Virginia Department of Health Professions
Board of Counseling

Agenda
Full Board Meeting

May 31, 2019
Board Room 1
10:00 a.m.

10:00 a.m. Call to Order – Kevin Doyle, Board Chair

- Welcome and Introductions
- Emergency Egress Procedures
- Mission of the Board

Approval of Minutes

- Board Meeting – February 8, 2019*
- Regulatory Committee Meeting – February 7, 2019

Ordering of Agenda

Public Comment

The Board will receive public comment related to agenda items at this time. The Board will not receive comment on any pending regulation process for which a public comment period has closed or any pending or closed complaint or disciplinary matter.

Agency Report - David E. Brown, DC

Chair Report – Kevin Doyle

Legislation and Regulatory Actions – Elaine Yeatts

- Report on 2019 Legislative Actions
- Report on Status of Regulations
- Regulatory Actions
  - Adoption of Fast Track Regulations Governing Delegation to an Agency Subordinate (18VAC115-20-10 et. seq.) *
  - Review of public comment and adoption of proposed guidance document on the practice of conversion therapy.*
- Discussion of Recommendations from the Regulatory Committee
  - Review public comment and adoption of Final Regulations Governing the Registration of Qualified Mental Health Professionals.*
  - Review public comment and adoption of Final Regulations Governing the Registration of Peer Recovery Specialists.*
  - Petition for Rulemaking to accept a bachelor's degree in criminology and criminal justice to qualify for registration as a QMHP-C and to accept supervised experience obtained in another state.*

- Petition for Rulemaking to amend regulations to waive the requirement for an examination for licensed clinical social workers who can show clinical experience based in substance abuse service to become licensed substance abuse treatment practitioners.*
- Review public comment on proposed Guidance Document on Substance Abuse Treatment Functions by Regulated Professions.*
- Consideration of Virginia Sex Offender Treatment Association as an approved provider of continuing education.
- Adoption of NOIRA for Regulations Governing the Certification of Rehabilitation Providers (18VAC115-40-10 et.seq.) *
- Discuss Virginia Code of Virginia § 32.1-127.1:03.F. Health records privacy – release of records.
- Consideration of a Guidance Document for Credential Appeal Process

Unfinished Business

- Goals for 2019
- Interstate Compact
- Criminal Background Checks

Staff Reports

- Executive Director's Report – Jaime Hoyle
- Discipline Report – Jennifer Lang, Deputy Executive Director
- Licensing Manager's Report – Charlotte Lenart, Licensing Manager

Board Counsel Report – James Rutkowski, Assistant Attorney General

Committee Reports

- Board of Health Professions Report – Kevin Doyle
- Legislative/Regulatory Committee – John Brendel
- Ad Hoc Committee on Tele-Assisted Counseling and Supervision – Terry Tinsley

New Business

- Workforce Expansion – Mobile Crisis Intervention & Stabilization Presentation
- Bylaw Discussion

Closed Session – Consideration of Recommended Decisions and Consent Order

Next Meeting – August 16, 2019

Meeting Adjournment

Probable Cause Review

*Indicates a Board Vote is required

This information is in **DRAFT** form and is subject to change. The official agenda and packet will be approved by the Board at the Quarterly Board meeting. One printed copy of the agenda packet will be available for the public to view at the Board Meeting pursuant to Virginia Code Section 2.2-3707(F).

Counseling Quarterly Board Meeting Minutes

February 8, 2019

DRAFT
BOARD OF COUNSELING
QUARTERLY BOARD MEETING
Friday, February 8, 2019

TIME AND PLACE:	Dr. Doyle called the meeting to order at 10:03 a.m. on Friday, February 8, 2019, in Board Room 1 at the Department of Health Professions, 9960 Mayland Drive, Henrico, Virginia.
PRESIDING:	Kevin Doyle, Ed.D., LPC, LSATP, Chairperson
BOARD MEMBERS PRESENT:	Barry Alvarez, LMFT Johnston Brendel, Ed.D., LPC, LMFT Natalie Harris, LPC, LMFT Bev-Freda L. Jackson, Ph.D., MA, Citizen Member Vivian Sanchez-Jones, Citizen Member Maria Stransky, LPC, CSAC, CSOTP Terry R. Tinsley, Ph.D., LPC, LMFT, CSOTP, NCC Holly Tracy, LPC, LMFT Tiffinee Yancey, Ph.D., LPC
BOARD MEMBERS ABSENT:	Jane Engelken, LPC, LSATP Danielle Hunt, LPC
STAFF PRESENT:	Christy Evans, Discipline Case Specialist Jaime Hoyle, J.D., Executive Director Jennifer Lang, Deputy Executive Director Charlotte Lenart, Licensing Manager Brenda Maida, Licensing Specialist
OTHERS PRESENT:	David E. Brown, D.C., DHP Director James Rutkowski, Assistant Attorney General Allyson Tysinger, Senior Assistant Attorney General Elaine Yeatts, DHP Senior Policy Analyst
WELCOME & INTRODUCTIONS:	Dr. Doyle welcomed the Board members, staff, and general-public in attendance.
ADOPTION OF AGENDA:	The Board adopted the agenda after agreeing to move the consideration of policy action on conversion therapy discussion and the presentation regarding interstate compacts prior to the discussion on legislation and regulatory actions.
PUBLIC HEARING	See “Attachment A”
PUBLIC COMMENT:	Members of the public provided comments that included personal experience with conversion therapy, the need for clearly defining conversion therapy, the concern that conversion therapy is not evidence-based treatment and the request to follow the Board of

Psychology in developing a Guidance Document related to this issue.

APPROVAL OF MINUTES: Upon a motion made by Dr. Brendel, and seconded by Ms. Sanchez-Jones, the Board voted unanimously to approve the Quarterly Board meeting minutes of November 2, 2018.

Upon a motion made by Dr. Brendel, and seconded by Ms. Stransky, the Board voted unanimously to approve the QMHP Information Session minutes of November 27, 2018.

DHP DIRECTOR'S REPORT: Dr. Brown apologized for not including a member from the Board of Counseling in the workgroup related to *Virginia Core Competencies in Addiction, Opioids and Pain Management for Non-Prescribers*.

Dr. Brown reviewed and discussed the Board's options regarding the Board's regulatory action related to requiring accreditation by the Council for Accreditation of Counseling & Related Educational Programs (CACREP).

Dr. Brown reported that the agency is working on a new website. The new website will be user-friendly for both internal staff as well as the public. In addition, the agency is working on having wireless capability for the public during board meetings.

CHAIRMAN REPORT: Dr. Doyle encouraged Board members to attend the Counseling Regulatory Boards Summit on August 7-9, 2019 in Washington, D.C. Dr. Doyle covered many other issues related to the chairman report throughout other parts of the agenda.

LEGISTLATION AND REGULATORY ACTIONS: **Regulatory/Legislative Report** - Ms. Yeatts provided a chart of current regulatory actions as of January that listed:

- 18VAC 115-20 Regulations Governing the Practice of Professional Counseling - requirement for CACREP accreditation for educational programs (action 4259); Re-Proposed at the *Attorney General.*

- 18VAC 115-20 Regulations Governing the Practice of Professional Counseling – Credential review for foreign graduates (Action 5089) Proposed – At *Secretary's Office for 3 days*

- 18VAC 115-20 Regulations Governing the Practice of Professional Counseling - acceptance of doctoral practicum/internship hours towards residency requirements (action 4829); Final – At *Secretary's Office for 7 days*

- 18VAC 115-30 Regulations Governing the Certification of Substance Abuse Counselors updating and clarifying regulations (Action 4691) –proposed – Registered Date: 10/29/18, Comment closed: 12/28/18, Board to adopt final: 2/8/19.

  Mr. Alvarez motioned to adopt proposed amendments as final regulations. Ms. Stransky seconded the motion, and it passed unanimously.

- 18VAC115-70 Regulations Governing the Registration of Peer Recovery Specialist (under development) – Initial regulations for registration (action 4890) emergency/NOIRA – Proposed – Register Date: 2/4/19, Comment period: 2/4/19 to 4/6/19

- 18VAC115-80 Regulations Governing the Registration Qualified Mental Health Professionals (under development) – Initial regulations for registration (action 4891) emergency/NOIRA Proposed – Register Date: 2/4/19, Comment period: 2/4/19 to 4/6/19

Periodic Review:

The Board reviewed the Regulatory Committee's recommended changes to the Professional Counseling Regulations. Dr. Brendel made a motion, which was properly seconded, that the Board adopt the recommended changes to the Regulations Governing the Practice of Professional Counseling in concept and publish the draft language along with a Notice of Intended Regulatory Action (NOIRA). The motion was passed unanimously.

The Board reviewed the Regulatory Committee's recommended changes to the Marriage and Family Therapy Regulations. Dr. Brendel motioned, which was properly seconded, that the recommended changes to the Regulations Governing Marriage and Family Therapists in conception be published as a Notice of Intended Regulatory Action (NOIRA) with the draft language. The motion passed unanimously.

The Board reviewed the Regulatory Committee's recommended changes to the Substance Abuse Treatment Practitioners Regulations. Dr. Brendel motioned, which was properly seconded, that the Board adopt the recommended changes to the Regulations Governing Licensed Substance Abuse Treatment Practitioners in concept and publish the draft language along with a NOIRA. The motion passed unanimously.

Petition for Rule-Making:

Willard Vaughn, LPC, LSATP, CSAC petitioned the Board to amend the Regulations to prohibit those who are considered "Residents in Counseling" from promoting or advertising their services independently in any manner to solicit business form the general public.

Dr. Brendel made a motion, which was properly seconded, to not move forward/reject the petitioner's request. The motion passed unanimously.

Jamie West, Resident in Marriage and Family Therapy, petitioned the Board to amend the Regulations Governing Marriage and Family Therapists to allow for up to 900 hours of supervised experience in a Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) or CACREP doctoral program toward hours of residency.

Dr. Brendel motioned, which was properly seconded, to accept the petitioner's request using the wording presented by Ms. Yeatts and to adopt the amendments as a fast-track action. The motion passed unanimously.

UNFINISHED BUSINESS:

Consideration of Policy Action on Conversion Therapy-
The Board discussed the draft Guidance Document providing guidance on its interpretation of a standard of conduct in regulation that persons regulated by the Board must practice in a manner that does not endanger the public health, safety, or welfare. The Guidance Document cites professional sources that state that practicing conversion therapy/sexual orientation change efforts with minors has the potential to be harmful and therefore could result in a finding of misconduct and disciplinary action against the licensee, certificate holder, or registrant of the Board. Dr. Brendel made a motion, which was appropriately seconded, that the Board accept the draft Guidance Document on conversion therapy, as presented by Ms. Yeatts, with amendments. The motion passed with nine in favor, one in opposition.

Dr. Brendel motioned, which was appropriately seconded, that the Board adopt a NOIRA regarding the practice of conversion therapy for the Regulations Governing the Practice of Licensed Professional Counselors, Marriage and Family Therapists, Licensed Substance Abuse Treatment Practitioners and Certified Substance Abuse Counselors. The motion passed with eight in favor, two in opposition.

Reciprocity Agreements-
The Board discussed reciprocity agreements. The Code allows the Board to enter into such an agreement; however, the Board would need to adopt regulations regarding reciprocity agreements if it wanted to go that route. The Board decided to take no action take at

this time.

Criminal Background Checks –
No action taken. The Board will discuss the issue more at a future meeting.

PRESENTATION:

Dr. David Kaplan, Ph.D., Chief Professional Officer, American Counseling Association (ACA) provided a presentation on ACA's efforts in developing an Interstate Professional Licensing Compact to allow for those who are licensed to engage in multistate practice and to allow for pathway to seamlessly move from one state to another and offer their services.

Dr. Brendel motioned, which was appropriately seconded, that the Board support ACA in the process for the advancement of the Interstate Professional Licensing Compact. The motion passed unanimously.

EXECTUIVE DIRECTOR'S REPORT:

Ms. Hoyle presented the financials that were included in the agenda packet, and updated the Board on the Qualified Mental Health Professionals (QMHPs).

DEPUTY EXECUTIVE DIRECTOR'S DISCIPLINE REPORT:

Ms. Lang presented the discipline statistics, current number of open cases and Key Performance Measures, and indicated that she included the report in the agenda packet.

LICENSING MANAGER'S REPORT:

Ms. Lenart reported that in 2018, the Board received over 17,000 online applications for QMHPs and Registered Peer Recovery Specialists.

On November 27, 2018, the Board facilitated and led a QMHP Information session. Representatives from the Department of Behavioral Health and Developmental Services (DBHDS) and the Department of Medical Assistance Services (DMAS) presented information and helped to answer questions concerning the registration of QMPHs. Feedback was positive and the session was overall helpful for those who attended.

Ms. Lenart provided a staffing update and thanked her staff for working tirelessly in processing the overwhelming amount of applications, phone calls, and emails.

BOARD COUNSEL REPORT:

No report.

BOARD OF HEALTH PROFESSIONS REPORT:

No report.

LEGISLATIVE/REGULATORY COMMITTEE REPORT:	Ms. Tracy made a motion, which was appropriately seconded, to approve the Guidance Document related to the scope of practice for substance abuse practitioners as amended. The motion passed unanimously.
AD HOC COMMITTEE ON TELE-ASSISTED COUNSELING AND SUPERVISON REPORT:	Mr. Tinsley indicated that that Ad-hoc committee will meet again in May. Mr. Tinsley reported that he will attend the Mid-Atlantic Telehealth Resource Center (MATRC) Telehealth Summit in March. Additionally, Mr. Tinsley reported that MATRC will be presenting at the next Board meeting.
NEW BUSINESS:	Preliminary conversation regarding the Board goals for 2019 were discussed. A more detailed discussion to occur at the at the May 2019 meeting.
NEXT MEETING:	Next scheduled Quarterly Board Meeting is May 31, 2019 at 10:00 a.m.
ADJOURN:	The meeting adjourned at 2:43 p.m.

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Kevin Doyle, Ed.D., LPC, LSATP
Chairperson

Jaime Hoyle, J.D
Executive Director

ATTACHMENT A

Virginia Board of Counseling
Public Hearing

Time and Place: Friday, February 8, 2019 at 9:15 a.m.
Virginia Department of Health Professions
Perimeter Center, 2nd Floor, Board Room 1
9960 Mayland Drive, Henrico, Virginia 23233

Presiding: Kevin Doyle, Ed.D., LPC, LSATP, Chairperson

Members Present:
Barry Alvarez, LMFT
Johnston Brendel, Ed.D., LPC, LMFT
Natalie Harris, LPC, LMFT
Bev-Freda L. Jackson, Ph.D., MA, Citizen Member
Vivian Sanchez-Jones, Citizen Member
Maria Stransky, LPC, CSAC, CSOTP
Terry R. Tinsley, Ph.D., LPC, LMFT, CSOTP, NCC
Holly Tracy, LPC, LMFT
Tiffinee Yancey, Ph.D., LPC

Staff Present:
Christy Evans, Discipline Case Specialist
Jaime Hoyle, Executive Director
Jennifer Lang, Deputy Executive Director
Charlotte Lenart, Licensing Manager
Brenda Maida, Licensing Specialist

Others Present:
David E. Brown, D.C., DHP Director
James Rutkowski, Assistant Attorney General
Allyson Tysinger, Senior Assistant Attorney
Elaine Yeatts, DHP Senior Policy Analyst

Purpose of the Hearing: To hear public comment related to the proposed Regulations Governing the Registration of Peer Recovery Specialists and Regulations Governing the Registration of Qualified Mental Health Professionals.

Public Comment: Dianne Simons, Ph.D., OTR/L, FAOTA VCU Assistant Professor provided written and verbal comments regarding the history, education, licensing qualification and recognition of the occupational therapy as a provider of mental health service by congressional actions and federal agencies, QMHP requirements in other states and mental health provided by occupational therapist worldwide. Ms. Simons request the Board consider amending the requirements for Part II Requirements for Registration 18VAC115-80-40 B.5. and 18VAC115-80-50 B.4 to accept licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with person with mental illness or one year of experience in a mental health setting.

Judith Coleman, QMHP-A, QMHP-C provided public comment regarding her QMHP-C registration. Ms. Coleman stated that she was approved by the Virginia Board of Counseling for QMHP-C registration; however, during a recent audit the Virginia Department of Behavioral Health & Developmental Services (DBHDS) sited her agency due to Mr. Coleman not having a human services or special education degree. Ms. Coleman stated that this type of citation was unfair as she was approved by the Virginia Board of Counseling as a QMHP-C but DBHDS states that she does not qualify.

Joni Watlings, OTR/L provided public comment regarding requirement for occupational therapist for registration as a QMHP. Ms. Watlings supports the statements of Dr. Simons and asked the Board to consider changing the wording to the regulations regarding occupational therapist as stated by Dr. Simons.

Counseling Regulatory Committee Meeting Minutes

February 7, 2019

VIRGINIA BOARD OF COUNSELING
REGULATORY COMMITTEE MEETING
DRAFT MINUTES
Thursday, February 7, 2019

TIME AND PLACE:	The meeting was called to order at 10:00 a.m. on Thursday, February 7, 2019, in Board Room 1 at the Department of Health Professions (DHP), 9960 Mayland Drive, Henrico, Virginia.
PRESIDING:	Johnston Brendel, Ed.D., LPC, LMFT, Chairperson
COMMITTEE MEMBERS PRESENT:	Kevin Doyle, Ed.D., LPC, LSATP Danielle Hunt, LPC Vivian Sanchez-Jones, Citizen Member Holly Tracy, LPC, LMT
OTHER BOARD MEMBERS PRESENT:	Maria Stransky, LPC, CSAC, CSOTP
STAFF PRESENT:	Christy Evans, Discipline Case Specialist Jaime Hoyle, JD, Executive Director Jennifer Lang, Deputy Executive Director Charlotte Lenart, Licensing Manager Brenda Maida, Licensing Specialist
OTHERS PRESENT:	Elaine Yeatts, DHP Senior Policy Analyst
PUBLIC IN ATTENDANCE:	No public in attendance.
ORDERING OF THE AGENDA:	Staff recommended amending the agenda to discuss new business prior to the unfinished business. The Committee agreed.
APPROVAL OF MINUTES:	Ms. Sanchez-Jones moved to approve the minutes of the January 4, 2019 meeting. Ms. Tracy seconded the motion, and it passed unanimously.
PUBLIC COMMENT:	There was no public comment.

DISCUSSIONS:

I. Unfinished Business:

- Reciprocity/Compact Agreements: No action by the Board is required at this time. The Committee will discuss this item at a future meeting.

- Periodic Review Discussion: The Committee re-visited its periodic review discussion.

Chapter	Board of Counseling	Outcome of Discussion
18 VAC 115-20	Regulations Governing the Practice of Professional Counseling	The Committee reviewed draft changes to the Regulations. Dr. Doyle moved, which was properly seconded, that the Committee recommend the draft changes to the

		Regulations Governing the Practice of Professional Counseling in concept to the full Board and that the Notice of Intended Regulatory Action (NOIRA) include a draft of the proposed changes.
18 VAC 115-50	Regulations Governing Marriage and Family Therapists	The Committee reviewed draft changes to the Regulations. Ms. Tracy moved, which was properly seconded, that the Committee recommend the changes to the Regulations Governing Marriage and Family Therapists in concept to the full Board and that the NOIRA include a draft of the proposed changes.
18 VAC 115-60	Regulations Governing Licensed Substance Abuse Treatment Practitioners	The Committee reviewed draft changes to the Regulations. Dr. Doyle moved, which was properly seconded, that the Committee recommend the changes to the Regulations Governing Licensed Substance Abuse Treatment Practitioners in concept to the full Board and that the NOIRA include a draft of the proposed changes.

- Guidance Document on Scope of practice for Certified Substance Abuse Counselors (CSAC and CSAC Assistants): The Committee reviewed and discussed Ms. Hoyle's draft guidance document related to the scope of practice for substance abuse practitioners developed to provide clarification to the public. Dr. Doyle moved, which was properly seconded, that the Committee recommend to the full board adoption of the draft guidance document with the identified changes.

II. New Business:

Petition for Rule-Making Discussion:

- Willard Vaughn, LPC, LSATP, CSAC, petitioned the Board to amend the Regulations to prohibit those that are considered "Residents in Counseling" from promoting or advertising their services independently in any manner to solicit business form the general public. The Committee discussed the petition and the public comments related to the petition. Dr. Doyle moved, which was properly seconded, that the Committee recommend to the full Board that the Board reject the petitioner's request. Ms. Tracy suggested that the Committee consider drafting a guidance document to address this issue.

- Jamie West, Resident in Marriage and Family Therapy, petitioned the Board to amend the Regulations Governing Marriage and Family Therapists to allow for up to 900 hours of supervised experience in a COAMFTE or CACREP doctoral program toward hours of residency. Mr. Yeatts presented a draft of the proposed Regulations to mirror the adopted changes to the Regulations Governing Professional Counselors. Dr. Doyle moved, which was properly seconded, that the Committee recommend to the full Board that the Board accept the petitioner's request using the drafted wording presented by Ms. Yeatts and to recommend that the Board adopt the amendments as a fast-track action.

NEXT SCHEDULED MEETING: The next Committee meeting is scheduled for May 30, 2019.

ADJOURNMENT: The meeting adjourned at 2:05 p.m.

Johnston Brendel, Ed.D., LPC, LMFT
Chairperson

Date

Jaime Hoyle, JD
Executive Director

Date

Regulatory Actions

Adoption of Fast Track Regulations Governing Delegation to an Agency Subordinate

Agenda Item: Adoption of Amendments for Delegation to an Agency Subordinate

Included in the agenda package:

Copy of minutes of November 2018 Regulation Committee (report on Periodic review of regulations)

A copy of the proposed regulations

Action:

Adoption of amendments to regulations by a Fast-track actioin

VIRGINIA BOARD OF COUNSELING
REGULATORY COMMITTEE MEETING
Thursday, November 1, 2018

TIME AND PLACE:	The meeting was called to order at 10:05 a.m. on Thursday, November 1, 2018, in Board Room 2 at the Department of Health Professions (DHP), 9960 Mayland Drive, Henrico, Virginia.
PRESIDING:	Johnston Brendel, Ed.D., LPC, LMFT, Chairperson
COMMITTEE MEMBERS PRESENT:	Kevin Doyle, Ed.D., LPC, LSATP Danielle Hunt, LPC Vivian Sanchez-Jones, Citizen Member
ABSENT:	Holly Tracy, LPC, LMFT
STAFF PRESENT:	Tracey Arrington-Edmonds, Licensing Specialist Jaime Hoyle, Esq., Executive Director Jennifer Lang, Deputy Executive Director Charlotte Lenart, Licensing Manager
OTHERS PRESENT:	Elaine Yeatts, DHP Senior Policy Analyst
PUBLIC IN ATTENDANCE:	Chuck Wilcox of the Virginia Association of Addiction Professionals Becky Bowers-Lanier of Virginia Association of Treatment and Recovery Providers (VATARP)/Substance Abuse Addiction Recovery Alliance (SAARA).
PUBLIC HEARING:	The Committee held a public hearing to discuss amended regulations for certified substance abuse counselors (CSAC) and certified substance abuse counseling assistant (CSAC-A). Mr. Wilcox, of the Virginia Association of Addiction Professionals, suggested that the Board should consider listing the scope of practice and the supervisor responsibility for each substance abuse, regulated credential to be stated in the regulations. Mr. Wilcox also suggested the Board detail this information on the website.
ORDERING OF THE AGENDA:	The agenda was accepted as presented.
APPROVAL OF MINUTES:	Ms. Sanchez-Jones moved to approve the minutes of the May 17, 2018 meeting. Dr. Doyle seconded the motion, and it passed unanimously.
PUBLIC COMMENT:	There was no public comment.

DISCUSSIONS:

I. **Unfinished Business:**

- **Foreign degree discussion:** The Committee voted to recommend that the Board adopt Proposed Regulations for foreign degree graduates. The regulatory action would provide a pathway for foreign-trained graduates in counseling to obtain licensure as a professional counselor in Virginia if they can provide documentation from an acceptable credential evaluation services that allows the board to determine if the program meets the requirements set forth in regulation.

II. **New Business:**

- **Petition for Rule-Making Discussion:** Charles R. McAdams, III petitioned that the Board adopt proposed language of the National Counselor Licensure Endorsement Process (NCLEP) in section B, Chapter 18VAC115-20-45 Prerequisites for licensure by endorsement of the Regulations Governing the Practice of Professional Counselor (Title of Regulations 18 VAC 115-20-10) "PC". Dr. Doyle made a motion to reject the petitioner's request to initiate rulemaking but to consider the content during the scheduled periodic review. Ms. Hunt seconded the motion, and it passed unanimously. Ms. Hunt made a motion that the Committee take action during the periodic review to recognize Certified Clinical Mental Health Counselors (CCMHC) by the National Board for Certified Counselors (NBCC) as a Board recognized entity for purposes of endorsement. Dr. Doyle seconded the motion, and it passed unanimously.

- **Residency Status Discussion:** Joan Normandy-Dolberg informed Board staff that she was pursuing a legislator to sponsor legislation during the 2019 General Assembly to authorize the Board of Counseling to issue a temporary, resident license to individuals approved to begin their residency towards licensure as a professional counselor. No action required at this time, but Ms. Normandy-Dolberg wanted the Board to know of her plans in advance, and have the opportunity to voice any concerns.

- **The Association for Addiction Professionals (NAADAC) National Certified Addiction Counselor, Level I (NCACI) Examination – Online Proctoring Discussion: Examination Trends** –NAADAC does not prohibit anyone from taking the examination online under the observation of a proctor. The Committee requested staff to schedule a demonstration at the next meeting.

- **Reciprocity Discussion:** Dr. Doyle made a motion made for staff to compile a report of the contiguous states (Maryland, West Virginia, Tennessee, Kentucky and North Carolina) and the District of Columbia licensure requirements in order for the Committee to pursue reciprocity agreements. Dr. Brendel seconded the motion, and it passed unanimously.

- **Periodic Review Discussion:** The Committee began its periodic review discussion.

Chapter	Board of Counseling	Outcome of Discussion
18 VAC 115-15	Regulations Covering Delegation to an Agency Subordinate	Ms. Hunt made a motion that 18VAC115-15-20 Criteria for delegation, be updated as follows: "Cases that may not be delegated to an agency subordinate include violations of standards of practice as set forth in regulations governing each profession registered, certified or licensed by the Board, except as may otherwise be determined by a single person (agency subordinate or determined by the Board) in consultation with the Board chair." It was

		seconded by Dr. Doyle and passed unanimously.
18 VAC 115-20	Regulations Governing the Practice of Professional Counseling	No action. To be discussed at an additional Regulatory Committee meeting in January 2019.
18 VAC 115-50	Regulations Governing Marriage and Family Therapists	No action. To be discussed at an additional Regulatory Committee meeting in January 2019.
18 VAC 115-60	Regulations Governing Licensed Substance Abuse Treatment Practitioners	No action. To be discussed at an additional Regulatory Committee meeting in January 2019.

NEXT SCHEDULED MEETING: Staff will work with the committee to schedule an additional meeting in January 2019. Then, the usual quarterly meeting is scheduled for February 7, 2019.

ADJOURNMENT: The meeting adjourned at 12:05 p.m.

Johnston Brendel, Ed.D., LPC, LMFT
Chairperson

01/04/2018
Date

Jaime Hoyle, JD
Executive Director

1/4/19
Date

Project 5853 - none

BOARD OF COUNSELING

Periodic review

18VAC115-15-20. Criteria for delegation.

Cases that may not be delegated to an agency subordinate include violations of standards of practice as set forth in regulations governing each profession registered, certified, or licensed by the board, except as may otherwise be determined by the executive director ~~probable cause committee~~ in consultation with the board chair.

Review Public Comments and Adoption of Proposed Guidance Document on the Practice of Conversion Therapy

Agenda Item: Consideration of Comment on Conversion Therapy Guidance Document

Included in your agenda package are:

A copy of the Guidance Document adopted on February 8, 2019

Summary of public comment

Copies of comments on the document

Comments posted on the Virginia Regulatory Townhall may be viewed at: http://townhall.virginia.gov/L/GeneralNotice.cfm (click on "recently expired")

Board action:

The Board needs to determine whether to: 1) retain the guidance document as published; 2) revise the guidance document in response to comment; or 3) withdraw the guidance document.

Based on its decision, the Board will then need to discuss its response to comments.

Virginia Board of Counseling

Guidance Document on the Practice of Conversion Therapy

For the purposes of this guidance "conversion therapy" or "sexual orientation change efforts" is defined as any practice or treatment that seeks to change an individual's sexual orientation or gender identity, including efforts to change behaviors or gender expressions or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the any gender. "Conversion therapy" does not include counseling that provides assistance to a person undergoing gender transition or counseling that provides acceptance, support, and understanding of a person or facilitates a person's coping, social support, and identity exploration and development, including sexual-orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, as long as such counseling does not seek to change an individual's sexual orientation or gender identity in any direction.

In 18VAC115-20-130 of the *Regulations Governing the Practice of Counseling*, the Virginia Board of Counseling ("Board") has stated that: "The protection of the public health, safety, and welfare and the best interest of the public shall be the primary guide in determining the appropriate professional conduct of all persons whose activities are regulated by the board. Regardless of the delivery method, whether in person, by phone, or electronically, these standards shall apply to the practice of counseling."

One of the standards of practice established in regulation is that persons licensed, certified or registered by the Board shall:

"*Practice in a manner that is in the best interest of the public and does not endanger the public health, safety, or welfare*"

See 18VAC115-20-130(B)(1) of the *Regulations Governing the Practice of Counseling*; 18VAC115-30-140(B)(1) of the *Regulations Governing the Certification of Substance Abuse Counselors and Substance Abuse Counseling Assistants*; 18VAC115-50-110(B)(1) of the *Regulations Governing the Practice of Marriage and Family Therapy*; and 18VAC15-60-130(B)(1) of the *Regulations Governing the Practice of Licensed Substance Abuse Treatment Practitioners.*

Many national behavioral health and medical associations have issued position and policy statements regarding conversion therapy/sexual orientation change efforts, especially with minors. Such statements have typically noted that conversion therapy has not been shown to be effective or safe. The American Counseling Association (ACA) opposes conversion therapy because "it does not work, can cause harm, and violates our Code of Ethics. ACA will continue to support state legislation that bans this discredited practice."

The consensus opinion of the ACA Ethics Committee is that the basic goal of reparative/conversion therapy is to change an individual's sexual orientation from homosexual to heterosexual. The ACA Ethics Committee states that counselors who conduct this type of

therapy view same-sex attractions and behaviors as abnormal and unnatural and, therefore, in need of "curing." The belief that same-sex attraction and behavior is abnormal and in need of treatment is in opposition to the position taken by national mental health organizations, including the ACA.

Consistent with the established position of the ACA, the Board considers "conversion therapy" or "sexual orientation change efforts" (as defined above) to be services that have the potential to harm patients or clients, especially minors. Thus, under regulations governing practitioners licensed, certified, or registered by the Board, practicing conversion therapy/sexual orientation change efforts with minors could result in a finding of misconduct and disciplinary action against the licensee, certificate holder, or registrant.

Guidance Document 115-10, Practice of Conversion Therapy

Board of Counseling

The Board submitted Guidance Document 115-10, Practice of Conversion Therapy, for publication in the *Register of Regulations* and posted it on the Virginia Regulatory Townhall with request for comment from 3/18/2019 to 4/17/2019. There were 599 comments posted on Townhall and an additional two comments received by email. (*Three comments were posted after the deadline at midnight on the 17th; nine of the commenters were not clear about their position; several commenters posted more than once.)*

There were 198 comments in support of the Board's guidance document. Commenters noted that conversion therapy has no scientific basis, is not supported by any mental health professional organization, has shown to be ineffective, harmful, unethical, and destructive to individuals and families.

There were 371 comments in opposition to the Board's guidance document. Commenters noted any prohibition of practice is a violation of a psychologist's freedom of religion and free speech. Patients should have the right to receive counseling for unwanted sexual feelings. Parents have a fundamental right to make decisions for their children.

Board response

The Code of Virginia (§ 2.2-4002.1. Guidance documents) provides:

C. If a written comment is received during a public comment period asserting that the guidance document is contrary to state law or regulation, or that the document should not be exempted from the provisions of this chapter, the effective date of the guidance document by the agency shall be delayed for an additional 30-day period. During this additional period, the agency shall respond to any such comments in writing by certified mail to the commenter or by posting the response electronically in a manner consistent with the provisions for publication of comments on regulations provided in this chapter.

Therefore, the effective date of the guidance document will be "delayed for an additional 30-day period." During that 30-day period, the Board will need to respond to comments in writing.

The Board needs to determine whether to: 1) retain the guidance document as published; 2) revise the guidance document in response to comment; or 3) withdraw the guidance document.

Based on its decision, the Board will then need to discuss its response to comments.

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VIRGINIA REGULATORY TOWN HALL

Logged in as
Elaine J. Yeatts

Agency Department of Health Professions

Board Board of Counseling

All good comments for this forum Show Only Flagged

Next Back to List of Comments Page 1 of 2 500 comments per page go

Commenter: Bambi Shingler 3/19/19 7:20 pm

Conversion Therapy

Counselors are ALLOWED to help a minor client to explore and facilitate same-sex feelings, attractions and behaviors, or even to "change" their sex altogether, but they are strictly PROHIBITED from helping a minor client struggling with unwanted same-sex attractions from developing a natural and Biblical sexual ethic, or aiding a child dealing with gender dysphoria in learning to embrace his or her biological status as either male or female. So, children can change in one direction, but not the other. Why the bias? Please allow equal justice by allowing counselors to help those seeking to disengage from harmful dames sex attractions. Stop the one sided pursuit of encouraging sexual disfunction and discouraging common sense therapy choice.

The Boards "guidance" to counselors is clear and simple: If you hold to the natural, biological, historical and/or Biblical understanding of human sexuality, be prepared to lose your professional license.

Commenter: Justin Jordan, Virginia Tech 3/19/19 7:28 pm

Conversion therapy is unethical practice

Conversion therapy is, without a doubt, unethical practice and against the values of counseling and allied mental health professions. The archaic idea that mental health providers can or should change someone's gender expression/identity or their affectional orientation is based on a history of stigmatization and pathologizing of normal and positive identities. The board of counseling has a moral and ethical responsibility to ban these practices that increase the risk of suicide of our brothers and sisters by traumatizing them via conversion therapy, which has no valid research support. Please ban this tactics immediately for the health and wellness of our society.

Commenter: Carol Schall, Virginia Commonwealth University, Autism Center for Excellenc 3/20/19 7:06 am

Ban all conversion therapy

Conversion therapy, (aka: Sexual Orientation and Gender Identity Change Efforts) are not scientifically sound practices and they cause significant harm to all. Banning these practices from use with minors is a good start. Next we must ban them outright from all professional use.

Commenter: Isabel Jane Dowrick 3/20/19 7:11 am

Please ban conversion therapy

I am not a health care professional, but am aware of findings of professionals that sexual preferences, both hetero and non-hetero are not a product of a disorder, but rather the inherent makeup of an individual, and therefore conversion therapy should be banned because it runs counter to what we know about sexual preference.

Commenter: Marlene meade 3/20/19 8:21 am

Ban Conversion Therapy

Conversion Therapy is unethical,, unkind, and unsupportive. It causes great pain to those it is used on. People are born differently and that's ok.

Commenter: Marcy Walsh 3/20/19 8:30 am

Conversion Therapy is Dangerous

Leading mental health organizations (APediatricsA, AMA, APsychiatricA, etc.) are opposed to the dangerous practice of conversion therapy. There is no evidence that it is helpful and plenty of evidence that it is psychologically harmful to participants. The practice should be considered abuse in this state and outlawed in order to protect children and adults. Already members of the LGBTQ community experience suicide at greater rates than the general population. Conversion therapy is dangerous.

Commenter: Stephanie Malady 3/20/19 9:12 am

Ban the erroneously named abuse known as Conversion Therapy

Leading mental health organizations (American Pediatrics Assn, American Psychiatric Assn, etc.) are opposed to the damaging effects of conversion therapy. There is no evidence that it is helpful and plenty of evidence that it is psychologically harmful to participants. The practice, simply put, is sanctioned abuse by this state and must be outlawed in order to protect the mental and emotional well being of both children and adults. It can be reasonably argued that members of the LGBTQ community experience suicide and assault at greater rates than the general population, in part, due to the continued authorization of such bigoted abuses as Conversion therapy.
The archaic idea that mental health providers can or should change someone's gender expression/identity or their affectional orientation is based on a history of stigmatization and subjective, restrictive sexual identities. The board of counseling has an ethical responsibility to ban these actions that increase the risk of suicide of our children from trauma via conversion therapy. Ban this psychological and emotional torture immediately for the health and well being of our entire society.

Commenter: Jane Cornelius 3/20/19 10:46 am

Conversion therapy is torture. Ban it!

I heard a talk recently by a man who had been forced to undergo conversion therapy. He described how torturous it was to him psychologically, and of course it didn't have the desired effect. Conversion therapy has been documented to have adverse effects, especially to youth. Please help put an end to this traumatizing and barbarous practice.

Commenter: Julianna Williams, Virginia Tech 3/20/19 10:55 am

Ban Conversion Therapy

The mental health professions have agreed, based on extensive research, that same-sex sexual attractions, behavior and orientations are NOT indicative of mental or developmental disorders and attempts to change sexual orientation are unlikely to be successful and involve risk of harm. Moreover, there are many natural and positive variants of human sexuality and the notion of "conversion" is misguided. Conversion "therapy" is a dangerous and unethical practice and should be banned by the Board of Counseling.

Commenter: Rebecca Seymour 3/20/19 11:43 am

Conversion Therapy is Unethical

The DSM is a manual that most all clinicians in the United States work out of for guidance on diagnosis, treatment, considerations, and more. Clinicians rely on the information within the DSM to make sure that the work they are doing is helpful. Almost FIFTY YEARS ago homosexuality was removed from the DSM; therefore, there should be no clinician attempting to treat homosexuality in the present day.

The following is a list of ethical codes that using conversion therapy would break. After this list of ethical violations, there is a list of peer-reviewed sources (all published within the last 5 years) that discuss the harm that conversion therapy can cause.

A.1.a. Primary Responsibility: The primary responsibility of counselors is to **respect the dignity and promote the welfare of clients.**

A.2.c. Developmental and Cultural Sensitivity

A.4. **Avoiding Harm and Imposing Values**

A.4.a. Avoiding Harm Counselors **act to avoid harming their clients**, trainees, and research participants and to minimize or to remedy unavoidable or unanticipated harm.

A.4.b. Personal Values Counselors are aware of—and **avoid imposing—their own values, attitudes, beliefs, and behaviors**. Counselors **respect the diversity of clients**, trainees, and research participants and seek training in areas in which they are at risk of imposing their values onto clients, especially when the counselor's **values are inconsistent with the client's goals** or are **discriminatory in nature**.

B.1.a. Multicultural/Diversity Considerations Counselors maintain **awareness and sensitivity regarding cultural meanings** of confidentiality and privacy. Counselors respect differing views toward disclosure of information. Counselors hold ongoing discussions with clients as to how, when, and with whom information is to be shared.

C.5. Nondiscrimination Counselors **do not condone or engage in discrimination against prospective or current clients**, students, employees, supervisees, or research participants based on age, culture, disability, ethnicity, race, religion/spirituality, **gender, gender identity, sexual orientation**, marital/ partnership status, language preference, socioeconomic status, immigration status, or any basis proscribed by law.

C.7.a. Scientific Basis for Treatment When providing services, **counselors use techniques/procedures/modalities that are grounded in theory and/or have an empirical or scientific foundation.**

C.7.b. Development and Innovation When counselors use developing or innovative techniques/procedures/ modalities, they explain the potential risks, benefits, and ethical considerations of using such techniques/procedures/ modalities. **Counselors work to minimize any potential risks or harm when using these techniques/procedures/modalities**

C.7.c. Harmful Practices **Counselors do not use techniques/procedures/modalities when substantial evidence suggests harm**, even if such services are requested.

E.5.a. Proper Diagnosis Counselors take special care to provide **proper diagnosis of mental disorders**. Assessment techniques (including personal interviews) used to determine client care (e.g., locus of treatment, type of treatment, recommended follow-up) are carefully selected and appropriately used.

E.5.b. Cultural Sensitivity Counselors recognize that **culture affects the manner in which clients' problems are defined and experienced**. Clients' socioeconomic and cultural experiences are considered when diagnosing mental disorders.

E.5.c. Historical and Social Prejudices in the Diagnosis of Pathology Counselors recognize historical and social prejudices in the **misdiagnosis and pathologizing of certain individuals and groups** and strive to become aware of and address such biases in themselves or others.

References:

Doyle, C. J. (2018). A New Family Systems Therapeutic Approach for Parents and Families of Sexual Minority Youth. *Issues in Law & Medicine*, *33*(2), 223.

McGeorge, C. R., Carlson, T. S., & Toomey, R. B. (2015). An Exploration of Family Therapists' Beliefs about the Ethics of Conversion Therapy: The Influence of Negative Beliefs and Clinical Competence With Lesbian, Gay, and Bisexual Clients. *Journal of Marital & Family Therapy*, *41*(1), 42–56.

Flentje, A., Heck, N. C., & Cochran, B. N. (2014). Experiences of Ex-Ex-Gay Individuals in Sexual Reorientation Therapy: Reasons for Seeking Treatment, Perceived Helpfulness and Harmfulness of Treatment, and Post-Treatment Identification. *Journal of Homosexuality*, *61*(9), 1242–1268.

Turban, J. L., Beckwith, N., Reisner, S., & Keuroghlian, A. S. (2018). 4.10 Exposure to Conversion Therapy for Gender Identity is Associated With Poor Adult Mental Health Outcomes Among Transgender People in the US. *Journal of the American Academy of Child & Adolescent Psychiatry*, *57*, S208.

Mahler, L., & Mundle, G. (2015). A need for orientation: The WMA statement on natural variations of human sexuality. *International Review of Psychiatry*, *27*(5), 460–462.

Commenter: Lindsay Grohowski 3/20/19 1:06 pm

Coversion therapy is abuse and current research shows this practice is NOT effective.

Commenter: Erik Fessler 3/20/19 3:15 pm

"Conversion Therapy" is Threat to Virginia Minors

I am writing to support restrictions - and an outright ban - on so-called "sexual orientation conversion therapy" in the Commonwealth.

Conversion therapy is opposed by most major professional health and mental health organizations (American Pediatrics Assn, American Psychiatric Assn, etc.) are opposed to the damaging effects of conversion therapy. These effects include significantly higher rates of depression and suicide among our fellow LGBTQ Virginians. Our children are suffering at the hands of a practice with no backing in science.

Please end this nightmare immediately.

Commenter: Christine Walther-Thomas 3/20/19 4:09 pm

Ban Conversion Therapy--Bad Science and Disastrous Outcomes for All

I am opposed to Conversion Therapy on many levels--as a teacher educator, education policy researcher, social justice advocate, friend, colleagues, and most of all, as the proud mother of a wonderful gay man.

For more than 30 years, medical and mental health communities have rejected the practice of conversion therapy as quackery. Science shows very clearly it is impossible to the sexual orientation with which someone is born. Efforts to change an individual's gender identity have disastrous effects for LBGTQ+ individuals and for their families. American Psychiatric Association declassified homosexuality as a mental disorder more than 40 years ago and in 1998 denounced conversion therapy because it is ineffective and causes "...substantial psychological pain by reinforcing damaging internalized attitudes." Similarly, the American Psychological Association rejected these practices many years ago and repeatedly affirmed its stance. Research clearly shows these misguided practices can produce serious physical and mental health to LGBTQ+ children, adolescents, and adults. Many national and international organizations have also rejected these practices because they are not scientifically, socially-, or ethically sound. Some of these organizations include the **World Health Organization, American Medical Association, American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry,** and the **American Counseling Association.** In addition, more than 15 U. S. states, the District of Columbia, and 50+ major cities have banned conversion therapy.

Good public policy is based on evidence, core principles and values, and respect for all. Unfortunately, well-respected research often takes years to become the everyday evidence needed to improve the lives of people. When it does, effective policies and practices replace ineffective ones; knowledge and skills unfounded myths, fears, and superstitions and social attitudes change.. The Commonwealth has long been recognized as a national and international leader championing knowledge, justice, freedom, and respect for all. As such, Virginia must help lead the way of banning conversion therapy and ensuring the protection of our citizens and especially our most vulnerable children and youth.

Commenter: Jenny Moore 3/20/19 8:31 pm

Ban Conversion Therapy

Homosexuality is not a mental disorder in need of being changed. Conversion therapy is not an appropriate treatment plan for any individual. Psychological peer-reviewed journals site that conversion therapy is not effective in changing an individual's sexual orientation. It is appaling that in 2019 there would still be a discussion about the validity of this unethical practice.

Commenter: Susan Moore 3/20/19 9:57 pm

Long overdue!

Conversion therapy been rejected by every mainstream medical and mental health organization for decades. It is a very harmful practice. Young people are especially vulnerable as conversion therapy can lead to depression, anxiety, drug use, homelessness, and suicide.

To date, over a dozen states have laws or regulations protecting youth from this abusive practice. I am glad that Virginia plans to get on board and prohibit licensed counselors from engaging in conversion therapy. This is long overdue.

Commenter: Jennifer Oribello 3/20/19 10:29 pm

Sexual conversion therapy is an abhorrent and abusive practice

Sexual conversion therapy is a abusive practice that should not be permitted in the Commonwealth, and any medical professional who performs such "therapy" should be subject to discliplinary action by the Virginia Board of Psychology if not have their license revoked. To force a child, or anyone, against their will to change their sex is medically unnecessary and factually ineffective at what it purports to achieve. Being gay, lesbian or transexual is not a choice and those who would attempt to "fix" a child's gender through converstion therapy are only creating physical and mental trauma.

Commenter: William A Harrison Jr 3/22/19 4:41 pm

"Conversion therapy" does not work

I went through "Christian" therapy years ago and as an end result married a woman. I knew full well that i was still homosexual, but did what i thought God wanted me to do. As an end result my marraige ended in a horrible, painful divorce. and trust me, none of that "was what God wanted." Sexual orientations cannot be changed. Putting children through this IS THE SIN, not being gay.

Commenter: Renee Staton 3/22/19 5:34 pm

Conversion Therapy is Unethical Practice

SAMHSA has provided 3 compelling points relevant to considerations of conversion therapy:

- Diversity regarding gender identity and expression is normal
- The premise on which conversion therapy is based is not supported by research; and
- Interventions such as conversion therapy can be harmful and should not be considered viable treatment options.

These points clearly indicate that conversion therapy is an unethical practice that is not endorsed by professional counseling and psychology organizations. This position has been affirmed, in various ways, by the American Counseling Association as well as other reputable organizations such as the American Psychiatric Association, the American Psychological Association, and the National Association of Social Workers.

I appreciate the Board of taking the step of joining other states and ensuring that licensed counselors in Virginia do not engage in unethical practice and may not refer to individuals who offer this practice.

3/22/19 7:13 pm

Commenter: Richard Rutherford

ban so-called "conversion therapy," especially for minors

This fake, destructive "therapy" does just the opposite of "no harm." It is known to cause damage to the extent of self-destructive behavior, and most critically, is never successful in changing a person's sexual orientation. Please do not allow it in the Commonwealth.

Commenter: Ralph 3/24/19 2:54 pm

conversion therapy

tell the VA Board of Counseling not to punish licensed counselors for helping patients overcome their unwanted sexual feelings by affirming biological realities concerning male and female. The key word being unwanted. And it should be between a counselor and the patient to decide which route to take.

Commenter: William Esswein 3/25/19 11:00 am

Ban Conversion Therapy NOW!

I am delighted to here that the VA Board of Counseling is considering putting a ban on conversion therapy. I believe this is also long overdue, especially since there has long been evidence that it does not work. In fact, the evidence points in the direction of conversion therapy being harmful towards those who are put through it. It is unethical and irresponsible for any counselor in this day and age to be practicing this type of therapy. Potential clients deserve to be protected from this harmful practice henceforth.

Commenter: Julie Miller 3/25/19 8:24 pm

Ban conversion therapy

Conversion therapy does not make gay people straight. It makes gay people (usually gay kids) ashamed and guilt-ridden. The kids wind up full of such self-loathing that they wind up committing suicide. We need to protect our LGBTQ youth from this harmful practice and show them we love them exactly as they are.

Commenter: Jamie Bennett 3/27/19 10:35 am

Conversion Therapy

A counselor should be able counsel a minor according to the specific needs of the child. They should not be restricted from discussing the option and benefits of pursuing a heterosexual relationship. The focus is all pointing towards encouraging children to pursue homosexual relationships. Anyone that discusses the alternative is branded homophobic and in the case of a counselor, the movement is to outlaw promotion of heterosexuality. Minors are highly impressionable and many are influenced by their peers, teachers, and peers. Hollywood promotes homosexuality. The LGBTQ community is militant about promoting their agenda and that is to silence all opposing viewpoints. I ask that you please not 'outlaw' the ability for counselors to discuss the benefits of heterosexuality with their patients.

