would welcome any further discussion about potential paths forward. - James Roach
I think it would be beneficial to require multicultural counseling CEU's for KS licensees.
I think it would be helpful for LPCs to be able to provide telehealth through larger networks, like better health.
I wish consideration would be given to LPCs who have been working in the field for several years and attempted the test multiple times but were unable to pass to be considered to move to the clinical level. It is sad that we are relying on 1 test and a person's memory to dictate the level of a therapist.

I wish we could work with Colorado, Nebraska, Oklahoma, and Missouri to make licensing requirements all the same so it was easier to get licensed in all the surrounding states.
I would like to see more available resources for clinical hours to be obtained for LPCs wanting to reach LCPC licensure that may not work as a therapist such as a licensed case manager
I would like to see more guidelines around protecting client confidentiality/records release and something concrete regarding what age minors can sign their own therapy paperwork to engage in therapeutic services.
I'm not sure. I don't feel like I have been practicing long enough to offer feedback
Idk
I'm glad to be in a profession where it is regulated, yet I do believe continuing technology advancements may necessitate change.
I'm grateful that BSRB has leadership and staff that are supportive and really tries to do a good job. Anne, Tyla, and Rhonda were all very responsive and helpful in getting me through the hoops as quickly as possible.
I'm particularly excited/interested to see movement towards compacts which allow states to accept qualifications, hours, etc between each other. As a military spouse trying to get supervised hours between moves to another state presents a sometimes overwhelming challenge.
It was REALLY difficult to find a supervisor in my rural central Kansas area who has an LCPC-S and could take me on. Could those with a clinical license and supervision certification with a different license be considered to supervise an LPC?
Less paper work!!
Make the BSRB and KDADS websites more user friendly.
Make the telehealth regulations more easily accessible.
More accommodation for virtual supervision especially for counselors who travel alot due to other responsibilities.
More advocacy with insurance providers to allow for more options to be paneled as a LPC versus only as a LCPC.
My biggest concern at this time is how the current presidential administration may attempt to enact executive orders or legislation that affects the mental health profession and the clients served by counselors like me. This is especially a concern when it comes to minorities, women, and LGBTQ+ individuals. I hope that the BSRB will remain informed about these issues and provide ongoing guidance to mental health professionals in the state about how to provide the best care possible and how to protect themselves as professionals.
No (103 times)
Not at this time. I appreciate the opportunity to provide feedback via survey.
Not at this time. Thank you for all that you do!
Nothing at the present. I have always had positive experiences with the BSRB.
Offering more flexibility on clinical supervision requirements would be appreciated.
Perhaps allow transition from loc to lcpc based on years of practice and demonstrable hours and letters of recommendation from peers.

Please help with TELEMED and creating a relationship with the state of MO and streamlining that process for practitioners. Thousands of clients and providers would be technically out of compliance when MO changed the statutes with zero notice, zero options made available for clinicians and their already established clients.

Please, please, please protect the ethical and structural provisions that require nondiscrimination and prioritization of multiculturalism and social justice values within our professional board requirements. We need our licensing boards and ethics codes to support and protect clinicians who are serving vulnerable populations (which *anyone* who requires/accesses mental health services are automatically vulnerable in some way).

Potentially having info gatherings for new counselors.

Recently, I have heard of BSRB taking a lot of time to respond back or to review applications.

Reduce the amount of hours needed or make it a flat time line of two years. We're not all given job opportunities where the quota is easily met which also makes affording a supervisor a financial burden. So change requirements or place licensee's with a job that allows requirements to be met in a timely manner.

See above regarding licensees from other states.

Since I'm new to this LPC title I'm sorry I'm not of more help but I'm definitely eager to learn. Thanks!

Some how we have to do better about advocating for our group. Social workers have such a strong advocacy and have taken over everything. I think counselors could be represented better some how.

Support LPCs who are not in a traditional mental health setting.

Thank you for the hard work you do!