Commenter: Equality Virginia 3/28/19 11:25 am

Re: Support for Guidance Document 115-10, on the Practice of Conversion Therapy

Dear Virginia Board of Counseling,

Equality Virginia is pleased to support **Guidance Document 115-10, on the Practice of Conversion Therapy**, which would protect youth under the age of 18 from so-called "conversion therapy" at the hands of licensed counselors in Virginia. Equality Virginia is the leading advocacy organization in Virginia seeking equality for lesbian, gay, bisexual, and transgender people.

Conversion therapy, sometimes referred to as "reparative therapy," "ex-gay therapy," or "sexual orientation change efforts," is a set of practices by mental health providers that seek to change an individual's sexual orientation or gender identity. This includes efforts to change behaviors or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include psychotherapy that aims to provide acceptance, support, and understanding of clients or the facilitation of clients' coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices. Nor does it include counseling for a person seeking to transition from one gender to another.

There is no credible evidence that any type of psychotherapy can change a person's sexual orientation or gender identity. In fact, conversion therapy poses critical health risks to lesbian, gay, bisexual, transgender, and queer young people, including depression, shame, decreased self-esteem, social withdrawal, substance abuse, risky behavior, and even suicide. Nearly all the nation's leading mental health associations, including the American Psychiatric Association, the American Psychological Association, the American Counseling Association, the National Association of Social Workers, the American Academy of Pediatrics, and the American Association for Marriage and Family Therapy have examined conversion therapy and issued cautionary position statements on these practices.

Research shows that lesbian, gay, and bisexual (LGB) youth are 4 times more likely, and questioning youth are 3 times more likely to attempt suicide as their straight peers.[1] Nearly half of young transgender people have seriously thought about taking their lives and one quarter report having made a suicide attempt.[2] Young people who experience family rejection based on their sexual orientation, including being subjected to conversion therapy, face especially serious health risks. Research reveals that LGB young adults who report higher levels of family rejection during adolescence are 8.4 times more likely to report having attempted suicide, 5.9 times more likely to report high levels of depression, 3.4 times more likely to use illegal drugs, and 3.4 times more likely to report having engaged in unprotected sexual intercourse compared with peers from families that reported no or low levels of family rejection.[3]

Virginia law already prohibits discredited and unsafe practices by licensed therapists. This guidance would prevent licensed psychologists in Virginia from performing conversion therapy with a patient under 18 years of age, regardless of the willingness of a parent or guardian to authorize such efforts. The guidance will curb harmful practices known to produce lifelong damage to those who are subjected to them and help ensure the health and safety of LGBTQ youth. We thank you for proposing this important guidance.

Sincerely,

Equality Virginia

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804-643-4816

Equalityvirginia.org

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[1] 2011 CDC, "Sexual Identity, Sex of Sexual Contacts, and Health-Risk Behaviors Among Students in Grades 9-12."

[2] Arnold H. Grossman & Anthony R. D'Augelli, "Transgender Youth and Life-Threatening Behaviors," 37(5) *Suicide Life Threat Behav.* 527 (2007).

[3] Caitlyn Ryan et al., "Family Rejection as a Predictor of Negative Health Outcomes in White and Latino Lesbian, Gay, and Bisexual Young Adults," 123 *Pediatrics* 346 (2009).

Commenter: Jeff Caruso, Virginia Catholic Conference 3/28/19 11:40 am

Oppose Guidance Document

Dear Virginia Board of Counseling,

The Virginia Catholic Conference is the public policy agency representing Virginia's Catholic bishops and their two dioceses. The Conference urges the Board of Counseling to reject the draft "Guidance Document on the Practice of Conversion Therapy (115-10)." If implemented, 115-10 would usurp the primary and fundamental role of parents, violate First Amendment rights, and exceed regulatory authority.

Role of parents

Healthcare decisions involving the mental and emotional health of children do not fit neatly into "one-size-fits-all" regulations. Parents are closest to their children's challenges. They know their unique needs and are in the best position to identify solutions. Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life compatible with their religious or personal values. In either instance, there should be options available for families to make informed decisions.

Just as parents must give consent for over-the-counter medications,[1] field trips, and extracurricular activities, they have the constitutional right to guide mental health care for their children.

The child is not the mere creature of the State; those who nurture him and direct his destiny have the right, coupled with the high duty, to recognize and prepare him for additional obligations.[2]

115-10 also violates the presumption of parental autonomy in Virginia. Code Sec. 1-240.1 provides that a parent has the fundamental right to make decisions concerning the upbringing, education and care of the parent's child.

Families should also be free to make these decisions in private consultation with their child's counselor.

First Amendment

The First Amendment prohibits the government from favoring one viewpoint over another.

[T]he government has no power to restrict expression because of its message, its ideas, its subject matter or its content.... [T]he requirement that the government be content neutral in its regulation

of speech means that the government must be both viewpoint neutral and subject-matter neutral. The viewpoint-neutral requirement means that the government cannot regulate speech based on the ideology of the message.[3]

115-10 defines "conversion therapy" or "sexual orientation change efforts" as *any practice or treatment that seeks to change an individual's sexual orientation...or eliminate or reduce sexual or romantic attractions or feelings toward individuals of any gender.* Because it seeks, for example, to prohibit the provision of licensed services to help clients achieve alignment between their subjective sense of gender and their objective biological sex while permitting services to assist clients towards a subjective sense of gender at odds with their objective biological sex, it is neither content nor viewpoint neutral. In addition, 115-10 would allow those who provide services to assist clients in directing their attractions in one direction but not in the other direction.

Document 115-10, therefore, gives the Board sweeping authority to sanction counselors' speech and engage in unconstitutional viewpoint discrimination.

As applied to faith-based, licensed counselors, 115-10 also would result in censorship of religious beliefs in violation of the First Amendment.

To comply with 115-10, these counselors must terminate or self-censor any conversation with a client that may tend toward reducing same-sex attraction, regardless of the client's or family's desire to seek counsel. Because of this, 115-10 would also impermissibly restrict a patient's First Amendment freedom to speak candidly about intimate concerns and to receive counsel.

Ethics rules should be enforced and frequently examined for effectiveness and uniformity across all professions. They should also not be applied in ways that are biased to favor certain viewpoints or to target others for sanction. At a minimum, speech must be protected.

Conversely, 115-10 sets a double standard. It does not, for example, sanction dangerous treatments to accelerate "gender transition" among children, e.g., through irreversible surgery or hormonal treatments.

Exceeding regulatory authority

For reasons such as those explained above, the General Assembly has rejected legislation to ban "conversion therapy." In 2016, the legislature rejected three such bills in committee: (**SB 262 and SB 267,** Senators Surovell and Dance; and **HB 427**, Delegate Hope) that would have prohibited "conversion therapy" on persons under 18 to change sexual orientation or gender identity.

Similarly in 2018, the General Assembly rejected two bills (**HB 363**, Delegate Hope; **SB 245** Senator Surovell) which would have prohibited counselors from providing any treatment to those under 18 which would seek to change an individual's sexual orientation or gender identity, including efforts to change behaviors or gender expressions or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Nearly identical to 115-10, these bills were also defeated in committee.

Administrative agencies can adopt rules and policies to carry out duties delegated by the legislature. The rules and policies, however, should be consistent with statutory provisions.[4] The General Assembly has specifically and repeatedly rejected proposed "conversion therapy" bans. The Board does not have the authority to adopt 115-10 because doing so would circumvent the General Assembly's decisions in this matter.

Accordingly, the Virginia Catholic Conference urges the Board of Counseling to reject 115-10.

Sincerely,

Jeff Caruso

Executive Director

Virginia Catholic Conference

[1] http://www.doe.virginia.gov/support/health_medical/medication/manual_training_admin-meds.pdf

[2] *Pierce v. Society of Sisters*, 268 U.S. 510 (1925). See also *Wisconsin v. Yoder* (1972).

[3] Erwin Chemerinsky, *Content Neutrality as a Central Problem of Freedom of Speech in the Supreme Court's Application*, Southern California Law Review, Vol. 74: 49, 51 (2000). Citing *Police Dep't. v. Moseley*, 408. U.S. 92, 95 (1972).

[4] *Mobil Oil Exploration & Producing Southeast v. United Distrib. Cos.*, 498 U.S. 211 (U.S. 1991)

Commenter: Elizabeth Surma, VCU 3/29/19 12:45 pm

Ban Conversion Therapy!

Ban conversion therapy! It only causes harm! It is a horrible practice that is unfounded in research. No person should ever have to suffer through conversion therapy due to ignorant practices.

Commenter: Sarah Deprey-Severance 3/30/19 6:06 pm

Stop Conversion Therapy

I am writing in support of Guidance Document 115-10: Guidance on conversion therapy. "Homosexuality," or same-sex attraction and partnership, has not been listed as a diagnosable psychiatric condition since 1973. Still, social stigma and mainstream narratives about how humans *ought* to be in consensual relationship (romantic, sexual) with other humans continues to contribute to pathologizing of non-heterosexual identities, and LGBTQ+ youth are vulnerable to these narratives and judgements. LGBTQ+ youth are three times as likely as their non-LGBTQ+ peers to report suicidality and are six times more likely to experience depression than the general population (Marshal et al., 2011; NAMI, 2019). This already vulnerable population should not be subject to ineffective and harmful treatments like conversion therapy. Research on conversion therapy from peer-reviewed literature released by the American Psychiatric Association, the American Psychological Association, and the American Academy of Child and Adolescent Psychiatry has shown no evidence that conversion therapy is effective in changing sexual identity, and other peer-reviewed journals have published evidence that this treatment is harmful (Drescher, 2016).

Certainly, mental health professionals may encounter clients who are interested in changing their sexual identity, and yet mental health professionals would do well to wonder about the *why* of this request. LGBTQ+ youth often experience "minority stress," which, according to NAMI (2019) are disparities in this community, made from a combination of "social stigma, discrimination, prejudice, denial of civil and human rights, abuse, harassment, victimization, social exclusion and family rejection." This minority stress may be a primary factor in a young person's desire to change their sexual identity, since humans are wired to be in connection with others, and the components of minority stress, as listed above, produce considerably disconnected experiences.

Before engaging in treatment, it is important for mental health professionals to understand the context in which a client is experiencing distress, and certainly if that distress is societally-inflicted and not due to the fault of the client of interest (which is how I, as an emerging mental health counselor, conceptualize difficulty related to sexual identity in clients I see), it would be important to instead treat the distress in a way that is affirmative, empowering, and healing. As the American Counseling Association (2013) states in "Ethical issues related to conversion or reparative therapy," counselors are ethically bound to share information about potential treatments

and must have expertise and training in the treatment methods they utilize. Since there is no ACA-approved training or certification for conversion therapy, a counselor engaging in conversion therapy is not acting within the ethical code for the profession, and counselors who are being asked to provide referrals for a therapist who offers conversion therapy are bound by the ethical code of the profession to share this information with the client prior to a referral, as well. I encourage anyone within the field of professional counseling, mental health, and the helping professions to read the ACA statement on conversion therapy to clarify how the counseling profession views conversion therapy, located here: https://www.counseling.org/news/updates/by-year/2013/2013/01/16/ethical-issues-related-to-conversion-or-reparative-therapy

Commenter: Aleta E Strickland EdS, NCSP, Louisa Psychological Consulting, PC 3/31/19 2:10 pm

Protect vulnerable youth and end child abuse disguised as mental health treatment.

The idea that homosexuality is a mental disorder or that the emergence of same-sex attraction and orientation among some adolescents is in any way abnormal or mentally unhealthy has no support among any mainstream health and mental health professional organizations. Any practitioner using it is doing so fraudulently and unethically. It is time for Virginia to protect its youth by banning this horrific practice. Why are we allowing clinicians to harm children? The only outcomes documented from this approach are negative and harmful. Make it stop.

Commenter: Kirsten O'Nell 4/3/19 2:16 pm

Ban Conversion Therapy

Conversion therapy is torture plain and simple. It does long term damage to a child's psyche and should never be practiced.

Commenter: Zachary Whitten, Virginia Commonwealth University 4/3/19 7:00 pm

End Conversion Therapy

I wholeheartedly support guidance document: 115-10 and wish for it to be enacted. As noted in the document, conversion therapy "does not work, can cause harm, and violates [The ACA's] Code of Ethics". For this reason alone, conversion therapy should be prohibited in Virginia. But moreover, conversion therapy is a disgusting practice which seeks to invalidate the LBGTQ+ community. As noted in 115-10, "The ACA Ethics Committee states that counselors who conduct this type of therapy view same-sex attractions and behaviors as abnormal and unnatural and, therefore, in need of 'curing'". I see no way Virginia can proclaim itself an inclusive commonwealth, can hold "Virginia is for Lovers" as a motto without burning hypocrisy, if it allows such a horrifying and undignified practice to be allowed. For upholding basic human dignity, I respectfully implore you to enact guidance document: 115-10.

Zachary Whitten

Commenter: Latasha Howlett 4/6/19 9:25 am

Not your place!

It is not your place to dictate or overthrow Christian idealogies to support culture's idea of societal norms. As a Christian it is my right to seek out assistance for my child that may struggling with any sin including same sex attraction. To suggest that my efforts are harmful emphasis just how far this culture has moved from the truth of JESUS! There is nothing wrong with seeking help if a person is struggling and limiting a parent's ability to raise their child so long as it does not offend a subset of the culture is not cool. This subset is always talking about tolerance how about they show some tolerance for those that disagree with them. I don't tell anyone how to live their lives don't dictate to me how to live mine or raise my kids

iot right

Commenter: Michael Kim 4/6/19 9:52 am

In support of Jeff Caruso

I support the comment submitted by Jeff Caruso who is against the ban.

Commenter: Sue Barger 4/6/19 3:46 pm

YES TO SAFE AND EFFECTIVE CONVERSION THERAPY

As with any medical and mental health procedures, safe and effective is always part of the goal. To say no to conversion therapy as a whole is BOGUS to say the least.

As for the POLITICS surrounding this topic, let me REMIND, the US Declaration of Independence was written BEFORE the US Constitution—the first thing our Founders did in forming this nation was to declare our Creator and that our rights come from him, so by recognizing the Creator, we recognize his standards, thusly a child in the womb as a life and people are physically born male and female, stating otherwise is contrary—so, if you choose to be contrary and not recognize this Creator, please know you live in a nation that tolerates non-belief but learn to BE AS TOLERANT AND RESPECTFUL AS THE FEW EARLY AMERICANS who were contrary to the Creator but that recognized the good in the Protestant principles of Liberty and Freedom.

Unfortunately and wrongfully, far too long the spirit of US Declaration has been divorced from the US Constitution in many arenas and especially in decision making, this must be reconciled. Thank you.

Commenter: Katherine 4/6/19 5:24 pm

Ban conversion therapy

Please ban the awful and dangerous practice.. freedom of religion doesn't give anyone the right to hurt others

Commenter: Carey Mason Perkins 4/8/19 9:00 pm

Ban conversion therapy

Please, Virginia, ban this therapy which is known to be harmful to gay and lesbian children and adults. Just show them we love them just the way they are!

Commenter: Susan Ricci 4/8/19 10:06 pm

Ban Conversion Therapy

Conversion therapy should be banned. It is damaging to our LGBTQ citizens. LGBTQ youth especially need support and acceptance. Being homosexual isn't a disease that can be treated and eradicated.

Commenter: Deborah Cohen 4/9/19 10:38 am

Ban Conversion Therapy

Gay people are just fine the way they are. "Conversion therapy" is a bunch of religious nonsense used by Christian supremacists to enforce their hate of gay people using the law. Thank you for standing against this utter stupidity and hate! The only conversion therapy needed is to convert white/male/religious/wealth supremacists into human beings with compassion & empathy!

Commenter: Josh Hetzler, Legislative Counsel for The Family Foundation of Virginia 4/9/19 4:08 pm

Unlawful Prior Restraint on Speech

I write to express The Family Foundation of Virginia's opposition to the Board of Counseling's proposed Guidance Document 115-10. Such guidance will not only cause numerous ethical and moral harms to professionals, and developmental harms to children, but it is at odds with the laws of Virginia and the Constitution of the United States.

As a general matter, the Virginia Code expressly provides that parents, not the government and its regulatory agencies, have a "fundamental right to make decisions concerning the upbringing, education, and care of the parent's child." Va. Code § 1-240.1 However, the effect of this Guidance Document would unduly limit the right of parents to make decisions concerning the upbringing, education, and care of their child by preventing them from getting them the help they and their child need and desire.

Virginia's constitution declares that "the right to be free from any governmental discrimination upon the basis of religious conviction . . . shall not be abridged[.]" Constitution of Virginia, Article 1, Section 11 (Bill of Rights). This Guidance Document would directly discriminate against Christian, Jewish, and Muslim health professionals who maintain, as a fundamental tenet of their faith, that human beings are created by God as either male or female and that human sexuality is only properly expressed between a man and a woman in the context of marriage. Such a conception of human sexuality reflects the historical, conventional, and orthodox views of these major faith traditions, and has transcended cultures and boundaries for millennia. Denying licensed psychologists through this policy the right to acknowledge this while acting in their professional capacity subjects them to "discrimination on the basis of religious conviction," and thus runs afoul of one of Virginia's most basic constitutional guarantees.

The Board's policy as expressed in this proposed Guidance Document would also be unconstitutional in light of the U.S. Constitution because it would infringe on the free speech rights

of professional counselors by prohibiting them from speaking certain messages (or, if not strictly prohibiting it, then by significantly "chilling" their free speech). In 2018, the U.S. Supreme Court rejected the state of California's claim that so-called "professional speech" receives less First Amendment protection than ordinary speech, stating that: "This Court has not recognized 'professional speech' as a separate category of speech. Speech is not unprotected merely because it is uttered by 'professionals.'" National Institute of Family and Life Advocates (NIFLA) v. Becerra, 138 S. Ct. 2361, 2371-72 (2018).

The Supreme Court's opinion highlighted three cases – two of which involved state bans on so-called "conversion therapy" for minors – as being erroneously decided for holding that counseling was afforded less constitutional protection as a matter of free speech. As a result, the lower court cases upholding bans on "conversion therapy" were effectively overruled. Because this policy would have the direct and immediate effect of censoring the protected speech of health professionals in Virginia, it would not likely survive a legal challenge. If this Board does go forward with such a violation of free speech, it should expect such a challenge.

Effectively prohibiting the practice of so-called "conversion therapy" among licensed counselors, as the draft Guidance Document defines that term, goes too far in its attempt to address the hypothetical concerns some have raised. (It is worth noting that no known complaint has ever been received by any of the health regulatory boards concerning "conversion therapy.") As the term is now over-broadly and vaguely defined, it "compels individuals to contradict their most deeply held beliefs, beliefs grounded in basic philosophical, ethical, or religious precepts, or all of these." NIFLA v. Becerra, 138 S. Ct. 2361, 2379 (Kennedy, J., concurring).That is something this Board may not do.

The Supreme Court in NIFLA cautioned that "when the government polices the content of professional speech, it can fail to 'preserve an uninhibited marketplace of ideas in which truth will ultimately prevail.'" Id. at 2374 (quoting McCullen v. Coakley, 134 S. Ct. 2518, 2529 (2014)). There are significant disagreements about the merit of therapies which help a young person resolve, and in many cases by reversing (read testimonies of many for whom this happened at https://changedmovement.com/) their unwanted sexual attractions or gender confusion. These disagreements should be settled in the marketplace of ideas and according to the wishes of the minor and his or her parents. The effect of this regulation, however, would only be to silence unpopular ideas and suppress information.

We urge this Board to heed the U.S. Supreme Court's words when it observed that "'the best test of truth is the power of the thought to get itself accepted in the competition of the market' and the people lose when the government is the one deciding which ideas should prevail." Id. at 2375 (quoting Abrams v. United States, 250 U.S. 616, 630 (1919) (Holmes, J., dissenting)).

Commenter: Casey Pick, The Trevor Project 4/9/19 5:08 pm

Support for Guidance Document 125-9, on the Practice of Conversion Therapy

Dear Virginia Board of Counseling,

The Trevor Project is proud to support Guidance Document 125-9, on the Practice of Conversion Therapy, which would protect youth under the age of 18 from so-called "conversion therapy" at the hands of licensed psychologists in Virginia.

The Trevor Project is the world's largest suicide prevention and crisis intervention organization for LGBTQ (Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning) young people. We work every day to save young lives by providing support through free and confidential suicide prevention and crisis intervention programs on platforms where young people spend their time: our 24/7 phone lifeline, chat, text, and soon-to-come integrations with social media platforms. We also run TrevorSpace, the world's largest safe space social networking site for LGBTQ youth, and operate innovative education, research, and advocacy programs.

In the past year alone, The Trevor Project has been contacted by more than 2,500 young Virginians. Nationally, many of the young people that we serve are survivors of conversion therapy or have a credible fear that their family members will compel them to go through conversion therapy. Supervisors for The Trevor Project's crisis services report that these issues come up regularly in conversation with youth coming to us for help, and as often as weekly. These impressions are borne out by data collected on TrevorLifeline, TrevorText, and TrevorChat, as our records show that since 2010 hundreds of contacts have reached out to The Trevor Project with specific concerns around this practice and terms like "conversion therapy," "reparative therapy," and "ex-gay" have appeared on our text-based platforms with disturbing frequency.

Some of these LGBTQ youth contact us because their parents are threatening to send them to conversion therapy. Others call us because they are in conversion therapy, it is not working, and their feelings of isolation and failure contribute to suicidal thoughts and behaviors. We've had youth reach out because friends or loved ones are being subjected to conversion therapy. And finally, young people have come to The Trevor Project in a state of profound distress because a someone they know has died by suicide during or after being subjected to conversion therapy.

The Trevor Project is invested in ending conversion therapy in every state because we know from experience and rigorous social science that conversion therapy contributes to an increased likelihood of suicide attempts among the youth we exist to serve. Recent research by The Family Acceptance Project has found that rates of attempted suicide by LGBT youth whose parents tried to change their sexual orientation were more than double (48%) the rate of LGBT youth who reported no such attempts to change their orientation (22%). Suicide attempts for LGBT young people who reported both home-based efforts to change their sexual orientation by parents and formal change efforts by therapists and/or religious leaders were three times higher (63%).

Far from being a relic of history, the practice of conversion therapy is active and ongoing in Virginia today. A 2018 study by the Williams Institute at the University of California, Los Angeles School of Law shows that nearly 700,000 LGBTQ adults have been subjected to conversion therapy, with 350,000 of them receiving the dangerous and discredited treatment as youth. That number grows by thousands each year as the Williams Institute estimates that nearly 57,000 LGBTQ youth will be subjected to conversion therapy in the next few years by either a religious or spiritual advisor. **An estimated 20,000 LGBT youth currently ages 13 to 17 will undergo conversion therapy from a licensed healthcare professional before the age of 18. These are the youth this guidance would protect.**

As to questions raised by conversion therapy proponents about the constitutionality of protections for youth from these practices, policymakers can be assured that multiple federal courts—including the Third and Ninth U.S. Circuit Courts of Appeals—have upheld similar laws protecting youth from conversion therapy. The U.S. Supreme Court has also twice declined to hear appeals to positive federal court rulings upholding laws restricting conversion therapy. The power of states to regulate medical treatments, including professional therapy, to ensure the public's health and safety is long established in Supreme Court precedent; indeed, it is a core purpose of professional licensing boards to regulate potentially dangerous medical treatments. Conversion therapy is no exception.

This policy does not restrict any protected First Amendment speech. It prohibits discredited treatments by state-licensed mental health care professionals. It does not apply to clergy or to individuals who provide religious instruction not selling these discredited practices in the public marketplace. It also does not prevent anyone from publishing, discussing, or advocating any viewpoints or beliefs regarding sexual orientation, gender identity, or anything else.

Despite these facts, conversion therapy proponents have suggested that dicta from *NIFLA v. Becerra* supports their oft-repeated and rejected claim that protecting youth from conversion therapy violates the free speech rights of licensed professionals. This is not the case, as *NIFLA*'s discussion of the professional speech doctrine has no effect on the constitutionality of conversion therapy bills. *NIFLA* concerned a California law that required licensed and unlicensed crisis pregnancy centers to post certain notices. By contrast, anti-conversion therapy policies regulate professional *conduct*, not professional speech, so the *NIFLA* case is inapplicable. In fact, in his opinion in *NIFLA*, Justice Thomas reaffirmed a distinction between professional speech and

professional conduct, by explicitly stating that "under [the Supreme Court's] precedents, States may regulate professional *conduct*, even though that conduct incidentally involves speech."

Likewise, it is long established that the fundamental rights of parents do not include endangering their children by forcing them to undergo medical practices that have been rejected by the scientific community as discredited and harmful. The law already protects against other forms of child endangerment, and legal protections and professional guidance make it clear to parents that so-called "conversion therapy" is a dangerous and discredited practice that has no legitimate purpose. These regulations serve to protect parents from being taken advantage of by practitioners of conversion therapy who would attempt to cloak their actions with the legitimacy and authority of a state-issued license.

Virginia law already prohibits discredited and unsafe practices by licensed therapists. This guidance would prevent licensed mental health providers in Virginia from performing conversion therapy with a patient under 18 years of age – nothing more, nothing less. The guidance will curb harmful practices known to produce lifelong damage to those who are subjected to them and help ensure the health and safety of LGBTQ youth.

For these reasons and on behalf of the youth who depend upon our services, The Trevor Project strongly supports Guidance Document 125-9. Thank you for your consideration of this importance guidance.

Sincerely,

Casey Pick
Senior Fellow for Advocacy & Government Affairs
The Trevor Project

Commenter: Rev. Donald Spitz 4/9/19 5:10 pm

VA Board of Counseling should not punish licensed counselors

VA Board of Counseling should not punish licensed counselors for helping patients overcome their unwanted sexual feelings by affirming biological realities concerning males and females.

Commenter: Mark Bowyer 4/9/19 5:11 pm

FREEDOM IN DANGER!

There is a serious free speech principle here. While some forms of therapy may indeed cause harm, it is up to the medical community to oversee that, NOT the government. The matter of whether people may need or want therapy to address their sexuality is a personal one. Banning ANYTHING related to therapy is an egregious overstepping of constitutional rights. All these folks that want conversion therapy banned are barking up the wrong tree! NOT a matter for governent!

Commenter: Judy Cook 4/9/19 5:12 pm

Christian counseling

Christian counselors have the right to offer counsel based on a Biblical worldview as well as the latest scientific research.

Judy Cook. over this text and enter your comments here. You are limited to approximately 3000 words

Commenter: William Hyde 4/9/19 5:13 pm

Don't stop peoplw from getting the help they want

Don't listen to activists looking to the state to enforce their beliefs by violating g other people's first amendment rights. No one forced people to participate in therapy and any abusive therapeutic relationships are are already covered by other laws and regulations. If people want to undergo therapy and a therapist wants to help them they should be allowed to do so. Mental health treatments need to be left to therapists and their patients.

Commenter: Patricia Magyar 4/9/19 5:17 pm

NO censorship: administrative regulations!!!

Please stop the hostility towards counselors who uphold these natural, biological and/or Biblical viewpoints of human sexuality, and its willingness to violate any and all free speech and conscience protections in order suppress these deeply held beliefs. Please do not punish licensed counselors for helping patients overcome their unwanted sexual feelings by affirming biological realities concerning males and females.

Commenter: Stephanie Seely 4/9/19 5:22 pm

freedom of conscience for counselors and safety for the families they help

Do not **punish licensed counselors for helping patients overcome their unwanted sexual feelings by affirming biological realities concerning males and females.** This is censorship! It presents an ethical dilemma for counselors who do not agree with this policy, and will damage the children being counseled. To take away a counselor's license because he/she followed their conscience is WRONG!

Commenter: George Elliott 4/9/19 5:24 pm

counseling gender confusion

The VA Board of Counseling should not punish licensed counselors for helping patients overcome their unwanted sexual feelings by affirming biological realities concerning males and females.

Commenter: Paul Perrone 4/9/19 5:29 pm

Let Counselors Do Their Job

Counselers should be allowed to do their jobs to help patients who want to change. They should not be held hostage to well-financed political organizations who have a political agenda to change the culture.

4/9/19 5:31 pm

Commenter: Marsha Johnson

Allow clients with unwanted same sex feelings to get the help they want

When a child wants help with unwanted same sex feeling you are forbidding him or her from getting that help. Do not punish licensed counselors for helping patients overcome their *unwanted* sexual feelings by affirming biological realities concerning males and females. Banning honest communication between therapist and client creates a blatant double standard whereby counselors would be free to help minor clients explore and possibly cultivate same-sex feelings or even to "change" their gender, while simultaneously prohibiting them from helping minor clients flee from unwanted same-sex attractions and embrace natural sexual expressions and/or their true gender. Licensed counselors have a responsibility to speak honestly with their minor clients about life's fundamental truths, and any state policies that compel them to repress those truths during counseling would lead to real ethical dilemmas, not to mention damage to those children.

Commenter: Henry Polczer 4/9/19 5:39 pm

Counselors MUST be allowed to speak their option

Allow counselors to speak honestly and not be centured by the state! Licensed counselors have a responsibility to speak honestly with their minor clients about life's fundamental truths, to include dealing with harmful same sex attraction, and any state policies that compel them to repress those truths during counseling would lead to real ethical dilemmas, not to mention damage to those children.

Commenter: Richard W Firth 4/9/19 5:43 pm

ALLOW COUNSELING OF HOMOSEXUALS

IT IS GOD'S MOST HOLY WILL not **to punish licensed counselors for helping patients overcome their unwanted sexual feelings by affirming biological realities concerning males and females. This is a SPIRITUAL MATTER not a secular one with grave consequences for not dealing with it as such.**

Gpd created us either a female or male with no go betweens Until we realize we are but one sex, either a male or female people will have no peace or happiness.

Commenter: James Ludington 4/9/19 5:47 pm

Re: counselling young people with same-sex attractions

The board has no need to restrict counsellors from helping young people through periods of same-sex attraction. Same-sex attractions are real, and so is homosexuality, gender dysphoria, etc. People with these needs require real help, not agenda driven laws or regulations that strip them of the needed counselling and therapy. I object to this board being driven by the LBGQT etc. agenda.

Thank you for your consideration.

Commenter: Dean Welty, Director, Valley Family Forum 4/9/19 5:54 pm

One Standard for All: Protect Choice in

Commenter: JOSE COSSIO 4/9/19 5:54 pm

Do not ban nor interfere with conversion therapy

If you are an adult, you can be an LGBT and get all the STD you want. But, DO NOT MESS WITH MY CHILDREN!

Commenter: Dennis Smith 4/9/19 5:58 pm

Counseling For Those who Do Not Want Same-Sex Attraction

Please do not punish licensed counselors for helping patients overcome their unwanted same-sex feelings of attraction. Why should an individual not be allowed to live the lifestyle they want? No matter if they are gay, straight, Jewish, Muslim, or Christian. Smoker or non-smoker. Vegan or meat eater. Is not the goal here for people to have the choice to be what they choose to be? Or is it that like too often is the case the majority in power wants to dictate to everyone else what is morally acceptable?

Commenter: Dean Welty, Valleyfamilyforum.org 4/9/19 6:04 pm

One Standard for All: Protect Choice in Counselling

Just as abortion supporters believe in a woman's right to choose, so should we apply the same standard for those those who are dealing with various types of sexual attractions. Let each individual choose the kind of counsellinig that best responds to his/her particular need or desire.

To ban one or another type of counselling is a form of tyranny that seeks to impose your choice on others even though they may have a different need or goal than yours. Give them the same freedom you demand for yourself. ###

Commenter: Everett Hines 4/9/19 6:07 pm

DON'T punish councelors for helping patients overcome unwanted feelings or desires!

Please don't punish licensed counselors for helping patients overcome their unwanted sexual feelings by affirming biological realities concerning males and females. Anyone

seeking counseling should be able to get the help they need no matter what other people think. If someone wants so called "Conversion Theraphy" they should be able to get it. And if someone else doesn't want so called "Conversion Theraphy" they don't have to get it. But no counceling services or practices should be restricted from the people who want them.

Commenter: Hermits of Divine Mercy 4/9/19 6:08 pm

safe counseling

A person who wishes to have a counselor to speak to who is of a certain faith should be of the utmost importance for any person. Forceing a person to go only to a person who geared to the side of what is deemed a sin should not have to be forced to be brainwashed into accepting that they have to be gay then. That Religion does not matter at all. on the other hand forceing a person to not accept who they are is not right either. counseling is how to deal with who you are in an appropriate way withing your belief system so you can function in society and be a happy person as best as possible.

Commenter: Rex Latham 4/9/19 6:09 pm

Oppose Guidance Document That Bans Counselors From Following Their Consciences

I support the points raised by both Josh Hetzler, Legislative Counsel for The Family Foundation of Virginia and Jeff Caruso, Virginia Catholic Conference. They are logical and persuasive.

Commenter: Linda E. Stowell 4/9/19 6:16 pm

Counseling

Please do not to punish licensed counselors for helping patients overcome their unwanted sexual feelings by affirming biological realities concerning males and females.

Commenter: Kathy 4/9/19 6:20 pm

Banning counseling is destructive for our children

I know too many people who were helped with counseling for unwanted same sex attraction. Don't lump counseling & conversion therapy into the same bucket. Until conversion therapy is correctly defined, this banning counseling will destroy this generation.

Commenter: Doris A. Dippel 4/9/19 6:26 pm

Unbiased Counseling

I am a clinical specialist with a Master's degree in Psychiatric/Community Mental Health nursing with training in individual, group and family counseling. A major tenet of our counseling foundation is that the client(s) should be allowed to explore any aspect of their life that troubles them or creates conflict. The fact that a client would come to me with questions about their sexuality opens

the door for discussion of all aspects of that query and their desire to establish their sexual identity without censure from me regardless of what is their decision.

To say it is wrong for me to counsel the client(s) if they wish to define their biological gender more definitely, while at the same time giving me free rein to direct them toward transgender identification, is contrary to the basic foundation of counseling and restricts the client's privilege to receive an unbiased viewpoint from me. Client-directed therapy should allow the client to express their questions and wishes and permit me, the counselor, to work with them toward that goal. To legally ban that freedom dismembers what counseling is really about and redefines its meaning and substance. It also incorporates bias into the counseling relationship which is never supposed to be evident.

Commenter: Richard E. Cooley 4/9/19 6:32 pm

One Standard for counselors

Do not punish licensed counselors for helping patients overcome their unwanted sexual feelings by affirming biological realities concerning males and females. Assisting a person to become one of opposite sex is not of any value in the course of their lives; only more confusion as they live their lives.

Commenter: Jeanette Perrington 4/9/19 6:33 pm

Counselors MUST have the freedom to speak honestly with clients

A counselor cannot be restricted in his/her guidance to clients. Each case is different - the client is a real human being. Freedom of speech and of conscience is critical and the only ethical way to help a client, especially vulnerable young people.

Commenter: Kelly M Starbuck 4/9/19 6:45 pm

Counselors must maintain right to work honestly and justly according to fairh

Commenter: Willard Rockwell 4/9/19 6:50 pm

Stop meddling with valid proven conversion therapy

Not one comment here opposed to this therapy includes a single fact or sound argument. What is established fact is that homosexuality is a choice and always involves violence, grotesque and unnatural sexual abuse of at least one person involved, and typically progresses to pedophilia and multitudes of either revolting criminal, sociopathic and even psychopathic behaviors that disrupt social order and destroy families. We as a society do not accept this on any terms and will never rest until all sodomy results in institutionalization. This therapy is a very small part in defending against devious evil behaviors and strengthening the rule of law. We will accept nothing less than zero interference with it.

4/9/19 6:53 pm

Commenter: Thomas Vette

Equal counciling

When state tax payers moneys are paying for your jobs and the programs that you run or manage then equal counciling is expected, not some agendas by some out-of-state organization, do your jobs for all children no matter what color, faith or gender... we expect it and demand it

Commenter: Abe Jacob 4/9/19 7:13 pm

VA Board of Counseling Proposed Regulations PUNISH and SILENCE Faith-Based Counselors!!!

VA Board of Counseling Proposed Regulations PUNISH and SILENCE Faith-Based Counselors!!!

Do not punish or restrict the free-speech rights of licensed counselors for helping patients overcome their unwanted sexual feelings by affirming biological realities concerning male and female.

The Board's highly biased and extreme definition of "conversion therapy" is in its draft Guidance Document is indicative of a blatant double standard it sets up:

"For the purposes of this guidance 'conversion therapy' ... is defined as any practice or treatment that seeks to change an individual's sexual orientation or gender identity, including efforts to change behaviors or gender expressions or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of any gender."

However, the Board continues...

"'Conversion therapy' does not include counseling that provides assistance to a person undergoing gender transition or counseling that provides acceptance, support, and understanding of a person or facilitates a person's coping, social support, and identity exploration and development, including sexual-orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, as long as such counseling does not seek to change an individual's sexual orientation or gender identity in any direction."

In other words, counselors are ALLOWED to help a minor client to explore and facilitate same-sex feelings, attractions and behaviors, or even to "change" their sex altogether, but they are strictly PROHIBITED from helping a minor client struggling with unwanted same-sex attractions from developing a natural and Biblical sexual ethic, or aiding a child dealing with gender dysphoria in learning to embrace his or her biological status as either male or female. So, children can change in one direction, but not the other.

The Board's "guidance" to counselors is clear and simple: If you hold to the natural, biological, historical and/or Biblical understanding of human sexuality, be prepared to lose your professional license. This ideologically-driven action is wrong, dangerous, and unconstitional. **The proposed Guidance violates free speech, religious liberty, and endangers children** who should be able to receive helpful and godly counsel to avoid dangerous behaviors and to address the underlying issues likely contributing to certain feelings.

As Fredericksburg, Virginia constituents, my family and I strongly oppose VA Board of Counseling Proposed Regulations that PUNISH and SILENCE Faith-Based Counselors!!!

Commenter: Matthew Hatcher 4/9/19 7:19 pm

Clients deserve the freedom to reject same-sex attraction by receiving counseling

Many people experience sexual desires that they believe are wrong. We should empower the client to reach out and receive therapy that helps to deal with unwanted sexual attractions, including same-sex attractions. This may be due to their religious beliefs, their understanding of biology (the parts don't fit together), or because of their culture. Don't let politics decide an issue that is much more complex than the LBGTQ agenda.

Commenter: June Meek 4/9/19 7:22 pm

Suppressing Faith and 1st Amendment

It seems that the Satanic Agenda is to turn everything upside down. Religious people, and others like me are against the pushing of this Satanic Agenda. And it is a Satanic Agenda. The psychiatric field was forced to stop diagnosing and helping people who believed they were the wrong sex. They are being FORCED to push these people to transgender or believe they are one of countless different genders. To suppress those who are against this is violating their 1st Amendment rights, which is the freedom of speech and religion. There are only two sexes on this planet. Male and female. It is FACT. Cannot change it..

Commenter: Laura Sentiger 4/9/19 7:26 pm

Double Standard

It is unbelievable that we can push for such a double standard. As counselors your jobs are to be neutral and assist consenting patients to whatever logical conclusion they arise at for themselves. Since when do we impose our opinions on patients? If we can support our patients that wish to pursue a same sex relationship or to "change" their gender, then why can't we also support the patient that does not wish to live with these unwanted sexual feelings? Do NOT punish licensed counselors for helping patients overcome their unwanted sexual feelings by affirming biological realities concerning males and females.

Commenter: Ann Hodge 4/9/19 7:27 pm

Allow people who don't want same sex attraction to get the counseling they need

Counselors should be able to counsel clients according to their faith. People who don't want the feelings they have or are confused about their feelings should be able to choose to be counseled by someone who will help them to the outcome that they desire. They need to have faith options for professional help.

Commenter: Connie DesMarais 4/9/19 7:28 pm

guidance on conversion therapy

Please DO **NOT** to punish licensed counselors for helping patients overcome their unwanted sexual feelings by affirming biological realities concerning male and female.
Licensed counselors have a responsibility to speak honestly with their minor clients about life's fundamental truths, and any state policies that compel them to repress those truths during counseling would lead to real ethical dilemmas, not to mention damage to those children. Clients should be able to go to a counselor that can help them in the way they want to be helped.

Why would you limit their options? Let's be clear here - you have an agenda to silence a particular set of people and you are SO WRONG.

Commenter: Nancy S Pendergrass, MPH, RDN 4/9/19 7:38 pm

Do not punish licensed counselors

Please do not to punish licensed counselors for helping patients overcome their unwanted sexual feelings by affirming biological realities concerning males and females.

Commenter: Samuel Heywood 4/9/19 7:48 pm

Punishing a counselor for his "politically incorrect views" is denial of his First Amendment rights

Counselors are entititled to their own opinions. And you know what opinions are often likened to.

Everybody has one, so the saying goes.

Commenter: Ellie Gudeman 4/9/19 7:52 pm

Interfering with licensed counselors

We strongly urge you to not punish licensed counselors for helping patients overcome their unwanted sexual feelings by affirming biological realities concerning males and females.

Commenter: Glyn Roberts 4/9/19 7:59 pm

I lost a sister and a daughter to suicide. Don't threaten counselors

This one-size-fits-all limitation on counselors is potentially harmful, and totally inappropriate.

Commenter: Jacqueline D Johnson 4/9/19 8:07 pm

Do not punish licensed counselors

Please do not punish licensed counselors from helping clients that want help with their unwanted sexual feelings with the members of the same sex. Also, please don't punished those people who are seeking help. Thanks you!

Commenter: Barry Oxford 4/9/19 8:09 pm

Conversion Therapy -Guidance Document 115-10

You're attacking the counselors' First Amendment rights, specifically free speech; what next, religious freedom?

Commenter: Sheila Simmons 4/9/19 8:10 pm

Denial of critical care

It is unethical to deny any patient the opportunity to address psychological issues as they choose. It is especially egregious to censor scientific facts in order to promote a trendy agenda.

Commenter: Velva Oliver 4/9/19 8:10 pm

Do Not Punish Counselors!!

Please do not punish counselors. If someone wants to have conversion therapy then they should be allowed to do so. If they do not want to, then they should not have to. The problem is taking that option off the table completely is absolutely wrong! Some people don't want to have an attraction to the same sex and they should be allowed to get the counseling they are seeking after!

Commenter: Jill Maneck 4/9/19 8:21 pm

Conversion Therapy

Does Freedom of Speech not apply to faith based counselors?

Commenter: Elizabeth 4/9/19 8:30 pm

Allow Faith Based Counselors To Do Their Jobs

Please allow counselors to serve the populations that seek them out!

Commenter: Erin Brewer 4/9/19 8:35 pm

A Ban On Conversion Therapy Can Be Harmful

I would like an opportunity to share my concerns about conversion therapy legislation

Many people want to stop conversion therapy, if gender orientation is included in this legislation it would require doctors to affirm the mental disfunction of a child with gender dysphoria.

LGBTQ activists insists that gender identity is fixed, that a child can be born in the wrong body, and the only treatment for this condition is to affirm the child's gender dysphoria and support them in transitioning, first socially and then medically.

From my own personal experience with childhood gender dysphoria as well as from dozens of others who have talked publicly about their experience with gender dysphoria, I know that the activists are wrong.

As a child, I developed gender dysphoria as a result of a sexual assault in the summer prior to first grade. During first grade the school psychologist evaluated me because of my insistence that I was a boy. I am thankful the psychologist didn't recommend that my mother and teachers "affirm" my gender dysphoria. Instead, my mother and teachers were asked to provide me with positive female role models. At the time, there were not therapists who specialized in cognitive behavioral therapy or other therapeutic techniques that help resolve dysphoric and dysmorphic feelings.

I would have benefited from what many consider conversion therapy if it was available. It took years before I met with a therapist who connected the sexual assault to my resulting gender dysphoria.

Before getting appropriate mental health services, I developed deep seated self-hatred. I engaged in self-harm. I did everything I could to present as a boy because in my mind, I would not be vulnerable to another sexual assault if I was male.

Sexual assault isn't the only cause of childhood gender dysphoria.
Gender dysphoria can result when homophobic parents fear that their child is gay or lesbian and decide to transition their child so that the child will present as heterosexual.
Gender dysphoria can result when children sense that their parents prefer the opposite gender.

Gender dysphoria can result when a child with autism struggles with conforming to stereotypical gender roles.

Dr. Lisa Littman recently identified another cause of gender dysphoria, rapid onset gender dysphoria (ROGD). Littman has suggested that ROGD might be the result of a social contagion.

I have heard adolescent girls who are going through the normal struggles of accepting the discomfort of their periods being told that they are gender dysphoric and need to transition to alleviate the negative feelings they have about their periods.

Children who are gender non-conforming are now being labeled as gender dysphoric just because they don't adhere to traditional gender stereotypes.

All of these children would be harmed if mental health providers were legally compelled to "affirm" a child's gender dysphoria. In addition, in states that have passed similar legislation, parents are threatened with having their children removed by protective services if they don't "affirm" their child's gender dysphoric feelings. Doctors are compelled to provide puberty blockers and cross-gender hormones to children as young as eight years old. Taking hormones at such a young age renders a child sterile. In addition, children's reproductive organs start to atrophy, becoming extremely painful and have to be surgically removed. Girls as young as thirteen are getting double mastectomies to have their healthy breast tissue removed.

There is no other instance where therapists are required to affirm the magical thinking of children. There is no other instance where therapists have to affirm a child's self-hatred, disconnection and/or disassociation with their body. Requiring therapists to do so will have untold harmful effects on children for whom gender dysphoria is a symptom of an underlying issue.

I made a video about my experience with gender dysphoria, and the dangers of passing conversion therapy legislation. The link to it is: https://youtu.be/jGdzWgb9ktA

Please feel free to contact me if you have any questions.

Commenter: Denise Lansdell 4/9/19 8:39 pm

Please do not censor faith-based Counselors' free speech rights

Please do not punish licensed counselors for helping patients overcome their unwanted sexual feelings by affirming biological realities concerning males and females.

It is obvious you are attempting to overwhelm those opposed to this censorship by promulgating regulations on multiple fronts. The intended goals of your combined regulatory actions are to promote the radical LGBTQ agenda and prevent minors and adolescents from being able to acquire the counseling they prefer to give them relief from unwanted sexual feelings.

One of the more alarming aspects put forward is creating a blatant double standard whereby counselors would be free to help minor clients explore and possibly cultivate same-sex feelings or

even to "change" their gender, while simultaneously prohibiting them from helping minor clients flee from unwanted same-sex attractions and embrace natural sexual expressions and/or their true gender. Confusion is not the answer here.

And the consequence of violating this policy could be the state-imposed loss of their professional license? This is simply unacceptable. Licensed counselors have a responsibility to speak honestly with their minor clients about life's fundamental truths, and any state policies that compel them to repress those truths during counseling would lead to real ethical dilemmas, not to mention damage to those children.

Clearly this Board has hostility towards counselors who uphold these natural, biological and/or Biblical viewpoints of human sexuality, and is perfectly willing to violate any and all free speech and conscience protections in order to suppress these deeply held beliefs.

Thank you for your serious consideration of this matter.

Commenter: Jonathan Clough 4/9/19 8:39 pm

A therapy ban is wrong, dangerous, and unconstitutional - protect counselors and patients

I implore you NOT to advance administrative rules that would attempt to end-run the legislative process and achieve a so-called "conversion therapy" ban that was defeated legislatively already during the 2018 session.

Such a ban is wrong, dangerous and unconstitutional.

It is *wrong* because it is a blatant assault on free speech and the truthful acknowledgement and recognition of biological and genetic reality. It is *dangerous* because it denies patients access to facts, tools, resources, and assistance to reconcile their feelings with their biology and avoid the often self-destructive paths that gender
dysphoria often takes. Finally, it is *unconstitutional* because there is no statute authorizing such policy or rulemaking, and if there were such a statute, it would run afoul of the Virginia constitution.

Commenter: R Seto 4/9/19 8:50 pm

It is wrong!

It is wrong to penal licensed counselors for helping people work through their sexual attraction problems and gender dysphoria.

Commenter: Isha Youhas 4/9/19 8:58 pm

Grave Liberty Concerns

I strongly object to these guidelines. There are significant legal, political, ethical, and spiritual problems with this guidance document. First, the science behind these guidelines is suspect at best and in need of more study. This has been rejected by the legislature and is an end-Run on the political process in the name of scientific chicanery. You invade core first Amendment protected speech and invade the privacy of the sacred position of trust between a patient and their counselor. Do you want patients to get the help they need? If my child was struggling in this area, I would want a counselor to not have a pre-directed course of treatment banned. Several studies have shown that conversion therapy is helpful particularly for deeply religious persons. Also, the

transgender issue needs significantly more study. I ask you to reject these guidelines or I will have no choice but to reject your entire profession.

Commenter: John W. Lee 4/9/19 9:02 pm

Do Not Punish Faith Based Counselors

Do not punish licensed faith based counselors for helping patients overcome their unwanted sexual feelings by affirming biological realities concerning male and female. No counselors, doctors, nurses or social workers should be treated as "unprofessional" or punished for standing up for what is true and what is best for children and adults.

Regulations must not stifle licensed professionals' free speech rights, with the direct consequence of denying patients their basic right to direct the objectives of the counseling they seek.

Commenter: Garland Brown 4/9/19 9:16 pm

Do not ban a families right to the counseling of their choice

Commenter: Carolyn Roberts 4/9/19 9:22 pm

Counselors

This is wrong! People that have had unwanted sexual feelings for the same sex, and people with sex disphoria have been helped by what you call conversion therapy. If you censor counsellors for helping them, you are indeed forcing people to be something, or change to something that they do not want!

Commenter: Beth Miller 4/9/19 9:23 pm

Help for ALL

Please do NOT limit counselors to only one track of assistance and counsel. How can you possibly believe that denying clients help that they desire and seek is a good decision? If clients are wrestling with issues within themselves they should definitely have options available to them. Only offering one view cannot be in their best interest. Certainly they can pursue other counseling if faith based biblically aligned perspective does not meet them where they are. Silencing that perspective would be robbing many of the very assistance they are searching for.

Commenter: Carolyn Roberts 4/9/19 9:23 pm

Guidance on conversion therapy

This is wrong! People that have had unwanted sexual feelings for the same sex, and people with sex disphoria have been helped by what you call conversion therapy. If you censor counsellors for helping them, you are indeed forcing people to be something, or change to something that they do not want!

Commenter: Edward Paul 4/9/19 9:25 pm

Respect Professionals and protect children

Children with sexual confusion should receive treatment that is evidence based and provides for the needs of the children and their parents. Counselors should respect the religious life of their clients. The government should not hinder any type of counseling just because politicians and activists dislike the reality that not everyone believes the same way they do. Please do not punish faith-based counselors who would simply help a minor work through struggles with unwanted sexual attractions or gender dysphoria. If anything, the government should have protections in place so that counselors do not encourage children to indulge in immoral behavior that conflicts with parents religious beliefs.

Commenter: Cheryl Forbes 4/9/19 9:44 pm

Conversion. Therapy

Please do not punish licensed counselors for helping patients overcome their unwanted sexual feelings by affirming biological realities concerning male and female. Thank you.

Commenter: Janet Phillips 4/9/19 9:48 pm

Mind control legislation of this kind is abhorrent.

Denying Counselors the freedom, ability or right to provide counseling help to those seeking relief from unwanted same sex attraction unless it follows a narrowly prescribed agenda advanced by a small segment of society that favors same sex relationships is an overreach of bizarre proportions. Requiring mind control in this way is characteristic of a totalitarian state not a free society.

Commenter: Karen Cruess 4/9/19 10:27 pm

Allow client and counselor freedom of religion

A counselor cannot force his or her religious ideologies upon a client, but if a client should want to help in overcoming struggles regarding sexual orientation or gender confusion there should not be any obstacle imposed by the state to inhibit his or her ability to obtain this help from a counselor who holds the same values that they do.

Commenter: Ronald Quasebarth 4/9/19 10:46 pm

Respect Society and the Individual

Why does the need state need to get involved in areas like this which so very political and covert and on vulnerable young people?

4/9/19 11:06 pm

Commenter: Mick Staton

Children need counselors, not enablers

When a child sufffers from anorexia or body dysphoria, do we expect counselors to be forced to affirm their affliction? Do we expect counselors to give them a gym membership and encourage them to lose more weight? A counselor is not supposed to simply enable their patient to continue in their distress. They are meant to help the patient to heal.

Gender Identity disorder and gender dysphoria are a form of mental illness. The idea that a boy can look in the mirror and see a girl is simply not normal, and cannot ever be considered normal. Gender affirmative treatment inevitable leads to hormone therapy and mutilating surgery, which then leads to suicide attempts for over 50% of cases. How can leading your patient towards a life that leads to an incredibly high rate of suicide ever be considered safer than trying to help them cope with their confusion and eventually reconcile and accept the biological truth of their existence?

Counselors need the freedom to be able to speak with their patients without fear of persecution. Turn down this politically motivated guidance document and protect counselors from extremists looking to silence any dissenting points of view.

Commenter: Joseph Ellena 4/9/19 11:29 pm

Allow patients to get what they request of counselors, and allow counselors to serve patients.

Do not create a blatant double standard whereby counselors would be free to help minor clients explore and possibly cultivate same-sex feelings or even to "change" their gender, while simultaneously prohibiting them from helping minor clients flee from unwanted same-sex attractions and embrace natural sexual expressions and/or their true gender.

Commenter: Gail Flynn 4/10/19 3:23 am

I support unbiased counseling

Commenter: Gail Flynn 4/10/19 3:50 am

Explanation for my previous comment "I support unbiased counseling"

The patient seeking counseling should be able to get the help he or she seeks, not be turned away from help when he or she wants to see emotions and feelings from a specific perspective/faith. I support unbiased counseling, therefore I do not support the effort to punish faith-based counseling.

Commenter: LaVerne Waybright 4/10/19 4:44 am

Va board of counseling/stop the harassing of counselors

Do not punish licensed counselors for helping patients overcome their unwanted sexual feelings by affirming biological realities concerning males and females your comments here.

4/10/19 6:38 am

Commenter: Robert Lee

Provide freedom of conscience for patients and providers

Patients and providers should have freedom of conscience on this controversial issue. A person experiencing unwanted same sex attraction should be allowed to frame their therapy to identify the causes of the attraction, rather than having a counselor insist that their feelings cannot change. We should not remove therapeutic options from clients who feel true distress over any unwanted feelings. Please support freedom of conscience for patients and providers by NOT implementing this punative requirement.

Commenter: Gordon Goetz 4/10/19 6:54 am

Faith-Based Counselors

Do not to punish licensed counselors for helping patients overcome their unwanted sexual feelings by affirming biological realities concerning males and females. This creates a blatant double standard whereby counselors would be free to help minor clients explore and possibly cultivate same-sex feelings or even to "change" their gender, while simultaneously prohibiting them from helping minor clients flee from unwanted same-sex attractions and embrace natural sexual expressions and/or their true gender. The consequence of violating this policy could be the state-imposed loss of their professional license, and that is simply unacceptable. Licensed counselors have a responsibility to speak honestly with their minor clients about life's fundamental truths, free from ideology. Any any state policies that compel them to repress those truths during counseling would lead to real ethical dilemmas, not to mention damage to those children.

Commenter: Ken Zenzel 4/10/19 6:55 am

Sexuality Counseling

Please protect those seeking counseling from "counselors" whose agenda is to convert from natural sexuality or to validate alternative sexuality to what God created. God's plan should be understood and embraced. It is clear, simple and wonderful. It does not even require spiritual faith and requires little explanation. Do not type over God's purposes for man and woman.

Commenter: Donna Lauderdale 4/10/19 7:18 am

Counseling

Dear Virginia Board of Counseling

I have read the recent Guidance Document on "conversion therapy." I am appalled that it is so clearly designed to ignore biology of the human race and advocate for genderless society. Is that really what we want?

Our genetics is clearly male and female when it occurs normally. When all the chromosomes occur without defect, a normal, healthy and heterosexual human is born. Without heterosexuality, humanity would cease to exist.

When there are errors in chromosome makeup, there are problems. Many errors result in health issues, frequently undiagnosed until they become a serious problem. I am one of those people who has a genetic defect that does not force my body to excrete toxins quickly, but rather stores

them, causing an endless stream of negative symptoms and illnesses. I have sought treatments to help overcome the results of this defect.

When the sex determining genetics has an error, the result is a human with abnormal feelings about themselves and other human beings. This defect is no different from mine or any other. It creates problems for the human being and we should strive to correct the problems or the cause of the problem through treatment, whether physical or psychological.

Your changes in counseling denies people who do not want to have aberrant sexual feeling or act on those feeling, the opportunity to receive treatment. Currently, to my knowledge, we do not have a way to correct errors in the sex-determining genes, but we do have psychological treatment and counseling methods that can help a person live with their problem in a healthier way.

Why should it be that those who want to transform themselves to another gender should have that opportunity and be encouraged to do so, but those who do not want to transform themselves should be denied the opportunity to make their lives better? Why is is not equally healthy to help a person live well within their physical gender as to help them transform to another gender either physically or psychologically.

This perhaps the most insidious form of discrimination I have heard of to date. There is a lot of lip service given to justice and equality today, but your new regulations clearly do not offer either. Many of the counselors who help those who do not want to transgender are faith based. In addition, Constitutionally, expression of faith must not be denied in the counseling room as it must not be denied in the public square or in the media.

Do not adopt these Guidance/regulations and do not disallow any of the currently available counseling for people with gender problems. People should be allowed to seek the kind of counseling that best serves their psychological and physical needs, not have it dictated by a political agenda.

Regards,

Donna Lauderdale

Manassas Virginia

Commenter: Ruth E Edens 4/10/19 7:42 am

Allow counselors to use their professional judgment

Please do not base regulatory decisions on one sided research that "might" show a damaging effect of therapy directed at helping people with gender dysphoria. The CDC has plenty of research that shows the lifelong consequences of affirming gender dysphoria. Sexually transmitted disease, suicide, depression, alcohol and drug abuse, and domestic abuse are all much higher in these communities than in the general population. As this behavior is accepted, affirmed and celebrated widely in our culture, these statistics haven't really improved. Please allow couselors who are willing to help those wanting to align their sexual feelings to their biological reality to do so.

Thank you

Commenter: John Andrews 4/10/19 7:57 am

Wisdom

The reality of most adolescent years is that we struggle with who we are, what we want to be, and whether our lives have meaning. It is most common to wonder if we match up to the gender we were born with. The biological realities of our gender are very clear and the most compassionate thing a counsellor can do is to help a young person realize his or her potential in the bodies they

were given. I am not a Dr. but the process of gender reassignment must be a very difficult and probably painful (both physically and emotionally).

Young people are generally confused about life and what they will become, but to make such radical changes when life is still in flux emotionally is not real wisdom. To limit the type of counselling given is to take responsibility for the life these folks will have to live.

An agenda that puts aside the best interest of an individual by giving no alternatives is despicable. Why would anyone want to be responsible for bad decisions made that create harmful psychological issues. You think you know what is best and that is really frightening. Government is to protect its constituents, not conform them to what it thinks is best by their so-called "compassionate" thinking. Just a casual look at the changing psychological profiles of young people as they mature should prevent anyone from believing that they should guide anyone to such a radical decision early in life that data may suggest does irreparable harm later in life.

Commenter: Eric Hammond 4/10/19 8:24 am

Do not punish those seeking help and those providing help

Do not to punish licensed counselors for helping patients overcome their unwanted sexual feelings by affirming biological realities concerning males and females!

Commenter: Al Yancey 4/10/19 8:31 am

Do not let activists gag counselors

Parents are responsible for the raising of their children. Virginia is the home of free speech and they have the right to choose the best counselors for their children. This includes faith based counselors should a parent want that. The state has no warrant to eliminate choices due to a loud single interest group that wants to restrict basic freedoms.

Commenter: colleen collins, FNP-C 4/10/19 8:41 am

Do not punish those seeking to help youth with gender dysphoria

Commenter: Pete Lepine,Registered voter & concerned citizen 4/10/19 9:08 am

making it difficult for family counselors to do their jobs

Being an adolescent comes with its own unique challenges. Our popular culture already bombards our youth with all sorts of left leaning propaganda, further adding to the confusion some adolescents already face.It is extremely important that licensed counselors be allowed to do their jobs without fear of losing their jobs or licenses because of left wing bias.

Commenter: Eric Marx 4/10/19 9:09 am

Keep Free Speech in the Counselor's Office

A person usually seeks counseling because they have a situation or feelings they don't like or want, including sexual attractions or gender confusion. How can you compel a counselor with such a client to refuse to help that client and instead push them further down the road they are trying to get off of?

Commenter: Lisa Kyle 4/10/19 9:11 am

Censorship of licensed counselors' free speech rights

I am asking you not to punish licensed counselors for helping patients overcome their unwanted sexual feelings by affirming biological realities concerning males and females. A councelor needs to practice as he or she sees fit concerning minor clients and their sexual orientation. Government interferance has no place in this area and should stay out of this business. One should not be allow to influence a minor to act on their same sex feelings or transistion especially if they are not allowed to talk them through these unwanted sexual feeling and have them remain the gender God gave them or hetersexual. These issues should not be sensored either way. Please do not censor licensed counselors' free speech rights.

Commenter: Ken Zenzel 4/10/19 9:13 am

Sexuality Counseling

Why is government involved in this at all? The national debt it so overwhelming that it is ignored. It should be easy to conclude that public spending on this is not justifiable.

Commenter: Amy Miller 4/10/19 9:31 am

Protect Vulnerable LGBT Youth

Please protect troubled LGBT youth from the dangerous ideologies that drive those who wish to interfere with the patient/counselor relationship. The Board must **not to punish licensed counselors for helping patients overcome their unwanted sexual feelings by affirming biological realities concerning males and females.**

Commenter: Raymond E Grant 4/10/19 9:32 am

Banning any counseling on unwanted same-sex attraction is unconstitutional

For the board to ban counseling that does not fit the agenda of affirming same sex advocates is certainly a violation of the rights of both sincere counselors and of those seeking help who know the viewpoint of those counselors.

Commenter: Doyle Tate, Psychology PhD candidate at UVA 4/10/19 9:49 am

Conversion therapy is harmful and does not work

This "therapy" harms people and can lead to life-long damage. Conversion "therapy" must be banned for the well-being of those who do not have a choice or voice. Many who are forced to undergo these "sessions" are children who have parents that cannot accept the fact that they have

a child who is not straight. Conversion "therapy" should be banned to protect minors and those who do not have a choice. It does not work,it causes damage, and has no worth.

Commenter: Stephen Judy 4/10/19 9:52 am

Banning any counseling on unwanted same sex attraction IS UNCONSTITUTIONAL

Banning a counselor from counseling someone, whether adolescent or adult, on questions of same sex attraction, when the issue is whether the one being counseled, is seeking answers to questions about their sexuality and what to do about it - and thus providing the counseled person with only one direction in which to go is not just a violation of free speech, it is a violation of conscience. To require counselors to speak in only one direction is the same as tyranny as it is government restricting a person's right to hear all needed information in order to make informed decisions. A thought or behavior is not made right simply because one is precluded from hearing the alternatives. That is called censorship.

Commenter: Jeff Lown, Virginia Counselors Association 4/10/19 9:58 am

Support this regulatory change to protect vulnerable youth.

Comments of opposition to this intended regulatory action on the basis of individual freedom and rights rest on the assumptions that engaging in conversion therapy causes no harm, or that requesting such therapy would be prohibited or dismissed. Neither of these suppositions are born out in reality. As studies and recommendations from the ACA and the NIH have shown, conversion therapy is at best ineffective but more likely it does in fact a traumatic and disruptive experience that can require years of ethical therapy to repair, if full recovery is ever possible. The research is plain and clear and I would ask the Board to review it again if necessary, but suspect they already have. Regarding the individual who is seeking treatment being able to request such therapy, this regulation does not require they be dismissed. The counselor may still be able to work with the individual within the ethical guidelines if the client is agreeable. If they are not, they would be free to pursue such activity from non-licensed individuals who purport to provide a service that would change their sexual orientation. This does not ban the practice of conversion therapy, this prohibits licensed counselors from doing so. The board is beholden to the code of ethics and ought to protect the integrity of the Virginia counselor by doing so. This regulation would achieve that. I therefore support this intended regulatory action.

Commenter: Patrick J White 4/10/19 10:25 am

Allow those in the LGBTQ community to seek the help they desire

The state does not have the right to suppress the rights of individuals within the LGBTQ commnuity from seeking counseling, if they so desire. Thousands of individuals have found relief and freedom from unwanted same sex attraction, gender dysphoria, etc. If an individual wants to seek assistance within the counseling community, who are you to deny them? In addition, many within the LGBTQ community battle depression and anxiety. Why are you making them Second Class citizens unworthy of receiving counseling? Is the state saying that these individuals do not have the mental capacity to make such decisions for themselves? The proposed legislation oppresses: 1) the rights of licensed counselors to practise their trade, and 2) the human rights and diginity of those within the LGBTQ community to seek counseling, if they wish.

4/10/19 10:59 am

Commenter: Joseph P. Allen, Ph.D., Hugh P. Kelly Professor of Psychology, U. VA.

Free speech is never a justification for allowing harmful medical practice

The scientific evidence regarding conversion therapies suggests that these are extremely unlikely to change an individual's sexual orientation, but instead are far more likely to increase levels of harm and distress, by directly implying that same sex attractions are disordered.

'Free speech' has never been accepted as a rationale to allow harmful or ineffective medical practice. Nor has it been used to allow providers to make unjustifiable claims about their practice (i.e., claiming that they can change sexual orientation in the absence of evidence that this is a reasonable possibility).

For consenting adults, allowing conversion therapy provides a degree of freedom, but only at the cost of encouraging a practice that is expensive and almost certainly ineffective at best and borderline fraudulent at worst.

For adolescents, allowing conversion therapy is far more likely to be quite harmful, as it stigmatizes an adolescent for their innate sexual orientation at a vulnerable time in life. It is far less likely to be used by consenting individuals in this case, and far more likely to be used as a result of parental panic or intolerance. The results of allowing this discredited practice to continue are likely to be very significant harm to the adolescent at a critical period in their development.

Commenter: Sharon Little, Southside Church 4/10/19 11:21 am

Support for the Right to Engage in Conversion Therapy

I feel very strongly that licensed counselors remain free to provide necessary care to help patients overcome their unwanted sexual feelings by affirming biological realities concerning males and females. Licensed practitioners should not be punished for providing legitimate, desired conversion therapy which is vital to the mental, physical, and emotional well-being of men, women, children, and teens who find themselves struggling with issues related to sex and sexuality. How dare we as a society strip our citizens of necessary medical care on the basis of subjective moral perspectives? Any civilized government which deems it necessary to punish the medical and therapeutic community for doing so raises the serious concern of overstepping its role as protector of freedom. Governments focused on punishing its citizens for adhering to selected worldviews and opinions strip themselves of their right and proper place in the public domain and instead become nothing more than vehicles for the indoctrination of continuously changing cultural shifts.

Commenter: Todd Gathje, Ph.D., The Family Foundation 4/10/19 11:39 am

Don't Prohibit Biologically Affirming Counseling

Dear Virginia Board of Counseling,

The Family Foundation of Virginia urges the Board to reject the draft Guidance Document on the Practice of Conversion Therapy (115-10). This policy would generate severe consequences for both patients and counselors.

Denies Services Desired by Patients

The Guidance Document and any proposed regulations would prevent children and adolescents from being able to receive the proper and desired care they need to relieve them of any distress from unwanted same-sex attractions or gender dysphoria, which could lead to severe outcomes, including bodily harm. Prohibitions on talk therapies – which this Document effectively creates –

would prevent minors from receiving the guidance they seek by preventing licensed professionals from recognizing their minor client's right to control the goals and direction of his or her life.

Furthermore, the policy appears to imply that all children are sufficiently mature and autonomous to determine, permanently and without question, both their gender and sexual identification. If that is so, then it must be equally true that they are sufficiently mature and autonomous to consent to receiving guidance to overcome unwanted feelings or confusion about these same matters. The very essence of the guidance document would prevent counselors from fulfilling their ethical duty to respect patient autonomy.

Usurps Parental Rights

The Guidance Document would be in direct conflict with Virginia law, which makes clear that parents, not the government and its regulatory agencies, have a "fundamental right to make decisions concerning the upbringing, education, and care of the parent's child" (§ 1-240.1 of the Code of Virginia). This includes seeking the most viable form of treatment.

Violates Counselor Free Speech

Furthermore, the Guidance Document and any proposed regulations would violate the free speech rights of licensed professional counselors by employing viewpoint-based restrictions on speech, or more commonly "viewpoint discrimination." Illegitimate viewpoint discrimination is clearly evident in the draft regulation before this workgroup. While counselors would be free to support and encourage patients to explore their sexuality in various ways, even to the point of undergoing physical bodily changes, they are simultaneously prohibited from encouraging and supporting a person to affirm and embrace natural sexual expressions and in the physical body they were born in. Under this proposed policy, those who do will face state-imposed loss of their professional license.

Professional counselors likewise have a duty to deal truthfully with their minor clients. This surely encompasses life's most fundamental truths, such as the known biological (as well as non-biological) differences between males and females. For licensed professionals who acknowledge these truths, being compelled to repress them when in contact with a minor client would inevitably create for them real ethical dilemmas.

Contradicts the General Assembly

While administrative agencies can promulgate rules and policies to carry out duties delegated by the General Assembly, they cannot do so outside the statutory parameters established by it. In fact, the General Assembly has specifically and repeatedly rejected proposed bans on so-called "conversion therapy" for numerous years, and as recently as 2018 (HB 363, Delegate Hope; SB 245 Senator Surovell) through the committee process.

This proposed Guidance Document, therefore, is clearly an administrative action in direct contravention of the will and intentions of the General Assembly.

For these reasons, The Family Foundation urges this Board to reject any Guidance Document or regulatory language that places undue restrictions on licensed professionals by preventing them from providing the care that their patients desire and need.

Commenter: Alexandra Werntz, MA, University of Virginia 4/10/19 11:41 am

End this ineffective and unethical practice

Conversion therapy is an unethical practice whereby a practitioner tries to change a patient's sexual orientation, following from the outdated notion that attraction to same-sex individuals is an illness. **Critically, conversion therapy has no evidence supporting its efficacy** (see https://www.jmronline.org/doi/full/10.30770/2572-1852-102.2.7). This is NOT a question of

free speech - as suggested by other commenters - because free speech does not cover practicing "treatments" that are unethical.

This outdated and unethical practice should be banned in the state of Virginia, not only because it promotes the idea that LGBTQ people are ill, but also because it allows practitioners to practice ineffective "treatments." We would not allow a medical doctor to perform outdated medical practices that do not show efficacy - why would we hold our counselors to a lower bar? Conversion therapy should be banned in the state of Virginia.

Commenter: Lynn M Kuitems 4/10/19 11:51 am

Counseling to help with gender dysphoria and confusion is a constitutional right to be upheld.

If aperson has become pysphoric or confused about their body and gender it will help them to receive counsel that matches their faith background. In the DSM these items have legitimate basis for being an emotionally based disorder. It is right and constitutional for these people to receive services from faith based counselors of their choice. The VA government should not in any way hinder people from getting the help they need.

Commenter: Ryan Kirkpatrick, Psychology PhD Candidate, University of Virginia 4/10/19 12:00 pm

Ban All Conversion Therapy

Conversion therapy is harmful, has been condemned by a plethora of medical professionals, and is ineffective. The Internet is filled with stories of persons adversely affected by conversion therapy (http://www.nclrights.org/bornperfect-survivor-stories-and-survivor-network/). Some of the potential risks of conversion therapy include: depression, helplessness, social withdrawal, substance abuse, stress, feelings of dehumanization, and increased likelihood of committing suicide. None of these risks are worth the possibility that one's sexual orientation can be shifted.. The very existence of this practice assumes LGBTQ people have an illness which is an entirely false premise. No one should be allowed to practice conversion therapy, and conversion therapy must be banned to prevent licensed therapists from harming innocent people.

Commenter: Audrey Wittrup, University of Virginia 4/10/19 12:02 pm

dangerous treatments are not protected speech

The First Amendment does not prevent a state from regulating treatment even when that treatment is performed through speech alone.

Scientifically discredited and dangerous practices are not safeguarded by the First Amendment (e.g., doctors are sanctioned when they express false or harmful medical opinions to a patients). And to be clear, conversion therapy can be extremely dangerous and, in some cases, fatal. Conversion' therapy, is at its core based on an understanding of sexuality that has been summarily rejected by virtually all the major health and mental health professions. The practice is opposed by the American Medical Association, the American Psychiatric Association, the American Academy of Pediatrics, and every other mainstream medical organization in the United States

While some would argue parents have the constitutional right to control the upbringing of their children, **this right does not allow them to subject children to harmful forms of treatment**.

Banning conversion therapy fits squarely within a state's well-established authority to prevent health care professionals, including therapists, from harming their patients.

Commenter: Katharine Shaibani 4/10/19 12:11 pm

don't limit the free-speech rights of counselors

Many young people go through a time of sexual confusion that is temporary. Kids who want to live according to their biological gender should not be denied counseling that will assist them in doing that, and counselors should be not limited in the advice they can offer.

Commenter: Andrea Negrete, Psychology PhD Candidate, University of Virginia 4/10/19 12:19 pm

Ban All Conversion Therapy

I am writing to urge you to pass regulations banning conversion therapy in Virginia. Thank you.

Commenter: Alida Davis, Psychology PhD Candidate, University of Virginia 4/10/19 12:32 pm

harmful procedures should be banned

No research has ever been published in the peer-reviewed literature that demonstrates the efficacy of conversion therapy efforts with gender minority youth or adults. On the other hand, **conversion therapy has been found to result in depression and suicide**, among other severe, negative outcomes.

Would you let a physician try out a medical procedure on you or your child, if that procedure had *never* been shown to work, but *had* been shown to have detrimental outcomes?

We must also consider what could happen if we set a precedent of protecting medical treatments that are **widely known to be harmful** under the first amendment. It could leave room for a doctor who genuinely thinks that shooting your kid in the head seems like a really great way to cure your kid's headache to be protected in doing so, under the first amendment.

It's time for Virginia to ban the ineffective, unethical and damaging practice that is conversion "therapy".

Commenter: Deborah Hawkins, LMFT 4/10/19 12:37 pm

Protect minors from the cruel indignity of a discredited, unethical, disgraceful practice

Section 18VAC115-20-130 of the standards of practice says a licensed counselor shall: "Be able to justify all services rendered to clients as necessary and appropriate for diagnostic or therapeutic purposes". The American Psychiatric Association determined in 1973, forty-five years ago, that homosexuality is not to be classified as a mental disorder. A professional counselor cannot, therefore, diagnosis nor treat homosexuality as a mental disorder.

Also counselors are encouraged to use "evidenced based" treatments which rely on methods proved to be safe and effective, with a goal of improving the client's quality of life, relieving symptoms and boosting a patient's sense of well-being. Conversion therapy is not classified as evidence-based. Given that there is no evidence that efforts to alter sexual orientation are effective, beneficial, or necessary, and the possibility that they carry the risk of significant harm, such interventions are contraindicated. Conversion 'therapy' has been condemned by the American Psychiatric Association, the American Medical Association, and the American Psychological Association, none of which allows its members to practice it. In 2014, the American Association of Christian Counselors amended its code of ethics to eliminate the promotion of conversion therapy. While contemporary versions of conversion therapy are less shocking and extreme than some of those more frequently used in the past, they are equally devoid of scientific validity and pose serious dangers —especially to minors, who are often forced to undergo them by their parents or legal guardians, and who are at especially high risk of being harmed.

Another part of the standards of practice for counselors is training. Counselors must "practice only within the boundaries of their competence, based on their education, training, supervised experience and appropriate professional experience." There is no Virginia recognized accredited college, university, or continuing education course that teaches or provides supervision to interns on conversion therapy. Therefore, technically a counselor cannot legitimately be competent in this treatment.

To summarize, first treating minors with conversion therapy is unethical because it does not meet an acceptable standard of care and a counselor could not have received accredited training for this kind of treatment. Second, no respected medical or mental-health group in the country supports conversion therapy because it is considered immensely harmful quackery. The First Amendment obviously protects homophobic expression. And government cannot free people from stigma. However, you can combat stigma by not continuing to legitimize or even tacitly endorsing conversion therapy. Let's put this topic to rest now in Virginia and protect minors from the cruel indignity of a discredited, unethical, disgraceful practice.

Deborah Hawkins, L.M.F.T. license # 071700110

Commenter: N. Dickon Reppucci, PhD, Professor Emeritus, University of Virginia 4/10/19 12:37 pm

Conversion Therapy

Conversion therapy is unethical and has no scientific basis of effectiveness. It should be totally banned!

Commenter: melody titus 4/10/19 12:51 pm

ban conversion therapy

Please do ban conversion therapy. IT's inhuman period.

Commenter: Sean Womack, MA, University of Virginia 4/10/19 1:12 pm

Ban conversion therapy

There is no empirical base for conversion therapy as an efficacious treatment. However, there are documented iatrogenic effects of conversion therapy including, but not limited to, depression, anxiety, and suicide. Conversion therapy should be banned.

Commenter: Ronald D Ford 4/10/19 1:28 pm

legislature to silence counselors

VA Board of Counseling shoul not punish licensed counselors for helping patients overcome their unwanted sexual feelings by affirming biological realities concerning males and females. One of the more alarming aspects of the Guidance/regulations put forward is that it creates a blatant double standard whereby counselors would be free to help minor clients explore and possibly cultivate same-sex feelings or even to "change" their gender, while simultaneously prohibiting them from helping minor clients flee from unwanted same-sex attractions and embrace natural sexual expressions and/or their true gender. The consequence of violating this policy could be the state-imposed loss of their professional license, and that is simply unacceptable. Licensed counselors have a responsibility to speak honestly with their minor clients about life's fundamental truths, and any state policies that compel them to repress those truths during counseling would lead to real ethical dilemmas, not to mention damage to those children. Thank you, Ronald Ford

Commenter: Carole S Denner, RN 4/10/19 1:44 pm

Freedom of speech for counselors

Although I believe the Board is intending to act in the best interest of Virginians, government censorship of speech is not only chillingly reminiscent of totalitarian governments, it is blatantly unconstitutional. Licensed counselors do not lose their constitutional guarantee of free speech to the Board. Such a Draconian measure to ensure conformity to one ideology does not advance scientific knowledge. It prevents counselors from addressing the needs presented by their patients and therefore prevents the best care for all.

Individuals and, in the case of minors, parents are quite well equipped to find counselors that meet their needs without government censorship. The Board is tasked to promote safety. Censorship most certainly does not!

Commenter: Ariana Rivens, Psychology PhD Student, University of Virginia 4/10/19 1:45 pm

Ban Conversion Therapy

Major professional medical and counseling organizations have already denounced conversion therapy, so the state of Virginia would be upholding this standard by banning its use. It is unethical to promote a treatment that lack credibility and has been found to actively harm individuals by exacerbating psychological distress, some of which may contribute to suicide and self-harming behaviors among this population. Adolescents deserve to have evidence-based treatment that prioritizes their overall well-being, values their agency, and allows them to navigate their sexuality with respect rather than condmenation.

Commenter: Hyeonjin Bak 4/10/19 2:09 pm

Ban Conversion Therapy

Unethical and harmful medical practice should also be unlawful.

Commenter: Chad Palmer 4/10/19 2:15 pm

Freedom of speech and right to seek treatment of choice

To prevent someone from getting counseling about how to get rid of UNWANTED sexual atrraction or gender dysphoria is a gross overreach of government. People have a right to determine how they want to live their lives and to seek treatment that helps them live according to their beliefs. This is clearly an agenda to to promote the LGTB religion above all others and to force it on people who don't want it. No one on either side should be forced into or prevented from getting the kind of treatment they want.

Commenter: Daniel Willingham, PhD, Dept. of Psychology, University of Virginia 4/10/19 2:27 pm

Ban conversion therapy

This practice is unethical and is, in any event, known to be ineffective. There's not reason to allow it in our state.

Commenter: Berlin Taylor 4/10/19 2:55 pm

Self worth is at stake.

Don't punish licensed counselors for helping patients overcome their unwanted sexual feelings by affirming biological realities concerning males and female.

Commenter: Kelly Wroblewski, Ph.D 4/10/19 2:56 pm

Conversion therapy stongly linked to mental harm

The Virginia government should **ban conversion therapy**

I am a scientist that investigates how social environments can cause changes in the brain. Based on many research studies and numerous personal accounts, it is clear that conversion therapy is strongly linked to mental harm such as depression, anxiety, loneliness, withdrawn symptoms, and stress in romantic relationships. These types of feelings are predictive of a lower quality of life, and are also strongly predictive of dying sooner. Simply put, **banning conversion therapy will result in a population that will live happier and longer lives.**

This conclusion is backed up by emprical research, not just opinion.

Commenter: N.J. Fitts 4/10/19 3:09 pm

Gender Counseling

Do not punish licensed counselors for helping patients overcome their unwanted sexual feelings. It is cruel and unethical to deny this support to those seeking it.

Commenter: Joseph P. Allen, Ph.D., Hugh P. Kelly Professor of Psychology at U.Va. 4/10/19 4:00 pm

Free speech laws aren't meant to protect harmful medical practices

Conversion therapy is not only ineffective, it is also often harmful, especially when youth are pressured into it.

Even for adults, the essence of offering conversion therapy involves something very close to a fraudulent practice in that it promises something (the ability to change one's sexual orientationv via therapy) that the practitioner is not able to deliver. For both youth and adults, this not only wastes time and resources, it also stigmatizes an innate orientation.

In brief, there is no good rationale for allowing a harmful medical/therapy practice to occur in Virginia. Banning it is no different than banning any other discredited practice.

Commenter: Jason Sumontha, PhD Candidate, University of Virginia 4/10/19 4:00 pm

Same-sex attraction isn't an illness that needs to be cured.

"Unwanted same-sex attraction" is a misnomer. People internalize negative beliefs about their identity and attraction, not because these identities are wrong or bad, but **because they face stigma**, discrimination, and prejudice that communicates to them that their feelings and self are shameful and wrong. **That is what conversion therapy does--**it reinforces negative meessages about being LGBTQ+, being who you are and were born as.

The goal of any mental health professional should be to improve mental health and mental well-being. Strong, empircal, peer-reviewed evidence suggests that conversation therapy **does not work**. Not only is it largely ineffective in "changing" an individuals romantic or sexual attraction, but it has been found to more likely cause harmful effects rather than improve well-being. **Ban conversion therapy.**

Commenter: Lewis Sheckler 4/10/19 4:23 pm

Do not unfairly and prbably illegally punish counselors

Do not punish licensed counselors for helping patients overcome their vunwanted sexual feelings by affirming biological realities concerning males and females.

Commenter: Abha Basargekar, PhD student, University of Virginia 4/10/19 4:31 pm

Ban conversion therapy

No one should be shamed or made to feel that they are bad for being who they are and conversion therapy does exactly that. It has been associated with devastating problems such as depression, suicide and substance abuse. We must ban this practice completely.

Commenter: Virginia Student Environmental Coalition 4/10/19 4:34 pm

ban conversion therapy

Sexual orientation is neither a crime nor a mental illness; conversion therapy must be banned immediately.

Commenter: Sharon Watkins BSN RN MA 4/10/19 5:00 pm

Prohibiting "conversion counseling" is Bias against Christian Counselors and their clients

The boards proposed change assumes "one size fits all" approach to the layered complexities of gender identy and sexual orientation. Prohibiting Christian counselors to provide clients seeking a Christian perspective and support for "conversion" therapy promoted politically motivated anti-Christian agenda by assuming "harm". The science that supports " harm" from conversion therapy is neither conclusive nor unbiased.

Commenter: Diane-Jo Bart-Plange, Psychology PhD student 4/10/19 5:04 pm

Ban the unethical practice of conversion therapy

I am writing to fervently urge the banning of conversion therapy. Mental health and medical associations around the country have already denounced the practice, noting that is not a credible practice, and being lesbian, gay, bi-sexual, or transgender is not a mental illness that needs to be cured. Banning the practice of conversion therapy sends a strong message, and protects LGBT+ people from dangerous practices that could cause great harm. Thank you.

Commenter: Janie Blomquist 4/10/19 5:36 pm

Freedom to Counsel the children in what ever help they need .

Do not punish the licensed counselors for wanting to help a patient overcome their unwanted sexual feelings by affirming biological realities concerning males or females . There is a root cause for this being attracted to the same sex could be of some trauma or sex abuse of famliy or friend that can cause wanting comfort from the same sex, This has to do with emotions that this patient has experience and when they come for help then the counselors need to help them every way possible to get to the root of the issue. You dont just become gay if comes from a root problem, and they have to right to get help! This is not normal and will never be no matter what other people say. I stand by Gods word and nobody can change that , I mean nobody.

Commenter: Alexis Stanton, MPH, Psychology PhD Student, University of Virginia 4/10/19 6:27 pm

Ban Conversion Therapy

I am writing to urge you to pass regulations banning conversion therapy in the state of Virginia. Many influential professional organizations oppose and have denounced conversion therapy, given that it is not a credible, ethical, and evidence-based treatment.

Commenter: Rickie Carter 4/10/19 8:21 pm

No Gay Gene: The largest study ever done by Andrea Ganna in "science mag.com"

The study found no Gay gene, no "x" chromosome link and the four chromosomes researched (chromosome 7,11,12 & 15) "had no predictive power over someone's sexual orientation". So people should be given the right to determ their on destiny. To deny them that is evil.

Commenter: Charlie Narr Ebersole, PhD Candidate, University of Virginia 4/10/19 9:52 pm

Ban Conversion Therapy

Conversion therapy is both unethical and ineffective. Freedom of speech does not guarantee the right to harm others. Conversion therapy is a threat to the LGBTQ community and banning it is an important way to support that community.

Commenter: Meghan Costello, Clinical Psychology PhD Student, University of Virginia 4/10/19 10:19 pm

Conversion Therapy is Harmful, Ineffective, Unethical, and Irresponsible

Conversion therapy is both ineffective and unethical. Continuing to permit this harmful practice would make a very strong statement that disavows the valued LGBTQ+ members of our society.

No peer-reviewed scientific work suggests that conversion therapy is effective. Furthermore, no ethical research institution would ever engage in rigorous research involving this therapy because the potential for harm to participants that are exposed to conversion therapy is too great.

Ethically, there should be no question about the practice of conversion therapy. The shame and trauma that are associated with conversion therapy have led to mental health problems such as depression, suicide, and substance abuse. Furthermore, the use of conversion therapy with adolescents is abusive. Before they turn 18, these individuals are extremely vulnerable and do not have the ability to adequately advocate for themselves in making the choice to pursue conversion therapy. Continuing to allow individuals in power to shame teens and children for something that they have no control over is unethical and irresponsible.

Conversion therapy should be banned, to preserve the health and safety of our community members.

Commenter: Robert G. Moulder, Psychology PhD Candidate, University of Virginia 4/11/19 12:23 am

Conversion therapy fails at all a mathematical level, a biological level, and a moral level

Conversion therapy is an umbrella term for processes aimed at changing an individual's sexual orientation or gender identity. The name is fairly misleading as rarely do these methods "convert" any individual, nor is it recognized as a therapy by the American Psychological Association (APA) or the Association for Psychological Science (APS). APA and APS are the two largest psychological research associations in the United States and both of these institutes, and the scientific community at large, agree that conversion therapy is a waste of time at best and abhorrent/torturous at worst. To quote the APA, "The longstanding consensus of the behavioral and social sciences and the health and mental health professions is that homosexuality per se is a normal and positive variation of human sexual orientation" and thus does not necessitate therapy. Numerous studies have shown mathematically and statistically that homosexuality is healthy and that conversion therapy is ineffective. Numerous studies have also shown natural biological differences in brain structure between homosexual and heterosexual individuals. Homosexuality is then scientifically shown to be natural. If science does not persuade you (it should), then at a moral

level, should not good individuals who are consenting adults be allowed to do as they please? Should not younger individuals be given guidance by trusted adults and their peers as opposed to being told that they are wrong or broken for simply being themselves? Why waste time, energy, and state funds on a "treatment" that has been shown not to work? Regulating conversion therapy is not enough as its very existence is unethical and harmful. Appeasing individuals should never come before the truth and the best tools we have for determining truth is science. Scientists at large say to stop conversion therapy as it is, in and of itself, harmful. It may be best to listen.

Commenter: Bambi Shingler 4/11/19 5:30 am

General Notice Comment

One of the more alarming aspects of the Guidance/regulations put forward in this practice is it creates a blatant double standard whereby counselors would be free to help minor clients explore and possibly cultivate same-sex feelings or even to "change" their gender, while simultaneously prohibiting them from helping minor clients flee from unwanted same-sex attractions and embrace natural sexual expressions and/or their true gender. The consequence of violating this policy could be the state-imposed loss of their professional license, and that is simply unacceptable. Licensed counselors have a responsibility to speak honestly with their minor clients about life's fundamental truths, and any state policies that compel them to repress those truths during counseling would lead to real ethical dilemmas, not to mention damage to those children. This policy is obviously agenda driven and evil to its core. Stop this madness and leave our children alone!

Commenter: Meret S. Hofer, M.A., PhD Candidate, University of Virginia 4/11/19 9:18 am

Conversion "therapy" is harmful and cannot be presented as a viable therapeutic option!

Banning conversion therapy has nothing to do with protecting free speech rights, and has everything to do with the primary mandate of the helping professions to do no harm. In addition to being unethical and harmful, conversion therapy has been discredited and proven to be ineffective. This "therapy" has no place in ANY therapeutic environment and should never be presented as a viable medical or therapeutic option.

Commenter: Sara Rowekamp 4/11/19 9:52 am

Freedom to get and give gender counseling

I can't bellieve that we are even needing to address the protection of a person's right to seek counseling for an unwanted behavior. We are not demanding that you make it illegal to counsel someone who wants to practise a LGBT lifesytle. Why should you be wanting to impose penalties on someone who is attempting to help someone who is seeking help? A person who wants help against that lifestyle should have the same freedom as anyone else to gain support.

Commenter: Jeffrey Lieberman 4/11/19 10:14 am

Harmful and devoid of compassion

Conversion therapy is proven to be psychologically harmful, and it's practice goes against every supposed value that Christians claim to hold dear. Do not allow it to continue, do not reject the fundamental identity of your own child, do not continue destroying lives and torturing children. Accepting one's own identity can be hard enough without your own family rejecting you, and then

forcing you into a program that uses fear, physical harm, and psychological torture to try to beat you down into pretending to be 'cured'. THERE IS NO VALID ARGUMENT FOR THIS 'TREATMENT'

Commenter: Jake Oster, High School Science Teacher 4/11/19 10:46 am

Unethical, Unmoral, and Damaging

Conversion Therapy and any affiliated "reparative" therapy for trying to change a youth's gender or sexual identity are unethical and unmoral at the highest of levels. Not only is it falsely based in fear and pseudoscience, these practices claim that being LGBTQ is a choice that can be cured.

These harmful practices cause long-lasting damage from psychological and physical abuse. No youth or person should have to undergo the rejection, shame, and subsequent mental health issues at the hands of a mental health "professional".

We cannot allow another person to be targeted and hurt by these dangerous practices.

Commenter: Charles Shepard, LPC, NCC, President-elect Central Valley Counselors Assoc. 4/11/19 10:55 am

Ban Conversion Therapy

The practice of converstion therapy, also known as reparative therapy, has been considered unethical and considered harmful to clients by every major professional organization related to mental health care for some time now. It is time for Virginia to join the 16 other states across the nation and disallow this practice by licensed practitioners at the very least. An ongoing discussion is necessary about generally considering this practice as abusive, even when practiced by non-licensed practitioners.

Commenter: Stewart Nafziger 4/11/19 11:20 am

Ban Conversion Therapy

The practice of converstion therapy, also known as reparative therapy, has been considered unethical and considered harmful to clients by every major professional organization related to mental health care for some time now. It is time for Virginia to join the 16 other states across the nation and disallow this practice by licensed practitioners at the very least. An ongoing discussion is necessary about generally considering this practice as abusive, even when practiced by non-licensed practitioners.

Commenter: Alana Johnson 4/11/19 11:21 am

Stop imposing restrictions on free speech

I am amazed at the misinterpretation and false claims made by the Board of Counseling and others regarding so-called "conversion therapy." There is definitely a place for aiding a counselee to overcome unwanted sexual attractions or sexual identities imposed upon them by the culture or other influences. There are many approaches to counseling, and the Board of Counseling "guidance" is in error when it tries to govern a counselor's theory, method or practice in providing help to a client. Let the client determine if he or she is receiving the type of help they are seeking. Stop imposing restrictions on free speech!

Commenter: Jensen Wohlgemuth 4/11/19 12:02 pm

Ban Conversion Therapy

Conversion therapy is an abusive and harmful practice. There is no evidence to back up any positive effects, and it is based on lies and pseudoscience. There is, however, plenty of evidence linking it to poor mental health and increased risk of suicide. Banning conversion therapy would make people safer and prevent unethical people from profiting off of lies and fearmongering.

Commenter: Jennifer Elgart 4/11/19 12:08 pm

Conversion Therapy

Conversion therapy is wrong and very harmful to any persons who are subjected to it. This is not an opinion, as conversion therapy has been shown to result in negative mental health. As sexual orientation has been taken out of the mental illness classification, conversion therapy should not still be going on. Being transgender, gender queer, or gender fluid is equally not a mental illness and therefore not to be "cured" by conversion therapy. Conversion therapy is cruel and wrong. Thank you for your consideration for my words.

Commenter: Tucker Rankin 4/11/19 12:08 pm

Ban Conversion Therapy

Conversion therapy is an unconstitutional use of pain and suffering that discriminates against the LGBTQ community. This is morally and physically wrong to allow this in the state of Virginia.

Commenter: Lia Derdeyn 4/11/19 12:08 pm

Ban conversion therapy

Conversion therapy is extremely detrimental and completely ineffective.

Commenter: Catherina Hurlburt 4/11/19 12:10 pm

Conversion Therapy Is Harmful to Minors

Commenter: Catherina Hurlburt 4/11/19 12:11 pm

Conversion Therapy Is Harmful to Minors

As the parent of a transgender son, who graduated college with honors and is a healthy and fulfilled young adult who now feels whole and happy, I am writing to support guidance that recommends against so-called conversion therapy. Adults have silenced the voices and personhood of young gay, lesbian, bisexual, transgender, agender/asexual youth by forcing them to undergo this dangerous so-called therapy. No one is "silencing" so-called counselors who push this unfounded "therapy." We are asking minors be protected from being forced to undergo this

abusive practice that ignores their well-being and wholeness for who they are -- in favor of personal religious beliefs that erase who they are as individuals. This guidance protects young people from state-licensed therapists in Virginia who falsely claim to parents and youth that being LGBTQ is a mental illness, and therefore taking advantage of parents and harming vulnerable youth. These harmful practices use rejection, shame, and psychological abuse to force young people to try and change who they are. These practices are known to be extremely dangerous and can lead to depression, decreased self-esteem, substance abuse, and even suicide attempts. Please frame the guidance to acknowledge that so-called conversion therapy is a harmful practice that puts youth in danger. Thank you.

Commenter: Ethan Sylvia, Virginia Student 4/11/19 12:15 pm

Ban Conversion Therapy

As the youth of Virginia, I feel that conversion therapy is destructive and almost a form of psychological torture. Set an example for the youth of today by showing that homosexual behavior is a normal part of biological nature.

Commenter: Shannon Mullins 4/11/19 12:16 pm

Conversion therapy

Commenter: Peter J Braun 4/11/19 12:16 pm

Ban Conversion Therapy

Really I don't even know how any sane and educated person can consider Conversion Therapy as anything other than torture and brainwashing at this point in our civilization's history. Even as a conservative myself this practice is barbaric. How can you be pro-freedom and also pro-conversion therapy without being a complete hypocrite.

Commenter: Tiffany Goodman 4/11/19 12:23 pm

Conversion Therapy Does More Harm Than Good

Conversion therapy has a very, very small chance if ever being helpful. Many times the only reason people agree to go to such sessions are because they were forced to by their parents or they saw themselves as "different" or "freaks" for having such feelings. Conversion therapy is only good for insighting fear and traumatizing children and young adults, it does not actually change someone's sexual identity. And if they claim that it does, it is only to stop the sheer torture that these individuals are forced to experience. Conversion therapy does nothing and will continue to do nothing because you can not change someone's sexual identity or orientation. You can not change how someone feels about such topics. Converison therapy is barbaric and tortures today's youth because they do not follow the traditional societal norms. It needs to be stopped immediately.

Commenter: Shirley Carley, Free Mom Hugs, Va 4/11/19 12:31 pm

Ban conversion therapy

Conversion therapy leads to psychological problems and even death.

Commenter: Shannon Mullins 4/11/19 12:43 pm

Mideval and Meritless

Conversion therapy is not actually therapeutic. It aims not to help LGBTQ+ people, but to traumatize them and make them hate themselves. This practice has been continually discredited -- no self-respecting counselor or therapist would do this kind of harm to someone's mental state, let alone impressionable children who are often the victims of forced conversion therapy. This practice is rooted in the mideval idea that homosexuals are sinful and need to be fixed. This has no place in modern society. LGBTQ+ people need to be supported and embraced, not made to deny their identities and conform to ancient religious ideas.

Commenter: Joshua England 4/11/19 1:12 pm

Conversion therapy destroys families

Conversion therapy has been proven by medical professionals as detrimental to familes and the LGBT who are forced into it. It is cruel and torturous. It should be banned.

Commenter: Emily Sproul, Shenandoah LGBTQ Center 4/11/19 1:17 pm

Dangerous and manipulative therapies must stop

Conversion therapy is bigotry, coercion and a horrific use of religion. It preys upon youth and young adults who are vulnerable to suggestion and often eager to please or fit in. It does nothing of what it purports to do, and is tantamount to trauma, a trauma that can take decades and a great deal of therapy to overcome. At its worst, it sets up LGBTQ young people for frighteningly high rates of suicide. This must end.