Thank you for this opportunity

Thank you for this opportunity!

Thank you for your work!

The amount of direct service and supervision hours in order to obtain LCPC licensure should be reduced some. It's very difficult to obtain these hours for many clinicians, for a variety of reasons, especially starting out. Many jobs only hire LCPC licensure counselors. This makes it very difficult starting out and getting work. I understand the importance of experience and what goes into structuring hours. It does seem slightly extensive in my opinion. A slight reduction in required hours would be very much appreciated and supportive of the many LPC's out there busting their tails.

The BSRB website is not very intuitive and it is difficult to find needed information. However, I love the CE tracker. I think this was a great addition.

The initial application process, including the temporary license waiting to complete the NCE, was confusing. I think it would be helpful if universities made a flow chart to give to students before graduation. It might be helpful for you to have a flow chart as well. I know you have everything in writing, but a visual is often easier to understand.

the overworking of therapists by the supposedly non profit company - who instruct us to have 45 min sessions so they can increase the head count for which they get paid now that they are a CCBHC. I have 13 available slots a day on my schedule and am held responsible if clients don't make their appointments and it affects my quota. There is no consideration for burning out the therapist - just maximising their income and turning us over like chattel. The client can't possibly be best served nor protected by such practices - and the therapist is being taken advantage of. Unethical.

There is a mental health crisis and not enough clinicians. All the hoops clinicians have to jump through make getting licensed and caring for those in need difficult. There has to be a happier medium.

There needs to be more clarity of hours, telehealth guidelines, and overall expectations, not just written, but in various accessible formats.

There seems to be a shortage and a huge need for counselors, so help those who have the credentials to get things like supervision so that there are more of us that could be out there practicing.

To help with the availability of LCPC supervisors, might the BSRB reduce the two year time frame to one year? With the appropriate number of clinical supervision hours.

Unsure

With therapeutic interventions being as difficult as they are to obtain, The state of Kansas must do better at making licensed therapy accessible to passionate therapist. I've been a psychologist for more than 15 years, Due to the restrictions of the Kansas State legislation, I had to get another masters degree, and now I must have a supervisor as a LPC.

We have army wives in the area who would make valuable additions to our therapeutic Community However, based on the restrictions, they refused to practice.

Yes - for clinical licensure - if a doctorate is completed while pursuing clinical licensure then the requirements for clinical licensure should be automatically lowered to the doctoral standards. A refile of a plan and having to start at "0" hours again is unnecessary.

Also, please get an updated online system to submit documents, have secure communication, etc.

LCPC 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 professional counseling profession? (278 responses)

A balanced presentation about the limitations of medications and side effects as part of informed consent seems to be an area that is treated as settled. I think there needs to be more education for therapists. Case presentations with colleagues has been helpful to me in getting another perspective, and it is mutually supportive professionally.

Add an across state lines telehealth certification

adopt the way social workers provide CEU's to raise the standard of training for counselors

Advocacy for Art Therapy Licensure in Kansas with House Bill 2027

Allow LPC's to pass the test at the clinical level the first time. Have various levels of offenses, I see lots of people with a first time offense and they receive the same punishment as someone doing this for years.

Allowing LCPC to obtain CEU provider status and not just the social workers.

Being more universal or unified and practice in other states with more ease and convenience.

Consideration for waiving the requirement of NSA documentation for therapists in private practice.

Could the paper licensure credentials mailed to us be wallet-sized (credit card sized)? A laminated or plastic card would be even better.

Counselors/Therapists deserve to receive a trauma responder discount. Some treat at the scene and others treat after the scene. Mental Healthcare Professionals are impacted just like other first responders. We are at times the 1st responders and support responders. Therapists are the continuous responders who walk through the trenches with people. Where is our responder federal and state discounts and benefits as a Mental Health Professional?

Do not lower any more standards for professional or client contact hours to sit for LCPC exam.

Education and CEU requirements are on the books but can't make clinicians learn or implement . Thanks for this opportunity.

Even though Art Therapists are pursuing a licensure bill, it should be noted that education and training is comparable to counselors in the state and should be considered for licensure as a related mental health field.

Feel free to give me a call

Good luck & thank you for your work! Things continue to change so quickly; regulations must be a rather difficult thing to maintain these days.

I am a proud LCPC and approved supervisor. I value that the BSRB requires LCPCs to take the extra training to become board approved. I feel very equipped to provide quality, ethical supervision.

I appreciate the BSRB and Advisory Committee upholding high standards for licensees.

I appreciate your work. Thank you.

I do not! Thank you for what you do

I don't think so

I have been retired for 9 years so did not answer any of the questions pertaining to direct counseling.

I know that Kansas is more regulated than other states with how it licenses counselors. I don't mind this as I've not known differently. However, I've had several coworkers who struggled to get licensed in Kansas after moving here from other states. If there is anything that could be done to help make these transitions easier it would be beneficial to our state in my opinion.

I run a telehealth-only practice and want continued advocacy for maintaining telehealth practice permanently and advocacy with insurance payors to do the same.

I see many therapists being targeted unfairly by disgruntled individuals (often in contentious child custody cases) who then wreak havoc on the therapists' lives. I'm not sure what can be done to better serve and protect those in the profession, but it would be beneficial.

I think something that would be helpful to consider is the procedure for applicants coming from previous states either for reciprocity or within schools. I moved here from another state and when I applied for licensure, it took 6 months for me to get my application approved which meant I could not practice. I also had a lot of difficulties getting clinical supervision hours transferred from another state. While I truly appreciate ensuring that education and experience aligns with KS standards, I do wish this process was not as long. I think it also will be interesting to see more about the counseling compact and how that impacts licenses transferring across states or seeing clients in other states.

I think the current statutes and recommendations are sufficient and have met my needs over the years. I appreciate the efficient renewal process.

I think things are great the way they are.

I wish telehealth was not perceived as inferior in the wording on the licensure/supervision requirements.

I wish there was some feature on the regulatory board that was a support and help to the counselor. It often feels like the board is against us and sometimes we have so many other barriers and challenges to navigate. I understand our liability insurance is there to protect us. However, they cannot offer us help unless someone files a charge against us. So, it would be really helpful if there was some sort of support for us. So when we have a question or when we need to feel like someone's in our corner we have someone to call.

I would hope that the licensure committee would leave in place the possibility of virtual supervision by LCPC Board supervisors. I think this is a MUST.

I would love to be more involved with the BSRB.

I would love to become someone who does supervision for others but the current requirements per fluid me from moving forward with that.

In my opinion, this is one of the most challenging careers to select. It is lonely. We spend more time with our clients than our own friends and family, in one sided relationships - they don't know us - and by the time we get home we are too exhausted to pour into our families. I cannot mentally tolerate working 40 hours so I'm always financially strapped.

We cannot unhear things. These stories are stuck inside our brains. Forever. I have been seeing clients for over 18 years. I love what I do. Love. But damn it's hard. I don't know that this is helpful for your survey, but I was hoping you might read this and get a feel for the temperature of some clinicians.

I would not encourage my children to pursue this field. It's hard pouring in constantly with so little coming back.

It would be great if the national compact for LPCs could finally be active, but I'm not sure what level of government is in control of that.

It would be great to have 2 licenses to be able to renew at the same time (I have LCPC and LCAC.)

It would be helpful to have an online system for making recommendations for students and supervisees.

It would be nice to have quicker email responses to questions about licensure. Getting licensed through reciprocity was a bit confusing. The FAQ section did not match the requirements listed when it comes to how many years someone must be licensed in another state to qualify.

It would really help if we could push the Counseling Compact to a reality. It's been sitting in "coming soon" for too long, and BSRB could advocate and lobby more aggressively I believe.

Item 14 of this survey needs to provide respondents the option, "None". I do not superior anyone. Thanks for asking.