Commenter: Elizabeth Rinaldi 4/11/19 1:17 pm

Ban unethical and harmful conversion therapy!

Commenter: Elijah Baadte 4/11/19 1:38 pm

It's unethical and harms the child.

It's a form of torture and physical abuse used to push antiquated view of morality. And not only that there is no practical nor justifiable proof that it works.

Commenter: Mary Ann Suddarth 4/11/19 2:12 pm

conversion therapy is helpful

Those who do not want same sex attraction should have professional help available to them. To outlaw conversion therapy would force them to be on their own and could be dangerous to them. The dangers of conversion therapy that others are mentioning reference practices that probably haven't been used in 60 years. It would be very unfair, unwise, and unsafe to only give one way therapy for sexual problems.

Commenter: Victoria Mauer, PhD Candidate, University of Virginia 4/11/19 2:24 pm

Conversion therapy is incredibly dangerous and goes against the ethics of the counseling profession!

Dear Virginia Board of Counseling,

Hello, my name is Victoria Mauer and I am writing in support of **Guidance Document 115-10, on the Practice of Conversion Therapy,** which would protect youth under the age of 18 from so-called "conversion therapy" at the hands of licensed counselors in Virginia.

Conversion therapy is a set of practices by mental health professionals that seek to change an individual's sexual orientation or gender identity. This therapy seeks to change behaviors or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include psychotherapy that aims to provide acceptance, support, and understanding of clients or the facilitation of clients' coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices. Nor does it include counseling for a person seeking to transition from one gender to another.

I was trained as a mental health counselor at Northwestern University and saw, first hand, the trauma that is inflicted upon LGBTQ individuals who are not accepted for their identities. Many of the nation's leading medical *and* mental helath organizations have spoken out against conversion therapy and its use of of shame, verbal abuse, and sometimes physically abusive practices and the risks they pose to inflict serious physical and mental harm on LGBTQ individuals. These practices are based in a fundamentally false notion that individuals who identify as LGBTQ are choosing these identities and therefore need to be repaired from their problematic ways. Trying to change a young person's sexual orientation and/or gender identity is harmful, abusive, traumatic, and goes against the ethical principles of the field of mental health. It is a danger to LGBTQ youth that therapists in every state continue to engage in these practice that cause lifelong trauma for these youth.

Researchers know that there is no credible evidence that *any* type of psychotherapy can change a person's sexual orientation or gender identity. In fact, conversion therapy poses critical health risks to lesbian, gay, bisexual, transgender, and queer young people, including depression, shame, decreased self-esteem, social withdrawal, substance abuse, risky behavior, and even suicide. Nearly all the nation's leading mental health associations, including the American Psychiatric Association, the American Psychological Association, the American Counseling Association, the National Association of Social Workers, and the American Academy of Pediatrics, and the American Association for Marriage and Family Therapy have examined conversion therapy and issued cautionary position statements on these practices.

Research shows that lesbian, gay, and bisexual (LGB) youth are 4 times more likely, and questioning youth are 3 times more likely to attempt suicide as their straight peers. Nearly half of young transgender people have seriously thought about taking their lives and one quarter report having made a suicide attempt. Young people who experience family rejection based on their sexual orientation, including being subjected to conversion therapy, face especially serious health risks. Research reveals that LGB young adults who report higher levels of family rejection during adolescence are 8.4 times more likely to report having attempted suicide, 5.9 times more likely to report high levels of depression, 3.4 times more likely to use illegal drugs, and 3.4 times more likely to report having engaged in unprotected sexual intercourse compared with peers from families that reported no or low levels of family rejection.

Existing law provides for licensing and regulation of various mental health professionals, including physicians and surgeons, psychologists, marriage and family therapists, clinical social workers, and licensed professional counselors.

This guidance would prevent licensed mental health providers in Virginia from performing conversion therapy with a patient under 18 years of age, regardless of the willingness of a parent or guardian to authorize such efforts. The guidance will curb harmful practices known to produce lifelong damage to those who are subjected to them and help ensure the health and safety of LGBTQ youth. We thank you for proposing this important guidance.

Sincerely,

Victoria Mauer

Commenter: Catherine Burgess 4/11/19 2:28 pm

There is no place for conversation therapy in modern society, it should have been banned long ago!

Commenter: Keith Arthurs 4/11/19 3:02 pm

Sexual orientation is not persistent in children, they should be able to receive therapy

According to "Adolescent Sexual Orientation: Surprising amounts of change", they state:

"The idea that adolescent same-sex attraction will always become adult same sex attraction is quite incorrect."

They go on to say, "That is, 16 year olds saying they have an SSA or Bi-orientation are 25times more likely to change towards heterosexuality at the age of 17 than those with a heterosexual orientation are likely to change towards bi-sexuality or homosexuality. "

The notion that you are born that way, that sexual orientation is persistent goes against the scientific reality. Kids experiencing issues with their sexual orientation, discomfort, or a desire to receive therapy for it should have that option.

Further, a person who converts to a religion, such as Christianity or Islam, who is homosexual, should have therapy available that will help them become heterosexual if they choose to have that therapy. While many studies show it is difficult to change behavior/habits once formed, it is possible and has been done for many people. The option for someone to have therapy to help them with this should remain available for people who want such therapy. Other difficult to change behaviors, such as eating disorders, have such therapy available. Such therapy options needs to be available to persons who want it, or need it.

Children especially, as they go through puberty and have the normal preteen-teenage discomforts with their sex and attractions, should especially have therapy available. Kids are much more likely to go through radical changes, and are much more susceptible to changing.

Again, from the above paper, "There will be those who are Bisexual or SSA at age 16 who retain that attraction pattern unchanged the rest of their lives, but from the survey data we would have to say that this is very unusual. "

Sexual orientation is not permanent in children, in fact, they are more likely to change to become heterosexual through puberty, than to change and become homosexual. Studies prove this. If someone wants therapy to help them with their sexual orientation, especially children, it should be available to them.

Thank you,

Keith Arthurs

Commenter: Berkley Holston, Central VirginiaCounseling 4/11/19 4:48 pm

Conversion Therapy is dangerous and should be banned. Persons practicing Conversion Therapy should l

Conversion therapy should've banned. Persons who practice this treatment should lose their license to practice.T

Commenter: Rebecca Brown 4/11/19 4:54 pm

Ban conversion therapy

Conversion therapy should be banned because it violates codes of Ethics, can cause harm to patients, and attempts to provide "therapy" to something that is not a mental disorder.

Commenter: Paige Long 4/11/19 4:56 pm

Ban conversion therapy

Scientific research has proven that conversion therapy is incredibly harmful. Identifying as LGBTQ+ is no longer classified as a mental health condition. People in the LGBTQ+ community are 4x more likely to die by suicide, and individuals who undergo conversion therapy are 8x more likely to die by suicide. This practice is archaic and rooted in blatant disregard for individual freedoms. If we care about our children, we must ban conversion therapy immediately. We should've done it yesterday, the day before, and 30 years ago.

Commenter: Steven Milgrim, Milgrim & Associates, P.C. 4/11/19 4:58 pm

Stop calling it "therapy."

The goal of therapy is to treat or cure a mental health disorder. Homosexuality is not a disorder and this is not therapy. This is the misapplication of techniques to pursue a political, moral or religious agenda. No legitimate mental health professional engages in this type of unethical behavior. Ban it and sanction it.

Commenter: Stephanie W Crowe, LPC, INC 4/11/19 4:59 pm

Ban Conversion therapy.

CT is archaic, never should have been practiced, and has no place in any ethical counseling regimen.

4/11/19 5:01 pm

Commenter: Erin Mahone, #IfYouCouldSeeMe

Ban Conversion Therapy

This is a dangerous practice with no justifiable benefits. It is used to damage people and often to harm children. I am studying to become a counselor and I am hoping that my future profession will take a stand against this disgusting and abusive practice.

Commenter: Dr. David Julius Ford, Jr. 4/11/19 5:01 pm

Ban Conversion "therapy"

Conversion "therapy" goes against the ACA Code of Ethics and is harmful to our clients. In the onset, it tells our clients that because they experience same-sex attraction, they are abnormal, diseased, have a diagnosable condition, and need to be fix (converted). We, as Counselors, should never send that message to anyone. Our clients should be allowed to live and we should let them live--in the fullness of who they are. Being same gender loving is not a condition to be rewired or fixed. It's a part of who we are, not a temporary condition. I ask that Virginia bans this unethical, medieval, and empirically unsopported act of violence and trauma to an already marginalized, traumatized, and vulnerable population.

Commenter: Katelyn Kiley, Resident in Counseling 4/11/19 5:02 pm

Ban conversion therapy!

Conversion therapy is actively harmful and should be prohibited to protect the best interests of clients. Thank you for your attention to this matter.

Commenter: Darlene Vaughn, MT Rogers CSB 4/11/19 5:02 pm

Conversion Therapy

Conversion therapy shames and is a detriment to an individual's mental health and emotional well-being. As a member of the American Counseling Association practicing in southwest Virginia, I request that Virginia not approve conversion therapy certification in the promotion of wellness and harm-reduction.

Darlene Vaughn, MEd MMsc CSAC FACASAC NCC LPCC, PhD graduate May 2019-Counselor Education & Supervision

Commenter: Audra Mrini 4/11/19 5:11 pm

How are we defining conversion therapy?

There should be a distinction made between harmful and helpful practices. The term Conversion Therapy is being used loosely and should be better defined. There may be instances in which such a practice under certain circumstances would be harmful, for example, in a situation where a client does not want assistance with their sexual orientation and it is thus imposed on them. There are other instances in which clients seek and want to, and should be able to, in a safe, trusted therapeutic relationship, to be able to explore and make their own decisions about how to

proceed. We should be able to provide this type of support when the client seeks it. We need to define this term as a practice rather than just banning a concept.

Commenter: Oliver 4/11/19 5:14 pm

Conversion therapy is detrimental

Conversion therapy does not work on anyone, it just hurts kids and can cause permanent damage. Being LGBTQ is in no way bad and even if it was this would do nothing to stop anyone from being transgender or gay. Conversion therapy has been proven to be directly linked to increased self harm and suicide rates among both teens and adults who have endured it. We need to be supporting people through their difficult struggle with identity rather than telling them they are wrong for something out of their control, which does not affect anyone else. Leave LGBTQ people and especially LGBTQ kids alone, and stop policing their lives!

Commenter: Marie Paddock, LPC 4/11/19 5:19 pm

Caution -- a ban could be unconstitutional

First, we need to stop using the name Conversion Therapy in our dialogue, it has negative connotations and many conflicting definitions. Second, I disagree with the emotionally and physically abusive treatment modalities that some individuals used in the past when working with clients exploring sexual identity conflicts. That being said, I do NOT feel a BAN is the correct action. Under a BAN, counselors could be penalized for working with clients who are seeking a safe therapeutic environment for self-exploration. It would be unconstitutional to BAN counselors and clients to openly explore sexual identity and sexuality conflicts.

Commenter: Christine Reid 4/11/19 5:25 pm

"Conversion Therapy" not supported by empirical evidence, and causes significant harm

"Conversion Therapy" is not only philosophically problematic (trying to "fix" something that is a natural part of human diversity), but ineffective. Empirical evidence shows that it does not work, and does cause very real harm to people who go through the experience. There is good reason for banning this harmful practice, as evidenced by bans already in place in New Jersey, California, Oregon, Illinois, Vermont, New Mexico, Connecticut, Rhode Island, Nevada, Washington, Hawaii, Delaware, Maryland, New Hampshire, New York, Massachussetts, Washington D.C., and Puerto Rico, as well as many additional counties, municipalities, and communities. More details are available
through https://en.wikipedia.org/wiki/List_of_U.S._jurisdictions_banning_conversion_therapy.

Commenter: Elizabeth Hatchuel, PhD, LPC 4/11/19 5:26 pm

Ban coversion "therapy"

Continuing to support conversion "therapy" acts in opposition to our professional responsibility to "do no harm." As advocates for the LGBTQ community, we can NOT support a policy that dishonors one's identity and could lead to shame and trauma.

Commenter: Tammie Taylor 4/11/19 5:40 pm

Ban this harmful practice !

Conversion is not THERAPY!!! It's harmful, unethical and abusive. Ban this Practice !!

Commenter: Susanne Oshry 4/11/19 5:51 pm

Conversion Therapy

Conversion Therapy is not therapy. Its a violation of of human rights.

Commenter: Sharon Brammer 4/11/19 6:10 pm

Ban conversion therapy!

As a long time child therapist, I completely agree that conversion therapy is harmful to children.

Commenter: ASHLEY TERRY 4/11/19 6:14 pm

No to conversion! It is a personal choice, not our choice.

I am a LPC practicing in the state of Virginia. I do not agree with conversion "therapy". I oppose this idea and practice because it violates the Code of Ethics I apply, can cause harm to patients, and attempts to provide "therapy" to something that is not a mental disorder. I am writing to encourage others to not support this nontherapeutic practice.

Commenter: Jessica Johnson 4/11/19 7:12 pm

Conversion Therapy... NO

This practice is doing harm to many individuals!

Commenter: Liz Signorelli Moore, LPC LSATP 4/11/19 7:15 pm

Conversion therapy is dangerous, and it doesn't belong in our discipline

I am in strong support of the guidance above. Conversion is not evidence-based practice. It should not be considered in the same domain as EMDR, CBT, and other treatments. I have worked with adults suffering with the aftermath of shame and guilt from it. I am horrified that we can't stop it all together, but I am glad to have it cast out of our field.

Commenter: Alexis Dovel, MSW 4/11/19 7:15 pm

No more conversion therapy

I support a ban on conversion therapy as it is an ineffective practice and one that likely causes harm to participants. Conversion therapy is associated with increased depression and anxiety. In addition, it perpetuates shame of one's body and desires. It is not a practice that is productive to achieve greater happiness, comfort, self-actualization, or stability in one's life. An environment of support and inclusion is much more likely to foster healthy individuals.

This is not an issue of freedom of speech. Those trained in counseling are skilled in using techniques grounded in theory that enable an individual to examine their own thoughts and behaviors, and empower them to make changes in their own lives. A high quality professional counselor has done work with themselves to examine their own internal biases and how that may affect their practice. In order to provide the best counseling, a counselor cannot express every personal opinion, belief, or thought that they have. They must take the time to share what the client needs, not what the counselor needs and not what the client's family needs (who are often sending their adolescent children to conversion therapy). Conversion therapy exists to make others feel better and does nothing to assist someone struggling with the discovery that they are LGBTQ what that may mean in their lives.

Families likely seek this counseling out of fear that their child is different, a lack of understanding that homosexuality is a normal variant of human sexuality, or for religious reasons. None of these reasons are good reasons to take their money and deliver services that have no credible evidence that they work. It is unethical at best and likely fraudulent.

Commenter: John Bernadyn, MS 4/11/19 7:43 pm

Conversion Therapy is Dangerous

Hello and thank you for the opportunity to submit my comment. I am encouraged by the mere proposal to have conversion therapy completely made illegal in the State of Virginia. For far too long, we have known that this false therapy has caused so much pain and has led to severe psychological trauma and even suicides. It is important that we remember we are here to help people heal. Conversion therapy, regardless of rationale, causes harm. It is my hope that our laws will change to reflect this and protect others from pedalers of this false therapy.

Commenter: Amy Cannon 4/11/19 7:45 pm

Conversion (Therapy) Torture

Banning so-called "conversion therapy" in Virginia is necessary to protect children from this harmful practice. "Conversion therapy," is a dangerous and discredited practice aimed at changing the sexual orientation or gender identity of a person, often against their will. This is based on the false claim that being lesbian, gay, bisexual, transgender, or queer (LGBTQ) is a mental illness that needs to be cured—a view with no scientific basis.

We must protect young people from state-licensed therapists in Virginia who falsely claim to parents and youth that being LGBTQ is a mental illness. They are taking advantage of parents ,and harming vulnerable youth. These harmful practices use rejection, shame, and psychological abuse to force young people to try and change who they are. "Conversion therapy" tactics are known to be extremely dangerous and can lead to depression, decreased self-esteem, substance abuse, and even suicide attempts. No young person should ever be shamed by a mental health professional into thinking that who they are is wrong. Mental health professionals should provide care that is ethical and affirming for lesbian, gay, bisexual, and transgender young

people. We can't allow one more young person to be targeted and hurt by these dangerous and discredited practices.

Commenter: Kevin Doyle 4/11/19 8:19 pm

Ban conversion therapy

Ban it

Commenter: Ashley Laws 4/11/19 8:24 pm

No to Conversion "therapy"

Please ban conversion "therapy" is determential to all clients involved and does not identify indviduals as people. Also it is horrible for clinicians to attempt this "treatment" and very unethical.

Commenter: Brian T McMahon 4/11/19 8:55 pm

UNEQUIVOCAL NO TO CONVERSION THERAPY

I AM FAMILIAR WITH THE ISSUES UNDER CONSIDERATION HERE. AS EARLY AS 1999, AS A BOARD MEMBER OF ACA, WE DEBATED THE CONSEQUENCES OF THIS PRACTICE AND SENT A STRONG RESOLUTION TO THE CHINESE GOVERNMENT TO OVERTURN THEIR LAWS ON THIS MATTER. IT IS EMBARRASING AND REGRETTABLE THAT THIS MATTER WOULD BE BROUGHT BEFORE OUR LEGISLATURE. SEXUAL ORIENTATION IS NOT A DISEASE, DISORDER, OR CHARACTER FLAW. IT IS A PERSONAL CHARACTERISTIC, PERIOD. GAY AND LESBIAN PEOPLE HAVE EXISTED SINCE THE ORIGIN OF OUR SPECIES AND ALL MANNERS OF LIVING ANIMALS. AS A TAXPAYER FOR 53 YEARS I WOULD STRONGLY OBJECT TO MY TAX REVENUES BEING USED TO TRAIN OR COMPENSATE COUNSELORS FOR A PRACTICE THAT IS NOT COUNSELING, BUT MISGUIDED PERSONAL INTRUSION.

NO, ABSOLUTELY NO, TO THIS IRRESPONSIBLE AND UNPROFESSIONAL ACTIVITY. LET THOSE WHO ENDORSE THIS FOLLY RECEIVE SOME REPAIRING THEMSELVES.

JUDGE NOT .....

Brian T. McMahon, Ph.D., CRC

Professor, VCU Department of Rehabilitation Counseling

Fellow, American Psychology Association and APA Division of Rehabilitation Psychology

Mary E Switzer Distinguished Research Fellow, NIDILRR

NCRE Distinguished Career in Rehabilitation, 2018

VCU, PO Box 980330, Richmond, VA 23298-0330

(804)240-4587 (cell). Download my research at:

https://www.researchgate.net/profile/Brian_Mcmahon7

Attachments area

Commenter: Caroline Thomas 4/11/19 9:03 pm

Ban Conversion Therapy

There is no empirical evidence whatsoever that supports the efficacy of Conversion Therapy. All aspects of Conversion Therapy are unethical, immoral, and inhumane.

Commenter: Karen Painter 4/11/19 9:10 pm

Ban Conversion "therapy"

Harmful, dangerous, and detrimental. Ban it!

Commenter: John L. Ehlers, III, M.A., LPC, NCC 4/11/19 9:46 pm

Conversion Therapy Does Harm

Conversion therapy is and has always been a misguided attempt to change a core aspect of identity that does not need to be changed. Only harm can come from this unethical approach.

Commenter: Amanda G. Francis M.Ed/Ed.S LPC 4/11/19 10:39 pm

Conversion "Therapy " is Not Ethical

Conversion Therapy should not be condoned/allowed by professionals in the mental health field. Virginia should ban Conversion "Therapy." This is not an issue of preference in treatment modalities, this is not an issue of "free speech" or an issue of "choice." As a credible profession we as counselors must take a stance and continue to make choices based on research. Research does not support Conversion "Therapy" and research does indicate it causes harm. Our Ethical codes are clear and human rights should take a priority. We have made great strides in this field, and I appreciate that the board in making this a prority for those practicing in our field.

Commenter: Stephanie Miller 4/11/19 10:46 pm

Conversion Therapy is At Best Redundant, and At Worst Traumatic

I would like to address several previous comments on this forum that claim banning the practice of conversion therapy will prevent people from getting the help they need. First, this issue is specifically in reference to the treatment of children. Children, in most cases, cannot seek out counseling without the permission of their parents or guardians. Further, parents and guardians can schedule appointments and demand that their children attend counseling, even if the child objects. The Board of Counseling, and the community, must consider that in a large number of child and adolescent cases, the "client" is not actually the minor, but the parent or guardian. More often than not, the minor is resistant to counseling regardless of the method being used, because they did not make the choice to be there. Therefore, it is inaccurate to claim that this practice is a refuge children seek it out voluntarily.

Second, the idea that this ban would limit counselors in their ability to help children is ludicrous. Claiming that children will not get the help they need if not for this single practice displays incredible ignorance of the counseling field. There are a myriad of techniques available to

clients today, and several are backed by substantial evidence. Just about every modern counseling method is centered around the idea of client change. Therefore, if a client comes into counseling and is experiencing conflict or distress about their sexual orientation or gender identity, counselors trained in a variety of methods should be able to help them. A client who genuinely wants to change and is willing to put in the effort to achieve change can do so through a variety of counseling techniques. Therefore, if conversion therapy is meant to help people change, it is really just yet another technique. It is redundant. It is not a necessary technique for professional counselors to achieve therapeutic outcomes with a client.

On the other hand, consider what happens if conversion therapy is not banned by the board. A simple Google (scholar) search clearly reveals the ineffective and potentially harmful nature of conversion therapy. It is built on the idea that the client is inherently flawed; it paints change as "correct" and self-acceptance as "wrong." This goes against the nature of counseling, which is to help the client achieve their therapeutic goals in a supportive, nonjudgemental way. Conversion therapy is more of a training than a therapy. Further, conversion therapy can be coercive and abusive. There are horror stories of shock therapy and physical abuse, but in reality just telling a client that they, or even a part of them, is bad or wrong will devastate their self esteem. A counselor who rejects a client struggling with sexual orientation and/or gender identity can traumatize them, and make them feel even more isolated and alone. Plain and simple, these techniques are dangerous for clients.

To allow licensed professionals to perform potentially traumatic techniques on children, who often cannot consent on their own behalf, is abuse. Conversion therapy goes against the nature of counseling, and there are plenty of other evidence-based theories to support individuals with sexual orientation and gender identity issues. The well being of children must be prioritized over the politically-charged preference of a few.

Stephanie Miller, Master's Student

Rehabilitation and Mental Health Counseling

Virginia Commonwealth University

Commenter: Connie Honsinger 4/11/19 10:53 pm

Conversion therapy is harmful

Time to stop this practice of trying to change someone's identity. This is not therapy.

Commenter: Traci Jones, Ph. D. Candidate, RPRS 4/12/19 3:36 am

A question of ethics

In the American Counseling Association (ACA) Code of Ethics (2014) it specifically states that a counselor must "act to avoid harming their clients, trainees, and research participants". Further. "Counselors are aware of-and avoid imposing- their own values, attitudes, beliefs, and behaviors (section A4a-b). Conversion therapy is in sharp contrast to these stated values. I do not speak from personal experience, but on behalf of a participant in my program who is a survivor of conversion therapy. This person found themselves traumatized by the practice that was said to help. Prior to conversion therapy, this person was an active member of working society with no major mental health history. After, this person is riddled with anxiety, dependent on benzodiazepines, and reliant on disability income. Conversion therapy only seems to help the counselors who practice it impose their values, attitudes, beliefs, and behaviors. This is why it should be banned.

Commenter: Okey Nwokolo, Virginia Tech 4/12/19 5:00 am

Conversion Therapy

Conversion therapy is unethical, misguided and oppressively harmful. The immediate ban and ratification of its prohibition, by the Board, is a step in the right direction.

Commenter: Kathleen McCleskey 4/12/19 9:15 am

Ban Conversion Therapy

Conversion therapy seeks to limit normal variations in affectional or sexual orientation or gender identity. There is no emprical basis that these attempts work. There is high likelihood that clients will be harmed by conversion therapy. The American Counselign Association says, "The American Counseling Association opposes conversion therapy because it does not work, can cause harm, and violates our Code of Ethics." Please ban this practice.

Commenter: Jennifer Lassiter 4/12/19 9:16 am

Conversion therapy is not therapy. Protect the Commonwealth.

American Academy of Child and Adolescent Psychiatry, *The AACAP Policy on "Conversion Therapies"* (2018), *available at* https://www.aacap.org/AACAP/Policy_Statements/2018/Conversion_Therapy.aspx.

"The American Academy of Child and Adolescent Psychiatry finds no evidence to support the application of any "therapeutic intervention" operating under the premise that a specific sexual orientation, gender identity, and/or gender expression is pathological. Furthermore, based on the scientific evidence, the AACAP asserts that such "conversion therapies" (or other interventions imposed with the intent of promoting a particular sexual orientation and/or gender as a preferred outcome) lack scientific credibility and clinical utility. Additionally, there is evidence that such interventions are harmful. As a result, "conversion therapies" should not be part of any behavioral health treatment of children and adolescents."

American Academy of Pediatrics, *Homosexuality and Adolescence*, 92 Pediatrics 631 (1993), *available at* http://pediatrics.aappublications.org/content/92/4/631.full.pdf.

"Therapy directed at specifically changing sexual orientation is contraindicated, since it can provoke guilt and anxiety while having little or no potential for achieving changes in orientation."

American Association for Marriage and Family Therapy, *AAMFT Position on Couples and Families* (2009), *available at*http://www.aamft.org/imis15/content/about_aamft/position_on_couples.aspx.

"[T]he association does not consider homosexuality a disorder that requires treatment, and as such, we see no basis for [reparative therapy]. AAMFT expects its members to practice based on the best research and clinical evidence available."

American College of Physicians, *Lesbian, Gay, Bisexual, and Transgender Health Disparities:*

Executive Summary of a Policy Position Paper From the American College of Physicians, Ann Intern Med. Published Online (2015), *available at*http://annals.org/article.aspx?articleid=2292051.

"8. The College opposes the use of "conversion," "reorientation," or "reparative" therapy for the treatment of LGBT persons.

Available research does not support the use of reparative therapy as an effective method in the treatment of LGBT persons. Evidence shows that the practice may actually cause emotional or physical harm to LGBT individuals, particularly adolescents or young persons. Research done at San Francisco State University on the effect of familial attitudes and acceptance found that LGBT youth who were rejected by their families because of their identity were more likely than their LGBT peers who were not rejected or only mildly rejected by their families to attempt suicide, report high levels of depression, use illegal drugs, or be at risk for HIV and sexually transmitted illnesses. The American Psychological Association literature review found that reparative therapy is associated with the loss of sexual feeling, depression, anxiety, and suicidality."

American Counseling Association, *Ethical Issues Related to Conversion or Reparative Therapy* (2013), *available at*http://www.counseling.org/news/updates/2013/01/16/ethical-issues-related-to-conversion-or-reparative-therapy.

"The belief that same-sex attraction and behavior is abnormal and in need of treatment is in opposition to the position taken by national mental health organizations, including ACA. The ACA Governing Council passed a resolution in 1998 with respect to sexual orientation and mental health. This resolution specifically notes that ACA opposes portrayals of lesbian, gay and bisexual individuals as mentally ill due to their sexual orientation. . . . In 1999, the Governing Council adopted a statement 'opposing the promotion of reparative therapy as a cure for individuals who are homosexual.' . . .

[T]he ACA Ethics Committee strongly suggests that ethical professional counselors do not refer clients to someone who engages in conversion therapy or, if they do so, to proceed cautiously only when they are certain that the referral counselor fully informs clients of the unproven nature of the treatment and the potential risks and takes steps to minimize harm to clients. . . . This information also must be included in written informed consent material by those counselors who offer conversion therapy despite ACA's position and the Ethics Committee's statement in opposition to the treatment. To do otherwise violates the spirit and specifics of the ACA Code of Ethics."

American Medical Association, *Health Care Needs of Gay Men and Lesbians in the United States*, 275 J. Am. Med. Ass'n 1354 (1996), *available at* http://jama.jamanetwork.com/article.aspx?articleid=401656.

"Aversion therapy (a behavioral or medical intervention which pairs unwanted behavior, in this case, homosexual behavior, with unpleasant sensations or aversive consequences) is no longer recommended for gay men and lesbians. Through psychotherapy, gay men and lesbians can become comfortable with their sexual orientation and understand the societal response to it."

American Medical Association, *H-160.991 Health Care Needs of the Homosexual Population,* (reaffirmed 2012), *available at* http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/glbt-advisory-committee/ama-policy-regarding-sexual-orientation.page.

"Our AMA: (c) opposes, the use of 'reparative' or 'conversion' therapy that is based upon the assumption that homosexuality per se is a mental disorder or based upon the a priori assumption that the patient should change his/her homosexual orientation."

American Psychiatric Association, *Position Statement on Therapies Focused on Attempts to Change Sexual Orientation (Reparative or Conversion Therapies)* (2000), *available*

at http://www.psychiatry.org/File%20Library/Advocacy%20and%20Newsroom/Position%20Statements/ps2000_ReparativeTherapy.pdf.

"Psychotherapeutic modalities to convert or 'repair' homosexuality are based on developmental theories whose scientific validity is questionable. Furthermore, anecdotal reports of 'cures' are counterbalanced by anecdotal claims of psychological harm. In the last four decades, 'reparative' therapists have not produced any rigorous scientific research to substantiate their claims of cure. Until there is such research available, [the American Psychiatric Association] recommends that ethical practitioners refrain from attempts to change individuals' sexual orientation, keeping in mind the medical dictum to first, do no harm.

The potential risks of reparative therapy are great, including depression, anxiety and self-destructive behavior, since therapist alignment with societal prejudices against homosexuality may reinforce self-hatred already experienced by the patient. Many patients who have undergone reparative therapy relate that they were inaccurately told that homosexuals are lonely, unhappy individuals who never achieve acceptance or satisfaction. The possibility that the person might achieve happiness and satisfying interpersonal relationships as a gay man or lesbian is not presented, nor are alternative approaches to dealing with the effects of societal stigmatization discussed.

Therefore, the American Psychiatric Association opposes any psychiatric treatment such as reparative or conversion therapy which is based upon the assumption that homosexuality per se is a mental disorder or based upon the a priori assumption that a patient should change his/her sexual homosexual orientation."

American Psychoanalytic Association, *Position Statement on Attempts to Change Sexual Orientation, Gender Identity, or Gender Expression*(2012), *available at* http://www.apsa.org/content/2012-position-statement-attempts-change-sexual-orientation-gender-identity-or-gender.

"As with any societal prejudice, bias against individuals based on actual or perceived sexual orientation, gender identity or gender expression negatively affects mental health, contributing to an enduring sense of stigma and pervasive self-criticism through the internalization of such prejudice.

Psychoanalytic technique does not encompass purposeful attempts to 'convert,' "repair," change or shift an individual's sexual orientation, gender identity or gender expression. Such directed efforts are against fundamental principles of psychoanalytic treatment and often result in substantial psychological pain by reinforcing damaging internalized attitudes."

American Psychological Association, *Resolution on Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts* (2009), *available at*http://www.apa.org/about/policy/sexual-orientation.pdf.

"Therefore be it resolved that the American Psychological Association affirms that same-sex sexual and romantic attractions, feelings, and behaviors are normal and positive variations of human sexuality regardless of sexual orientation identity;

Be it further resolved that the American Psychological Association reaffirms its position that homosexuality per se is not a mental disorder and opposes portrayals of sexual minority youths and adults as mentally ill due to their sexual orientation;

Be it further resolved that the American Psychological Association concludes that there is insufficient evidence to support the use of psychological interventions to change sexual orientation;

Be it further resolved that the American Psychological Association encourages mental health professionals to avoid misrepresenting the efficacy of sexual orientation change efforts by promoting or promising change in sexual orientation when providing assistance to individuals distressed by their own or others' sexual orientation;

Be it further resolved that the American Psychological Association concludes that the benefits reported by participants in sexual orientation change efforts can be gained through approaches that do not attempt to change sexual orientation;

. . .

Be it further resolved that the American Psychological Association advises parents, guardians, young people, and their families to avoid sexual orientation change efforts that portray homosexuality as a mental illness or developmental disorder and to seek psychotherapy, social support and educational services that provide accurate information on sexual orientation and sexuality, increase family and school support, and reduce rejection of sexual minority youth;

Be it further resolved that the American Psychological Association encourages practitioners to consider the ethical concerns outlined in the 1997 APA Resolution on Appropriate Therapeutic Response to Sexual Orientation (American Psychological Association, 1998), in particular the following standards and principles: scientific bases for professional judgments, benefit and harm, justice, and respect for people's rights and dignity[.]"

American School Counselor Association, *The Professional School Counselor and LGBTQ Youth*(2014), *available at* http://www.schoolcounselor.org/school-counselors-members/about-asca-%281%29/position-statements.

"The professional school counselor works with all students through the stages of identity development and understands this may be more difficult for LGBTQ youth. It is not the role of the professional school counselor to attempt to change a student's sexual orientation or gender identity. Professional school counselors do not support efforts by licensed mental health professionals to change a student's sexual orientation or gender as these practices have been proven ineffective and harmful (APA, 2009). School counselors provide support to LGBTQ students to promote academic achievement and personal/social development. Professional school counselors are committed to the affirmation of all youth regardless of sexual orientation, gender identity and gender expression and work to create safe and affirming schools."

American School Health Association, *Quality Comprehensive Sexuality Education* (2007).

"[T]he American School Health Association . . . expects that comprehensive sexuality education in schools will be scientifically accurate and based on current medical, psychological, pedagogical, educational and social research . . . [and recommends] that teachers be well-trained and competent to teach sexuality education as defined by . . . insight into and acceptance of their own personal feelings and attitudes concerning sexuality topics so personal life experiences do not intrude inappropriately into the educational experience."

National Association of Social Workers, *"Reparative" or "Conversion" Therapies for Lesbians and Gay Men* (2000), *available at*http://www.naswdc.org/diversity/lgb/reparative.asp.

"[P]roponents of reparative and conversion therapies, such as the most commonly cited group NARTH, claim that their processes are supported by scientific data; however, such scientific support is replete with confounded research methodologies. . . . [Reparative and conversion therapies] **cannot and will not change sexual orientation**. Aligned with the American Psychological Association's (1997) position, NCLGB believes that such treatment potentially can lead to severe emotional damage." (emphasis in original)

National Association of Social Workers, *Policy Statement: Lesbian, Gay, and Bisexual Issues* (2005), *available at* http://www.socialworkers.org/da/da2005/policies0505/documents/lgbissues.pdf.

"Taken to the extreme, homophobia in social workers and other practitioners can lead to the use of conversion or reparative therapies, which are explicitly condemned by NASW. . . . NASW reaffirms

its stance against reparative therapies and treatments designed to change sexual orientation or to refer practitioners or programs that claim to do so."

Pan American Health Organization: Regional Office of the World Health Organization, *"Cures" for an Illness That Does Not Exist: Purported Therapies Aimed at Changing Sexual Orientation Lack Medical Justification and are Ethically Unacceptable* (2012), *available at* http://www.paho.org/hq/index.php?option=com_docman&task=doc_view&gid=17703.

"'Reparative' or 'conversion therapies' have no medical indication and represent a severe threat to the health and human rights of the affected persons. They constitute unjustifiable practices that should be denounced and subject to adequate sanctions and penalties."

Just the Facts Coalition (American Academy of Pediatrics, American Association of School Administrators, American Counseling Association, American Federation of Teachers, American Psychological Association, American School Counselor Association, American School Health Association, Interfaith Alliance Foundation, National Association of School Psychologists, National Association of Secondary School Principals, National Association of Social Workers, national Education Association, School Social Work Association of America), *Just the Facts About Sexual Orientation and Youth: A Primer for Principals, Educators, and School Personnel* (1999), *available at*http://www.apa.org/pi/lgbt/resources/just-the-facts.pdf.

"The most important fact about 'reparative therapy,' also sometimes known as 'conversion' therapy, is that it is based on an understanding of homosexuality that has been rejected by all the major health and mental health professions. The American Academy of Pediatrics, the American Counseling Association, the American Psychiatric Association, the American Psychological Association, the National Association of School Psychologists, and the National Association of Social Workers, together representing more than 477,000 health and mental health professionals, have all taken the position that homosexuality is not a mental disorder and thus there is no need for a 'cure.'"

Commenter: J.Mercedes Dominguez 4/12/19 9:18 am

Conversion Therapy is the best, safest & most effective type of therapy as it frees the patient

Conversion Therapy is the best, safest and most effective type of therapy as it allows the patient to be freed from the bonds that he or she is struggling with and desperately wants to remove.

Commenter: Ramsay Cogen 4/12/19 9:50 am

Conversion Therapy

Conversion therapy is an abusive practice that contributes to the alarmingly high rates of suicide in the lgbtq community, especially among lgbtq youth. It is time to ban this practice in Virginia.

Commenter: Allison Ober, George Mason University 4/12/19 9:54 am

Ban conversion "therapy"

Conversion "therapy" has repeatedly been shown to be ineffective and harmful. As counselors, our code of ethics makes it clear that we must ban this detrimental practice:
A.4.a. Avoiding Harm

Counselors act to avoid harming their clients, trainees, and research participants and to minimize or to remedy unavoidable or unanticipated harm.

Commenter: Jillian Strand 4/12/19 10:24 am

Conversion Therapy

PLEASE BAN CONVERSION THERAPY! This would help keep our children safe. Thank you

Commenter: Maggie Parker 4/12/19 10:26 am

Conversion Therapy is harmful- sexuality is not something to change

Some of the comments that conversion therapy allows for individuals to change their sexuality if they want to concerns me. Sexuality is innate and is not changed- trying to change implies there is something wrong with sexuality and that is not accurate. The harm that can occur as a result does not uphold the ethical duties of beneficence and nonmaleficence.

Commenter: Sarah Horowitz 4/12/19 10:34 am

End Conversion Therapy

Conversion "therapy" is an incredibly harmful practice which seeks to change natural human variation in human sexual orientation. It should not be permitted in Virginia.

Commenter: Amy Jindra 4/12/19 11:05 am

not a freedom of speech issue

In previous comments, individuals remarked that conversion therapy is a matter of freedom of speech for the counselor. Counseling isn't about the counselor's agenda and will. Therapies support the wellbeing of the individual. The matter is about best practices and supporting the whole health of an individual. Conversion therapy seeks to dictate a preset agenda, not explore an individual's personal journey. Evidence based, best practices, and ethical principles should dictate what therapies are involved in treatment. Conversion therapy has been shown to be in opposition to core therapuetic concepts and ethical standards.

Commenter: Matthew R Lord, M.Ed., NCC, NCSC 4/12/19 11:15 am

Conversion "Therapy" and Youth

Allowing conversion therapy and thus, by default, promoting it will do serious harm to young people in the Commonwealth. Forcing more young people back into hiding will only increase suicide and other negative mental health outcomes. As a member of the American Counseling Association, the Virginia Counseling Association and the Virginia Alliance for School Counseling, I request that Virginia not approve conversion therapy and find licensed professionals who practice it to be unethical and revoke or suspend their licenses.

Commenter: Traci Terry, MS, LPC 4/12/19 11:21 am

Non-ethical, not evidence-based, abhorrent practice

Conversion "therapy" is not only unethical for counselors to provide, it is severely damaging to the individuals who are forced to participate and is not evidence-based either. There is absolutely no research that supports this as a viable resource for individuals and the roots of this type of "therapy" are deeply troubling. There is no place for this type of service anywhere. Our LGBTQ+ consumers deserve so much better. I stand with all those who oppose the abhorrent practice.

Commenter: Travis N Terry 4/12/19 11:28 am

Conversion therapy is baseless

There are no rigorous scientific justifications for berating and abusing someone's rightful choice to their prsonal preferences by attempting to convince them via unprecedented means of tax funded harassment.

Commenter: John Butler 4/12/19 11:31 am

Ban conversion therapy

This type of "therapy" lead to higher rates of suicide and depression. It is an archaic, harmful practice that needs to end immediately.

Commenter: Rocky Parker 4/12/19 11:32 am

Ban conversion therapy: protect LGBTQ Virginians

Sexual orientation (identifying as gay, lesbian, asexual, bisexual, pansexual) is a fixed, natural attribute for a person. Conversion "therapy" (to even call this a therapy maligns an entire profession) is barbaric and traumatizing, and this has been rejected completely by professional psychological associations as unscientific and, worse, harmful. LGBTQ Virginians deserve better than this, and we can't drive this legislation ourselves. We need you, our elected representatives, to voice your strong opposition to this kind of therapy. Please ban this harmful practice in our wonderful state. Keep our young people safe, especially from parents who seek to do such great damage to their very own children.

Commenter: Colin Cross 4/12/19 11:33 am

Conversion Therapy is a deplorable, senseless act of harm

There is no evidence to suggest that Conversion Therapy works and plenty finding that can have extremely harmful effects. It is against our ethical code to knowingly provide or allow organizations to provide harmful practices under the guise of counseling.

Commenter: Thomas Parker, Arkansas Retired Teachers Association 4/12/19 12:06 pm

Please produce evidence based articles pro or con on the issue of conversion therapy

Based on my experiences as a teacher and parent I would have to say that this issue should not be addressed by legislative mandates. This is giving in to religious convictions regarding personal and private convictions regarding complicated decisions about human sexuality and should be up to the individual. "Don't ask, don't tell" seemed to work quite well. Keep the government away from our constititional freedoms.

Commenter: Suzan Thompson, Ph.D., LPC 4/12/19 12:14 pm

Ban Conversion Therapy

I support the ban. Any "therapy" that is shown to be harmful already violates professional ethics.

Commenter: Mary Kidwell 4/12/19 12:33 pm

Licensed counselors

I am writing to urge that there be no ban or restrictions placed on licensed counselors assisting minors or adults who seek help overcoming unwanted same sex attraction or gender dysphoria. Any effort to prevent this type of help stems from religious bigotry or a desire of those in political power to impose their beliefs on others.

Commenter: E. R. Higgins 4/12/19 1:20 pm

Don't Prohibit Counseling Options - No Double Standard!

Counseling should help one to live with the truth. Prohibiting counselors for helping those who have unwanted same sex attraction denies help to those who want it. Licensed counselors have a responsibility to speak honestly with their minor clients about life's fundamental truths, and state policies should not compel them to repress those truths.

There is no way to change one's biological gender as our genes are programed at conception; to encourage others to think they can change their gender is deception. Our laws should help all to live in the truth and to cope with it when we are struggling.

Commenter: Dina 4/12/19 2:41 pm

Ban

I support the ban on conversion therapy!

Commenter: Anna Loftis, LSW 4/12/19 2:59 pm

Ban conversion therapy

This therapy is highly unethical. It leads to a higher rate of suicides among youth. The APA and the American Academy of Child and Adolecent Psychiatry both view it as unethical. Conversion/Reparative Therapy is based in the concept that homosexuality is wrong and needs to be "fixed", therefore the agenda is already determined, which does not respect the clients ability to direct their treatment. There is no evidence that it is effective. The originators of Reparative therapy use the concept that homosexuality is caused by poor attachment and nurturing from the same sex parent. But there is no evidence that single parent families, same sex couples, or military couples (where one parent is often absent), has any impact on the rate of homosexuality among thier children. So their theoretical foundation is false. This therapy is harmful. It is not our job as practitioners to determine if someones lifestyle is right or wrong, only to help them be their best selves.

Commenter: Concetta Fiorito 4/12/19 3:22 pm

Ban reparative therapy

It is important that you take these points into consideration:

- Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children.
- Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children.
- Some young people may be confused and need a trustful family environment to make a decision that can last a lifetime.
- ?Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions.
- A ban would deny families the religious freedom to seek counseling aligned with their faith.

Commenter: Ann Niermeyer 4/12/19 3:22 pm

Do not interfere with counselors

I support the points raised by both Josh Hetzler, Legislative Counsel for The Family Foundation of Virginia and Jeff Caruso, Virginia Catholic Conference. They are logical and persuasive. Counselors should be allowed to treat their patients without government interference.

Commenter: Deanne White 4/12/19 3:24 pm

Ban conversion therapy

Let's get it together folks. Homosexuality is not something you can "cure." Stop this nonsense, it is dangerous and ridiculous. Leave them alone and get on with your lives. Do we not have bigger issues on hand!?

Commenter: Anne Waite 4/12/19 3:25 pm

DON'T BAN VOLUNTARY CONVERSION THERAPY, PLEASE!

PLEASE DON'T BAN this kindly done, voluntary, very helpful counseling! It really helps!

Commenter: Therese Bermpohl 4/12/19 3:33 pm

Do not limit counseling options

Do limit counseling options. Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions.

Commenter: Dan Curtin 4/12/19 3:37 pm

Ban conversion therapy

Ban Conversion Therapy.

Commenter: Emily Macedonia 4/12/19 3:37 pm

Protect parental rights and religious freedom in counseling

Please do not ban conversion therapy! A ban would have an adverse impact on parental rights and religious freedom. Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children. Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children. Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions. A ban would deny families the religious freedom to seek counseling aligned with their faith. Thank you for considering my views on this important topic.

Commenter: Joanne W 4/12/19 3:38 pm

Don't ban counseling; don't do an end run around voters' wishes

Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children.

Commenter: Morgan Taylor 4/12/19 3:43 pm

Do not ban reparative therapy. Protect religious freedom.

Please do not ban reparative therapy. A ban would prevent persons who actually want help from getting it. Furthermore, a ban would be an infringement upon the first amendment right of religious freedom and on the right of parents to oversee their children's upbringing and to give them the care they think is best, and which the children themselves may want as well. Some children or even grown persons might want therapy, so denying it to them is not helping them or standing for their well-being. There is no reason to impose a ban; a ban would prevent persons who truly want assistance from getting it. Persons who do not want the therapy are not required to get it, so why make persons who do want it unable to have access to it?

Commenter: Craig Mays 4/12/19 3:48 pm

Protect parental rights and religious freedom in counseling

Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children.

Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children.

Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions.

A ban would deny families the religious freedom to seek counseling aligned with their faith.

Commenter: Juan Velasquez 4/12/19 3:50 pm

Therapy

Please do not ban conversion therapy! A ban would have an adverse impact on parental rights and religious freedom. Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children. Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children. Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions. A ban would deny families the religious freedom to seek counseling aligned with their faith. Thank you for considering my views on this important topic.

Commenter: Leo Titus Sr. 4/12/19 3:54 pm

Conversion Therapy

Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children!

Commenter: Dennis Huyck 4/12/19 4:01 pm

Reparative Therapy Regulation Destroys Parental Rights and Religious Freedom

Parents know their children best, and we should preserve parental rights to determine the type of therapy their child may need. The proposed regulation also destroys religious rights of people to provide therapies based upon their religious convictions. In addition, the Board is not a body elected by the people and has no right to override the General Assembly.

Commenter: NL 4/12/19 4:02 pm

conversion therapy - in favor of

So either parents, who know and love their children, should be in charge of making their medical/psychiatric/general weafare decisions, or we should hand that responsibility over to strangers who feel that they know better, and who disagree with the parents' choices? LBGT lobbies should not be in charge of the welfare of other people's children. That responsibility lies with the family of the child. Real science has been ignored or distorted in favor of supporting the current "popular" opinions.

Commenter: John Adams 4/12/19 4:12 pm

"Conversion" Therapy

There should be no ban on helping people overcome additions that they believe are harmful to them, including sexual behaviors and other sensitive issues. This is the USA and freedom is one of the most basic and most important rights that all Americans have, Let's keep it that way!

Commenter: Irene Maria DiSanto 4/12/19 4:21 pm

Protect Parental Rights from Government Overreach

Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children. Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children. Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions. A ban would deny families the religious freedom to seek counseling aligned with their faith.

Commenter: William Heipp, private citizen 4/12/19 4:25 pm

Conversion Therapy

This is another example of government sticking its nose where it does not belong. Do not diminish parental authority or responsibility in any way.

Commenter: Barbara H. Massey, private citizen 4/12/19 4:34 pm

Protect the freedom of Virginia families to acquire the counseling they choose.

- Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental,

emotional, and spiritual wellbeing of their children.

- Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children.

- Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions.

- A ban would deny families the religious freedom to seek counseling aligned with their faith.

Commenter: Pedro L Capestany Sr 4/12/19 4:35 pm

Conversion Therapy

It is inconceivable that reliefs rights are being attempted to be trampled via regulatory, or for that matter legislative maneuvers. Parents are closest to their children and know them best. Therefore, they have the right, as parents, to avail themselves of whatever means or services are available for the wellbeing of their children. Stop this unconstitutional work around by banning professionals from providing this therapy.

Commenter: Micah Cogen 4/12/19 4:39 pm

Conversation Therapy

If there is sufficient evidence that a practice or course of conduct causes substantial harm to another, then it is well within the bounds of permissible government action to prohibit the engaging in, or substantially assistance of others to engage in, the same. It is irrelevant that one's religious beliefs condone the conduct; once the government has sufficiently established the existence of substantial harm to another resulting from such conduct, the inquiry is over.

Commenter: Gary May 4/12/19 4:50 pm

Conversion Therapy

Banning conversion therapy is a violation of religious rights under the First Amendment of the Constitution. The Catechesim of the Catholic Church confirms its purpose of being presented as a full, complete exposition of Catholic doctrine, enabling everyone to know what the Church professes, celebrates, lives, and prays in her daily life. It stresses the importance of the *family* and provides concrete responsibilities of it's members. The Catechism states in paragragh 2204, "The Christian family constitutes a specific revelation and realization of ecclesial communion, and for this reason it can and should be called *a domestic church*."

The Catechism goes on to stress in paragragh, 2209 "The family must be helped and defended by appropriate social measures. Where families cannot fulfill their responsibilities, other social bodies have the duty of helping them and of supporting the institution of the family. Following the principle of subsidiarity, larger communities should take care not to usurp the family's prerogatives or interfere in its life."

Our Catholic Faith stresses in paragragh 2211, "The political community has a duty to honor the family, to assist it, and to ensure especially:

— the freedom to establish a family, have children, and bring them up in keeping with the family's own moral and religious convictions;

— the protection of the stability of the marriage bond and the institution of the family;

— the freedom to profess one's faith, to hand it on, and raise one's children in it, with the necessary means and institutions;

The Catholic Faith is very clear in the roles and responsibilities of parents with respect to their children. It states specifically in paragraghs:

2223, "Parents have the first responsibility for the education of their children. They bear witness to this responsibility first by creating a home where tenderness, forgiveness, respect, fidelity, and disinterested service are the rule."

2225 "Through the grace of the sacrament of marriage, parents receive the responsibility and privilege of evangelizing their children."

2228 "Parents' respect and affection are expressed by the care and attention they devote to bringing up their young children and providing for their physical and spiritual needs. As the children grow up, the same respect and devotion lead parents to educate them in the right use of their reason and freedom."

Banning conversion therapy denies parents of this vital treatment, rehabilitation, and institution upon which they may rely to train, treat, and raise children in the faith and fulfill their roles as instructed by their faith. In accordance with the doctrine of the Catholic Church, as instructed by our Catechism, I urge the Board of Counseling to reject 115-10.

Commenter: Fr. Stephen Vaccaro 4/12/19 4:52 pm

Do NOT Limit Counseling Options

Do limit counseling options. Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions.

Commenter: Julie Maimone 4/12/19 4:53 pm

Allow a voice, give people a choice

When parents and their children approach a counselor or therapist for help, they deserve to have that therapist free to work with them in any way they can. Banning "conversion" or "reparative" therapies simply leaves the therapist with his/her hands tied. We all know that no single method of therapy will work for every person. Not everyone will respond to treatments the same way. However, by removing a tool from the therapist's toolkit renders the patient and their parents potentially bereft of something that could have a benefit that might not be had with other treatments. Please leave this important decision making in the hands of the parents, their child, and their therapist.

Thank you for your consideration.

Commenter: Carolynn Nguyen 4/12/19 4:58 pm

Why ban specific therapy option?

A person seeking therapy has obviously acknowledged he/she needs help. Legislations specifically banning a certain point of view to be presented to the patient not only potentially harm the patient because comprehensive options have been suppressed, it may also be unconstitutional to suppress freedom of speech rights of the therapist. The patient has the right to make an INFORMED decision on what to belief, which is only possible if the therapist has the freedom the give the patient any information deemed necessary in the treatment.

Commenter: Thomas McCabe 4/12/19 5:00 pm

Reparative Therapy Should be Available to Parents and Others in the Commonwealth

I feel very strongly that Reparative Therapy is a choice that every parent and every citizen should have. Some of the most important reasons are:

- Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children.
- Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children.
- Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions.
- A ban would deny families the religious freedom to seek counseling aligned with their faith.

Furthermore, imposing this ban through the regulatory agencies of the state eliminates the important discussion of the issue, which needs to take place, by the General Assembly and effectively prevents the voices of Virginia citizens from being heard.

Commenter: Daniel Kirkland 4/12/19 5:00 pm

No Ban

Imposing this ban on reparative therapy is an attack on parental rights. Please do not undermine families' religious (or even non-religious) convictions by banning them from therapies that allow professionals to help children and families talk through what they see to be a problem. This flies in the face of the fundamental protection of parental authority and the exercise of religious beliefs.

The attempt to introduce this ban through regulations also undermines Virginia's system of governance. The General Assembly has chosen not to adopt this law in lieu of aforementioned concerns and it is very underhanded of this board to circumvent the legislative body appointed to speak on our behalf.

No to the ban, yes to the family.

Commenter: Pam Heminger 4/12/19 5:03 pm

Please do not limit parental options

I would ask that you not put in any regulations that would limit parental choice. Parents know their children best and know what is best for the child. And the children themselves would often desire to have the therapy that you are considering restricting. Why limit what kind of help a child can receive?

Please do not attempt to limit the scope of therapy that counselors are able to use with their patients. If the parents and child choose a counselor, they trust that counselor to help them according to their individual needs, and I do not see it as the place of this agency to regulate the therapy to be used.

Thank you for your consideration.

Commenter: David A Curcio 4/12/19 5:17 pm

Do not limit parental rights

Do not limit parents' ability to make decisions for their children. Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children. Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children.
Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions. A ban would deny families the religious freedom to seek counseling aligned with their faith.

Commenter: William Deady 4/12/19 5:24 pm

Don't take away the paren's fundamental rights guarranteed by Virginia Law

- Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children.
- Also, some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions.

Commenter: Aileen Uy 4/12/19 5:26 pm

Please do not ban

As a parent, it is my responsibility to care for and find solutions to my children's overall well being. When I was younger I needed counseling and was able to receive it. It definitely helped me through a difficult time in my life. I would want others to have that chance.

Commenter: Darcy McCabe 4/12/19 5:34 pm

Parents need all medical options for their children

I feel very strongly that Reparative Therapy is a choice that every parent and every citizen should have. Some of the most important reasons are:

Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children.
Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children.
Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions.
A ban would deny families the religious freedom to seek counseling aligned with their faith.

Furthermore, imposing this ban through the regulatory agencies of the state eliminates the important discussion of the issue, which needs to take place, by the General Assembly and effectively prevents the voices of Virginia citizens from being heard.

Commenter: Barbara Herath 4/12/19 5:49 pm

Counseling Guidelines

Please do not restrict the options for counseling nor threaten punishment to counselors who respond to clients cry for help with unwanted gender identity confusion or same sex attraction. Remember the body physically supports the biological birth sex with every cell having male OR female chromosomes (not both nor opposite of external sex obvious gender), and hormones supporting birth gender maintain the matching sex characteristics. When environment interferes (such as sexual abuse, overbearing mother or father, weak role model, illness disrupting hormones, curiosity after hearing about gender change, etc.) then gender confusion can disrupt normal feelings and behavior. There are hundreds of people who have been released from gender confusion and are so thankful for the counseling that freed them. Please don't restrict counseling to provide this gift.

Commenter: Patricia McGrath 4/12/19 6:10 pm

Conversion Therapy

Banning Conversion Therapy is a very bad idea. Some things such as this belongs in the hands of parents and those professionals parents choose for their children to see OR left to an individual who can choose for themselves. This not something to vote on and force people to live with a vote!

Commenter: A Wilkinson 4/12/19 6:20 pm

protect the freedom of Virginia families to acquire the counseling they choose.

Please protect the freedom of Virginia families to acquire the counseling they choose...

- Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental,

emotional, and spiritual wellbeing of their children.

- Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children.
- Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions.
- A ban would deny families the religious freedom to seek counseling aligned with their faith.

Commenter: Redmond Merrell 4/12/19 6:21 pm

Protect the freedom of Virginia families to acquire the counseling they choose

Protect the freedom of Virginia families to acquire the counseling they choose

Commenter: Stephanie Seely 4/12/19 6:38 pm

wrongheaded ban on reparative therapy

Boards who govern licensing requirements for counseling professionals should not "regulate away" the rights of families to act in accord with their conscience or their religion. This ban on reparative counseling constitutes infringement on religious freedom.

- Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children.
- Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children.
- Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions.
- A ban would deny families the religious freedom to seek counseling aligned with their faith.

Commenter: Mary Cannarella 4/12/19 6:47 pm

We oppose a ban on Reparative Therapy

Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children.

- Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children.

- Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions.

- A ban would deny families the religious freedom to seek counseling aligned with their faith.

Commenter: Cynthia Cook 4/12/19 7:06 pm

Counseling's

A ban would families the deny religious freedom to seek gounceling aligned with their faith.

Commenter: Pam Bishop 4/12/19 7:13 pm

Freedom of counseling

Parents and the counselors they trust enough to hire have the right to address these issues.

Commenter: Marianne Schoener 4/12/19 7:27 pm

Protect Fundamental Parental Right to Make Decisions Regarding Upbringing & Education of Their Child

Please protect the freedom of Virginia families to acquire the counseling they choose.

- Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children.

- Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children.

- Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions.

- A ban would deny families the religious freedom to seek counseling aligned with their faith.

Commenter: Patrice Chadbourne 4/12/19 7:44 pm

No Ban

There is no need to ban parents from accessing the counseling they feel necessary to help their child navigate the complicated issue of gender identity. What are the proponents of the ban afraid of? This is very narrow minded, and sounds like the state is deciding what beliefs its citizens should have. Very dangerous path to follow.

Commenter: JEANNE VAN GEMERT, LPC 4/12/19 7:51 pm

Ban Conversion Therapy

I am in aggreement with the American Academy of Child and Adolescent Psychiatry, which finds that conversion therapies "lack scientific credibility and clinical utility" and could "increase [the] risk of causing or exacerbating mental health condition in the very youth they purport to treat.

I have encountered a number of adults for whom conversion therapy provided lasting damage.

Commenter: Laurea DiJoseph, retired from Georgetown U 4/12/19 7:51 pm

Guidance on Reparative Therapy

My niece had transgender surgery all paid for by the state in Az. She is a mess. Good therapy would have helped her psychological not physical problems. So very sad that young lives are ruined. Confusion is promoted not help. Thank you for doing the right thing for people.

Commenter: Zac White 4/12/19 7:58 pm

No ban

A ban would deny families the religious freedom to seek counseling aligned with their faith.

Commenter: Helen Dickey 4/12/19 8:18 pm

No ban, yes freedom

A ban would deny people and families the freedom to seek the counseling they choose. A ban is too politically totalitarian for USA. It would unfairly force political propaganda and ideologies and this is contrary to what mainstream citizens agree with and have held since USA began.

Commenter: JEREMY PETER GREINER 4/12/19 8:23 pm

Do not ban reparative or "conversion" therapy to children

I do not think it is appropriate to ban reparative or "conversion" therapy to children just as I think it would be inapproprate to force parents to use it on their children. It really shouild be up to the parents. The therapy is talk therapy to help children figure out their feelings and also to educate them.

While I could end my comments there I will say that when I was a child, I wanted to grow up to be a dog. I even asked to be called the same name as a family friend's dog. I really thought I could grow up to be a dog. I never went to therapy, but you can guess it was not too long before I

realized I could not grow up to be a dog. Now while a male child may grow up to be attracted to another male, or may want to be a female. It is probally best to give it some time and reparative or "conversion" therapy to children can be a tool used to help the child figure out what his/her true feelings are be that because he/she agrees with the therapy or rejects it.

If the therapy is rejected, I understand the time delay may mean a more costly and painful "transition" but overall that might be better than having many people transitioning young only to outgrow those feelings. I know I am glad I never transitioned to a dog ;-)

Commenter: Leanne S. 4/12/19 8:37 pm

Protect parental rights and religious freedom in counseling

This ban would deny families the religious freedom to seek counseling aligned with their faith. This is very important to me!ype over this text and enter your comments here. You are limited to approximately 3000 words.

Commenter: M. Switzer 4/12/19 8:47 pm

No Ban

It is contrary to American values and ideals to not allow conversion therapy should someone desire it. The government has no right to tell us how to think.

Commenter: Dawn Beutner 4/12/19 9:00 pm

Do not ban reparative therapy

- Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children.
- Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children.
- Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions.
- A ban would deny families the religious freedom to seek counseling aligned with their faith.

Commenter: Chris Bowers 4/12/19 9:05 pm

Don't limit therapy choices

Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children. And some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In

either instance, there should be options for families to make informed decisions. A ban would deny families the freedom to seek counseling aligned with their faith and conscience, giving them only limited choices. Trust patients and their families with choices of therapy. Thank you.

Commenter: D Blomberg 4/12/19 9:10 pm

Parental Rights - 1st Amendment - Religious Freedom: DO NOT BAN OUR FREEDOM!!!

In NO WAY should there be a ban placed on the choice of therapy. This is AMERICA - this is a choice that should NEVER be "regulated".

over this text and enter your comments here. You are limited to approximately 3000 words.

Commenter: Jeffrey Datt 4/12/19 9:13 pm

Be Kind and Merciful

I would ask that you not put in any regulations that would limit parental choice. Parents know their children best and know what is best for the child. And the children themselves would often desire to have the therapy that you are considering restricting. Why limit what kind of help a child can receive?

Please do not attempt to limit the scope of therapy that counselors are able to use with their patients. If the parents and child choose a counselor, they trust that counselor to help them according to their individual needs, and I do not see it as the place of this agency to regulate the therapy to be used.

Thank you for your consideration.

Commenter: Loren Wilee 4/12/19 9:23 pm

Parental rights must be preserved.

Commenter: Elizabeth verbano 4/12/19 9:36 pm

Parental rights

Honor parental rights.

Commenter: Mary Ziegenfuss, M. S. Ed. 4/12/19 10:04 pm

No ban on therapy options for family life options

At this time in history, many professional therapy options exist for persons with various needs and challenges. The government and self-styled thought-leaders should not interfere with the services

that can expand a person's understanding and decision-making options. Do not limit our young people and their families!

Commenter: Elaine Landry, OLN parish, Roanoke, VA 4/12/19 10:37 pm

A child needs the parents' guidance.

A child needs the parents' guidance -- at least through the age of 16. Do not let a handful of politicians decide what is best for our children. Peace, Elaine Landry

Commenter: Sally 4/12/19 10:49 pm

Reparative Therapy; no ban

No to banning any counseling or therapy, for anyone. Children are the responsibility of their parents/guardians. Being able to care for their physical, mental, emotional and spirtual wellbeing, as they see best, is paramount. No state should punish a licensed counselor from providing care nor should any legislation remove an option for talk therapy, for an adolescent. Let us remember that an adolescent's rational part of the brain is not fully developed.

Commenter: Will Addison 4/12/19 10:54 pm

Please no ban. You will destroy the best chance some people have for happiness.

Commenter: Elizabeth Matthews 4/12/19 11:25 pm

Conversion therapy must be banned

As a parent of several LGBTQ+ kids, I support a ban on conversion therapy. Being LGBTQ+ is not a defect that needs fixing; people are born LGBTQ+, it's not something you can stamp out of them, and in fact trying to do so has been shown to be extremely harmful to their mental health. Conversion therapy is a form of abuse and should not be allowed to be peretrated on minor children.

Commenter: Marvin Weniger 4/12/19 11:34 pm

Ban on counseling of children

Any type of ban on the proper counseling of childrfen by parents, teachers, religious leaders, or professional counselors would be a serious viiolation of the fundamental rights of parents to rear their children. The proposed ban would be an unacceptable effort by the state to take over the education and training of children, which is the exclusive and fu ndamental right of parents.

Commenter: Barbara Firich 4/13/19 2:17 am

No ban

Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children.

Commenter: David C. Ptak 4/13/19 4:25 am

Don't Ban Patient Options

Don't restrict counseling options of professionals or most importantly parents, there should be no ban on any therapy that might be useful in helping patients. Parents know their children best and should be afforded the opportunity to engage in whatever therapy they or their child feels might be most beneficial.

Commenter: Elizabeth Moak 4/13/19 5:37 am

Do not ban this option

Thls type of therapy should stay an option for people to choose. It can help someone looking for a way to be more chaste and loyal in any relationship. All forms of therapy can be misused, but the examples cited do merit a full ban.

Commenter: Kathy Roper 4/13/19 7:20 am

The state has no right to interfere...Conversion Therapy

Therapy is between a patient and the doctor. The state has no right to intervene. Conversation Therapy has helped many people . " Gender options " is trending, just as anorexia did a few years back. These trends come and go. The government should not interfere.

Commenter: Emily 4/13/19 7:35 am

This is something that I think parents should have as an option for their children.

Commenter: Farrah Briest 4/13/19 7:52 am

Conversion Therapy, a Suicide Risk

Conversion therapy encourages an internal conflict that is a precursor to scuicidal behavior. It is especially dangerous during the vulnerable time of childhood, adolescence, and young adulthood.

As someone whose adolescent and early adulthood religious faith saw homosexuality as an abomination, I witnessed the danger of conversion attempts. I participated in many, what I saw as loving, attitudes and behaviors that encouraged conversion therapy, but changed my attitudes as I watched a friend struggle to match the heterosexual norms our community and her family strongly encouraged and required of her for acceptance. I was finally changed when she was near scuicide.

Thankfully she was an adult by this time and did not have to continue conversion therapy. She is now a flourishing member of her community, and no longer dealing with the dangers internal conflict that occurs with conversion therapy. I am frightened and disturbed thinking of the scuicide risk that comes with minors being forced to undergo conversion therapy. It's a practice that needs to end. We are posing a grave risk to people's lives and health. A ban is necessary for the health of our people and communities.

Commenter: Beth Martini 4/13/19 9:02 am

Parents should have the right to choose

Parents should have the right to choose the counseling and make decisions for their children

- Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children.
- Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children.
- Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions.
- A ban would deny families the religious freedom to seek counseling aligned with their faith.

Commenter: Mike O'Neill 4/13/19 9:19 am

No ban on raising Godly children

This is just another attempt of a regulatory or governmental agency to erode the rights of parents in properly providing for and raising their children, especially with regard to matters of faith and morals. No to any type of ban that prevents parents from doing their jobs and infringes upon our rights to exercise the freedoms given to in us in our Constitution.

Commenter: larry zenker 4/13/19 9:36 am

counseling regulations

The family should be the sole determinant of what counseling is best for their family. It is not a function of the government..

Commenter: Julia Hecton 4/13/19 9:50 am

Do not ban conversion therapy. People, young people need choices. Their rights are to be protected.

Commenter: Thomas & Lola Landvogt 4/13/19 10:02 am

GENDER IDENTIFY

It's cruel and oppressive to prevent individuals from receiving the pschological therapy they desire; or, in the case of children, the care that the child's parents desire the child to receive..

Commenter: Mark C. Brandt 4/13/19 10:07 am

No ban!

Commenter: Ann L. Petrie, Ph.D. 4/13/19 10:29 am

Freedom of cghoice for Clients

Respect for the diversity of clients' beliefs and faith are are longstanding ethical linchpins of the therapeutic relationship. The Board's activist attempts to eliminate parents' or clients' choices of treatment compatible with parents' religious beliefs is in fact a viuolation of therapeutic neutrality and professional ethics.

Commenter: John H. Sturniolo 4/13/19 10:39 am

No ban on reparative therapy

Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children. Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children.

Children are not pawns of the state.

Commenter: Richard M. Durand Jr. 4/13/19 10:48 am

No ban on reparative therapy

Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children. Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children. Children are not pawns of the state.

Commenter: Hugh E. McGuire, Jr. 4/13/19 11:01 am

Don't mess with my rights !!!

Don't mess with my rights, period. !!!

Commenter: Rita Wasilewski 4/13/19 11:16 am

"Conversion Therapy" undefined. Ban violates ACA Code of Ethics

"Conversion Therapy" has never been properly defined. Under this vague term, many good counseling practices could be considered "conversion therapy".

The proposed ban is a violation of the ACA Code of Ethics. Secion A.1.c "Counselors and their clients work jointly in devising counseling plans". Counseling plans are personal and are not to be determined by the government or by social or political agenda.

Commenter: Laura O'Neill 4/13/19 11:24 am

persons ARE NOT their attractions, do not limit counselor speech

Imposing one's worldview on a client is unethical. If you limit what a counselor can talk about with a client, that imposes the state's view onto the client. Leave the counseling room alone, leave the client FREE to pursue his or her own goals. If this ban is passed, out of a misguided attempt to protect people, what is a counselor to do if a client has unwanted same-sex attraction? The client is not allowed to talk about it? That is absurd. Conflating the human person with his or her attractions is unethical.

Commenter: Warren Corson 4/13/19 12:31 pm

Our Rights Are Being Eroded Slowly But Surely

T

- Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children.
- Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children.
- Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions.

- A ban would deny families the religious freedom to seek counseling aligned with their faith.

Commenter: DJ Potter 4/13/19 12:44 pm

Counseling

The board has a responsibility to ensure that counsellors are not denied to young people working through difficult periods, whether their need is to accept and live with their deep religious beliefs or their same-sex attraction. People with these needs require real help, not agenda driven laws or regulations that strip them of the needed counselling and therapy.

Commenter: Marilyn ODonnell 4/13/19 1:02 pm

Protect parental rights and religious freedom. No ban

Commenter: Richard L. Corrigan, Private Citizen 4/13/19 1:13 pm

Oppose Banning Reparative Therapy

Dear Sir/Madame:

I strongly oppose any attempts to administratively ban use of Reparitive Therapy in the Coimmonwealth. This underhanded tactic is an attempt by unrepresentative "special interest advocacy groups" to accomplish administratively what the Commonwealth's Legislature has wisely rejected a number of times.

It is more than ironic and hypocritical that those who loudly advocate "choice" regarding other controversial public policy issues, would take the "choice" of employing Repartive Therapy away from parents and others who may wish to employ this it.

I respectfully urge that all Administrative Bodies in the Commonwealth reject and efforts to administratively limit or ban the use of Reparative Therapy.

Sincerely yours,

Richard L. Corrigan
3150 Ariana Drive
Oakton, VA 22124

Commenter: Emily King 4/13/19 1:38 pm

Conversion therapy is harmful and should be banned

Conversion therapy and any derivative are very harmful in that it pathologizes normal identity. The harm done to individuals may last a lifetime.

Commenter: Anne Kelly 4/13/19 2:40 pm

Conversion therapy

Parents have the exclusive right to care for and make decisions for their children. The state has NO RIGHT to usurp this right by denying the parent to choose conversion therapy for their child, if they desire to do so. STOP TRAMPLING ON OUR RIGHTS,

Commenter: Amie Manis, PhD, LPC 4/13/19 2:56 pm

Support Ban - Evidence Show Conversion Therapy is Dangerous

I support the proposed ban on conversion therapy, which is really a misnomer. The position of the American Counseling Association is that this is an unethical and harmful practice, and the dangers of this type of aprpoach have been documented. In fact, the evidence supports gay affirmative approaches to counseling and therapy.

I hope that Virginia will stand against this practice as a measure of protecting the public and recognizing what all the major counseling, medical, and psychological associations have decades ago - and that is that sexual orientation is not a disease. Thus the concept of therapy to correct it is illogical, and furthermore denigrating to any and all who do not fit heternormative norms. Please prevent this practice which places our youth, especially, at significant risk of mental health disorders and, at worst, suicide.

Dr. Manis

Commenter: Roger, Mary & Jonathan Ritter 4/13/19 3:01 pm

Proposed Ban on Conversion Therapy

We respectfully oppose the proposed ban on conversion therapy. Adolescents who are sexually confused (and their parents) have the right to seek help from faith-based counselors who can listen to them with sympathy and assure them that such confusion is natural. Also, the proposed ban could prevent any faith-based counseling, which would be a violation of the First Amendment. Finally, such a far-reaching step should only be taken after full consideration by the legislature, not by an administrative agency.

Commenter: D. Rice 4/13/19 3:26 pm

Proposed Ban on Reparative Therapy

I oppose the proposed ban on conversion therapy. Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children. Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children. In addition, some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions. A ban would deny families the religious freedom to seek counseling aligned with their faith.

Commenter: Deacon Tom Grodek 4/13/19 5:03 pm

Please - NO Ban on Reparative Therapy

Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual

wellbeing of their children.

Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children.

Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions.

A ban would deny families the religious freedom to seek counseling aligned with their faith.

Commenter: Sue Huber 4/13/19 5:17 pm

No ban on licensed professionals providing reparative therapy to children

I am strongly opposed to any attempt to ban licensed professionals from providing reparative therapy to children because:

- Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children.
- Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children.
- Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions.
- A ban would deny families the religious freedom to seek counseling aligned with their faith.

Commenter: Camila 4/13/19 5:26 pm

Ban Conversion Therapy

Conversion therapy is harmful and has no place in modern society .

Commenter: Dawn Murray, MEd, MAEd 4/13/19 7:42 pm

The Evidence is Clear - "Conversion Therapy" is Dangerous. Please Ban!

My professional journey has included time in both schools and mental health organizations, and I've been proud to affiliate with both the American Counseling Association and the National Education Association. Those organizations, along with many others -- including every major professional organization representing mental health professions -- have spoken out repeatedly about the dangers of conversion therapy, especially as it pertains to LGBTQ youth. Conversion therapy is **in conflict with medical and scientific research,** and instead of healing vulnerable patients/clients, it **often leads to deeper despair and depression,** even up to the point of suicidal ideation and attempts. Our responsibility as mental heath professionals, as educators, as

Christians (for those who so identify, as I do), and as human beings is to **protect the vulnerable among us** from this dangerous practice.

Commenter: Jane Peworchik 4/13/19 7:47 pm

Do not ban raparative therapy

TAmericans for years have sacrificed their lives to preserve the rights of all citizens of this country. Since the people elected you to the Virginia Assembly PLEASE TRY TO REMEMBER what this country was founded on and why the citizens make sacrifices to preserve the U.S. Constitution.

- Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children.
- Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children.
- Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions.
- A ban would deny families the religious freedom to seek counseling aligned with their faith.

ype over this text and enter your comments here. You are limited to approximately 3000 words.

Commenter: National Task Force for Therapy Equality 4/13/19 8:00 pm

Keep Therapy Equality in Virginia, Freedom of Choice in Counseling

Virginia Board of Counseling:

Our organization of mental health professionals urges you to oppose any regulation that would ban so-called "conversion therapy" for minors. Many states have rejected these bans.

- Everyone has the freedom and the right to resolve unwanted feelings, love who they want, and embrace their body sex.
- Sexual orientation and gender identity are not biologically determined like skin color,1 and psychological and family factors are causes.2 Transgender identity may be pathological.3- American Psychological Association, APA Handbook of Sexuality and Psychology.4 which the APA has approved (given its "imprimatur") and declared "authoritative."5
- This regulation may put gender dysphoric children onto a path of experimental puberty blockers and toxic sex-change hormones, that often sterilize them for life, having their breasts chopped off, and potentially castration, all before they are old enough to drive, yet forbids them talk therapy to help them embrace their body.
- As many as 98% of boys and 88% of girls6 and no less than 75% of boys and girls7 come to identify with their innate body sex if supported through natural puberty

and not socially transitioned.8 - American Psychiatric Association, Diagnostic and Statistical Manual, Fifth Edition- American Psychological Association, APA Handbook of Sexuality and Psychology

- A rigorous study of 16-year-old boys who identified as exclusively same-sex attracted found that one year later, only 11% still did.9 90% of the exclusively and strongly same-sex attracted boys experienced father absence or loss.10 Absence of a parent, especially the parent of the same sex as the child, can lead to same-sex attraction, behavior, and orientation identity. - Several Studies That Meet Rigorous Scientific Standards11

- Childhood sexual abuse may potentially lead to having a same-sex partner for some. - American Psychological Association, APA Handbook of Sexuality and Psychology.12

- The full acceptance of transgender identity approach "runs the risk of neglecting individual problems the child might be experiencing...."13 - American Psychological Association, APA Handbook of Sexuality and Psychology

- Talk therapy treats individual problems that may be causing gender distress or same-sex attraction for some. A therapy ban takes away a child's right to that talk therapy.

- Even the Southern Poverty Law Center affirms "conversion therapy" uses only non aversive methods.14 Stories of "therapy torture" and "aversion therapy" have been documented to be fraudulent in a report sent to the Federal Trade Commission.15

- More than 100 years of research have found the therapy is safe and effective.16 A new five- year study of adult male clients who have unwanted same-sex attraction feelings is currently underway and meets APA standards. Results in the first year found distress decreased, sense of wellbeing increased, heterosexual thoughts and feelings increased, and homosexual thoughts and feelings decreased.17

- Leading suicide researchers found that, world-wide, 90% of people who commit suicide had mental disorders. The researchers' number one prevention recommendation is to let them have psychotherapy.18

- The following organizations support therapy that helps minors who have unwanted sexual attraction or gender identity feelings to go on their journey and become able to love who they want and love their body: Association of American Physicians and Surgeons, American College of Pediatricians, American Association of Christian Counselors, Christian Medical and Dental Association, Catholic Medical Association, and Alliance for Therapeutic Choice and Scientific Integrity. **Collectively, these organizations comprise over 100,000 licensed mental and medical health practitioners who value the right of self-determination for clients and their families.**

- Sincerely,
  National Task Force for Therapy Equality (TherapyEquality.org)

Endnotes

1 Diamond, L. & Rosky, C. (2016). Scrutinizing immutability: Research on sexual orientation and U.S. Legal Advocacy for Sexual Minorities."[A]dvocates for sexual minorities have...[argued] that sexual orientation is a fixed, biologically based trait that cannot be chosen or changed," but, "We hope that our review of scientific findings and legal rulings regarding immutability will deal these arguments a final and fatal blow."

The authors are two highly regarded LGBT civil rights activists—psychology professor Lisa Diamond, who is a co-editor-in-chief of the APA Handbook of Sexuality and Psychology, and law professor Clifford Rosky, who won the Equality award from the Human Rights Campaign.
2 The APA Handbook of Sexuality and Psychology states clearly, "Biological explanations...do not entirely explain sexual orientation," and psychological factors are causes of sexual orientation. Rosario & Schrimshaw, 2014, in APA Handbook, v. 1, p. 583.

3 Bockting, W. (2014). Chapter 24: Transgender Identity Development. In APA Handbook of Sexuality and Psychology,1:743.
4 Tolman, Deborah L. (Ed); Diamond, Lisa M. (Ed); Bauermeister, José A. (Ed); George, William H. (Ed); Pfaus, James G. (Ed);

Ward, L. Monique (Ed). (2014). APA Handbook of Sexuality and Psychology, Vol. 1: Person-based approaches. Washington, DC, US: American Psychological Association. xxviii 804 pp., http://dx.doi.org/10.1037/14193-000
5 Series Preface, in APA Handbook of Sexuality and Psychology, 1:xvi.
6 Calculated from American Psychiatric Association (2013) Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), p. 544. Arlington, VA: American Psychiatric Association, p 455.

7 Calculated from Bockting, in APA Handbook, 1:744.8 Bockting, 2014, in APA Handbook, 1: 744.

9 Udry, J.R., & Chantala, K. (2005). Risk factors differ according to same-sex and opposite-sex interest. Journal of Biosocial Science, 37, 481
–497. http://dx.doi.org/10.1017/S0021932004006765, p. 486; also reported in Savin-Williams, R. (2006) Who's Gay? Does it matter? Current Directions in Psychological Science, 15: p. 40)
10 Udry and Chantala found that 90% of boys who had strong same-sex interest had absent fathers—a very strong relationship. Among boys, the greater the degree of same-sex attraction, the greater the likelihood of father absence, delinquency, and suicidal thoughts. As opposite sex interest also rose to the highest level, that strong relationship completely disappeared (Udry & Chantala, 2005, p. 487).

11 Udry, J.R., & Chantala, K. (2005). Risk factors differ according to same-sex and opposite-sex interest. Journal of Biosocial Science, 37, 481
–497. http://dx.doi.org/10.1017/S0021932004006765. See also Frisch, M. and Hviid, A. (2006), Childhood family correlates of heterosexual and homosexual marriages: A national cohort study of two million Danes, Archives of Sexual Behavior, 35:533-547; Frisch, M. & Hviid, A. (2007). Reply to Blanchard's (2007) "older-sibling and younger-sibling sex ratios in Frisch and Hviid's (2006) national cohort study of two million Danes," Archives of Sexual Behavior, 36:864-867. Francis, A. M.(2008), Family and sexual orientation: The family-demographic correlates of homosexuality in men and women. Journal of Sex Research, 45(4):371-377, DOI:10.1080/00224490802398357; D.M. Fergusson, L.J. Norwood, & A.L. Beautrais, (1999), Is sexual orientation related to mental health problems and suicidality in young people? Archives of General Psychiatry, 56:876-880, esp. p. 879.

12 Mustaky, B., Kuper, L., and Geene, G. (2014) Chapter 19: Development of sexual orientation and identity. In APA Handbook of Sexuality and Psychology, pp. 609-610. The authors say, "One of the most methodologically rigorous studies in this area....found that men with documented histories of childhood sexual abuse had 6.75 times greater odds...of reporting ever having same-sex sexual partners....The effect in women was smaller...and a statistical trend..." They acknowledged there are "associative or

potentially causal links" between childhood sexual abuse and ever having a same-sex partner.

Wilson, H. & Widom, C. (2010). Does physical abuse, sexual abuse, or neglect in childhood increase the likelihood of same-sex sexual relationships and cohabitation? A prospective 30-year follow-up. Archives of Sexual Behavior, 39, 63–74. doi:10.1007/s10508-008-9449-3.
13 Bockting, 2014, in APA Handbook, 1:750.

14 National Task Force for Therapy Equality, Report To the Federal Trade Commission: In Their Own Words—Lies, Deception, and Fraud, May 1, 2017. http://www.therapyequality.org/national-task-force-therapy-equality-complaint-ftc-report?LTWA, pp. 16-17.
15 National Task Force for Therapy Equality, Report To the Federal Trade Commission: In Their Own Words—Lies, Deception, and Fraud, May 1, 2017. http://www.therapyequality.org/national-task-force-therapy-equality-complaint-ftc-report?LTWA

16 Phelan, J., Whitehead, N., & Sutton, P.M. (2009). What research shows: NARTH's response to the APA claims on homosexuality: A report of the scientific advisory committee of the National Association for Research and Therapy of Homosexuality. Journal of Human Sexuality, 1: 1-121. Available at www.narth.com at the online bookstore,https://media.wix.com/ugd/ec16e9_04d4fd5fb7e044289cc8e47dbaf13632.pdf

17 Pela, C. & Nicolosi, J. (March 10, 2016) Clinical outcomes for same-sex attraction distress: Well-being and change, Conference of the Christian Association for Psychological Studies (CAPS), Pasadena, CA. http://www.josephnicolosi.com/collection/outcome- research. Study is designed to meet standards of an APA 2009 task force.
18 Cavanagh, J., Carson, A., Sharpe, M. & Lawrie, S. (2003) Psychological autopsy studies of suicide: a systematic review.Psychological Medicine, 33: 395-405.

Commenter: Christopher Doyle, Institute for Healthy Families 4/13/19 8:33 pm

Regulating Therapy for Unwanted Same-Sex Attractions and Gender Identity Conflicts Discriminates

Virginia Board of Counseling:

I am writing in opposition to the proposed regulation of "conversion therapy" in Virginia. As a licensed professional counselor in Virginia and a leading practitioner of sexual/gender identity affirming therapy, this legislation will have an adverse impact on the clients my organization serves.

Clients, including minors, that seek therapeutic interventions to reduce unwanted same-sex attractioins/gender identity conflicts and/or explore sexual or gender fluidity in therapy often do not identify themselves as lesbian, gay, bisexual, or transgender (LGBT). In my professional experience, I have worked with a number of families and minors in Virginia seeking counseling to help with sexual and gender identity confusion. In many cases, these attractions and gender identity expressions are the result of early childhood trauma. Banning therapeutic interventions for these youth that do not accept or embrace an LGBT identity and seek to work on underlying causes of their unwanted attractions and/or identity is discriminatory. In the case of sexual abuse or other traumas, this regulation essentially victimizes a minor twice: First by the perpetrator, and second by the Commonwealth!

Licensed professional counselors in Virginia are bound by an ethics code to "Do No Harm"...this regulation would tie our hands to be able to help the clients described above, and may actually produce harm by not allowing counselors to offer the full range of services available. It may also force families to seek unlicensed, pseudo-professionals not adequately trained in mental health best practices. This would produce the reverse effect of this regulation: Putting vulnerable youth at risk with pseudo-professioinals not regulated by the Commonwealth! This is a very unwise and politically motivated regulation with potential severe consequences!

Additioinally, the organizations the Board cites that oppose so-called "conversion therapy" have not relied on scientific evidence for their claims. Had they done so, they would have admitted there are no (zero) outcome-based studies on minors undergoing so-called "conversion therapy" or sexual orientation change effort therapy. On the contrary, the following professional mental and medical health organizations support a client's right to pursue therapy for unwanted same-sex attractions/gender identity conflicts:

Association of American Physicians and Surgeons, American College of Pediatricians, American Association of Christian Counselors, Christian Medical and Dental Association, Catholic Medical Association, and Alliance for Therapeutic Choice and Scientific Integrity. Collectively, these organizations comprise over 100,000 licensed mental and medical health practitioners who value the right of self-determination for clients and their families.

Please do not discriminate against youth seeking to resolve sexual and gender confusion. Support the client's right to choose and a therapist's judgement to offer the clinical services most apporpriate for each client and family.

Respectfully yours,

Christopher Doyle, LPC

Manassas, Virginia

Commenter: C. Randolph Hyhde 4/13/19 8:44 pm

Do not ban any choice

A ban would deny families the religious freedom to seek counseling aligned with their faith. Not everyone will agree with the choice I make. But, I think the choice I make are correct and that is what matters to me.

Commenter: Virginia Counselors Association 4/13/19 9:06 pm

Ban Conversion Therapy

To the Virginia Board of Counseling:

First, thank you for the opportunity for us and other fellow counselors to express their perspectives on such an important issue. As the current President of the Virginia Counselors Association (VCA), I have the privilege of representing our organization through this statement and we, alongside the American Counseling Association (ACA), strongly urge you to oppose any regulations that would support conversion therapy, also sometimes referred to as repairative therapy. In 2018, under the guidance of then President, Dr. Gerard Lawson, ACA provided testimony before the House of Delegates to prohibt the use of converstion therapy on minors within Virginia. (Link provided below).

Additionally, the American Psychiatric Association (APA), the organization that also developed our primary Diagnostic Statistical Manual, made official statements in 1998, 2013, and 2018 in opposition to “any psychiatric treatment, such as “reparative” or “conversion” therapy, that is based on the assumption that homosexuality per se is a mental disorder or is based on the a priori

assumption that the patient should change his or her homosexual orientation." (Link provided below).

The American Psychological Association (APA), the American Psychiatric Association (APA) , and the American Counseling Association (APA) all conclude there is insufficient evidence in the effectiveness of conversion therapy and related methods. In fact, there is empirical research of conversion therapy and related methods having harmful and distressing consequences to clients. VCA stands against the use of these practice across the lifespan, and especially so for those clients who are 18 years old and younger.

According to the ACA Code of Ethics, our guiding ethical code, the practice of conversion therapy directly violates one of our overarching goals as counselors: to do no harm. Should conversion therapy remain a practice, counselors would be practicing unsubstantiated intervention(s) based on the false belief that same sex attractions are a mental health disorder in need of curing. VCA as well as the other representing organizations of psychologists, psychiatrists, and counselors no this not to be true.

Thank you for your consideration of these facts. We hope you reach out to us at the VCA should you need any more information or resources in banning conversion therapy as well as any recommendations for ethical, affirming, and culturally responsive counseling practices.

Respectfully submitted,

Monica P. Band, Ed.D., CRC, NCC
Virginia Counselors Association

President 2018-2019

APA Statement in Opposition of Converstion Therapy: https://www.psychiatry.org/newsroom/news-releases/apa-reiterates-strong-opposition-to-conversion-therapy

ACA Code of Ethics: https://www.counseling.org/resources/aca-code-of-ethics.pdf

Ethical Issues Related to Converstion Therapy or Reparative Therapy by the ACA Ethics Committee: https://www.counseling.org/news/updates/by-year/2013/2013/01/16/ethical-issues-related-to-conversion-or-reparative-therapy

ACA, 2018, Dr. Gerard Lawson's testimony: https://www.counseling.org/docs/default-source/government-affairs/testimony-of-gerard-lawson-final.pdf?sfvrsn=fbd7532c_2

Commenter: Bibiana Quiambao 4/13/19 10:06 pm

Conversion Therapy

Parents are the primary educators of their children. They have the fundamental and moral right to guide their children regarding their general well-being. Conversion Therapy also intrudes on privacy and religious freedom. Please ban Conversion Therapy for the good of our families and children.

4/13/19 10:45 pm

Commenter: Ed McCoy

Reparative therapies are client choices

Basic tenants of social work include that a client and their counselor choose what they discuss. To chose and select certain therapies that you disagree with and ban them is censorship-a suppression of speech, idealogies and counseling methods with which one disagrees. Further, this issue should be resolved at the voting booth rather than the counseling board. For example, I disagree with hypnosis, but would not prevent a client or their therapist from their choices for that therapy.

Commenter: Nathaniel Preston 4/14/19 8:33 am

Ban conversion therapy at least for children

Conversion therapy has been wildly debunked and proven to be dangerous to children. If adults seek out this therapy, then they've made a choice but parents are damaging their children when they force them to endure this torture

Commenter: Thomas Palumbo 4/14/19 8:49 am

Do not ban reparative therapy

I urge you not to ban reparative therapy: (a). Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children; (b) Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children; (c) Some young people may have attractions they desire to change or moderate;others may simply desire counseling to live a chaste life -- In either instance, there should be options for families to make informed decisions; (d) A ban would deny families the religious freedom to seek counseling aligned with their faith.

Commenter: Carole Gibson 4/14/19 8:55 am

Conversion Therapy Ban

Ban conversion therapy. Do not traumatize individuals for who they are.ver this text and enter your comments here. You are limited to approximately 3000 words.

Commenter: Waseem Amin 4/14/19 10:42 am

Conversion therapy needs to be banned

Conversion therapy needs to be banned as a measure of public safety. While the argument that individuals should have "choice of therapy" is understandable at first glance, this argument fails to acknowledge the great psychological damage done by reparative therapy. The American Psychological Association has already established that this practice is not scientifically valid, is ineffective at achieving its claimed goal, and is harmful to the individual undergoing it. Even preliminary searches on this topic will produce volumes of scholarly literature explaining the extreme detriment conversion therapy can cause, illustrating results as horrific as suicides

completed by those who were subjected to it. Worse still, mental health professionals engaging in this practice often fail to disclose to clients the ineffectiveness of conversion therapy and the damage it does to mental health, leaving clients to agree to this therapy without informed consent or knowledge of the harm that could be done to them. For the sake of protecting the wellbeing of LGBTQIA+ individuals, and especially those who are minors, conversion therapy needs to be completely banned from being practiced.

Commenter: Stephen Hertz 4/14/19 11:40 am

There is no basis for a ban

In searching for any credible basis for banning the therapy I found there is none. Placing a ban on such therapy is capricious and mis guided.

Commenter: S. Klose 4/14/19 11:50 am

Oppose the Board of Counseling's Proposed Regulatory Ban

- Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children.
- Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children.
- Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions.
- A ban would deny families the religious freedom to seek counseling aligned with their faith.

Commenter: Mo 4/14/19 2:09 pm

Ban

This should be ban right away. This is a horrible thing to be doing and it has no evidence of working.

Commenter: Dr. Lanice Avery, Professor of Psychology, University of Virginia 4/14/19 2:15 pm

Ban Conversion Therapy for State-Licensed Mental Health Providers

Conversion therapy is a widely discredited practice rooted in the a priori assumption that homosexuality is a mental disorder that must be "repaired" or "reversed" through treatment by a licensed health care professional. However, many of the nation's leading medical and mental

health organizations have spoken out against conversion therapy due to the dangerous practices associated with its methodological approach that include the use of shame, guilt, dehumanization, verbal abuse, and even physical aversion techniques like inducing vomiting and electric shocks. Nearly 20 years ago, the American Psychological Association (APA) published a position statement in the *American Journal of Psychiatry* (2000) confirming the harms of conversion therapy. In 2009, the APA issued another report enumerating a wide array of negative mental health effects associated with conversion therapy, including: anxiety, depression, suicidality, guilt, shame, hopelessness, helplessness, social isolations and withdrawal, increased substance use, stress, increased self-hatred, decreased self-esteem, problems with emotional intimacy, high-risk sexual behaviors, and deterioration of familial relationships.

To date, nine states and the District of Columbia have passed laws that prohibit state-licensed health care providers from engaging in conversion therapy with patients under the age of 18. Anti-LGBT organizations in California and New Jersey sued to have their existing conversion therapy bans overturned, but the Federal Appellate courts in both states upheld the decision to ban the use of conversion or reparative approaches to care that attempt to change the gender identity or sexual orientation of minors. In order to protect LGBT youth from undue trauma and minimize their already exacerbated health risks, legislative bans on conversion therapy should be applied to state-licensed mental health providers working with LGBT populations in the State of Virginia. The approach is in alignment with larger structural and societal prejudices against homosexuality, and the techniques employed pose serious health risks for LGBT populations.

References:

American Psychological Association. (2009). *Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation.* http://www.APA.org/pi/LGBT/ Resources/Therapeutic-Response.pdf

American Psychological Association. Commission on Psychotherapy by Psychiatrists. (2000). Position statement on therapies focused on attempts to change sexual orientation (reparative or conversion therapies). *The American journal of psychiatry*, *157*(10), 1719.

Commenter: Ronald McKinley 4/14/19 3:17 pm

Banning Reparative Terapy for Children

Pldeae oppose the attempt to ban this therapy..

Commenter: Snowa Chernor 4/14/19 4:16 pm

Conversion therapy is NOT anyone's choice

You CANNOT call conversion therapy anyone's choice when we live in a society where homophobia is this rampant; this so-called choice is either driven by fear of hate for being queer, or by familial/peer pressure. We live in a world where it is unsafe and unacceptable to be queer, and conversion therapy does not protect the patient or support religious freedoms. It only validates hatred and homophobia.

Commenter: Lucie Fielding, MA 4/14/19 4:18 pm

Ban Conversion Therapies

I write to strongly exhort the Board to enact a ban on practitioners providing conversion or so-called "reparative" practices. I do this both as a queer- and trans-identified citizen of the Commonwealth and as a resident in counseling who works to discharge shame and provide knowledgeable, competent, and affirmative support to members of the LGBTQQIA+ community. The clinical literature has consistently highlighted the damage wrought by conversion therapies. Moreover, practically every major medical and psychological/psychotherapeutic professional association (including the American Medical Association, the American Psychoanalytic Association, the American Psychological Association, the National Association of Social Work, the American Counseling Association, the American Association for Marriage and Family Therapists, and the American Association for Sexuality Educators, Counselors and Therapists) have concluded that the provision of conversion therapies is harmful, shame-nourishing, unethical, and thoroughly unsupported in the research and clinical literature. The Code of Ethics for the American Counseling Association (2014) specifically directs counselors and trainees to engage in care that respects client autonomy and does not provide harm. It also directs counselors and trainees to engage in evidence-based treatments. Conversion therapy violates each of these core values.

Commenter: S.Muir 4/14/19 4:40 pm

Do not ban conversion therapy

Commenter: James Van de Voorde 4/14/19 4:41 pm

Proposed Ban on Repairative Therapy

I am writing against the propsed ban. Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children. Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children. Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions.

A ban would deny families the religious freedom to seek counseling aligned with their faith. This ban removes potentially helpful options for licensed therapists.

Commenter: M. A. Paxton 4/14/19 4:45 pm

Ban this therapy...

Children, especially, need to develop into who they are. If adults want to seek therapy for what they perceive is a problem for themselves, that is their choice. However, therapists for children should be barred from using it on a child. This therapy allows the parents' biases and prejudices to override their judgment. Therapists should not be complicit.

Commenter: Sylvia Clifton 4/14/19 5:06 pm

Ban!

It's better for the parents to take care of their children. They no what is best.

Commenter: Roger Fortney 4/14/19 5:20 pm

Help people. Especially when they ask.

- Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children.
- Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children.
- Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions.
- A ban would deny families the religious freedom to seek counseling aligned with their faith.

Commenter: Anita Dean 4/14/19 5:25 pm

Therapy choice regarding minors' gender identity

It is! esential that parents and their minor children have every form of counseling available to them. Do not ban one form of therapy over another. Let parents decide..

Commenter: Richard Dunbar 4/14/19 5:56 pm

Reparative Therapy

Do not allow licensing boards to bypass the legislature on this topic in an attempt to ban reparative therapy. I support reparative therapy because:

Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children.

Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children.

Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions.

A ban would deny families the religious freedom to seek counseling aligned with their faith.

Commenter: Myriam Arroyo 4/14/19 6:13 pm

What a sad day

Why would anyone stop a educated counselor to guide someone out of confusion? I was there at one point. I am grateful no one put a gag over them to tell the truth to me. Why is this accpetable to anyone? I am living today and am free from the confusionand condemnation I would have gone thru for the rest of my life. Why the cover up? Why is this even up for discussion?

Commenter: Marwa 4/14/19 6:51 pm

Unscrupulous things shouldn't be condoned.

There is clear evidence that conversion therapy does not work, and some significant evidence that it is also harmful to LGBTQ people. Thus, it should be banned.