I've done tele health with many clients on the western portion of the state and it's really needed but insurance is too costly. Need more options like betterhelp

Kansas should be licensing art therapists as equals to mental health counselors.

Make it a little easier to become a supervisor, like MO.

There's a lot of hoops to jump through currently. Deters people from wanting to go through that process. We already work overtime in this society, we don't have time to give for all of that. Make it more attainable.

Make it easier to find relevant training for required CE's to become a supervisor. Provide obvious avenues to help with changes in insurance like the recent change to KMAP providers.

More awareness of the Advisory Committee.

Thank you.

More CEU on supervision, play therapy to refer to oneself as a play therapist , and dual relationships

Mostly the issue above. Being a primary telehealth clinician since Covid, I have been able to work with patients that are located in rural parts of Kansas I previously had never even heard of, areas which don't have an area therapist or the town is so interconnected it's too complicated dynamics to pursue therapy. Through platforms like psychology today, more people have access to finding telehealth options.

My only request is to keep diversity, equity, and inclusion, despite federal pushback, if possible. Removing this could cause significant harm to clients if they are unable to find a safe space.
National Telehealth rules would be nice. Some states allow out of state practitioners to see clients for X number of sessions within their state per year. Other states have special permission or licenses for out of state providers. It would be great if all states could do it the same way so it would be easy to provide continuity of care when clients travel.
Nk
No - thank you to the Advisory Committee!
No (159 times)
No but thank you
No but thank you for all you do!!!
No input
No not right now.
No thank you
No, I'm good.
No, Thank you for what you do and for making the effort to make Therapy a valuable asset to the communities!
No. I think the most recent changes regarding supervision requirements were amazing and I appreciate the Advisory Committee!
No. thank you for sending out a survey to get our feedback.
No. Thank you for the opportunity to fill out this survey
No; I think you all do a wonderful job and I love the new platform for tracking hours of CE
None are coming to mind right now - I will reach out should something come to mind
None at this time. Thank you.
Not at this time, but I'll keep thinking.
Not at this time. Thank you for asking.
Not at this time. Thanks to you all for your hard work.
Not at this time. Thanks!
Not fully the BSRB, but the reduction in required clinical hours, training, and the educational catering is impacting the field in a negative manner.
Offer dual licenses , I. E. = LCPC, masters level psychologist and/or behavioral analyst.
Offering more information on where to acquire CEUs or even offering some occasionally through the BSRB.
One thing I wish were different would be the ability to provide telehealth services to clients across state lines, particularly if a relationship is already established. (i.e., if an established client moves to another state)
Please change the statue "The BSRB requires a minimum of two supervision sessions per month, with at least one being individual supervision" by removing the one in person requirement. During Covid time, many of us received amazing supervision via telehealth. It worked and was just as valuable. The once per month in person requirement is a major barrier to those wanting to pursue full licensure. That barrier is unnecessary.