It's quite sad and alarming that something of such vast, unethical nature requires a multitudinous amount of consideration. Compose yourself, Virginia.

Commenter: Rachel Regal 4/14/19 7:09 pm

Support Ban of Conversion Therapy

To Whom It May Concern:

Thank you for this opportunity to offer my perspective on this critically important and timely public health issue. As a national certified counselor and LGBTQIA+ advocate/ally, I sincerely and fervently hope that Virginia will join the ranks of states banning conversion therapy.

Conversion therapy has been discredited as an effective means of "therapy". Sadly, it has been shown to have lasting harmful effects. As a counselor, my ethical and first duty is to my clients, to do no harm. Thus, this ban would prevent harm and support ethical, responsible practice statewide for vulnerable youth and marginalized adults. Perhaps this ban could be a step towards decreasing the high rates of suicide in this population. Additionally, it would send a message of support to our neighbors and loved ones, promoting safety and acceptance for all of us.

Personally, it causes me pain to know conversion therapy is continuing to be practiced. I don't think it is often we have the opportunity to *pr?event* pain and suffering through policy. While I am proud to live in a state that is having this discussion, I hope to be prouder still should it pass. Thank you for this opportunity to be heard.

All the best,

Rachel Regal?

Commenter: Nessalyn Dearce 4/14/19 7:19 pm

Ban Conversion Therapy

Conversion therapy is not empirically-based and is known to cause harm in LGBTQ+ individuals who have had it forced onto them as children and adolescents. It is therefore in against the spirit of beneficence and nonmaleficence to continue allowing this "therapy" to take place. LGBTQ+ identities are not mental illnesses to be treated, and homosexuality was removed from the DSM many years ago. Let's protect our clients (especially our children and adolescents) from being subjected to this "treatment."

Commenter: Bethany Teachman, Professor of Psychology, University of Virginia 4/14/19 8:33 pm

Conversion therapy has high potential to cause harm

The scientific evidence regarding conversion therapies suggests that these are very unlikely to change an individual's sexual orientation, but instead are far more likely to increase levels of harm and distress, by directly implying that same sex attractions are disordered.

'Free speech' has never been accepted as a rationale to allow harmful or ineffective medical practice. Nor has it been used to allow providers to make unjustifiable claims about their practice (i.e., claiming that they can change sexual orientation in the absence of evidence that this is a reasonable possibility).

For consenting adults, allowing conversion therapy provides a degree of freedom, but only at the cost of encouraging a practice that is expensive and likely ineffective.

For adolescents, allowing conversion therapy is likely to be harmful, as it stigmatizes an adolescent for their sexual orientation at a vulnerable time in life. The results of allowing this discredited practice to continue are likely to be significant harm to the adolescent at a critical period in their development.

Commenter: Nancy Jaminet 4/14/19 9:35 pm

Conversion therapy

Conversion therapy must be a banned practice.

Commenter: Bridget Kelley-Dearing 4/14/19 10:31 pm

Ban Conversion Therapy

Conversion Therapy is barbaric and it doesn't work. Count this Virginian as requesting that you ban the practice of conversion therapy. I agree with commenter Dr. Lanice Avery, Professor of Psychology, University of Virginia, except I believe it should be banned across the board for all minors. We are still hopefully a free country, so if an adult chooses this practice, who am I to restrict their freedom. "Ban Conversion Therapy for State-Licensed Mental Health Providers Conversion therapy is a widely discredited practice rooted in the a priori assumption that homosexuality is a mental disorder that must be "repaired" or "reversed" through treatment by a licensed health care professional. However, many of the nation's leading medical and mental health organizations have spoken out against conversion therapy due to the dangerous practices associated with its methodological approach that include the use of shame, guilt, dehumanization, verbal abuse, and even physical aversion techniques like inducing vomiting and electric shocks. Nearly 20 years ago, the American Psychological Association (APA) published a position statement in the American Journal of Psychiatry (2000) confirming the harms of conversion therapy. In 2009, the APA issued another report enumerating a wide array of negative mental health effects associated with conversion therapy, including: anxiety, depression, suicidality, guilt, shame, hopelessness, helplessness, social isolations and withdrawal, increased substance use, stress, increased self-hatred, decreased self-esteem, problems with emotional intimacy, high-risk sexual behaviors, and deterioration of familial relationships. To date, nine states and the District of Columbia have passed laws that prohibit state-licensed health care providers from engaging in conversion therapy with patients under the age of 18. Anti-LGBT organizations in California and New Jersey sued to have their existing conversion therapy bans overturned, but the Federal Appellate courts in both states upheld the decision to ban the use of conversion or reparative

approaches to care that attempt to change the gender identity or sexual orientation of minors. In order to protect LGBT youth from undue trauma and minimize their already exacerbated health risks, legislative bans on conversion therapy should be applied to state-licensed mental health providers working with LGBT populations in the State of Virginia. The approach is in alignment with larger structural and societal prejudices against homosexuality, and the techniques employed pose serious health risks for LGBT populations. References: American Psychological Association. (2009). Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation. http://www.APA.org/pi/LGBT/ Resources/Therapeutic-Response.pdf American Psychological Association. Commission on Psychotherapy by Psychiatrists. (2000). Position statement on therapies focused on attempts to change sexual orientation (reparative or conversion therapies). The American journal of psychiatry, 157(10), 1719."

Commenter: EG 4/14/19 11:39 pm

This ban violates freedom to practice one's faith/religion

A ban of an optional therapy that coincides with a family's/person's tenets of faith is unconstitutional and violates freedom of religion. To make it illegal for someone to follow ones faith and to select their means of finding wellbeing imposes communist like tyranny on Virginia's citizens.

Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children. Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children. This is unconstitutional government overreach. My family and I are strongly opposed to this proposed ban!

Commenter: Susan Marusco 4/15/19 9:25 am

Please ban this cruel, inhumane conversion therapy!

Please ban this cruel non-therapy. It is brainwashing, not therapy. It is particularly wrong to allow minors to be submitted to this therapy as they are trying to figure out their identity. This inhumane therapy statistically has led many youth to attempt or commit suicide. It is s shame-based therapy that inherently says—you are not good if you live the way you were born.

People promoting this horrific conversion therapy are right-wing, religious idealogues. They are trying to push their religious agenda on Virginians. Therapy is no place to push a religious agenda.

Commenter: Patrick Lowry 4/15/19 9:36 am

Please do not ban conversion therapy

Banning conversion therapy will cause cause serious harm to our state and communities.

No individual should be forced into an action they do not wish to carry out. This goes both ways - yes someone should not be forced or coerced into conversion therapy or any kind of therapy, but

also conversion therapy should not be banned. This would deny an individual who may be seeking this type of therapy with their own free will their right to receive it.

Please do not move forward with this legislation.

Commenter: Nicole Torres 4/15/19 9:42 am

Support of Ban

To Whom It May Concern:

Thank you for this opportunity to offer my perspective on this critically important and timely public health issue. As a national certified counselor and LGBTQIA+ advocate/ally, I sincerely and fervently hope that Virginia will join the ranks of states banning conversion therapy.

Conversion therapy has been discredited as an effective means of "therapy." Sadly, it has been shown to have lasting harmful effects. As a counselor, my ethical and first duty is to my clients, to do no harm. Thus, this ban would prevent harm and support ethical, responsible practice statewide for vulnerable youth and marginalized adults. Perhaps this ban could be a step towards decreasing the high rates of suicide in this population. Additionally, it would send a message of support to our neighbors and loved ones, promoting safety and acceptance for all of us.

When we see our neighbors being hurt by an immoral practice by those who say they have the best interest of the client in mind, the whole profession suffers. We cannot begin to erase the stigma on mental health issues if we continue to harm clients. As professionals who lead the way in trying to offer support to our communities, it is our privilege and duty to support every member of that community, starting with those members who cannot always speak for themselves, including children and marginalized groups. Society must be responsible and outlaw any practice that harms its participants. We must make a commitment to learn from our history and past mistakes and move forward, without clinging to outdated and harmful practices. I hope to see the pain inflicted by the practice of conversion therapy to end with this legislation.

I see many parents concerned about their ability to make choices that they believe are right for their children. As a parent, I know that my one priority is to provide for and make the best choices for my child that I can. I do this by completing peer-reviewed research, consulting professionals, and, of course, listening to my son. Many professional organizations and counselors hold the consensus that conversion therapy does harm to children. Let's make the responsible decision to embrace our children as they are and provide resources and support without stigma.

All the best,

Nicole Torres

Commenter: Sharon Landrum 4/15/19 9:46 am

Do not restrict freedom

Please do not to punish licensed counselors for helping patients overcome their unwanted sexual feelings. Our country was founded on freedom, and that includes allowing parents, children, and counselors to have a choice in therapy. As with other kinds of speech, regulating the content of professionals' speech poses the inherent risk that seeks not to advance a legitimate regulatory goal, but to suppress unpopular ideas or information.

Commenter: Joanne Holden 4/15/19 9:53 am

This is nothing but a political correct attempt at seeking voters. Why is conversion in One Directio

Commenter: Julia Peters 4/15/19 9:54 am

Conversion Therapy

Do NOT limit counseling options and parental rights

Commenter: Joanne Holden 4/15/19 9:56 am

This is nothing but a political correct attempt at seeking voters. Why is conversion in One Directio

This is just political correctness propaganda to obtain votes. Why is conversion in One Direction appropriate but conversion in another Direction in someone's Behavior or wishes is something to oppose? This is very hypocritical and very disappointing I'm sure folks will know and see your true motives and the end result is loss of respect and confidence

Commenter: Ted Lewis, Side by Side Va, Inc. 4/15/19 11:51 am

Side by Side Supports a Ban on "Conversion Therapy"

To Whom It May Concern:

On behalf of the youth and families of Side by Side (formerly ROSMY), I write in support of Guidance Document 115-10, which would protect youth under the age of 18 from so-called "conversion therapy" in Virginia psychological practice. For over 25 years, Side by Side has provided support and mental health counseling to lesbian, gay, bisexual, transgender, queer, and questioning youth ages 11-20 in Central Virginia. We have witnessed first hand the damage "conversion therapy" has on the mental health and stability of LGBTQ+ youth.

Being LGBTQ+ is not a psychological disorder that needs to be "converted" or "changed." This practice sends a message that there is something wrong with who LGBTQ+ youth are and that they need to be "fixed," when in fact if they are loved and accepted they can truly flourish. Instead of offering to change someone's sexuality or gender identity, LGBTQ+ youth should be affirmed in who they are and provided emotional peer and adult support.

Additionally, there is no credible evidence that this type of therapy works at all. Interestingly, Robert Spitzer, one of the initial leaders in "conversion therapy" has come out against the practice stating in an April 2012 letter to the editor of Archives of Sexual Behavior:

"I believe I owe the gay community an apology for my study making unproven claims of the efficacy of [conversion]/reparative therapy. I also apologize to any gay person who wasted time and energy undergoing some form of [conversion]/reparative therapy because they believed that I had proven that [conversion]/reparative therapy works..."

Even though this form of therapy does not work and even though there is nothing wrong with a young person being LGBTQ+ or questioning their gender or sexuality; LGBTQ+ youth still face intense bullying, harassment, and even violence both at school and sometimes at home. Parents of LGBTQ+ youth may turn to "conversion therapy" as a means to stop the pain their child is

enduring. They deserve to know the dangers of this practice and that it will not and cannot change their children. These parents and their children deserve to see counselors who can affirm who they are and provide the emotional support and guidance they need.

We implore you to consider adopting this ban on "conversion therapy" and ensuring LGBTQ+ youth in Virginia are protected, affirmed, and shown the love they deserve.

Sincerely,

Ted Lewis

Executive Director

Side by Side, VA

Commenter: Ken & Kathy Fredgren 4/15/19 11:58 am

Ban reparative and conversion therapy!

This is a cruel and unreal concept.

Commenter: Mary Louise Serafine, Ph.D., J.D. 4/15/19 12:00 pm

Voluntary speech is not "unsafe." Banning it is unconstitutional.

The statement in the Virginia Board's guidance document that "[s]ignificant research by both the American Psychological Association and the American Psychiatric Association substantiates that 'conversion therapy' should be prohibited in that it has the potential to be harmful to patients" is scientific nonsense. There is no such research that is scientifically valid. Please copy me by email and post these supposed studies to a nationwide forum so that serious scientists can evaluate them. I have never seen a single one with scientific validity. The statement itself is hedged, but the larger historical point is that the decline of freedom begins with politically favored views being wrapped in the cloak of science. This cloak is full of holes. Legislators need to understand that the American psychological and psychiatric associations are trade associations with a left-wing political agenda, not a scientific one. Quite possibly the hysteria to have the government impose "bans" on certain ideas about sexuality is far more harmful to young people and adults than any voluntary therapy or counseling---almost exclusively talk therapy---that one might seek. This is exactly the type of attempted speech and thought control that the constitution protects us against. For example, holding that the Texas psychology licensing law was in general, on its face, an overbroad infringement of speech, the Fifth Circuit Court of Appeals recently struck down that licensing law, because "[t]he ability to provide guidance about the common problems of life--marriage, children, alcohol, health--is a foundation of human interaction and society, whether this advice be found in an almanac, at the feet of grandparents, or in a circle of friends. There is no doubt that such speech is protected by the First Amendment." Serafine v. Branaman, 810 F.3d 354, 369 (5th Cir. 2016). That is what all therapy does---it provides advice in some form to those who want to hear it. The case cited above was not about conversion therapy, but more generally about the licensing of speech by psychology statutes. It should be a call to state legislatures everywhere that banning certain speech-content is unconstitutional. (I was the plaintiff in that case; see www.psychologyspeech.mlserafine.com). Legislators should see this "ban" for what it is: The gay community wants government to outlaw speech and ideas contrary to its own views; it is starting with therapeutic speech, but it won't end there. All such legislative bans will be too broad, lumping together any ideas we want to stop people from talking about and calling that speech "conversion therapy," and then associating it with the horrors of a by-gone era. Certainly all manner of horrors have been committed under the guise of "therapy," especially when involuntary. These are not being carried out today in out-patient settings and, to the extent they are, such as involuntary drug-use on children and ECT, many of us condemn it, though it continues

to be lawful. In out-patient therapy, if physical pain or sickness is imposed (especially on involuntary or minor patients), the ban should be on use of physical pain and sickness, not on voluntary ideas and speech that the speaker and listener choose for themselves. Bottom line: Speech and ideas about sexuality reflect the most private of domains. Any person or private organization should preach about it as they see fit. Government should stay out of it.

Commenter: Mary Wentzel 4/15/19 5:24 pm

Please do not ban conversion therapy.

This type of ban is an overreach by a regulatory agency. Please do not take away parental rights to do what is best for their child.

Commenter: Rachel Sidlauskas, MS 4/15/19 6:37 pm

conversion therapy is dangerous

Conversion therapy is a dangerous and inffective practice lacking research support. Its use has been discredited and is already banned in several states. Particularly when used on minors, it is comparable to child abuse, and should be avoided at all costs.

Commenter: Madeline Malarkey 4/15/19 8:28 pm

Oppose ban

Families should have options to be able to make informed decisions. pe over this text and enter your comments here. You are limited to approximately 3000 words.

Commenter: Sarah Shade, M.Ed., Resident in Counseling 4/15/19 8:35 pm

Conversion "therapy" is unethical and harmful

I am in full support of the proposed ban on conversion "therapy" for several reasons, the first of which is the unethical nature of the treatment process. Research shows that this treatment is largely unsuccessful as well as harmful to clients, which is in direct violation of the American Counseling Association Code of Ethics (I.e. "first, do no harm"). Clients who attempt conversion therapy tend to find they are still attracted to the same sex after treatment (much like a heterosexual person would still be attracted to the opposite sex). When these clients feel they have "failed" to become "straight," they often feel they have let down their families and believe they are doomed to go to hell (a belief typically perpetuated by "loving" parents). Feeling helpless, the client will often attempt or complete suicide, which is an inarguably negative outcome.

Furthermore, by definition, counseling services must only address those issues which arise as a result of a DSM-5 diagnosis. Homosexuality is not a disorder according to the DSM-5, and is therefore not a goal that can ethically be addressed in counseling/therapy. If an individual is struggling with being accepted as LGBTQ, or is struggling to accept their own sexual orientation, mental health professionals are able to help with the acceptance/identity issues, but we are NOT to attempt to change their sexuality. Similarly, I would not try to change someone's religious beliefs or political beliefs, but may help them better cope with issues surrounding their beliefs (I.e. if the client's relationships were strained due to differing beliefs, we would address the relationship, not

the beliefs). In sum, conversion "therapy" is not therapeutic, is harmful, is unethical, and should be banned.

Commenter: Edward K. Miller 4/15/19 10:08 pm

Reparative Therapy

A ban would deny families the relegious freedom to seek counseling aligned with their faith.

Commenter: Adam Trimmer, Born Perfect 4/16/19 12:34 am

Twofold Support of this Document

To the Virginia Board of Counseling,

I support this guidance document as both an individual and as part of an organization.

As an individual, I have some really painful memories from my time as an ex-gay. An ex-gay is an individual who, instead of identifying as gay, identifies as struggling with same-sex attraction, believing that one can heal from homosexuality. These attractions did not go away, but my enjoyment of life and self-confidence did. Instead of learning to love myself, I only learned to resent my parents as I was taught that my mother was overbearing and that my father was emotionally absent. This was taught to me as a "root cause" of me "developing unwanted same-sex attractions." As someone who was personally impacted by efforts to "heal from homosexuality," also known as sexual orientation change efforts (SOCE), or conversion therapy, I express a heartfelt thank you for defining it for what it is.

I make this comment as a survivor, but not without scars. There is still, and potentially always will be, lasting effects from this type of therapy. Relationship building is difficult and emotionally exhausting, as I was taught that because I struggled with same-sex attraction, that I was by default emotionally dependent. I was taught to micromanage and "be careful" about my male interactions. The relationships that I have now are extremely valuable, but I have had to work so hard with each and every one of them, overcoming the voice that says "back up." Finding self-confidence was a very difficult road, especially when that voice of shame and self-doubt never really goes away. I've just learned how to cope with it, understanding that these principles and "best practices" that I was taught are not helpful in any way. What has made the adjustment process so difficult for me is that I believed in this wholeheartedly at the time. For about a year, I thought that if I prayed hard enough, stripped away my identity, payed close enough attention, changed my vocabulary, and micro-managed my relationships in the way that I was taught, that I would be the model ex-gay. I was ashamed of myself for who I was, believing that I was an abomination, but I was encouraged to continue "fighting" to be in the acceptable image of God. The only thing that was affirmed in my ex-gay experiences was the shame, which is absolutely unacceptable. I was also falsely lured into this therapy, being told that it would be my method of healing from a suicide attempt. I did not find healing, nor did I find affirmation of my own identity. Thankfully, I got out, but what followed was a time of traumatized silence, moments where I was averted to another man's touch, I couldn't bring myself to fall in love with another man, and I felt emotionally numb.

I am, however, thankful for real, affirmative counseling, which helped me find strength and healing over a very long 2-year period. Nobody should ever have to go through therapy because of therapy, but for those of us who were scarred, we have to do something to find healing. It's difficult for a lot of us, because we don't trust the mental health community after a therapist or counselor is what brought us to need help. That's why I stayed in a traumatized, frozen state of silence for eight years. But, with therapy (not conversion therapy), I have finally found what the ex-gay lifestyle falsely promised me: freedom.

I also support this document on behalf of Born Perfect as Virginia's Born Perfect Ambassador. Born Perfect was created in 2014 by the National Center for Lesbian Rights to end conversion therapy. Few practices hurt LGBT youth more than attempts to change their sexual orientation or gender identity through conversion therapy, which can cause depression, substance abuse, and even suicide. But some mental health providers continue to subject young LGBT people to these practices—also known as "reparative therapy," "ex-gay therapy," or "sexual orientation change efforts"—even though they have been condemned by every major medical and mental health organization in the country. This guidance document is a fantastic step in the right direction.

Commenter: Donald Schwab 4/16/19 8:10 am

against prohibiting conversion therapy

TThis is a politically correct attempt at seeking voters. I am against prohibiting conversion therapyype over this text and enter your comments here. You are limited to approximately 3000 words.

Commenter: Suzanne Guilfoyle 4/16/19 8:16 am

We need conversion therapy for gender confused kids!

Most cases of gender identity confusion resolve themselves by the time the children reach their later teenage years. Parents have a right to get therapy to help their children and government need to stay out of it. The science is clear in favor of intervention!

Commenter: John Przybysz 4/16/19 8:18 am

Protect parental rights and religious freedom in counseling

Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children.

Commenter: joyce smith 4/16/19 8:19 am

No to conversion therapy for child under 18 without parent consent

I do not want the government raising my child!

Commenter: Patricia Capps 4/16/19 8:20 am

Do Not Ban Conversion Therapy

Do not support this ban on conversion/reparative therapy. It is just "talk" therapy. It is not forcing drugs or electric shock or anything heinous and harmful like that. Parents have the right to raise their children according to their values, not the Commonwealth (and most certainly not to some regulators). This is not just a First Amendment freedom of practice of religion and speech issue, but goes to the core of the fundamental rights of parents in the upbringing of their children. There will be a domino effect if this is allowed. First, regulators will think they can do what they want

regardless of what the General Assembly can pass or not. Second, regulators will think that they can tell parents what they can and can't say to their children about any cultural issue, like gay marriage, abortion, sex outside of marriage, and so on. This cannot happen.

Commenter: Kathleen Coady 4/16/19 8:24 am

Parents should have the freedom of choice in counseling their children!

To whom it may concern. When parents choose therapy for their children they have thought long and hard about the choice and have committed to a path that they believe is best for their child. Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children. To take this option away is usurping the rights of parents to pursue the best path for their children. Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children. To ignore this law is utter arrogance on the part of the board of counseling.

Commenter: James Tubbs, 4/16/19 8:31 am

Protect parental rights and religious freedom in counseling

- Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children.
- Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children.
- Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions.
- A ban would deny families the religious freedom to seek counseling aligned with their faith. It is unconstitutional and UnAmerican.

Commenter: Dr. Joseph Pellegrino 4/16/19 8:33 am

Young people need a choice - No Ban

A ban on therapies would limit the choices available to people who find themselves confused about their identity - a not uncommon occurence. Banning any therapies is restrictive and amounts to censorship and needs to be oppossed as the ultimate victims are our youth.

Commenter: Todd White 4/16/19 8:35 am

parental rights, religious freedom,

- Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children.

- Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children.

- Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions.

- A ban would deny families the religious freedom to seek counseling aligned with their faith.

Commenter: Danielle 4/16/19 8:38 am

Conversion therapy should not be forced on anyone. Forcing someone against their will is abuse

If a child wants conversion therapy he or she should get it. You do whatever you can legally available to help your client the child. That being said it is not the right of the parent to demand that a minor go to conversion therapy. That would be abusive and not in my mandate as a helping professional. This is not about conversion therapy. This is about controlling parents and giving in further to such intolerance is not theraputic for anyone.

Commenter: Dewey G. Cornell, University of Virginia 4/16/19 8:42 am

Ban conversion therapy

I write as a licensed clinical psychologist and a professor of education at the University of Virginia. Conversion therapy is an abhorrent, unscientific practice based on a misunderstanding of sexuality that is demeaning to human dignity. The mental health profession must strive to educate members of the public who mistakenly believe that sexual orientation is a matter of moral choice.

Commenter: Sarah Fortunato 4/16/19 8:43 am

Protect parental rights

Please protect parental rights! Counselors and therapists must be fully free to provide conversion therapy to people.

Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children.

Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children.

Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to

make informed decisions.

A ban would deny families the religious freedom to seek counseling aligned with their faith.

Commenter: William R Watts 4/16/19 8:45 am

Ban Conversion Therapy for State-Licensed Mental Health Providers

Ban Conversion Therapy for State-Licensed Mental Health Providers

Conversion therapy is a widely discredited practice rooted in the a priori assumption that homosexuality is a mental disorder that must be "repaired" or "reversed" through treatment by a licensed health care professional. However, many of the nation's leading medical and mental health organizations have spoken out against conversion therapy due to the dangerous practices associated with its methodological approach that include the use of shame, guilt, dehumanization, verbal abuse, and even physical aversion techniques like inducing vomiting and electric shocks. Nearly 20 years ago, the American Psychological Association (APA) published a position statement in the *American Journal of Psychiatry* (2000) confirming the harms of conversion therapy. In 2009, the APA issued another report enumerating a wide array of negative mental health effects associated with conversion therapy, including: anxiety, depression, suicidality, guilt, shame, hopelessness, helplessness, social isolations and withdrawal, increased substance use, stress, increased self-hatred, decreased self-esteem, problems with emotional intimacy, high-risk sexual behaviors, and deterioration of familial relationships.

To date, nine states and the District of Columbia have passed laws that prohibit state-licensed health care providers from engaging in conversion therapy with patients under the age of 18. Anti-LGBT organizations in California and New Jersey sued to have their existing conversion therapy bans overturned, but the Federal Appellate courts in both states upheld the decision to ban the use of conversion or reparative approaches to care that attempt to change the gender identity or sexual orientation of minors. In order to protect LGBT youth from undue trauma and minimize their already exacerbated health risks, legislative bans on conversion therapy should be applied to state-licensed mental health providers working with LGBT populations in the State of Virginia. The approach is in alignment with larger structural and societal prejudices against homosexuality, and the techniques employed pose serious health risks for LGBT populations.

Commenter: Jack Norris 4/16/19 8:52 am

Conversion therapy

The state should not interfere with this. The parents should have the right to seek whatever counsel they deem best for their child. There are too many instances in the literature where the surgical change of gender has led to not solving the problem, caused reverse surgery, or suicide. The government needs to stay out of it!

Commenter: Christina Maria Mac Cabe 4/16/19 8:52 am

Do not ban

- Parents have the fundamental right to make decisions regarding the upbringing, education and care of their children.

- Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children.
- Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions.
- A ban would deny families the religious freedom to seek counseling aligned with their faith.

Commenter: DIANA SNIDER 4/16/19 8:57 am

Protect parents' rights to protect and care for all of their children's needs

Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual well-being of their children.
Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children. Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions. A ban would deny families the religious freedom to seek counseling aligned with their faith.

Commenter: Caitlyn Largent 4/16/19 8:59 am

Ban Conversion Therapy

To begin with, the argument that this would take away parental rights is ridiculous. Parents do not have a right to harm their children, and there are numerous studies to show that conversion therapy is harmful (ex. 2009 APA report, George Rekers failed case in the 1970s). "Rights" as a parent do not outweigh the safety of a child.

As a counseling student and someone who is about to be in the field, I can say without a doubt that conversion therapy is unethical and wrong. It goes against everything that we believe in, including but not limited to enhancing human development throughout the life span; honoring diversity and embracing a multicultural approach in support of the worth, dignity, potential, and uniqueness of people within their social and cultural contexts; promoting social justice; safeguarding the integrity of the counselor–client relationship; and practicing in a competent and ethical manner (ACA Code of Ethics, 2014).

And to anyone who is in the LGBTQIA+ community that may be reading this; you are not broken. You are not damaged. You do not need to be "fixed". You are perfect and amazing and beautiful just the way you are. If you ever need mental health support, there are many therapists/counselors out there who are affirming and will be there to walk on your journey with you. You are not alone and please know that myself and many other people will be advocating with you to ensure that you and your rights are protected.

Commenter: Samantha Rainaldi 4/16/19 9:04 am

Protect parental rights

Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children. Period. No ban.

Commenter: Susan Bond 4/16/19 9:05 am

Do NOT Ban Reparative/Conversion Therapy

Please Do Not Ban Reparative/Conversion Therapy!

- Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children.
- Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children.
- Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions.
- A ban would deny families the religious freedom to seek counseling aligned with their faith.

Commenter: Kevin Streit 4/16/19 9:06 am

Oppose the Ban on Reparative Therapy

It would be a grave mistake for the government to interfere with parents' right and ability to select appropriate therapy for their children, as this bill would do. Parents are closest to their children and best know their children's needs, suffering, and wishes. Such a bill sets a dangerous precedent, interposing government authority to usurp parental authority in a matter integral to a child's well-being. The danger in such a precedent is manifest. Please oppose this ill-considered bill.

Commenter: M. Breighner 4/16/19 9:09 am

Proposed ban on reparative therapy

Parents have the rights to make fundamental healthcare decisions regarding their childreen.

Commenter: Chris Russo 4/16/19 9:10 am

Of course this is up to the parents and kids

Conversion therapy is up to the parents and kids.

4/16/19 9:10 am

Commenter: Ernest Kidd

Ban conversion therapy

Crusaders forced practices on aboriginal peoples. That was obviously an immoral force of religion on the basis of government upon a people. Our government is by design separated from religious practices and as such would be condoning immoral conduct against its citizens by allowing barbaric practices to be inflicted on the basis of religious beliefs. Moreover, science agrees this practice of conversion therapy to be harmful. The reparations for damage would far outweigh any perceived benefit (the oppressor May enjoy). To ensure a society remains intact of its freedom of religion it must also protect its citizens enjoy the natural freedom of expression in its pursuit of life, liberty and happiness. Ban conversion therapy.

Commenter: Gregory Thompson 4/16/19 9:16 am

It depends

So-called conversion therapy takes on various forms, at least some of which are abusive and unethical. I recognize the right of adults to undergo conversion therapy, and also their right to discontinue conversion therapy at any time they see fit. I also recognize the right of mental health professionals not to engage in means of therapy that are unethical in their professional judgment.

Commenter: Anonymous 4/16/19 9:19 am

Do not ban! Protect freedom of choice

- Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children.
- Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children.
- Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions. (Even if it may not help all who wish to change or moderate their desires, it may help some, and people should seek to improve the therapy for these people rather than ban it, which would give people no choice in how to deal with these emotions if they want to change them.)
- A ban would deny families the religious freedom to seek counseling aligned with their faith.

Commenter: Daniel Rowan 4/16/19 9:19 am

Freedom of Religion

Please do not force those with confused sexual identity to capitulate to the perverted lifestyle of the politically correct. Parents should make medical decisions for their children - religious freedom should be preserved. Counseling should be in line with the religious beliefs of the family. Do not abridge our religious freedom.

Commenter: Hugh Owen 4/16/19 9:20 am

Do Not Impose Totalitarian Restrictions on Parents and Counselors

I am a retired school principal with a permanent license to be a superintendent of schools or K-12 principal in the state of New York. To prohibit parents and counselors from helping children to overcome same-sex attraction or other disordered inclinations (such as pornography addiction) is a form of totalitarianism:

- Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children.
- Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions.
- A ban would deny families the religious freedom to seek counseling aligned with their faith.

Commenter: Joanne Summers 4/16/19 9:25 am

Conversion therapy must NOT be banned

This type of therapy must remain available to anyone/everyone who wants help for themselves or their minor children. Patient rights and parental rights must be protected from government-imposed bans.

Commenter: Anonymous 4/16/19 9:25 am

This would limit religious freedom

Commenter: Katherine Rings 4/16/19 9:28 am

Let the therapist do their job without ban

I oppose a ban on so-called reparative therapy. Any person, child or adult, may go through times where they struggle with their sexuality. The therapist should not be directed on how to handle this, but use their professional training to help their client to address this. They should not b e banned from a particular direction in that therapy.

Commenter: James K Disney 4/16/19 9:37 am

Conversion Therapy

I would like to align my comment to that of M L Serafine, Ph.D, J.D. The banning of conversion therappy is unscientific and unconstitutional. The efforts of those who would ban this practice is meant to overturn the rights of parents to raise their children. Appeal to worst and isolated cases do not lead to good practice or good legislation. The denial of religious belief and practice as reasonable and applicable in this discussion is heavy-handed. Please do not ban the reasonable and very humane practice of conversion therapy. I thank Dr. Serafine for her well informed contribution to this discussion in the Commonwealth of Virginia. -Jim Disney

Commenter: Teresa Donohue 4/16/19 9:39 am

Ban on conversion therapy

Parents are the ones who know their children and they should be the ones to decide on the proper therapy, not the State. Do not Ban conversion therapy.

Commenter: Lindsay Kozachuk 4/16/19 9:40 am

Support Conversion Therapy Ban - It is a dangerous practice

I understand that some commenting here are afraid that this ban will take away their religious rights, however conversion therapy has been discredited as an effective means of "therapy". Sadly, it has been shown to have lasting harmful effects. While using religion and exploring one's sexuality in therapy is certainly helpful, actively imposing one's values onto a client, especially a minor, about sexuality is unethical and dangerous.

As a counselor, my ethical and first duty is to my clients, to do no harm. Thus, this ban would prevent harm and support ethical, responsible practice statewide for vulnerable youth and marginalized adults. Perhaps this ban could be a step towards decreasing the high rates of suicide in this population. Additionally, it would send a message of support to our neighbors and loved ones, promoting safety and acceptance for all of us.

Personally, it causes me pain to know conversion therapy is continuing to be practiced. I don't think it is often we have the opportunity to prevent pain and suffering through policy. While I am proud to live in a state that is having this discussion, I hope to be prouder still should it pass.

Commenter: David McCarthy 4/16/19 9:43 am

Please do not impose your personal preferences on parents and their children.

Why would the Board of Counseling impose assymetrical restrictions on its own membership? Why would the Board presume that its Members know what's best for the children of loving parents, i.e., know that the Board's solution is always better for the child than the parents'?

I've known a high school girl who experienced wrenching adolescent turmoil. Among other manifestations she asserted that she was gay. She benefited from the finest counselling arranged by her loving father who happened also to be a leading pediatrician. Today she is happily married and in love with her husband, the biological father of her three children.

Why would you prevent or second-guess her outcome, i.e., her happiness?

Thanks for considering this perspective.

Dave McCarthy

Commenter: Joanne Seale 4/16/19 10:01 am

No Ban on Reparative Therapy

There should be no ban on reparative therapy. Perents know their children best and should be the ones to decide if their child should receive it. Protect parents' rights!

Commenter: Kelsey 4/16/19 10:04 am

Do Not Ban! Protect Choice!

There need to be options for families to make their best, conscientious choice.

Licensed professionals should be allowed to use their training to help their clients in the ways the professionals think is best. Do not limit the freedom of professionals to exercise their powers of healing in this important profession.

Parents are responsible for and should be allowed to make decisions for their children.

Many children who are of the age of reason may want this type of therapy, and denying them the ability to go through this process is a violation of their rights and the rights of their parents.

Commenter: Sandra-Joy K. Gray, PhD, LPC,LMFT 4/16/19 10:13 am

Conversion Therapy

This is not an easy topic and surely you will receive many disparate comments.

I have over thirty years of experience as a LPC and LMFT. Conversion Therapy is not my specialty. However, in those thirty years plus I have experienced the struggles that many clients have with their sexuality, It is my considered belief that any policy determined should not preclude a counselor from letting a client determine their eventual orientation. As you know, many clients may be in flux with this issue for many years due to a myriad of influences in their lives including their family backgrounds.

In this time of societal evolution of mores, less regulation is better.

Sincerely,

Sandra-Joy K. Gray PhD, LPC,LMFT

Commenter: Father Dan Beeman 4/16/19 10:14 am

Protect Parental Freedom | NO BAN

It is deeply troubling that the Commonwealth should think they know better than parents in how they be raised, taught, and treated.

If parents have the right to give their children hormone therapy or "gender transition" then certainly they should also have the right to have their children treated in other therapies that correspond to their beliefs and faith.

Stop this nonsense invasion into parental freedom.

Commenter: Susan Pauli 4/16/19 10:23 am

Yes to Conversion Therapy-protect Freedom and Parental Rights

Commenter: Kevin Bohli 4/16/19 10:32 am

NO BAN!

A ban would deny families the religious freedom to seek counseling aligned with their faith.

Commenter: Pam Watkins 4/16/19 10:37 am

DO NOT BAN!

Stop trying to take away parental rights. We keep taking away parental rights but then look to the parents when the children have done wrong. We cannot keep taking away parental rights without the government assuming the parental role which is not productive at all. We need to allow parents to raise their children within their faith circles and their beliefs without interferring. Abuse is one thing, but allowing parents to seek help when a child forgets who God created them to be should strictly be a parental right. Just because "Society" has lost their moral compass does not mean that all parents have. Leave parents to do their job.

Commenter: Patty Mathison, George Mason University 4/16/19 10:41 am

I support the Ban on Conversion Therapy

Conversion therapy is unethical and should be banned. This has nothing to do with freedom of speech, it is a harmful approach that has not proven to be effective but instead has shown significant harm to the individuals who have gone through this.

Conversion therapy is premised on the false notion that being LGBTQ is a mental illness that should be cured, despite all major medical associations' agreement that LGBTQ identities are a normal variant of human nature. In fact, the American Psychiatric Association determined that homosexuality was not a mental illness in 1973. Also a 2007 report by an American Psychological Association task force found that "results of scientifically valid research indicate that it is unlikely that individuals will be able to reduce same-sex attractions or increase other-sex sexual attractions through [sexual orientation change efforts]."

This is not about religious freedom or freedom of speech. This is about causing unnecessary and significantly deep harm to individuals. That is against what we do as counselors. Our aim is to help heal, not to hurt, harm and criticize. Please consider this ban thoughtfully. It is deeply unethical and it is not effective.

Commenter: William 4/16/19 10:42 am

Do Not Intervene in Family Matters

The decision to pursue therapy should be left to parents and their children. It is not the place of the state to intervene in these matters. What's next? Withdrawal of end of life treatments because a person is going to die anyway? Denial of life saving and therapeutic drugs because the state says they are too expensive? Denial of treatments for the same reason?

Commenter: Mr. Garcia 4/16/19 10:49 am

Let doctors do their job and parents raise their children DO NOT BAN CONVERSION THERAPY

Do not ban conversion therapy! Protect freedom of choice

- Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children.
- Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children.
- Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions. (Even if it may not help all who wish to change or moderate their desires, it may help some, and people should seek to improve the therapy for these people rather than ban it, which would give people no choice in how to deal with these emotions if they want to change them.)
- A ban would deny families the religious freedom to seek counseling aligned with their faith.

Commenter: Dcn. William Pivarnik 4/16/19 11:06 am

Guidance Regarding Conversion Therapy

As a parent, I strongly object to the proposed ban on professionals providing conversion therapy to children. The choice of the kind of treatment my children receive is mine to make and not the State's. If I choose to have my children treated in a particular way which corresponds to my religious beliefs, I have the legal right to do so. That right should not be restricted by a regulation preventing professionals from providing that therapy. To restrict my choices in this manner violates both my legal rights and my religous freedom. Please leave the raising of children to their parents where it belongs and do not restrict the parent's ability to a free choice.

Thank you.

4/16/19 11:07 am

Commenter: Catherine A. McClure

Reparative Therapy Proposed Ban

Parents are the primary caretakers of their children and should make the decisions that are best for them. I oppose bannning a law that would eliminate this right.

Commenter: Marianne Mazzatenta 4/16/19 11:12 am

Do not ban reparative or "conversion" therapy! Protect freedom of families to choose counseling!

Do Not ban licensed professionals from providing reparative or "conversion" therapy to children. Protect the freedom of Virginia families to acquire the counseling they choose.

- Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children.
- Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children.
- Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions.
- A ban would deny families the religious freedom to seek counseling aligned with their faith.

Commenter: bob 4/16/19 11:18 am

too much governmetn interference

why is this needed? ban it

Commenter: John Kehler 4/16/19 11:23 am

Protect Parents' Rights

Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children.

Commenter: Austin Farinholt 4/16/19 11:25 am

Do not ban

Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children. This ban is unconstitutional.

Commenter: Paul Kane 4/16/19 11:42 am

Objection to Proposal

This proposed requlation forms the structure of governmental interferrence and hinderance to the rights of parents guiding the care of their children. It's a bad idea.

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Commenter: J Campbell 4/16/19 11:48 am

No ban; if people can change gender, they should be able to change preferences, too

People should be free to seek the type of treatment they want. It is illogical to permit people to enter treatment to alter their biological sex, but to refuse therapy to others who desire to alter something else about themselves. A ban would be an invasion of privacy and a violation of personal agency. Please vote against it.

Commenter: Ba Catholic conference 4/16/19 12:05 pm

Protect parents rights

Commenter: John McMahon 4/16/19 12:09 pm

opposed to banning reparative therapy for children

Please do not ban reparative therapy for children.

Sincerely,

John McMahon

Commenter: Melissa Wysocki 4/16/19 12:12 pm

Do not ban.

Parents and health care professionals should reserve the right to make health care decisions for their family members according to their religious belief. The government does NOT have the right to intervene with health care or religious decisions. It is unconstitutional.

- Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children.

- Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children.

- Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions.

- A ban would deny families the religious freedom to seek counseling aligned with their faith.

Commenter: Mary 4/16/19 12:17 pm

Ban Conversion

It's the parents duty to protect their children.

Commenter: Joanne E Lynch 4/16/19 12:38 pm

Please Ban Conversion Therapy

Commenter: chuck Boyer 4/16/19 12:43 pm

Conversion Therapy controversy!!

To the Board of Counseling,

4/16/19

It's really up to the individual if they choose to be converted or not! Nothing is harmful to the person! What they might be participating as or doing could be very harmful to them. The person has a Constitutional right to decide on their own, which path to pursue. If the path they are on is becoming harmful, then they can choose counseling, whether conversion therapy counseling or not, to take a different path. This is is not free speech under our US Constitution! Pay attention to our Virginia Flag and tell me your reason is right.

Thank you for reconsidering free speech!!! It's the Virginia right way and US right way.

Chuck Boyer

Commenter: Bernie Marx 4/16/19 1:05 pm

asdf

Thank you

Commenter: Bernie Marx 4/16/19 1:06 pm

asdf

Thank you very much

Commenter: John Mosticone 4/16/19 1:37 pm

reparative or "conversion" therapy to children

protect the freedom of Virginia families to acquire the counseling they choose!

Commenter: Jim and Ruth Franconeri 4/16/19 1:46 pm

Conversion Therapy Proposal

Do not ban conversion therapy. That would take the parents out of the decision process for their children.

Commenter: Jay Corprew 4/16/19 1:46 pm

BAN CONVERTION THERAPY. My personal story

I had personally dealt with convertion therapy when I was a preteen. My parents and my church forced me to go. Not only was this against my will, but the therapy was abusive, homophobic and mysogonistic, and in no way theraputic! I was locked in a room with 3 male members of my church. They would discuss their personal views about lgbt community and use verses from the bible to somewhat back their ideas. I was not allowed to leave the room and not allowed to speak, not allowed to share what was said in the room this "therapy" continued for weeks and created my battle with life long depression and ideations of suicide. Convertion therapy isnt therapy! It is a way to make a child suicidal, depressed and also invoke ptsd or anxiety. It is abuse. If anyone actually is reading this I want you to know that crap haunted me for over 20 years and if it never happened I wouldnt have been suicidal from age 13 to age 32. If you are ok with causing children or teens or adults to want to kill themselves because they were not born like you feel they should have been born, then you need convertion therapy to be a better person. I am transgender. Born female but identify as male since age 5. I am also a straight man. If convertion therapy worked on me I would be living as a gay man right now. That sure doesnt make sense now does it? But instead. I worked hard to live my authentic true self as a man who is straight. And now happily married to my wife.

Commenter: Mary Sidhu 4/16/19 1:46 pm

Protect parents' rights and those needing help!

The state does NOT know best when it comes to raising children and certainly has NO right to impose its lack of judgement and morality on its citizens. People who suffer from same sex attraction should be helped to overcome it, not encouraged to practice an unhealthy lifestyle.

Commenter: Ann Smith 4/16/19 1:48 pm

Conversion therapy

Always protect parental rights and religious freedom .

Commenter: Ann Smith 4/16/19 1:50 pm

Parental rights and religious freedom

Commenter: Paula Madigan 4/16/19 1:50 pm

DO NOT BAN!

God created humans as either male or female and God never makes mistakes. It is a sin for any therapist to refuse conversion therapy to their client, either child or adult, who is confused about their gender or is homosexual, transexual, etc. Sodomy is one of the deadly sins. The Old Testament says that sodomy is an abomination to God. Jesus Christ says that God made them male and female.

Commenter: Peter Ingerick 4/16/19 2:00 pm

Do NOT Ban Conversion Therapy

- Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children.
-
- Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children.
- Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions.
- A ban would deny families the religious freedom to seek counseling aligned with their faith.

Banning Conversion Therapy would be dangerous, and take away much needed options from parents.

Commenter: Hilary Towers, Developmental Psychologist 4/16/19 2:17 pm

Stand Against this Ban

Neither licensure boards nor the General Assembly has the right to force Virginians to accept one view or another on this matter. Further, the science increasingly suggests children, in particular, are subject to great physical and emotional harm as a result of "gender transforming" surgeries and hormone therapies encouraged by counselors and doctors.

Let loved ones and their counselors decide the appropriate course of action for those individuals struggling with gender dysphoria.

Commenter: Samuel Sarmiento 4/16/19 2:22 pm

Please!

Please support this cause

Commenter: Rev. Robin Anderson, Commonwealth Baptist Church 4/16/19 2:29 pm

Conversion Therapy Causes Trauma

As a pastor, I have witnessed up close and personal the severe damage that conversion therapy causes those who experience it. I have counseled numerous LGBTQ individuals who struggle to recover from the trauma of conversion therapy, even decades after they received it. Some have told me stories of attempting suicide due to the pain and shame they were made to feel by well-meaning therapists. I can't adequately express how awful it is to watch faithful adults struggle to believe that they are beloved by God and their church because, in their youth, they were told otherwise and forced to try to deny who they are.

Please ban conversion therapy for minors in the Commonwealth of Virginia. It causes people life-long pain and trauma. It causes crises of faith, which sadly don't always heal. All too often, it's even deadly. We must do better for those who grow up in Virginia and everywhere for that matter.

Commenter: Aliza Weiss 4/16/19 2:32 pm

Support the Ban of Conversion Therapy

My duty as a counselor is an ethical one, and it is to do not harm. Additionally, I am part of a field that prides itself for advocating and protecting the rights of all. It is a human right not to be taken for granted to be accepted and appreciated as you are. How can we deny this right of some, and grant this to others?

What I hope is to impact policy as an example of banding together to prevent the promotion of hateful and discriminatory acts. Lets denounce the hatred that infiltrates this world and the beliefs that those have against marginalized individuals. I stand with those in support of the ban of conversion therapy, and I encourage you to as well.

Commenter: Philip Glass 4/16/19 2:38 pm

Do not circumvent the will of the people

Our legislators have voted on this issue. They represent us. Do not push a radical agenda against our will and basic liberties.

- Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental,

emotional, and spiritual wellbeing of their children.

- Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children.
- Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions.
- A ban would deny families the religious freedom to seek counseling aligned with their faith.

Commenter: James Eck 4/16/19 2:50 pm

Guidance on conversion therapy

I support the proposed ban. I believe that conversion therapy can have severe negative impacts on patients and by its very name is anything but an open minded procedure to help the patient.

Commenter: Joseph Osborne 4/16/19 3:08 pm

Do not ban Conversion Therapy

Most of the cases of gender identity confusion resolve themselves by the time the children reach their later teen years, and parents have a God given right to get therapy or other help for their children as they deem fit. Government must not interfer in our family decisions.

Commenter: Virginia cavender 4/16/19 3:20 pm

Do not ban!

Commenter: Phillip R. McDonald 4/16/19 3:28 pm

Do not ban options for parents

Please do not ban parents the option to seek help that they think most appropriate for children struggling with their sexual identity. This is a question of morality as well as medicine, since it involves behaviors children choose to engage in, and parents should be allowed to do what they think best in such cases.

Commenter: Laura Farmer, Ph.D., Licensed Professional Counselor 4/16/19 3:31 pm

End the practice of conversion therapy

I offer my comments below as a licensed professional counselor and approved clinical supervisor in Virginia, as well as a counselor educator, researcher, and professor. My research focuses on ethical and affirming counseling practices with LGBTQ+ clients and students/youth. I have worked with folks who identify as LGBTQ+ for over ten years, which has given me an up close and personal perspective on the harm caused by conversion therapy and similarly-motivated "treatments".

The issue at hand is not about restricting parents' freedom. It is about protecting the public, including and especially children, from an unethical, unproven "treatment" for a non-existent "mental health issue".

Identifying as gay, lesbian, queer, transgender, non-binary, genderfluid, etc. is a protected identity status and this is underscored by the professional code of ethics across mental health disciplines (counseling, social work, psychology, marriage and family therapy). It is unfortunate, but necessary, that the state become involved in the issue of conversion therapy – as practiced by licensed professionals - because it causes significant damage/ psychological harm to those impacted. Many of the comments and personal testimonies in this forum have documented the extent of that damage.

A licensed practitioner should receive sanctions and have their license revoked if they are practicing in any way that causes harm to individuals they are supposed to serve, help, and heal. Conversion therapy has been documented over and over again as an intervention that causes harm and has led to increased depression, anxiety, dissociation, and suicidality. I cannot think of any other "treatment" with such widespread reports of harm that continues to be practiced unquestioned. If parents wish to exert their freedom of choice in selecting an intervention for their child that is ultimately harmful, they can choose from any number of unlicensed, unauthorized persons who purport to provide such intervention. However, our regulating board needs to take action to prevent harmful practices, such as conversion therapy, from being used by licensed providers.

Commenter: Thomas J Duncan 4/16/19 3:33 pm

Reparative Therapy

Do not ban Reparative Therapy. Parents should have the right to try this therapy when they consider it in the best interest of their child. However, if used, it must be done with care.

Commenter: Hilary Towers 4/16/19 3:43 pm

addendum to my first comment

In recognition that reparative therapy concerns SSA, specifically, the principle below still applies. This is not an area in which the State should legislate or impose their values. Leave issues concerning sexual attraction and gender identity (another area of counseling under mounting scrutiny by boards and lawmakers) to individuals and their counselors to navigate.

(my first comment below)

Neither licensure boards nor the General Assembly has the right to force Virginians to accept one view or another on this matter. Further, the science increasingly suggests children, in particular, are subject to great physical and emotional harm as a result of "gender transforming" surgeries and hormone therapies encouraged by counselors and doctors.

Let loved ones and their counselors decide the appropriate course of action for those individuals struggling with gender dysphoria.

Commenter: Sharon Allen 4/16/19 3:49 pm

Do not ban reparative therapy

I strongly oppose a ban on this therapy practice for both children and adults. A ban would strictly limit therapy options for people struggling with same sex attraction and gender disphoria, and would prevent parents from making faith based council get decisions on how to best help their children and their families in these matters. Children in particular should not be denied the option to question their feelings, particularly since the majority of those who have these feelings at one point in their lives refute them later in life, and need the ability to talk though all options available to them.

Commenter: Pamela H Wilgus 4/16/19 3:56 pm

Reject the ban on reparative therapy.

Please protect the freedom of Virginia families to acquire the counseling they choose and reject the ban on reparative therapy. Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children. Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education, and care of their children. A ban would deny families the religious freedom to seek counseling aligned with their faith. Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions.

Commenter: TD 4/16/19 4:01 pm

counseling

I am against the ban for counseling. These individuals need as much help as they can get especially a doctor that works with young adults and teens that are undergoing adolescent changes in their lives.

Commenter: Christopher Martini 4/16/19 4:04 pm

Do Not Ban ban licensed professionals from providing reparative or "conversion" therapy to children

?Do not ban licensed professionals from providing reparative or conversation therapy to children:

- Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children.
- A ban would deny families the religious freedom to seek counseling aligned with their faith.

- Everyone wants choice- this will remove choice from parents.

Thank you!

Commenter: Kellie Sanders, resident in counseling 4/16/19 4:06 pm

Ban conversion therapy

If parents want to seek conversation therapy or other methods that have been proven ineffective and harmful, they can choose to seek out someone unlicensed. Any licensed counselor who has been trained under the guidelines set forth by the ACA and the VA Board of Counseling will be aware of the fact that conversion therapy goes against our code of ethics. Furthermore, this has absolutely nothing to do with freedoms of speech. It is about adhering to our promise to "do no harm".

Commenter: Lucy Klaus, Ministry for Life, St. Theresa Catholic Curch 4/16/19 4:09 pm

Government Intrusion has to stop.

How is this the government's business? Parents decide what is best and proper for their children. Permit such intrusions on parental rights and the next thing we know, this will be China. The government will tell us how many we may have and will indoctrinate them as they wish. They will assume to right to take them away for the benefit of the State. They have already legislated that the children can be aborted and are seeking to allow this while labor is taking place and after even after they are born! Children are not property and the State has no say in this matter.

Commenter: Kenny Boddye, Boddye for Supervisor 4/16/19 4:18 pm

End the Inhumane Torture of LGBTQ+ Youth

I wrote previously about how "conversion therapy" is in violation of several local, state, federal and international laws and treaties, and how it is inhumane. I'm writing today to reaffirm that stance in light of this new comment period.

Please continue to issue guidance which bans the use of so-called "conversion therapy," which is really just legalized torture with a sanitized name. There are a number of reasons to keep this guidance, including:

? "Conversion therapy," is a dangerous and discredited practice aimed at changing the sexual orientation or gender identity of LGBTQ youth, not actually helping them in any way.

? These practices are based on the false claim that being lesbian, gay, bisexual, transgender, or queer (LGBTQ) is a mental illness that can and should be cured.

? These harmful practices use rejection, shame, and psychological abuse to force young people to try and change who they are, which can lead to depression, decreased self-esteem, substance abuse, and even suicide attempts.

In short, these practices are barbaric, do nothing to help the youth they are used on, and perpetuate the lie that LGBTQ identity and expression are somehow wrong, temporary, and/or curable. No one whould be "cured" of who they are or who they love.

Please keep this guidance, which protects our youth.

Commenter: Sarah Morales 4/16/19 4:28 pm

Ban this

Ban this!

Commenter: FPT 4/16/19 4:48 pm

Confused, troubled children and adults need faith based guidance

From someone who needed 20 years of therapy integrated with the Catholic faith from a Catholic psychologist on another issue, I can say most definitely that anyone who needs reparative therapy is in need of proper guidance and direction, most specially children. They are confused and troubled if they don't know their gender. All homosexuals I encountered since high school had a history of abuse or dysfunctional parent issues. To let the world allow boys and girls to think they are the opposite gender they were born is destructive to society. If I didn't get the faith based therapy I needed on my abuse issue I would have fallen into the temptations of the world, others, and myself. I would be dead or in prison right now.

Commenter: B. Bashista 4/16/19 4:55 pm

Please do not deny individuals the religious freedom to seek counseling aligned with their faith

Type over this text anParents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual well being of their children. Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children. Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions. A ban would deny families the religious freedom to seek counseling aligned with their faith. d enter your comments here. You are limited to approximately 3000 words.

Commenter: Jay Timmons 4/16/19 5:00 pm

Please ban so-called "conversion therapy" for those under 18

I write in support of Guidance Document 115-10, which would ban so-called "conversion therapy" by licensed psychologists in Virginia for those under 18. Today, I am President and CEO of the National Association of Manufacturers, but I submit these comments not in that capacity but as a citizen of the Commonwealth and former Chief of Staff for Governor George Allen, to advance the same principles that we promoted when in office: Free Enterprise, Competitiveness, Individual Liberty and Equal Opportunity. Allowing individuals to come to terms with their authentic selves, to live honestly and to not endure painful, often forced, efforts to break them of who they are and of what they feel will help our Commonwealth and all people strengthen these core pillars of an exceptional America.

As a gay man myself, I know this conclusion to be true. There was a time that I thought I could change who I was and would consider any methods to do so, or ignore this side of myself, from trusted mentors, counselors and spiritual advisors. I wanted to make my parents proud, and to see their dreams for me fulfilled. So, coming to terms with who I was had me wrestle with many doubts, great fears and tortured thoughts—to find a different way to live and feel.

In my formative years, I turned to my studies, work and public service to wall-off this side of me, hoping that somehow my feelings would evolve. Over the years, I came to terms with the truth that I could not change who I was created to be, and ought not to, bolstered by people in my life who encouraged me that the path of truth and authenticity was the only way to live—and to love. I have the benefit of looking at my husband, Rick Olson, and our 3 children, C.J., Ellie and Jacob today knowing that advice made my life whole.

Unfortunately, not everyone has the benefit from this support structure and not everyone has seen their true life come to term. So-called conversation therapy has robbed people of their lives and created a whole class of survivors who have struggled in the face of individuals telling them they are not normal, challenging their relationships with their parents and family and working to distort their minds and their feelings. As a current colleague had said in *The Washington Post* seven years ago: "Imagine routinely hearing from a so-called expert that your mother had harmed you and that your father had failed you, despite having two loving parents who sacrificed career pursuits and much else to see you realize your dreams. Think about subjecting yourself to shock therapy — the most awful pain — as your therapist showed you images of same-sex relationships in an effort to break you of your natural feelings." That colleague came close to ending his life. These impacts are why the medical community has concluded that conversion therapy does not work, and that it often harms people and families.

As a people who value life, each individual and every family, because of their intrinsic worth and because they strengthen those pillars that make our country great, we must commit to end this practice that targets those very foundations of our society. While we can, and must, respect the role of religious institutions and counselors in helping all individuals live better lives and confront the great questions of life, we cannot give state-sanction to a harmful practice that puts young people and other individuals at risk of death and limits so many individuals' potential to contribute to our families, our communities and our country.

I urge favorable action on Guidance Document 115-10.

Commenter: GEORGE GOUNLEY 4/16/19 5:43 pm

End this assault on freedom of religion and the right of parents to raise children as they choose!

My family and I strongly object to all govenmental efforts to intrude into personal and family matters, such as what is proposed. We are human beings, not creatures of the state!

With respect to what is proposed:

- Despite the proponents of the nanny state, parents are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children.

- Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education, and care of their children.

- Believe it or not, some young people themselves would rather have their sexual attractions to accord with Judeo-Christian morality, and should have the right to seek counseling which has that objective as its end.

- A ban would deny families the religious freedom to seek counseling aligned with their faith. The proposed ban is unconstitutional on two grounds: freedom of religion and government establishment of (ir)religion.

Commenter: Jessie Z. 4/16/19 6:10 pm

It's up to the parents.

I do not want the government telling me what I can and cannot do regarding my children.

Commenter: Mary Yasenchak 4/16/19 6:12 pm

Do NOT ban conversion therapy

Commenter: Gregory Robinson 4/16/19 6:34 pm

Conversation therapy

As a parent I'm asking - please don't ban conversion therapy.

Commenter: M. G. 4/16/19 6:57 pm

Please do not deny individuals the religious freedom to seek counseling aligned with their faith

Commenter: Rev. Moffatt 4/16/19 7:39 pm

Freedom to get help and make a change

Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions. A ban would deny families the religious freedom to seek counseling aligned with their faith. Please do not deny the families of Virginia their right to choose care that aligns with their religious beliefs or with their personal convictions regarding what is best for their well-being.

Commenter: Dan Yasenchak 4/16/19 8:07 pm

You would be taking away the right and responsibility of a parent. Don't do it!

This is a God given responsibility given to parents not the state. Do not ban this through state regulation.

Commenter: Karen B. 4/16/19 8:42 pm

Do Not Ban Conversion Therapy

Parents have the responsibility to make decisions about what is best for their children. In a land of religious freedom, every person should have the right to respond to issues according to their

beliefs. This ban would encroach on the role of parents and it would limit religious freedom. Please do NOT ban conversion therapy.

Commenter: Stephen Long 4/16/19 9:08 pm

Preserve Parental and Religious Rights, Do Not Ban Conversion Therapy

Preserve Parental and Religious Rights, Do Not Ban Conversion Therapy.

It is important that our government does not begin to take religious rights from its citizens.

It is important that the govenment does not being to remove freedom of speach and the ability to offer conversion therapy to those who want it and those parents who want it for their dependent children.

Thank for preserving our constitutional rights.

Commenter: Lana Schexnader, M.E.V. 4/16/19 9:42 pm

Do not ban conversion therapy

A ban on conversion therapy would be political correctness at its finest and NOT what is best for the child.

Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children.

Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children.

Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions. Are we to deny them the counseling they desire and deserve?

A ban would deny families the religious freedom to seek counseling aligned with their faith.

Commenter: Anna Pham 4/16/19 9:42 pm

Do not ban the conversion therapy.

As a parent, I do not want to ban the conversion therapy.

Commenter: Shawn McGowan 4/16/19 10:08 pm

Do not ban reparative or "conversion" therapy

Commenter: Edward S. White 4/16/19 10:10 pm

Regulatory Ban on Conversion Therapy

I write to oppose the adoption of any regulation that would prevent licensed therapists from engaging in so-called "conversion therapy." Parents, who know their children best and, under Virginia law, have the fundamental right to make decisions regarding their upbringing, education and care, are in the best position to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children. Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions. A ban would deny families the religious freedom to seek counseling aligned with their faith. The State should not impinge on parental rights and religious freedom by prohibiting "conversion therapy," certainly not via a regulation where the policy could not garner majority support in the legislature.

Commenter: Shawn Marshall 4/16/19 10:41 pm

Conversion Therapy is a protected Right

It is simply unconstitutional to ban so called 'conversion therapy'. Homosexuality is objectively disordered and children are not slaves of the Commonwealth. This is religious persecution wrapped up in a rainbow flag. Why do they fear it?

Commenter: Felicia D. 4/16/19 10:43 pm

Protect parental rights and our religious freedom

Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children. Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children. Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions. A ban would deny families the religious freedom to seek counseling aligned with their faith.

Commenter: E. Saxe 4/16/19 10:45 pm

Ban conversion therapy

I am gay, this affects people like me greatly.

I, or any LGBT person, do not deserve to be tortured, traumatized, belittled, etc. for something that is not under my control and isn't at all a problem.

Religious freedom shouldn't let someone intentionally traumatize their child. Nothing can excuse intolerance, bigotry, abuse, and alienation.

Commenter: Eli Ott, Concerned Citizen 4/16/19 10:55 pm

Ban Conversion Therapy

Hi conversion therapy is a terrible thing that doesn't even work 90% of the time and often drives young people to suicide. Please ban it.

Commenter: Emily Outzen 4/16/19 11:15 pm

Ban Conversion Therapy for Minors

Conversion therapy treats queerness as something inherently wrong and to be fixed. Therapy for mental illness is sought by individuals who find their quality of life suffering due to said mental illness. Queerness does not affect the quality of life - it is simply a facet of a person. Seeking therapy to remove or improve that facet is of course allowed, but should only be sought by choice and not enforced on a child who cannot speak for themselves in a court of law. Conversion therapy should only be allowed for those who are over 18.

Commenter: Saint Francis of Assisi Care for the poor 4/16/19 11:25 pm

You must not try to illicitly override our General Assembly by regulations contrary to the assembly

You must not try to illicitly override our General Assembly by regulations contrary to the assembly..

Commenter: Tyler Thompson 4/16/19 11:28 pm

Ban Conversion Therapy

Conversion Therapy is listed as child abuse in my state and highly illegal. It's also a form of torture as well as abuse! It causes long-lasting mental trauma! It's appalling to me that anybody would willingly put their child through something like this.

Commenter: Rev. Marty Anderson, Commonwealth Baptist Church 4/16/19 11:30 pm

Protect Minors from Conversion Therapy

As a pastor with a degree in counseling, I often provide pastoral care to those who are spiritually wounded. I have counseled people struggling to recover from the damage done to them through conversion therapy. It is not uncommon for those who experienced conversion therapy to not trust their church, their pastors, or the love of their God. Some people never heal from this trauma. Please protect minors from having this dangerous, unscientific practice forced upon them.

Commenter: Tomn Wisnowski 4/16/19 11:47 pm

Ban Conversion Therapy

Conversion therapy has been discredited by the APA. The state has an obligation to ensure public safety and prevent psychological abuse of minors.

Commenter: Peggy Palizzi 4/16/19 11:56 pm

Protect the freedom of VA families to acquire the counseling they choose

Commenter: Noelle Hurd, UVA 4/17/19 12:35 am

Conversion therapy is toxic

I am writing this as a licensed clinical psychologist. Few practices have hurt LGBTQ people more than discredited, dangerous so-called "therapies" that attempt to change their sexual orientation or gender identity. Most therapists understand that trying to change a young person's sexual orientation or gender identity is harmful, wrong, and abusive. But, in every state, some therapists continue to engage in these dangerous practices, deceiving parents, and causing LGBTQ youth to suffer lasting trauma. All the nation's leading medical and mental health organizations have come out against these practices—which include the use of shame, verbal abuse, and even physical aversion techniques—saying they pose serious health risks, including depression, guilt, helplessness, hopelessness, and social withdrawal, which can lead to suicide risk. These practices continue to exist only because of homophobia and discrimination against LGBTQ people. These practices are based on false notion that LGBTQ youth need to be "converted" or "repaired."

Commenter: Angela O'Connor 4/17/19 12:45 am

Protect parental rights

Protect parental rights and religious freedom in counseling.

Commenter: D W Bain 4/17/19 4:10 am

Protect familial rights - Do NOT ban

Protect the freedom of Virginia families to acquire the counseling they choose.

Commenter: A Francis Guidarelli 4/17/19 5:38 am

Do not ban licensed professionals from providing reparative or "conversion" therapy to children

Parents are closest to their children. Parents are in the best position to see the challenges their children face. Parents are in the best position to identify solutions and to make healthcare decisions that involve their children's physical, mental, emotional, and spiritual health and wellbeing.

Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education, and care of their children.

Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions.

A ban would deny families the religious freedom to seek counseling aligned with their faith.

Commenter: Astrophel 4/17/19 5:39 am

Ban It.

If your argument is "religious freedom!" maybe you should consider that God wouldn't want you to tourture your own children? Just a thought.

Commenter: Jerome Bergfeld

Guidance on conversion therapy

Don't BAN parents rights to work with their doctors for the health and safety of their children .

4/17/19 7:13 am

Commenter: Dan Edwards, Ph.D.

Conversion Therapy is Harmful

I've worked with vulnerable children, youth, and families my entire career -- first as a classroom teacher and then as a clinical psychologist. Having known many healthy gay youth struggling to make it through a difficult period (called adolescence) -- I can say unequivocally that so-called "Conversion Therapy" is unethical, harmful, and dangerous. As such -- especially given the rise in suicide rates statewide -- it should be banned in the Commonwealth of Virginia.

"Conversion Therapy" attempts to teach gay youth that their feelings regarding sexual orientation are 'abnormal' and that their innate sexuality is sinful and wrong. And when it doesn't work, youth are left feeling even worse about themselves. As impressionable youth they need to hear messages of empowerment and confirmation not threats and abuse -- which happens typically because they've just been subjected to complete strangers who've told them they MUST change. Many teens succumb to the pressure, and the personal battle ends in suicide.

For those teens who are strong enough to pull through once "Conversion Therapy" treatment ends, they're saddled with the weight of self-hatred, depression and deteriorated family relationships. For a teenager in some of their most formative years, this type of emotional trauma can be devastating. They emerge with horror stories and flashbacks akin to members of the military with PTSD. No teen should be subjected to this. No parent should believe that this type of "therapy" actually works. (Parents need to understand that if they subject their child to this, it could forever end your relationship with them or worse; it could end their life by suicide.)

What gay teens need most is support and love. They need to be surrounded with people who can help them come to terms with their sexuality and continue loving themselves. They don't need to have messages of self-hate reinforced by strangers. They don't need to live in an environment that makes them feel like outsiders. Being a teen is hard enough. "Conversion Therapy" makes teen life insufferable. For many teens, it's the final straw. Offering a 'Therapy" that puts at-risk youth at further risk of suicide -- is simply unconscionable. And inconsistent with the Oath of Hippocrates which states "First Do No Harm."

Parents tend to be allowed to make choices on behalf of their children but there are lines they may not cross -- abuse, neglect, etc. Taking a child to a doctor when the child is not sick is a mental illness (called Munchausen's by Proxy) and is a form of abuse. This country does not allow parents to choose genital mutilation (even though some cultures and religions promote this practice in the name of purity and righteousness. There are safeguards in place to protect children even from their 'well-meaning' parents.

4/17/19 7:40 am

Commenter: Tamela and Jason Frick

Do NOT ban reparative therapy, conversion therapy!

Do not ban reparative, conversion therapy. This would be an infringement of parental rights and of religious freedom on the part of the one seeking counseling and of the professional therapist. Keep government out of these family, personal matters and do not reduce our options.

4/17/19 7:51 am

Commenter: Andrea Kowal

Protect parental rights

Please do not allow special interest groups to deny parents the right to chose the care and counseling services they see fit to care for their own children.

4/17/19 8:40 am

Commenter: Kay Kale, Parent and Child Loudoun

Do Not Ban

BOARD OF COUNSELING DO NOT BAN licensed professionals from providing reparative or "conversion" therapy to children.

Parents of children need the opportunity to personally choose the best medical assistance for their child's needs. Children in crisis and those with identity concerns need therapists who will unbiasedly examine the child's feelings and motivations and not be automatically labeled or pushed into advocacy of same-sex attraction, transgender ideology and even surgery. The Virginia Department of Health Professions is now categorizing standard mental health therapy as "conversion therapy." These children deserve high-quality standard mental health therapy rather than automatic affirmation. Parents will have to go out of state to find high-quality mental health therapy for their children if the Department of Health Professions requires counselors and other therapy providers to automatically affirm children in what is arguably a fluid and changeable identity but could lead them to serious, and likely permanent, psychological and physical changes should they be encouraged on a path of transition.

4/17/19 9:01 am

Commenter: Melanie Beeler

BOARD OF COUNSELING DO NOT BAN licensed professionals from providing reparative or "conversion" ther

4/17/19 9:03 am

Commenter: Courtney Diederich

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ype over this text and enter your comments here. You are limited to approximately 3000 words.

4/17/19 9:04 am

Commenter: Melanie Beeler

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4/17/19 9:06 am

Commenter: James H Miller, Concerned husband and father of three

Do not ban therapy that people are asking for

BOARD OF COUNSELING DO NOT BAN licensed professionals from providing reparative or "conversion" therapy to children. Parents of children need the opportunity to personally choose the best medical assistance for their child's needs. Children in crisis and those with identity concerns need therapists who will unbiasedly examine the child's feelings and motivations and not be automatically labeled or pushed into advocacy of same-sex attraction, transgender ideology and even surgery. The Virginia Department of Health Professions is now categorizing standard mental health therapy as "conversion therapy." These children deserve high-quality standard mental health therapy rather than automatic affirmation. Parents will have to go out of state to find high-quality mental health therapy for their children if the Department of Health Professions requires counselors and other therapy providers to automatically affirm children in what is arguably a fluid and changeable identity but could lead them to serious, and likely permanent, psychological and physical changes should they be encouraged on a path of transition. I personally know people who have been successfully treated using methods this proposal would ban. They live happy lives now, why ban that happiness for others?

4/17/19 9:28 am

Commenter: Donna Russell

BOARD OF COUNSELING DO NOT BAN licensed professionals from providing reparative or "conversion" ther

4/17/19 9:34 am

Commenter: Manuela Saenz

Please defer leasing in areas with outstanding wildlife habitat

4/17/19 9:34 am

Commenter: William Conley

Reparative Therapy

Do Not Ban. Respect the will of the people and PARENTS. Stay in Your Lane, This is Not Your Lane !!

4/17/19 9:35 am

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Commenter: Alexander Diederich, Citizen

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4/17/19 9:36 am

Commenter: Aura Gomez

Please defer leasing in areas with outstanding wildlife habitat

4/17/19 9:40 am

Commenter: Sandra Bermudez

Please defer leasing in areas with outstanding wildlife habitat

4/17/19 9:41 am

Commenter: Berta Estupinan

Please defer leasing in areas with outstanding wildlife habitat

4/17/19 9:42 am

Commenter: Alejandra Gonzales

Please defer leasing in areas with outstanding wildlife habitat

4/17/19 9:42 am

Commenter: Joanna Melton

Do Not Ban Reparative Therapy

Some young people may have attractions they desire to change or moderate and others may desire counseling to live a chaste life. Also, parents have fundamental rights to make decisions regarding the upbringing, care, and education of their children. There should be options for families to make informed decisions and seek counseling that is aligned with their faith. Banning reparative therapy would deny their religious freedom. Please do NOT ban reparative or "conversion" therapy.

4/17/19 9:44 am

Commenter: Scott Connery

Please defer leasing in areas with outstanding wildlife habitat

4/17/19 9:45 am

Commenter: Scott & Stephanie Goodspeed

Weigh the Evidence: The Dangers of "Affirmative Care"

It's important to realize that case studies and research that invalidate the LGBT activist narrative of "born that way" don't currently receive enough weight in the analysis by some policymakers. Indeed, much of it appears to be suppressed which is a dangerous approach in analyzing any social and public policy issue.

Most responsible therapy is inherently reparative in some fashion. Restored lives are living proof that change is possible if professionals are allowed the freedom to get to the root cause of an effect.

The Heritage Foundation has done some very responsible analysis aggregating the research into the resulting effect of affirming gender dysphoria in children and adults. It would be a good idea for any thoughtful and responsible policymaker to hear their analysis particularly in a world where wreckless activism quickly replaces responsible analysis.?

The Medical Harms of Hormonal and Surgical Interventions for Gender Dysphoric Children

https://www.youtube.com/watch?v=bnP_WoeNuwA

4/17/19 9:49 am

Commenter: Therese Obagi, concerned citizen of Virginia

Proposed ban

BOARD OF COUNSELING DO NOT BAN licensed professionals from providing reparative or "conversion" therapy to children.

Consider how many children and teens are influenced by peers, porn, or predatory adults into premature sexual actions. Such behavior often produces pain and confusion and a breakdown of boundaries. Surely those seeking help should not be automatically led to think to that their struggles are an inescapable part of them. It is unfair to insist that medical practitioners treat as normal inclinations which can be caused by wounds or choices which are not really free. It is also an a threat to healthy relationships to suggest that sexual identity (especially in a growing time) must be constantly indulged or analyzed.

Parents cannot be excluded from their children's lives. Parents of children need the opportunity to personally choose the best medical assistance for their child's needs. Children in crisis and those with identity concerns need therapists who will unbiasedly examine the child's feelings and motivations and not be automatically labeled or pushed into advocacy of same-sex attraction, transgender ideology and even surgery.

The Virginia Department of Health Professions is now categorizing standard mental health therapy as "conversion therapy." These children deserve high-quality standard mental health therapy rather than automatic affirmation. Parents will have to go out of state to find high-quality mental health therapy for their children. Please protect the rights of all the citizens of this state.

4/17/19 9:50 am

Commenter: Christine Birden

RIGHT TO CHOOSE

Individuals and/or families should have THE RIGHT TO CHOOSE counseling and therapy. An example of having the abiltiy to choose would be that sexually abused children often question thier sexual practices and identity, bans on therapy would deny them the help and healing they need. Do you want to live with the fact that you would deny a child/adolescent the RIGHT TO THERAPY and deny them the peace they so desperatly seek?

4/17/19 9:53 am

Commenter: Ann Hurley

parental rights and religious freedom in counseling

BOARD OF COUNSELING DO NOT BAN licensed professionals from providing reparative or "conversion" therapy to children.

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4/17/19 10:00 am

Commenter: Laura Justin

Against Proposed Ban

I am against the proposed regulatory guidance concerning conversion therapy (CT). There have been unsavory practices undertaken in the past as part of CT (e.g., electroshock "therapy") that I would welcome being banned. However, the proposed guidance document's definition of CT includes "any practice or treatment...", i.e., counseling or "talk therapy". Further, the proposed CT definition specifically excludes "counseling that provides assistance to a person undergoing gender transition". So it's acceptable for a counselor to help a minor change his/her "gender identity" (a process which may also include hormone treatments & surgery), but a counselor who helps a minor moderate unwanted same-sex attraction would be subject to disciplinary action? Virginia parents should have the freedom to seek help for their children from licensed professionals who are not precluded from addressing the issue of unwanted sexual attraction. The guidance infringes on a therapist's professional judgment, client rights and parental prerogative in an important area of child/adolescent development.

As an aside: it would be helpful if the guidance document at issue was linked to the comment forum. It took some effort to find the document, as entering the guidance document number in the search bar yielded no results.

4/17/19 10:03 am

Commenter: Andrew Santana

Please defer leasing in areas with outstanding wildlife habitat

4/17/19 10:05 am

Commenter: Samuel Sarmiento

Please defer leasing in areas with outstanding wildlife habitat

4/17/19 10:08 am

Commenter: Claudio Nazoa

Please defer leasing in areas with outstanding wildlife habitat

4/17/19 10:29 am

Commenter: Samuel Sarmiento

DO NOT Ban!

4/17/19 10:30 am

Commenter: K. David Vanarsdall

Doctor patient privacy

The state in its support of abortion has supported the privacy of a woman and her doctor. Why does the state now believe otherwise in this proposed law? Where else will the state now be allowed to enter this once private relationship is violated?

4/17/19 10:32 am

Commenter: Farhanna Mauio

DO NOT Ban!

4/17/19 10:34 am

Commenter: Beth Rochkind

Conversion therapy

I am deeply offended on so many levels that Conversion Therrapy is even under consideration. It has been proven a failure statistically. I am sorry that parents would engage and resort to changing the child/adult they have loved for their entire life. As the mother of a gay son, being gay is the least interesting thing about my funny, handsome, brilliant child..

4/17/19 10:42 am

Commenter: Ty Bachus

It Causes Harm!

Please strongly consider banning so-called reparative or conversion therapy. Anyone who's done their research knows the harm this approach can cause to children and young adults. I hear those wishing for parents rights to be protected... .but the rights of children who often have NO VOICE in this discussion and are

the one's too often harmed by these faux therapeautic approaches must be protected! Talk to anyone who has been subjected to this... it's often physically painful and psychologically damaging!

4/17/19 11:04 am

Commenter: Raymond Eck, George Mason University, Counseling Student

Maintain High Standards for Licensed Counselors

Virginia has led the way by setting the highest standards in the country for licensing when it comes to professional counselors education and training and that is why I will be proud to practice here when I graduate this May. Please make me even prouder to be a future Virginia counseler by banning conversion therapy for children. It has no place in our great Commonwealth and by banning it we will continue to lead the way with our high standards for licensure and professional counseling practice conduct.

4/17/19 11:16 am

Commenter: Matt H

Enough govt interference

Choice advocates say to stay out of a parent's decision to kill their unborn baby. Now you say govt should supercede parents interest. Which way is it? A ban would deny families the religious freedom to seek counseling aligned with their faith.

4/17/19 11:16 am

Commenter: Andrew Matt

I am against the ban

I am against the ban. It should be a freedom to choose whether the theraphy stays or not.

4/17/19 11:28 am

Commenter: Dante Bachus

Consider the kids and BAN reparative and conversion therapy

Please ban reparative and conversion therapy. The kids going through this often physically painful and mentally damaging process, often have no voice and no say in what's happening. Doing any research on it will show that this is harmful to both kids and adults.The voice of our children must be protected, as they are our future. Hold our therapists to better standards than this fake 'theraputic' approach.

4/17/19 11:53 am

Commenter: Dierdre Torres

Uphold Virginia law by allowing parents to make decisions for their children.

Uphold Virginia State law and allow parents to make decisions for their children.

4/17/19 12:05 pm

Commenter: E. C. Krattli

Protect the freedom of Virginia families to acquire the counseling they choose

This is a parents concern, not the government. Governments often do what is politically correct not what is right, and seeks to limit what is rightly between parents, their children, and their doctor and therapist. Parents are closest to their children's challenges and they are in the best position to identify solutions and to make

healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children. Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children. Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions. A ban would deny families the religious freedom to seek counseling aligned with their faith.

4/17/19 12:13 pm

Commenter: individual

Allow Conversion and faith based therapy

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4/17/19 12:29 pm

Commenter: Audrey Zimmermann

Parents trump social experiments

- NO to ban licensed professionals from providing reparative or "conversion" therapy to children over suggested social experiments or ideas that spread ideas and practices detrimental to children.
- Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children.
- Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children.
- Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions.
- A ban would deny families the religious freedom to seek counseling aligned with their faith.

4/17/19 12:35 pm

Commenter: Jenni Marchetti

Preserve parental and counselor freedom

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4/17/19 12:49 pm

Commenter: Werner A. Lind

Opposed to the gag rule

The proposed "guidance" document, authorizing government persecution of licensed counseling professionals who offer help to patients seeking to overcome gender confusion and unwelcome sexual desires, is an unethical pandering to a bigoted political lobby, which is pushing intellectually dishonest junk science as a cover for gagging opposing speech. The gag rule has the potental to cause significant psychological harm to the very minors it purports to be concerned with "protecting," is an egregious political interference with the counselor-client relationship and the duty of counselors to provide the best treatment for their clients, violates constitutional protections for free speech and religious freedom, and is patently based on an animus against particular religions which the Supreme Court has ruled is impermissible for government agencies to act upon.

4/17/19 1:12 pm

Commenter: Joan Gorman

Mental Health Therapy

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4/17/19 1:41 pm

Commenter: GABRIELA GOMEZ RAMIREZ

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ext and enter your comments here. You are limited to approximately 3000 words.

4/17/19 1:43 pm

Commenter: CHRISTOPHER LOPEZ

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4/17/19 2:14 pm

Commenter: Virginia Resident

Respect Parental Rights

- Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children.

- Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children.

- Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions.

- A ban would deny families the religious freedom to seek counseling aligned with their faith.

4/17/19 2:15 pm

Commenter: Jackie Kavookjian

BOARD OF COUNSELING

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4/17/19 2:25 pm

Commenter: Bonnie Hernandez

Do not Ban ...

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4/17/19 2:33 pm

Commenter: S Echaniz

No ban!

People should decide for themselves what type of therapy is most likely to help them. Government shouldn't be in the business of regulating what they should or should not want.

4/17/19 2:52 pm

Commenter: Timothy Thomas Cline

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4/17/19 3:02 pm

Commenter: Lisa Ruhl

Don't restrict the rights of medical professionals and parents!

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4/17/19 3:25 pm

Commenter: Kimberle Jacobs

Stick to your standard of care; ban conversion therapy

I see one argument against regulations for licensed counselors is that parents should be able to force their children into whatever kind of treatment the parent deems appropriate. However, counseling is a health care profession, which aheres to a standard of care. We don't let parents dictate other medical treatments, so why should they here? Having a counseling license should mean something and not engage in quackery just because a parent is misguided, ignorant or the like.

4/17/19 3:28 pm

Commenter: Hilary Collins

Counseling

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4/17/19 3:31 pm

Commenter: Heather Ward

PLEASE DO NOT BAN "CONVERSION" (Reparative) THERAPY

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4/17/19 3:45 pm

Commenter: Jacinta Whiting

Do NOT Ban Reparative Therapy

This proposed ban is an overreach to prevent freedom of choice when it comes to gender identity, and unduly limits religious freedom and parental rights. People should be free to choose therapists that can help them cope with or overcome unwanted sexual attractions. People should also be free to choose therapy that will align with their sincerely held religious beliefs. Parents should have the freedom to choose therapy for their children that will truly benefit them. Please do not adopt bans on issues that fall outside the scope of governmental responsibility.

4/17/19 3:51 pm

Commenter: J. W.

Do NOT Ban Reparative Therapy

Not your business!

4/17/19 3:59 pm

Commenter: C Turpin

Proposed ban on reparative/conversion therapy

BOARD OF COUNSELING DO NOT BAN licensed professionals from providing reparative or "conversion" therapy to children.

Parents of children need the opportunity to personally choose the best medical assistance for their child's needs. Children in crisis and those with identity concerns need therapists who will unbiasedly examine the child's feelings and motivations and not be automatically labeled or pushed into advocacy of same-sex attraction, transgender ideology and even surgery. The Virginia Department of Health Professions is now categorizing standard mental health therapy as "conversion therapy." These children deserve high-quality standard mental health therapy rather than automatic affirmation. Parents will have to go out of state to find high-quality mental health therapy for their children if the Department of Health Professions requires counselors and other therapy providers to automatically affirm children in what is arguably a fluid and changeable identity but could lead them to serious, and likely permanent, psychological and physical changes should they be encouraged on a path of transition.

pe over this text and enter your comments here. You are limited to approximately 3000 words.

4/17/19 4:04 pm

Commenter: Ephrem Bartolomeos

DO NOT BAN Reparative or Conversion Therapy

BOARD OF COUNSELING DO NOT BAN licensed professionals from providing reparative or "conversion" therapy to children.

Parents of children need the opportunity to personally choose the best medical assistance for their child's needs. Children in crisis and those with identity concerns need therapists who will unbiasedly examine the child's feelings and motivations and not be automatically labeled or pushed into advocacy of same-sex attraction, transgender ideology and even surgery. The Virginia Department of Health Professions is now categorizing standard mental health therapy as "conversion therapy." These children deserve high-quality standard mental health therapy rather than automatic affirmation. Parents will have to go out of state to find high-quality mental health therapy for their children if the Department of Health Professions requires counselors and other therapy providers to automatically affirm children in what is arguably a fluid and changeable identity but could lead them to serious, and likely permanent, psychological and physical changes should they be encouraged on a path of transition.

over this text and enter your comments here. You are limited to approximately 3000 words.

4/17/19 4:35 pm

Commenter: Robert Rigby, Jr. FCPS Pride

Prohibit "conversion therapy"

Concerted clinical efforts to change sexual orientation and gender identity are destructive to children's well-being. Clinicians in Virginia should not be permitted by licensing agencies to engage in such destructive practices.

4/17/19 5:04 pm

Commenter: Rich Bohmer

Reparative Therapy is a parents decision

Your apparent end run on a Parents decision to explore this option is a very personal decision by a family that you are not part of and should not be involved with in any way.

Your actions are consistent with governments that attempt to take a family's values and replace them with government sponsored mandates. I think this is called communism. Leave family's alone to make their own decisions.

4/17/19 5:18 pm

Commenter: Bernadette Macdonald, PMH CNS

Reparative Therapy

Please do NOT Ban Reparative therapy. Sometimes pre-teen and adolescents experience confusion over gender identity, which with the help of therapy and time, realize that this was more of a developmental issue and not something that might result in a more permanent damage to one's psyche, if a change in one's gender is pursued. Much more harm can be the result. Why not give the person a chance to explore with a therapist this issue?

4/17/19 7:20 pm

Commenter: William and Christine Elliott

Continue to permit options for parents and their children

Parents, starting at the birth of their children, are there to raise and nurture them and live along side them as they face life's questions. This includes identifying solutions and making healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children.

Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children.

Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions.

A ban would deny families the religious freedom to seek counseling aligned with their faith.

4/17/19 7:33 pm

Commenter: CCT

DO NOT BAN REPARATIVE THERAPY

Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children. Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children. A ban would deny families the religious freedom to seek counseling aligned with their faith.

4/17/19 7:35 pm

Commenter: Catherine Thompson

Reparative Therapy is a parental Right

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4/17/19 7:49 pm

Commenter: Brian Addington

Do not Ban Reparative Therpy

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4/17/19 7:55 pm

Commenter: Megan Silvestri

Counseling Ban

BOARD OF COUNSELING DO NOT BAN licensed professionals from providing reparative or "conversion" therapy to children.

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4/17/19 8:08 pm

Commenter: John Forrester

Ban on reparative counciling

Preventing a willing person from attempting to make a lifestyle change that does not do any harm should be allowed. Any therepudic help in making such a change easier should be treated as any service and be allowed to the extent that it does not infringe any rights of the people of our nation.

4/17/19 8:22 pm

Commenter: J S

Protect health care access, freedom of speech, and religious libery; reject this ban

I'm not in principle against banning specific treatments which are clearly harmful. However, the proposal bans any therapy being directed to reduce or mitigate unwanted same-sex attraction. That is an extremely broad and encroaches on first ammendment rights. Persons who seek help for unwanted same-sex attraction should not be denied it, desipite its controversial nature.

4/17/19 8:25 pm

Commenter: Tim Argauer

Against the ban

I am against the ban. Parents and the children should have the freedom to explore alternatives, inlcuding therapy, and counseling when faced with such a difficult problem.

4/17/19 8:44 pm

Commenter: Lisa Ciola

Freedom to choose therapy or not

?

- **Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions.**
-
- **Allow everyone the freedom to choose therapy or not.....banning therapy takes away their freedom to make their own decisions.**

4/17/19 8:46 pm

Commenter: Pia DeSantis Pell

Families need access to therapy

4/17/19 9:00 pm

Commenter: Pia DeSantis Pellp

Families need access to therapy

A three year old boy suddenly expressed his wish to become a girl. A visit to a therapist revealed the source of his desire: his newborn baby sister had severe health issues. His parents had to expend a lot of time and attention on her, and in his child's mind the only explanation he could come up with was that "they like girls better". So he decided he'd better become a girl. Once the therapist shared this with his parents, they instantly adjusted so that their little boy could get the attention and signs of love that he craved, and just as instantly, the

three year old was perfectly happy to be a boy. What if they hadn't been able to "treat" this child? So often "gender confusion" is the result of of such straightforward issues of family dynamics.

4/17/19 9:00 pm

Commenter: Annette Degnan

BOARD OF COUNSELING DO NOT BAN licensed professionals from providing reparative or "conversion" ther

BOARD OF COUNSELING DO NOT BAN licensed professionals from providing reparative or "conversion" therapy to children.

Parents of children need the opportunity to personally choose the best medical assistance for their child's needs. Children in crisis and those with identity concerns need therapists who will unbiasedly examine the child's feelings and motivations and not be automatically labeled or pushed into advocacy of same-sex attraction, transgender ideology and even surgery. The Virginia Department of Health Professions is now categorizing standard mental health therapy as "conversion therapy." These children deserve high-quality standard mental health therapy rather than automatic affirmation. Parents will have to go out of state to find high-quality mental health therapy for their children if the Department of Health Professions requires counselors and other therapy providers to automatically affirm children in what is arguably a fluid and changeable identity but could lead them to serious, and likely permanent, psychological and physical changes should they be encouraged on a path of transition.

4/17/19 9:00 pm

Commenter: Concerned citizen

Amend Guidance Document to protect all VA youth

This guidance document is written is such a way that people whose conscience is violated with acting out on same sex desires would not be able to find support from trained professionals who could use validated approaches such as cognitive-behavioral therapy to aid these clients in developing coping behaviors to achieve their goals of abstinence. This guidance document should be amended to protect clients that have given informed consent to the counseling process the freedom to receive counseling that supports their goals, recognizing the fundamental ethical principles of autonomy, the client's right to control the direction of one's own life. The supporters of this guidance document are supporting people who have no internal conflict with same sex desires or acting on them, disenfranchising many youth that are still trying to figure out their preferences but have a strong belief that same sex attraction is wrong for them and acting out on these desires would create shame. Supporters used research to back their claims. People who have taken classes in research understand that there are many factors in how the research is designed that can affect the results and how they are interpreted. Supporters are emphasizing that the National Boards have banned conversion therapy. Factually, the people on this board were appointed by a Democrat Governor and most likely share a progressive political view. A majority of the behavioral health profession leans toward a progressive political view so to use the national organizations as the source of ethical purity in this situation is somewhat dishonest. In the same way that sexual addiction was not included in the recent DSM because behavioral health professionals on the panels did not want to come across as moralizing, this issue of same sex attraction also is politically and morally impacted. Supporters try to simplify it to state that "people are born this way" does not even support the current trend of fluidity and recognizing the struggle that many adolescents experience in establishing identity. This guidance document needs to be amended to include minors who are still exploring their sexual identity and want support in not acting on same sex desires so that they would not violate their conscience. All citizens of VA need to be respected and protected not just the LGBTQ citizens. A separate informed consent document can be used to protect the autonomy of minors who want to follow their conscience. This could also prevent another part of the population of minors from experiencing depression, anxiety, suicidal ideations and shame because they cannot find professional support for their goals of not acting on same sex attraction. It is a cop out to say that this population can go to their pastors and church for help when the majority of pastors and church leadership does not have the training to effectively help youth struggling with these issues. How can this attitude coming from board members reflect the desire to protect all of the citizens of Virginia? Please make this guidance document reflect protecting all youth not just youth openly comfortable with their LGBTQ identity.

4/17/19 9:02 pm

Commenter: Paul Prebilic

Banning Conversion Therapy is Dangerous

Banning Conversion Therapy would limit free speech and freedom of religion unnecessarily and set a dangerous precedent. Please don't go down this path.

4/17/19 9:18 pm

Commenter: Tim and Lisa Ralston

Parental rights of choice of therapy for their children

BOARD OF COUNSELING DO NOT BAN licensed professionals from providing reparative or "conversion" therapy to children.

Parents of children need the opportunity to personally choose the best medical assistance for their child's needs. Children in crisis and those with identity concerns need therapists who will unbiasedly examine the child's feelings and motivations and not be automatically labeled or pushed into advocacy of same-sex attraction, transgender ideology and even surgery. The Virginia Department of Health Professions is now categorizing standard mental health therapy as "conversion therapy." These children deserve high-quality standard mental health therapy rather than automatic affirmation. Parents will have to go out of state to find high-quality mental health therapy for their children if the Department of Health Professions requires counselors and other therapy providers to automatically affirm children in what is arguably a fluid and changeable identity but could lead them to serious, and likely permanent, psychological and physical changes should they be encouraged on a path of transition.

4/17/19 9:19 pm

Commenter: Jill Bender

Conversion Therapy is a right

BOARD OF COUNSELING DO NOT BAN licensed professionals from providing reparative or "conversion" therapy to children.

Parents and children need the opportunity to personally choose the best medical assistance for their child's needs. Children need someone to talk to who can help them make healthy decisions. Tying the hands of the therapists and limitiing their tools to help children talk through their concerns is ridiculous. The professionals and parents should have the utmost concern for the health of the child and not be trying to push a political agenda or the latest cultural trend.

4/17/19 9:29 pm

Commenter: Mary Burke

Choice of therapies

Families have a right to choose therapy and counselling according to their own religious principles. No teenager should be forced to attend therapy sessions but they should be given the opportunity to learn why their families have chosen the sexual attitudes of their private faith. Teenagers are often confused about sexuality, and counselling can help them understand what it all means now and in the future.

4/17/19 9:34 pm

Commenter: James Carney

Ban the Board of Counseling

I Join the Virginia Catholic Conferencein opposing the Board of Counseling's misguided and unconstitutional proposal

4/17/19 9:43 pm

Commenter: Melissa George

No regulations or bans on Conversion Therapy

Virginia has always done well to protect religious freedoms and the personal rights of individuals. Please do not allow a ban or restrictions through regulations on reparative or conversion therapy. Restricting what a Counselor can talk about will only hurt those who struggle with identity confusion.

Restrictions or bans on conversion therapy will restrict the religious freedoms of families who wish to seek Counseling that that is aligned with their faith.

Some young people claim they want to identify with a different gender. However, they also can change their minds later on. Two years ago a teenage girl close to our family thought she wanted to identify as a male. She changed her mind, and I am grateful that she was able to do that on her own without the pressure from counselors to push her to remain something she now knows she is not. She was able to research both sides of the lifestyle and did a lof of therapy to determine she was indeed a female and wants to remain that way.

Thank you for protecting the freedom of Virginia families to acquire the counseling they choose.

4/17/19 9:50 pm

Commenter: James Keough

No Ban

A ban would deny families the religious freedom to seek counseling aligned with their faith.

4/17/19 9:52 pm

Commenter: Anna Price

Do not ban reparative therapy

Patients and parents of young patients need to have the option of reparative therapy, should they desire it.

4/17/19 9:58 pm

Commenter: Gabe Schaul

Don't Ban It

Every human being should have a right to change their body in whatever way they see fit. Banning it for small children is reasonable (I think it already is), but for teenagers with parental and parent consent, and especially for adults, they should definetly have this freedom.

4/17/19 10:00 pm

Commenter: Kevin Zrenda

A ban on 'reparative' therapy harms youth, impinges on moral freedom

Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions.

This is really a question of separation of church and state-- except for the fact that it would be the state infringing on legitimate personal, moral, and sometimes religious beliefs. If someone wants to remain a virgin, or simply live a life of chastity-- and better deal with their attraction to mixed sexes or same sexes, these bans would prevent counselors from giving helpful advice and support to their clientele. Maybe some people don't want to avoid same sex attraction... okay... maybe some people do... and that's okay too-- the legislature and professional bodies have no right to dictate a personal belief one way or the other.

4/17/19 10:01 pm

Commenter: James Ritchie

Do not ban reparative or conversion therapy

Patients and parents of young patients need to have the option of reparative therapy, should they desire it. Do not take away the rights of parents!

4/17/19 10:06 pm

Commenter: Richard Hayden

DO NOT BAN conversion therapy

Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children. This is an attempt to circumvent the legislative process where your efforts have previously failed. Parents know best how to deal with their children and restoratve/conversion therapy should always be available as a treatment option for them.

4/17/19 10:11 pm

Commenter: Rebecca Horvath

DO NOT BAN licensed professionals from providing reparative or "conversion" therapy to children.

BOARD OF COUNSELING DO NOT BAN licensed professionals from providing reparative or "conversion" therapy to children. Parents of children need the opportunity to personally choose the best medical assistance for their child's needs. Children in crisis and those with identity concerns need therapists who will unbiasedly examine the child's feelings and motivations and not be automatically labeled or pushed into advocacy of same-sex attraction, transgender ideology and even surgery. The Virginia Department of Health Professions is now categorizing standard mental health therapy as "conversion therapy." These children deserve high-quality standard mental health therapy rather than automatic affirmation. Parents will have to go out of state to find high-quality mental health therapy for their children if the Department of Health Professions requires counselors and other therapy providers to automatically affirm children in what is arguably a fluid and changeable identity but could lead them to serious, and likely permanent, psychological and physical changes should they be encouraged on a path of transition.

4/17/19 10:16 pm

Commenter: Concerned mother in Virginia

Parents must have the right to make decisions regarding the care of their children

It would be irresponsible to deny parents the right to make decisions regarding the health of their children. Parents are best suited to address concerns related to the physical, mental, emotional, and spiritual well-being

of their children. While some individuals with same-sex attraction do not wish to change their sexual orientation, there are plenty of others who wish to seek counseling to live a chaste life or to help their sexual orientation conform to their biological sex. Please do not ban conversion therapy.