Please ensure that LCPCs saying they are seeing couples and families have obtained appropriate training and supervision to do so.
Please serve all counseling clients equitably.
Portability of licensure is important to all I have spoken to in the last 30 yrs
Professional counseling is unlike any other mental health professional practice in terms of training content and process, ethical standards, scope of practice, and a wellness focus as compared to an illness or service model. Good supervision provided by another professional counselor within this context rather than an LP, LSCSW, or LCMFT or others is essential. This is especially true with regard to the scope of practice. While I understand the perceived needs of employers and those seeking the LCPC, allowing supervision by someone not trained as a professional counselor is not in any way appropriate, for protecting the citizens of Kansas. Would someone seeking to be an LP, LCP, or LSCSW or be permitted to be clinically supervised by an LCPC to reach that license level in their field? What is the reasoning for that do you suppose?
Provide free or low cost CEUs to struggling therapists, especially the first 5 years after licensing.
Ready for the counseling compact to be at the place where we can join; start serving individuals to allow for continuity of care.
Recent changes were necessary and appreciated. I don't know of any more that should be implemented at this time. Thank you for this opportunity.
Reciprocal licenses with MO Once a person has independent license in Ks, make it easier to get Mo license (get rid of 1 year wait period)
Regarding consent for treatment of youth especially when parents are divorced. Regulations about seeing clients who are out of state could be updated. For example, if a clinician sees college students in their practice and these students go home to another state for summer, treatment shouldn't have to stop. Same for clients on vacation.
remain in consistent contact with graduate schools of counseling degrees.
-revisit compact care law - appreciate the new & easier system for license renewal!
See above
see above comments about considering a Master Addiction License so that all addictions could be addressed, not just substance use addictions
See above comments. Do not lower standards.
See above. (3 times)
See answer to #17
Surveys like this are a helpful and accessible way to collect feedback and engage counselors who are not active in the Committee.
Thank you for all that you do!
Thank you for all the work on the counseling compact. I am excited to take part in that when I can.
Thank you for asking my opinion.
Thank you for what you do to provide continuous improvement in our profession.
Thank you for your service to our profession and care of the public.
Thank you for your service to our profession!

Thank you for your service!
The BSRB can issue protections against the use of AI.
The BSRB demands timely responses and follow up from clinicians but does not function in a timely manner. This is true with implementation of their own policies, issues with bringing board complaints to completion, or answering basic clarifying questions re: policies. New policies and board reports should have time stipulations before they are automatically in effect (policies)/dismissed (complaints).
The compliant process seems to be a slow grind, allowing counselors with serious complaints to continue to see clients without any consequence.
The licensure process should not be quite so hard to find information on. If I hadn't had assistance from other professionals that had already gone through it, I would have struggled to ensure I took all the appropriate steps in the appropriate order.
There is too much grey area around treating children of divorced/separated families. It would be helpful to have some guidelines of how to approach and treat children who fit this profile.
This is a growing profession and the needs of MH are escalating quicker- we need to improve reimbursement rates to help build a better service provider base.
This is too general for me. In the 40 years I have been involved, I always respond as best I can to an explicit request or question.
To have a streamline process to be able to practice in other states as psychologist do
To make the process more transparent.
Truly, the amount of time it takes to process an allegation is unacceptable and a disservice to all involved. It doesn't communicate that the BSRB is reliable and committed to ethical practice and the care of both the clients and clinicians. Creating new systems and processes to fix this issue is extremely needed.
We need help with helping our clients navigate insurance company practices that interfere with them accessing needed care are on the rise again.
We need reciprocity laws with other states to change more quickly.
When I was in clinical supervision post graduate school, I was working in a jail. This was so that I could support myself; there are not a lot of places for counselors to work with a limited license. The board contact for my supervision told me that I would only be able to practice in that scope after I got my full clinical license because that is where I had been working. That was infuriating and too narrow of an understanding of me as a counselor. I had done a 60-hour master's program and worked in a few settings before the jail.
Would it be possible to have licensees vote on proposed changes?
Would like more information on how to become a licensed supervisor.
Yes I think it should not be required that when being supervised the supervisor should have to have the same license/ education background. For instance only an LCPC can supervise an LPC rather than allowing a LSCSW for example. In community mental health we all do the same work but finding someone with 'the same letters' can be difficult or not provide as good of supervision. I ran in to this problem. I could have had my team leader who knew my caseload and already did supervision with me but couldn't because she was not the same license background

Yes, just offer once license that covers everything (IND, Marriage and Family, and Addictions).

Yes. I find the two year practice waiting period before being eligible to serve as a clinical supervisor is unnecessary bureaucracy and gatekeeping. If a fully licensed clinician pursues education/training in supervision, they should be able to qualify as a supervisor. After 3000 hours of supervisor practice post licensure, and 600+ in a masters program, they are as developed as they will ever be.

You are doing a good job. Thank you.

You're doing a great job – the improved communication is helpful, the new computer system to log onto the BSRB looks really good