4/17/19 10:26 pm

Commenter: Nathan Hitchen

Don't ban voluntary methods that might help people

Banning therapy methods that could help individuals in a voluntary setting doesn't make sense. Why restrict therapies that could help people? They might not help everyone, but if they might help someone, why ban it? If individuals seeking help don't feel safe, they can always voluntarily terminate counseling sessions.

This appears to be an undue regulatory burden on licensed professionals.

4/17/19 10:29 pm

Commenter: A Smith, Virginia

Please allow alternative therapies

- Parents are closest to their children's challenges and they are in the best position to identify solutions and to make healthcare decisions involving the physical, mental, emotional, and spiritual wellbeing of their children.
- Under Virginia law, parents have the fundamental right to make decisions regarding the upbringing, education and care of their children.
- Some young people may have attractions they desire to change or moderate. Others may simply desire counseling to live a chaste life. In either instance, there should be options for families to make informed decisions.
- A ban would deny families the religious freedom to seek counseling aligned with their faith.

4/17/19 10:31 pm

Commenter: Barbara Rice

Counselors deserve the freedom to offer various treatments.

Reparative talk therapy for young people struggling with gender issues should not be banned. Families deserve the right to choose this option.

4/17/19 10:59 pm

Commenter: Ruby Nicdao

Reject Ban, Respect Parental Rights

Those who suffer from gender dysphoria and want the therapy should not be discriminated against by banning therapy that will help them lead to accepting the truth about their bodies and reality.

Banning this therapy is an egregious attempt by the board to force a one-sided transgender ideology that is harmful to children.

4/17/19 11:03 pm

Commenter: Dan S

Do not ban reparative therapy - Protect freedom of speech and association

Do not ban reparative therapy - Parents should decide what is best for their children.

The goverment of The United States, and the state of Virginia are explicitly prohibited from curtailing free speech and freedom of association. Banning reparative therapy, a legitmate contracted service would extinguish both of those rights in Virginia, and hand to the to the government more power than it is due. Situations involving children are best addressed by those closest to the situation, parents, not bureacrats.

4/17/19 11:08 pm

Commenter: Elizabeth Berger

Right to choose therapy

Please allow people, especially children and their parents, to choose the proper therapy to achieve mental health. There is a cause for gender identity confusion in young people that can be treated and peace can be reached. Religious and other professionals should be allowed to help the people who need this assistance.

4/17/19 11:13 pm

Commenter: Jeannette Borneman

Reject ban

Counselors should be able to determine the best therapy for patients without restrictions. And patients should not be denied a therapy that may give them the relief they need.

4/17/19 11:22 pm

Commenter: Roland Winston

Regulate Conversion Therapy

Conversion Therapy isn't Therapy. Youth that identify as LGBTQ (Queer or Questioning) are always damaged by others telling them who they are. This isn't about parents rights, the first amendment or religious freedom. It is about arrogance, minipulation and control. From Christian Counselors Code of Ethics 1-330: Consent for Biblical and Spiritual Practices in Counseling ~~Christian counselors do not presume that all clients want or will be receptive to explicit, spiritual Judeo-Christian interventions in counseling

4/18/19 12:01 am

Commenter: Jennifer White

Respect the right to choose therapy options

Please reject the ban on conversion therapy in favor of allowing patients and families the right to choose the therapy option of their choice, including reparative therapy.

4/18/19 1:13 am

Commonwealth of Virginia

Yeatts, Elaine <elaine.yeatts@dhp.virginia.gov>

Comment on Counseling Board proposal regarding therapy

1 message

Frank Moncher <moncherphd@gmail.com>
To: elaine.yeatts@dhp.virginia.gov

Tue, Apr 16, 2019 at 8:54 AM

Dear Counseling colleagues,

Please accept and consider this comment on the Guidance Document on the Practice of Conversion Therapy. As a psychologist, I share your concerns regarding respecting the dignity of each person we serve. Still, I have concerns regarding how these guidelines would affect people seeking psychological services for assistance with unwanted or troubling habits or behaviors. First, the document overall appears to violate a core tenant of the Ethical Principles of Psychologists (Principle E - Respect for peoples rights and dignity) which states that "Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination." In particular, the ideal of self-determination in the document is hampered by the guidelines defining what type of sexual preferences, inclinations, and goals may or may not be addressed in therapy. If clients seek services that are aimed at a particular change of behavior that will facilitate their growth and flourishing, it is in their best interest for a therapist to provide assistance and support. A related concern would have to do with how the guidance would impact therapeutic work with those who consider themselves to have sexual compulsions that interfere with their ability to to function optimally at work or in relationships. The definition includes a language that would make it problematic to make "efforts to change behaviors... or reduce sexual ... feelings". This would impair the ability of psychologists to meet the needs of clients who are feeling out of control and want to improve self-mastery, a commonly hoped for outcome of treatment. Finally, the Virginia regulations governing psychology practice already stipulate that it is the duty of the psychologist to avoid harm to clients (18 VAC 125-20 ...), such that the additional guidance here does not provide any further assistance to the ethical practice of psychology.

Sincerely,
Frank J Moncher, PhD
Licensed Clinical Psychologist (VA #2824)

Commonwealth of Virginia

Yeatts, Elaine <elaine.yeatts@dhp.virginia.gov>

Comment on Sexual Orientation Change Efforts

1 message

Laura Haynes, Ph.D. <laurahaynesphd3333@gmail.com> Wed, Apr 17, 2019 at 4:50 PM
To: elaine.yeatts@dhp.virginia.gov

Please forward.

Dear Members of the Virginia Board of Counseling,

Thank you for the opportunity to offer comment in support of protecting a client's right to therapy to explore their potential for sexual attraction fluidity or to aid them in embracing their innate body sex. Our attached letter explains many of the harms of censoring therapy.

Thank you.

Sincerely,
Laura Haynes, Ph.D., Chair of Research and Legislative Policy,
representing the National Task Force for Therapy Equality.
Laura Haynes, Ph.D., California Licensed Psychologist
Chair of Research and Legislative Policy, National Task Force for Therapy Equality (TherapyEquality.org)
USA Representative, International Federation for Therapeutic and Counselling Choice (IFTCC.org)
Consultant, American College of Pediatricians (ACPeds.org)
Member Research Committee, Alliance for Therapeutic Choice and Scientific Integrity (TherapeuticChoice.com)
Member, California Counseling Coalition
Former President, Christian Association for Psychological Studies—Western Region
Lifetime Member, American Psychological Association
Member, California Association of Marriage and Family Therapists
P.O. Box 653, Tustin, CA 92781
714-665-3333

Harms of Therapy Bans - VA Board of Counseling 2019-4-17 *.pdf
507K

Protect the Right to Therapy.

Fact Sheet: Harms of Censoring Change-Allowing Therapy

Dear Virginia Board of Counseling,

HIGHLIGHTS OF OUR CONCERNS

(1) Therapy bans take away 1st Amendment rights. US Supreme Court: professional speech has the same 1st Amendment rights as other speech; effectively abrogated 9th&3rd Circuit Ct decisions on which bans have relied. Fed judge: Orlando, FL ban fails *all* 1st Amendment tests.

(2) A new study in a peer-reviewed journal adds to over a century of research showing some people change their sexual attraction and behavior through a variety of safe and effective, non-aversive, mainstream therapy methods. ACLU RI: marriages and families can be saved.

(3) APA Task Force: Said no research meeting scientific standards shows today's change-allowing talk therapy to be harmful or ineffective or gay-affirmative therapy to be better. Did *not* declare change-therapy unethical. Said aversive methods have not been used for 40-50 years.

4) Sexual orientation and childhood gender distress often shift or change. Living as the opposite sex and taking puberty blockers stop natural resolution of trans identity in minors.

(5) Body-altering hormones/surgery: unhealthy, 19 times higher rate of completed suicides. Sterilizing or castrating minors with hormones/surgery should be illegal. Talk therapy is safer.

6) Same-sex orientation and trans identity are *not innate,* professional organizations and research say. They say sexual abuse and family relationships may be causes for some.

(7) In these cases, *talk therapy* may be required and may result in change in sexual orientation or embracing their sex. WPATH does not recommend body-altering medical treatments when a psychiatric disorder is causing gender distress. Forbidding talk therapy leaves them no help.

(8) ACLU of Rhode Island warns: bans censor a *broad range* of therapy goals—go too far.

(9) Under a ban, change-desiring people get a therapy they don't want or none. Hopeless.

(10) Using therapy bans to influence public beliefs is unconstitutional viewpoint discrimination. Recent national research shows conservative religious sexual minorities are happy—but use a different path than progressive LGBTs. Conservative parents, ministries, and therapists can help religious minors/adults experience this happiness. Beliefs that give them real joy may not work for your or your family member, but should they have their freedoms taken away?

Everyone has the right to walk away from sexual practices and experiences that don't work for them. Professional organizations, religious organizations, and most states agree.
Documentary of Reintegrative Therapy™: https://www.freetolovemovie.com/documentary (37 min.)
Testimonies: VoicesOfChange.net, ChangedMovement.com, SexChangeRegret.com.

Laura Haynes, Ph.D., Chair of Research and Legislative Policy, Representing the
National Task Force for Therapy Equality, info@TherapyEquality.org; P.O. Box 653, Tustin, CA 92781

Fact Sheet: Harms of Censoring Change-Allowing Therapy

FOR THOSE WHO WANT MORE DETAILS AND REFERENCES:

(1) **SCOTUS: professional speech has the same 1st Amendment rights as other speech; effectively abrogated 9th & 3rd Circuit Court decisions on which therapy bans have relied.**[1] [2] [3] **Not permissible under our Constitution to allow affirmative but not change-allowing therapy.**[4] Federal magistrate judge reports Tampa, FL therapy ban was shown to fail **all** 1st Amendment tests.[5] **ACLU RI**[6] & **Religious Organizations**:[7] bans threaten 1st Amendment rights.

(2) **A new study in a peer-reviewed journal**[8] **shows some people safely change their sexual attraction and behavior through therapy. Adds to hundreds of studies, most peer-reviewed, spanning a century.**[9]
The men in this study decreased same-sex attraction and behavior, increased opposite sex attraction and behavior, decreased depression, substance abuse, and suicidality, and increased self-esteem. Many who experienced heterosexual attraction for the first time became only heterosexually attracted.
Rates of change: about the same as for anything else therapists treat.

- Therapists used a variety of safe, non-aversive,[10] well-established therapy practices used in clinics world-wide. Bans take away safe, effective therapy.
- Gay-affirming therapy[11] [12] was unacceptable to most on religious grounds.
- Some same-sex attracted minors and adults, like many people, want to be able to procreate children with their spouse and remain married, full-time parents.[13]
- ALCU Rhode Island: under a ban, there will be marriages that can't be saved.[14]
- **Several professional organizations support** this change-allowing therapy.[15]

(3) American Psychological Association (APA) Task Force: No research meeting scientific standards shows change-allowing therapy today is harmful/ineffective for adults/minors or affirmative therapy is better.

(3a) APA Task Force: Reputable change-allowing therapists have not used aversive or behavioristic methods for 40-50 years.
The APA Task Force Report (2009) said behavioristic and aversive methods were predominantly used 40-50 years ago, in the 1960's and early 1970's, and contemporary change-allowing therapists do not use them. Behaviorism was the dominant, mainstream form of therapy decades ago that used classical and op-

erant behavioristic methods that included rewards and aversive consequences to change overt behavior. Behavioristic and aversive methods never were a form of therapy designed just for addressing same-sex behavior. The methods were used for various kinds of unwanted behavior including drinking and smoking. They were even used for marriage counseling. Therapists who are open to sexual attraction or behavior change through therapy have used mainstream methods for their day. When therapists moved on to other forms of therapy, change-allowing therapists did as well.

Today's change allowing therapists do not focus on changing behavior. For example, they do not tell gay men to act more straight or to snap a rubber band on their wrist. Therapists today treat what clients feel are underlying causes. Changes in attraction or behavior are by-products of client-directed therapy.

(3b) Many mental health professionals and organizations are working from mistaken beliefs about contemporary change-allowing therapy.
Many professionals, and even the American Psychological Association in its *APA Handbook of Sexuality and Psychology (2014)*, mistakenly believe change-allowing therapists are using these methods today and base their opposition to change-allowing therapy on this erroneous understanding. For example, the *APA Handbook* says,

> The interventions are based on classical and operant principles. The efforts are unsuccessful even among the highly motivated individuals who pursue such interventions (for reviews, see American Psychological Association, 2009; Beckstead, 2012).[16]

The statement references the 2009 APA Task Force Report that actually says behavioristic methods turned out not to be effective and contemporary change-allowing therapists do *not* use them. The signer of this letter personally told Dr. Lee Beckstead, who was a member of the 2009 APA Task Force and who authored the 2012 paper the *Handbook* referenced, that the *APA Handbook* says change-allowing therapists are using these behavioristic methods. Dr. Beckstead replied, "It's not true."[17]

(3c) No research meeting scientific standards shows contemporary change-allowing therapy to be harmful.[18] [19]
The APA Task Force Report said it was unable to conclude from scientific evidence whether either affirmative therapy or change-allowing therapy was effective or harmful. It said there is no research meeting scientific standards that shows change-allowing therapy today is harmful, and it found no causal evidence of harm. It had no research that showed affirmative therapy is better than change-allowing therapy.

(3d) The APA Task Force Report conclusion was based on one-sided anecdotal, not scientific, evidence.
The Task Force said research provided anecdotal evidence that people said they changed sexual orientation and felt their lives were better for it, and some research provided anecdotal evidence some people felt they were harmed. The Task Force based its conclusion on a "key" view that sexual orientation (meaning same-sex attraction) does not change through life experience.[20] [21] This view was discredited by the *APA Handbook of Sexuality and Psychology* five years later (2014) and by several rigorous studies.[22] As a consequence of this erroneous view that sexual orientation never changes, the Task Force dismissed hundreds of publications that spanned over a century, including studies published by APA members in APA peer reviewed journals, showing that people change, saying they thought the people just felt better because they talked to someone. It then accepted anecdotal evidence of harm from a small number of studies that it said did not meet scientific standards. It said it based its recommendation against change-allowing therapy on one-sided anecdotal evidence of this small number of studies, not scientific evidence. It said its conclusion was tentative.

(3e) **The members of the APA Task Force were already committed to its conclusions on political or philosophical grounds** when the chair of the Task Force selected them. Professional therapists who are now members of our National Task Force for Therapy Equality wrote to the APA Task Force chair asking her to include qualified change-allowing clinicians and researchers who had ex-

pertise in change-allowing therapy and who had offered to serve, and we received letters in which she stated her refusal.

(3f) **Organization position statements are opinions influenced by activist members—not scientific evidence.**

The American Psychological Association based its position on this Task Force conclusion. The APA is the only professional organization we know of that attempted to base its position statement on a review of research. Professional organization position statements on change-allowing therapy are opinions influenced by political activist members, and they are not scientific evidence.

(4) **Sexual orientation and childhood gender dysphoria often shift/change.**

- Same-sex *attraction*, *behavior*, *identity*, and *questioning* often change,[23] mostly toward or to exclusive heterosexuality,[24] for adolescents[25] and adults, men and women (American Psychological Association, rigorous research).
- Gender dysphoria resolves in 75–98% of minors. (9 professional orgs.)[26]
- **Cross dressing and puberty blockers stop natural resolution in minors.**[27]

(5) **Affirmative medical treatment is unhealthy, hardly suicide prevention. It's a risky path of:** experimental puberty-blockers[28] (no research[29]), high dose, toxic[30] wrong-sex hormones (poor research[31]), permanent infertility, potential loss of sexual function, being a medical patient for life, destroying healthy breasts and reproductive organs,[32] 2-2.5 times higher rate of heart disease and cancer **deaths**, persisting 2.8 times higher rate of **psychiatric hospitalizations**, **19 times higher rate *completed* suicides**—even in an affirming society.[33] **These statistics come from the *best* available research.**[34] **ACLU of Rhode Island: this treatment is highly controversial even among professionals.**[35] **Talk therapy is safer. No research shows sterilizing minors/adults is better.**

(6) **Same-sex orientation and gender dysphoria are *not innate*.**[36] [37] **Professional organizations agree they may have pathological causes.**

- The American Psychological Association's *Handbook of Sexuality and Psychology* (2014) says there is no gay gene;[38] s*ame-sex sexuality* is not simply bio-

logically caused like skin color, always has psychological[39] or psychoanalytic (family)[40] causes, and may be caused by childhood sexual abuse for some.[41]

- 10 professional organizations say *gender dysphoria* is not simply caused by biological factors such as brain microstructures but has psychological causes.[42] The *APA Handbook*[43] and the World Professional Association for Transgender Health (WPATH) "Standard of Care"[44] say there may be pathological causes.

(7) **Treating underlying trauma or psychological causes *requires talk therapy* and may *as a by-product* change sexual orientation/gender identity.**

- The *APA Handbook* cautions the affirmative approach can neglect treating individual problems a gender dysphoric individual is experiencing.[45]
- **WPATH does not recommend medicalizing treatments when an underlying psychiatric disorder is causing gender dysphoria.[46] Banning therapy leaves therapists nowhere to go with these clients.**
- Failure to treat can lead to persisting trauma, adverse life consequences, and suicide. Worldwide, 90% of people who commit suicide have unresolved mental disorders.[47] So, for heavens sake, do not ban ordinary, client-directed therapy that may **as a by-product** result in sexual attraction or behavior change or in embracing innate sex. **That is all that change-allowing therapy actually is.**[48]

(8) **ACLU R.I.: Bans censor a broad range of therapy goals.**[49] For example celibacy. Also, attraction feelings for 5 year old children, sex or porn addictions, and more can only be treated if directed toward the opposite, not same, sex.[50]

(9) **Under a therapy ban, some minors don't get therapy, are left hopeless. A ban mandates therapists to affirm or be neutral about sexual and gender feelings caused by trauma.** This is harmful. People who want change-allowing therapy *do not want* LGBT-affirmative or so-called neutral therapy that just offer coping methods to go on living with it.[51] **In states that have these bans, many therapists are afraid, because of the law and legal counsel, to see change-desiring clients**, because a client's sexual attraction or gender identity may change during therapy, placing the therapist at risk. Many change-desiring minors get *no professional mental health services.* Some sexual minorities are sexual abuse victims or suicidal. Cutting off access to services is dangerous, unjust.

(10) A purpose of bans is to coerce compliance with a progressive view in a mistaken belief that the same view is best for all.

A recent *national* study *and joint* research by affirmative and change-allowing researchers finds liberal and conservative religious sexual minorities are equally happy, thriving, healthy, and resolved in how they relate their sexual attractions with their religious beliefs.[52]

The Ryan 2018 study near San Francisco *omitted* happy/changed conservative sexual minority youths, because they are not in LGBT venues near San Francisco. The small study *excluded* youths who *want* change therapy. Conservative therapists, ministries, and parents can help conservative minorities experience happiness. No ideological shift is needed.

A view that brings true joy for some may not work for you or your family member, but should they have their freedoms taken away?

Viewpoint discrimination in law is unconstitutional[53] and bullying.

(11) People commonly seek therapy to shift or change sexual attraction or behavior for personal reasons, not due to social pressure. Examples include: (1) They feel it was caused for them by childhood sexual abuse (and the American Psychological Association says excellent research supports this claim). (2) They feel it was caused by family experiences (and rigorous research backs their belief). (3) Being gay didn't work for them, so it is not their preference. (4) It is endangering their marriage and family. (5) It does not align with their values and beliefs that should be respected. Ethical change-allowing therapy is client-directed therapy.

Therapy that is open to fluidity or change through the intense life experience known as therapy is (1) client-directed therapy (2) that treats factors that rigorous research shows are influences on or causes of same-sex attraction and behavior (3) by means of evidence-based methods or well-established practices (4) to help those who want to live according to their preferences or religious values and beliefs. The APA Task Force Report says, "EBPP is, as defined by APA's Policy Statement on Evidence-Based Practice in Psychology (2005a), 'the integration of the best available research with clinical expertise in the context of patient charac-

teristics, culture, and preferences.[154] **Change-allowing therapy should be considered ethical and should not be censored.**

Everyone has the right to walk away from sexual practices and experiences that don't work for them and should have support to do so.

National Task Force for Therapy Equality, info@TherapyEquality.org

ENDNOTES: MORE INFO & REFERENCES at TherapyEquality.org/HarmsOfTherapyBans

ENDNOTES GIVING MORE INFORMATION AND REFERENCES:

[1]PROFESSIONAL SPEECH HAS THE SAME CONSTITUTIONAL RIGHTS AS ANY OTHER SPEECH.

(*NIFLA v. Becerra*, 138 S.Ct. 2361, 2018.) In *NIFLA*, the Supreme Court expressly rejected the principle legal basis for the decision in *Pickup v. Brown*, in which the 9th Circuit said that SB1172, which banned sexual orientation change efforts for minors, was constitutional.

Justice Thomas, who wrote the main opinion, said (p. 14):

> This Court has never recognized 'professional speech' as a separate category of speech subject to different rules. Speech is not unprotected merely because it is uttered by professionals.
>
> As defined by the courts of appeals, the professional-speech doctrine would cover a wide array of individuals—doctors, lawyers, nurses, physical therapists, truck drivers, bartenders, barbers, and many others. See Smolla, Professional Speech and the First Amendment, 119 W. Va. L. Rev. 67, 68 (2016). One court of appeals has even applied it to fortune tellers. See Moore-King, 708 F. 3d, at 569. All that is required to make something a "profession," according to these courts, is that it involves personalized services and requires a professional license from the State. But that gives the States unfettered power to reduce a group's First Amendment rights by simply imposing a licensing requirement. States cannot choose the protection that speech receives under the First Amendment, as that would give them a powerful tool to impose "invidious discrimination of disfavored subjects.

[2] PROFESSIONAL SPEECH HAS THE SAME CONSTITUTIONAL RIGHTS AS ANY OTHER SPEECH—continued.

(*National Institute of Family and Life Advocates v. Becerra*, 138 S.Ct. 2361, 2018.) In *NIFLA*, the Supreme Court brings into serious question the 9th Circuit Court's decision in *Pickup v. Brown*, on which authors of therapy bans have relied.

Mary McAllister of Liberty Council re CA consumer fraud therapy ban bill, AB2943, 2018:

> ...the United States Supreme Court's June 26, 2018 opinion in *NIFLA v. Becerra*, No. 16–1140....This decision, which reverses Ninth Circuit decisions regarding the Reproductive Freedom, Accountability, Comprehensive Care, and Transparency Act (FACT Act), places into serious question the Ninth Circuit's decision in *Pickup v. Brown,* 740 F. 3d 1208 (9th Cir. 2014), upon which the authors of AB2943 have relied. The Supreme Court's criticism of the *Pickup* ruling should be of concern to the State Senate as it considers AB2943;" Analysis: https://drive.google.com/file/d/0B9njBaZTrCfSdmZiLWF5VnJvNDExcXg5T0FPTWtvNlZn-X2xB/view. Alliance Defending Freedom analysis: https://drive.google.com/file/d/0B9njBaZTrCfSVklGell1WXZ0NG8tbmgzVGs5eGtpS0NBV0hB/view

Alliance Defending Freedom analysis of *NIFLA v Becerra* and analysis of AB 2943. https://drive.google.com/file/d/0B9njBaZTrCfSVklGell1WXZ0NG8tbmgzVGs5eGtpS0NBV0hB/view

[3] Change-allowing therapy also is not only commercial speech, so it is protected speech under the U.S. Constitution. Matt Sharp, senior counsel of the constitutional law firm, Alliance Defending Freedom, gave this analysis of therapy bans when he wrote of a California bill, AB 2943, in personal communication:

> The Supreme Court has made clear that commercial speech is "speech which does no more than propose a commercial transaction." *Va. State Bd. of Pharmacy v. Va. Citizens Consumer Council, Inc.*, 425 U.S. 748, 762 (1976). Even when there is a commercial aspect to speech, that speech does not "retain[] its commercial character when it is inextricably intertwined with otherwise fully protected speech," *Riley v. Nat'l Fed'n of the Blind of N.C., Inc.*, 487 U.S. 781, 796 (1988). When protected speech is part of the speaker's message, this Court will "apply [its strict scrutiny] test for fully protected expression." *Id.* Here, AB 2943intrudes upon the purest sort of private, noncommercial, communications between a counselor and the client. It goes far beyond regulating speech that merely proposes a commercial transaction because it regulates what a counselor or therapist can and cannot say during a private session with a client. Thus, AB 2943 would be subject to strict scrutiny, which it is unlikely to survive.
>
> Importantly, the same argument regarding commercial speech was made by California when defending the California Reproductive Freedom, Accountability, Comprehensive Care, and Transparency Act in the case of *NIFLA v. Harris.* Even the 9th Circuit Court of Appeals rejected the argument that law was designed to regulate commercial speech, recognizing that it regulated the speech inside a pregnancy care center:
>
> > We find unpersuasive Appellees' argument that the Act regulates commercial speech subject to rational basis review. *See Zauderer v. Office of Disciplinary Counsel of Supreme Court of Ohio*, 471 U.S. 626, 651, 105 S.Ct. 2265, 85 L.Ed.2d 652 (1985). Commercial speech "does no more than propose a commercial transaction." *Coyote Pub., Inc. v. Miller*, 598 F.3d 592, 604 (9th Cir. 2010) (citation omitted). The Act primarily regulates the speech that occurs within the clinic, and thus is not commercial speech.
>
> *Nat'l Inst. of Family & Life Advocates v. Harris*, 839 F.3d 823, 835 n.5 (9th Cir. 2016), *rev'd and remanded sub nom. Nat'l Inst. of Family & Life Advocates v. Becerra*, 138 S. Ct. 2361 (2018).

[4] Under a therapy ban, a therapist may provide affirmative therapy at the direction of the client, but a therapist is forbidden to provide change-allowing therapy at the direction of the client. Such non-neutral application of the law is not permissible under our Constitution. Masterpiece Cakeshop, Ltd. v. Colorado Civil Rights Commission, 138 S.Ct. 1719 (2018).

Alliance Defending Freedom (personal communication):
"How does the recent ruling in Masterpiece Cakeshop impact the constitutionality of AB 2943 (the consumer fraud therapy ban bill in California that the sponsor pulled on 8/31/2018)?

> The Supreme Court held that the state of Colorado did not act with the required neutrality towards Jack Phillips when it prosecuted him for declining to create a custom-designed wedding cake to celebrate a same-sex wedding. The lack of neutrality was evidenced by the state upholding the freedom of other cake artists to decline to create cakes that celebrate messages they found offensive.
>
> AB 2943 operates in a similar manner. Counselors, religious organizations, and even churches are subjected to differential treatment when they provide fee-based services and resources to those seeking personal life changes based on their religious views. A counselor who, at the direction of a client, helps affirm the client's same-sex attractions remains free to do so. But a counselor who, also at the direction of a client, helps a client explore and pursue personal life changes for unwanted attractions is subject to liability. Such non-neutral application of the law is not permissible under our Constitution.

[5] U.S. Magistrate Judge in the Middle District of Florida recommended a preliminary injunction on Tampa, FL therapy ban, relying on, among other authorities, NIFLA v. Becerra.
Liberty Counsel press release says, "...the plaintiffs demonstrated that the law violates each and every test of the First Amendment. The plaintiffs demonstrated that the ordinance is unconstitutional because it is (1) a content restriction that is not narrowly tailored; (2) a viewpoint discrimination; (3) unconstitutionally overbroad; (4) a prior restraint; and (5) unconstitutionally vague.
https://lc.org/newsroom/details/013019-tampa-counseling-ban-enjoined-1
The judge's "Report and Recommendation:"
http://lc.org/013019TampaPIOrder.pdf

[6]ACLU of Rhode Island (March 22, 2017), Why the ACLU of Rhode Island opposes conversion therapy, but also opposes legislation to ban it. http://www.riaclu.org/blog/post/the-aclu-of-rhode-island-opposes-conversion-therapy

[7] RELIGIOUS ORGANIZATIONS that oppose a consumer fraud ban on change-allowing therapy include the two largest: **California Catholic Conference** which is the political action organization for all the Catholic bishops of the state of California and the **Ethics & Religious Liberty Commission of the Southern Baptist Convention** which is far and away the largest Protestant denomination in the U.S.(https://erlc.com/resource-library/articles/californias-latest-threat-to-religious-liberty-and-free-speech). See AB2943.com for many clergy, for example hundreds of California pastors in **Church United** (http://www.churchunited.com/impact/), **Awake America** (http://awakeamericaca.org/alerts/) and other organizations that oppose a consumer fraud ban and defend for their First Amendment rights.

[8]Santero, P., Whitehead, N., & Ballesteros, D. (2018), Effects of therapy on religious men who have unwanted same-sex attraction, *The Linacre Quarterly, 85(3).*

[9] Over a century or research, 600 publications, and 5 meta-analyses, including peer reviewed articles published by APA members in APA journals, converge on finding that when change allowing therapy is done right, people have changed their same-sex attractions and behaviors.

On research 2000 to present:
Sprigg, P., 2018, Are Sexual Orientation Change Efforts (SOCE) Effective? Are They Harmful? What the Evidence Shows, Family Research Council, https://www.frc.org/issueanalysis/are-sexual-orientation-change-efforts-soce-effective-are-they-harmful-what-the-evidence-shows :
Read the Full Version (Issue Analysis): https://downloads.frc.org/EF/EF18I04.pdf
Read the Abbreviated Version (Issue Brief Report Summary): https://downloads.frc.org/EF/EF18I05.pdf

On research through 2009:
Report Summary: What research shows: NARTH's response to the APA claims on homosexuality: Summary of *Journal of Human Sexuality* (Volume I), pp. 1-5.
https://www.scribd.com/document/125145105/Summary-of-Journal-of-Human-Sexuality-Volume-1.
Full Report: Phelan, J., Whitehead, N., & Sutton, P.M. (2009), What research shows: NARTH's response to the APA claims on homosexuality: A report of the scientific advisory committee of the National Association for Research and Therapy of Homosexuality. *Journal of Human Sexuality, 1:* 1-121. https://www.scribd.com/doc/115507777/Journal-of-Human-Sexuality-Vol-1

[10] SAFETY OF CHANGE-ALLOWING THERAPY—It's non aversive:

The American Psychological Association's (APA) task force (2009, p. 82), the SPLC itself (website, 2016), law professor Clifford Rosky who writes therapy ban bills (testimony to Utah House Judiciary Committee on 3/1/2019), and licensing boards records agree: change-allowing therapy today uses *non*-aversive methods. Testimonies of aversive methods have been documented to be fraudulent and reported to the Federal Trade Commission. The APA task force authors found "no valid causal evidence" of harm (p. 42), and did not declare change therapy unethical. Actually, they said they had no scientific evidence that *LGB-affirmative* therapy is safe or effective (p. 91), and recent reviews say LGBT-affirmative therapy still has many limitations, yet the task force gave affirmative therapy a pass and recommended it. Opponents of change-allowing therapy have relied heavily on the APA Task Force Report, because the APA is one of the few organizations, perhaps the only one, that attempted to conduct a research review as a basis for its position on change-allowing therapy.

National Task Force for Therapy Equality (May 2, 2017), Federal Trade Commission Report: In Their Own Words - Lies, Deception, and Fraud - SPLC HRC NCLR, https://www.voiceofthevoiceless.info/wp-content/uploads/2017/05/In-Their-Own-Words-Lies-Deception-and-Fraud-National-Task-Force-Complaint-to-the-Federal-Trade-Commission.pdf

APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation (2009), *Report of the Task Force on Appropriate Therapeutic Responses to Sexual Orientation*. Washington, DC: American Psychological Association.

Recent reviews find LGBT-affirmative therapy research still has many limitations: O'Shaughnessy, T., & Speir, Z. (2017) The state of LGBQ Affirmative Therapy Clinical Research: A mixed-methods systematic, p. 22. Preprint. DOI: 10.1037/sgd0000259.
Catelan, R., Brandelli Costa, A., & de Macedo Lisboa, C. (2017) Psychological Interventions for Transgender Persons: A Scoping Review, *International Journal of Sexual Health, 29*:4, 325-337, DOI: 10.1080/19317611.2017. Hembree et al (2017).

APA presidents have provided successful change therapy and opposed bans.
Former APA president: Perloff, R. (2014). A call for the American Psychological Association to recognize the client with unwanted same-sex attractions, *Journal of Human Sexuality 6*: 6-21.
Former APA president Nicolas Cummings, Ph.D., (July 30, 2013), Sexual Reorientation Therapy Not Unethical, USA Today. https://www.usatoday.com/story/opinion/2013/07/30/sexual-reorientation-therapy-not-unethical-column/2601159/
Former APA President Nicholas Cummings' endorsement: Nicolosi, J. (2009). *Shame and Attachment Loss: The Practical Work of Reparative Therapy*, Downers Grove IL.: IVP Academic.

Fact Sheet: Harms of Censoring Change-Allowing Therapy

[11] GAY-AFFIRMATIVE THERAPY DOES NOT MEET THE NEEDS OF EVERYONE:

It may be against the religion of some or not meet their needs in a number of ways.

- **People commonly seek change allowing therapy for sexual attraction or behavior for personal reasons, not due to social pressure. Examples:**
- (1) Being gay or trans is not fulfilling for them.
- (2) They feel same-sex feelings or behaviors were caused for them by childhood sexual abuse (the American Psychological Association says excellent research supports this claim). Or they feel gender distress was caused for them by psychological or family experiences or an underlying psychiatric disorder (8 medical and mental health organizations support the possibility for that claim).
- (3) Being gay or trans does not align with their values and beliefs that should be respected. (4) They, like many people, want a heterosexual marriage and natural children with their spouse.
- **LGB-affirmative therapy for sexual orientation merely offers change-desiring clients help to clarify their sexual orientation identity self-label, in case they are interested in that**, but it does not help them change same-sex behavior or attraction.
- **It only offers support to cope with the suffering of not diminishing their unwanted feelings, but it does not lift a finger to offer trauma treatments that are open to change** (APA Task Force, 2009, p. 4). **What is more compassionate, to help people change feelings and behaviors they don't want, or to tell them they have to go on living with them?**
- **Frequently, it does not evaluate whether trauma or other psychological factors may be causing the same-sex attraction feelings or behaviors.**
- **There is no research that shows it is safe or effective to force affirmative therapy on people who don't want it.**
- **No research that meets scientific standards shows gay-affirmative therapy is better than change-allowing therapy for people who want change-allowing therapy.**

TRANS-AFFIRMATIVE THERAPY FOR GENDER DYSPHORIA DOES NOT MEET THE NEEDS OF EVERYONE:

- **It offers body-harming treatments not everyone wants.**
- **Some cannot have these treatments for medical reasons.**
- **It does not offer psychological intervention to resolve distress.**
- **Frequently, it does not evaluate whether an underlying psychiatric disorder is causing the distress over ones sex.**
- **No research that meets scientific standards has compared medical treatment to change ones body versus psychotherapy to embrace ones body (Zucker, 2018).**
- **Talk therapy is safer.**

[12]LGBT-AFFIRMATIVE THERAPY HAS LIMITED RESEARCH SHOWING IT'S SAFE OR EFFECTIVE:

American Psychological Association Task Force Report (2009), p. 91.

O'Shaughnessy, T., & Speir, Z. (2017) The state of LGBQ Affirmative Therapy Clinical Research: A mixed-methods systematic, p. 22. Preprint. DOI: 10.1037/sgd0000259. Hembree et al (2017).

Catelan, R., Brandelli Costa, A., & de Macedo Lisboa, C. (2017) Psychological Interventions for Transgender Persons: A Scoping Review, *International Journal of Sexual Health, 29*:4, 325-337, DOI: 10.1080/19317611.201

[13]**According to the American Psychological Association and abundant rigorous research internationally, most people who experience same-sex attraction also experience equal or greater opposite-sex attraction. Like many people, some both-sex attracted people desire to both conceive and raise children with their spouse. Many both-sex attracted people are in opposite-sex relationships by preference. They have a large capacity for sexual orientation change.** They commonly shift along a spectrum that ranges exclusively homosexual to mostly homosexual to bisexual (about equally attracted to both sexes) to mostly heterosexual to exclusively heterosexual. They change mostly toward or to exclusively heterosexual. Even a change of 1 or 2 steps along that spectrum toward greater opposite-sex attraction may enable someone to live their dream. Shouldn't they have the right to counseling they may need and desire to explore their capacity to make that change?

"Hence, directly contrary to the conventional wisdom that individuals with exclusive same-sex attractions represent the prototypical 'type' of sexual-minority individual, and that those with bisexual patterns of attraction are infrequent exceptions, the opposite is true. Individuals with nonexclusive patterns of attraction are indisputably the 'norm,' and those with exclusive same-sex attractions are the exception." This pattern has been found internationally.

Diamond (2014), in *APA Handbook of Sexuality and Psychology, 1*:633; see also Diamond, L. & Rosky, C. (2016), Scrutinizing Immutability: Research on Sexual Orientation and U.S. Legal Advocacy for Sexual Minorities. *Journal of Sex Research, 00*:1-29. DOI: 10.1080/00224499.2016.1139665.

"The largest identity group, second only to heterosexual, was 'mostly heterosexual' for each sex and across both age groups, and that group was 'larger than all the other non-heterosexual identities combined'" (abstract). "The bisexual category was the most unstable" with three quarters changing that status *in 6 years* (abstract). "[O]ver time, more bisexual and mostly heterosexual identified young adults of both sexes moved toward heterosexuality than toward homosexuality" (p 106).

Savin-Williams, R., Joyner, K., & Rieger, R. (2012). Prevalence and stability of self-reported sexual orientation identity during young adulthood. *Archives of Sexual Behavior 41:* abstract, p. 106. https://link.springer.com/article/10.1007/s10508-012-9913-y; reviewed in Diamond & Rosky (2016), p. 7, Table 1; Diamond (2014), in *APA Handbook, 1*:638.
Mostly heterosexual individuals generally do not identify as LGB and can get overlooked by popular surveys.

[14]ACLU of Rhode Island (March 22, 2017), Why the ACLU of Rhode Island opposes conversion therapy, but also opposes legislation to ban it. http://www.riaclu.org/blog/post/the-aclu-of-rhode-island-opposes-conversion-therapy

[15]MEDICAL AND MENTAL HEALTH PROFESSIONAL ORGANIZATIONS have opposed bans on change-allowing therapy for an unwanted sexual orientation or unwanted gender identity and/or supported the right of clients to change-allowing therapy for unwanted same-sex attractions and/or unwanted gender identity: 4 Organization Joint Statement—American College of Pediatricians, American Association of Physicians and Surgeons, Christian Medical and Dental Association and Catholic Medical Association—Support Minors' Right to Therapy (5-25-2017), (https://www.acpeds.org/wordpress/wp-content/uploads/5.25.17-Joint-Therapy-letter-with-signatures.pdf), American Association of Physicians and Surgeons (https://aapsonline.org/california-proposes-bills-to-outlaw-self-determination-in-medical-therapy/), American College of Pediatricians (https://drive.google.com/file/d/0B9njBaZTrCfSZ09tRDFQaVVFN1hqVnpH-b3I5RTlqcTI5bHlB/view), Christian Medical and Dental Association (see joint statement), Catholic Medical Association (https://www.cathmed.org/resources/cma-protests-california-bill/), Society of Catholic Social Scientists, International Network of Orthodox (Jewish) Mental Health Professionals, and Alliance for Therapeutic Choice and Scientific Integrity (https://docs.wixstatic.com/ugd/ec16e9_1d6108cfa05d4a73921e0d0292c0bc91.pdf), American Association of Christian Counselors (AACC Code of Ethics, 2014, 1-120f, 1-330, 1-340, https://www.aacc.net/code-of-ethics-2/)

[16]Rosario, M. & Schrimshaw, E. (2014). Theories and etiologies of sexual orientation. In Tolman, D. & Diamond, L., Co-Editors-in-Chief (2014). *APA Handbook of Sexuality and Psychology*, Washington D.C.: American Psychological Association. *1:* 581-582.

[17] Personal communication between Laura Haynes, Ph.D. and Lee Beckstead, Ph.D. at the conference of the Alliance for Therapeutic Choice and Scientific Integrity in Salt Lake City, Utah on October 20, 2017, following Dr. Beckstead's participation in a panel presentation.

[18] NO RESEARCH THAT MEETS SCIENTIFIC STANDARDS HAS FOUND THAT CHANGE-ALLOWING THERAPY FOR SEXUAL ATTRACTIONS OR BEHAVIOR OR FOR GENDER IDENTITY INCONGRUENCE IS HARMFUL OR INEFFECTIVE FOR ADULTS OR MINORS.

Most often cited studies re change-allowing therapy for sexual attraction or behavior:
Sprigg, P., 2018, Are Sexual Orientation Change Efforts (SOCE) Effective? Are They Harmful? What the Evidence Shows, Family Research Council, https://www.frc.org/issueanalysis/are-sexual-orientation-change-efforts-soce-effective-are-they-harmful-what-the-evidence-shows :
Read the Full Version (Issue Analysis): https://downloads.frc.org/EF/EF18I04.pdf
Read the Abbreviated Version (Issue Brief Report Summary): https://downloads.frc.org/EF/EF18I05.pdf
Recent study by et al (2018):
This study researched a small sample of young adults who identify as LGBT and go to gay venues. It automatically overlooked minorities who are happy religious conservatives or who have successfully changed, because these people do not identify as LGB or go to gay venues. The researchers rejected people who initiated getting change-allowing therapy for themselves as adolescents—people who wanted change. The researchers did not define "conversion therapy." Was it is a parent's comment discouraging gay behavior but without effort to change the adolescent? Or 1-2 visits with a pastor not trained in counseling? It is not known how many participants even experienced therapy from a licensed, professional therapist who was actually trained in change-allowing therapy. So what the research actually studied is unknown.
(Ryan, C., Toomey, R., Diaz, R., & Russell, S. (2018), Parent-initiated sexual orientation change efforts with LGBT adolescents: Implications for young adult mental health and adjustment, *Journal of Homosexuality*,DOI:10.1080/00918369.2018.1538407, published online Nov. 7, 2018.)
The APA Task Force Report said studies claiming to show negative outcomes of change-allowing therapy did not meet scientific standards. No conclusions can be drawn from them (pp. 37-42). It said it found "no valid causal evidence of harm" (p. 42).
It said it could draw no scientific conclusions about the safety or effectiveness of either affirmative (p. 91) or change-allowing (p. 42) therapy.
It said it based its tentative recommendations on [one-sided] anecdotal, not scientific, evidence. The report said its conclusions were tentative (p. 85).
APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation. (2009). Report of the Task Force on Appropriate Therapeutic Responses to Sexual Orientation. Washington, DC: American Psychological Association..
The APA task force chair refused expert change-allowing clinicians and researchers who offered to serve on the task force and chose LGB professionals who were already committed to the conclusions on political or philosophical grounds.

Zucker re change-allowing therapy for gender incongruence:
Zucker, K. (2018), The myth of persistence: Response to "A critical commentary on follow-up studies and 'desistance' theories about transgender and gender non-conforming children" by Temple Newhook et al. (2018), *International Journal of Transgenderism*, p. 9, https://doi.org/10.1080/15532739.2018.1468293

[19] Contemporary change-allowing therapy uses *non*-aversive methods (APA Task Force Report, 2009, p. 82). Opponents of change-allowing therapy have relied heavily on the APA Task Force Report, because the APA is one of the few organizations, perhaps the only one, that attempted to conduct a research review as a basis for its position on change-allowing therapy. The Task Force said research on *both* affirmative therapy (p. 91) *and* sexual orientation change efforts (pp. 28, 82-83) did not meet meticulous standards for the Task Force to be willing to conclude whether either of these approaches was effective or safe. It found "no valid causal evidence" of harm for change-allowing therapy (p. 42). The APA Report said it based its conclusion on anecdotal evidence—*not* scientific evidence (p. 42). APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation (2009), *Report of the Task Force on Appropriate Therapeutic Responses to Sexual Orientation.* Washington, DC: American Psychological Association.

• *Recent reviews find LGBT-affirmative therapy research still has many limitations:*
O'Shaughnessy, T., & Speir, Z. (2017) The state of LGBQ Affirmative Therapy Clinical Research: A mixed-methods systematic, p. 22. Preprint. DOI: 10.1037/sgd0000259.
Catelan, R., Brandelli Costa, A., & de Macedo Lisboa, C. (2017) Psychological Interventions for Transgender Persons: A Scoping Review, *International Journal of Sexual Health, 29*:4, 325-337, DOI: 10.1080/19317611.2017. Hembree et al (2017).

[20] The APA Task Force Report said it discouraged sexual orientation change efforts based in part on its so-called "scientific findings" that sexual *identity* self-label changes but sexual *attraction* ("orientation") does not (pp. 86, also pp. 2, 10, 22, 30—footnote 19, 85; sexual behavior and identity appear to have been taken as identity labels as well; pp. 14, 77). That was in 2009.

In 2014, the *APA Handbook of Sexuality and Psychology,* that the American Psychological Association declared authoritative (*1*:xvi), corrected the Task Force Report, concluding that indeed sexual attraction, behavior, and identity—all three—change. SEE ENDNOTE 16.
Several rigorous studies have now established that many experience change—mostly toward or to exclusively heterosexual—and this is true internationally. SEE ENDNOTE 16.

One of the "three key findings" on which the Task Force "built" its recommendations was scientifically invalid, and the *APA Handbook* abandoned it.

[21] The APA Task Force Report (2009) also said a key finding on which it based its conclusions is that same-sex sexuality is not caused by psychoanalytic factors or trauma (pp. 54-55, 63, 86).
But the *APA Handbook of Sexuality and Psychology* (2014) said psychoanalytic factors or "nurture" are always present.
"Biological explanations, however, do not entirely explain sexual orientation. Psychoanalytic contingencies are evident as main effects or in interaction with biological factors....A joint program of research by psychoanalysts and biologically oriented scientists may prove fruitful" (Rosario & Shrimshaw, 2014, in *APA Handbook of Sexuality and Psychology, 1*: 583).
"The inconvenient reality....is that social behaviors are always jointly determined" by nature, nurture, and opportunity (Kleinplatz & Diamond 2014, *APA Handbook*, v. 1, pp. 256-257).

Whenever something is caused by nature or psychoanalytic factors, there is the likelihood that these factors and their effects are not invariably ideal or normal. It would be remarkable, if not a miracle, if trauma could effect seemingly every aspect of human experience except sex—including sexual identity and sexual orientation.

In fact, the *APA Handbook* also said there is evidence that childhood sexual abuse trauma may lead to having a same-sex partner for some, based on rigorous research, including a *30 year* study of *documented* cases of childhood sexual abuse published right after the Task Force Report was published.
(Mustanski, B., Kuper, L., and Geene, G. (2014), *APA Handbook of Sexuality and Psychology.* Roberts, A., Glymour, M., & Koenen, K. (2014).) (Considering alternative explanations for the associations among childhood adversity, childhood abuse, and adult sexual orientation: Reply to Bailey and Bailey (2013) and Rind (2013), *Archives of Sexual Behavior 43*:191-196.)

The Task Force Report had based one of its "scientific facts"—that same-sex orientation is invariably normal and not caused by psychoanalytic factors or trauma—on studies that failed to meet its own scientific standards. (Rosik, C., 2012, Did the American Psychological Association's r*eport on appropriate therapeutic responses to sexual orientation* apply its research standards consistently? A preliminary examination. *Journal of Human Sexuality 4*:68-84.)

The *APA Handbook (2014)* corrects the APA Task Force Report (2009): sexual orientation does change, has psychoanalytic causes, and may be caused by trauma.
Many professional organizations and the so-called SAMHSA report (that states it does *not* necessarily represent the views of SAMHSA) repeat the same unsupported claim that same-sex sexuality is invariably normal and can never be otherwise. AB 2943 and these reports are based on anecdotal evidence and scientific errors.

[22] According to the American Psychological Association and abundant rigorous research internationally, most people who experience same-sex attraction also experience equal or greater opposite-sex attraction. Like many people, some both-sex attracted people desire to both conceive and raise children with their spouse. Many both-sex attracted people are in opposite-sex relationships by preference. They have a large capacity for sexual orientation change. They commonly shift along a spectrum that ranges exclusively homosexual to mostly homosexual to bisexual (about equally attracted to both sexes) to mostly heterosexual to exclusively heterosexual. They change mostly toward or to exclusively heterosexual. Even a change of 1 or 2 steps along that spectrum toward greater opposite-sex attraction may enable someone to live their dream. Shouldn't they have the right to counseling they may need and desire to explore their capacity to make that change?

"Hence, directly contrary to the conventional wisdom that individuals with exclusive same-sex attractions represent the prototypical 'type' of sexual-minority individual, and that those with bisexual patterns of attraction are infrequent exceptions, the opposite is true. Individuals with nonexclusive patterns of attraction are indisputably the 'norm,' and those with exclusive same-sex attractions are the exception." This pattern has been found internationally.

Diamond (2014), in *APA Handbook of Sexuality and Psychology, 1*:633; see also Diamond, L. & Rosky, C. (2016), Scrutinizing Immutability: Research on Sexual Orientation and U.S. Legal Advocacy for Sexual Minorities. *Journal of Sex Research, 00*:1-29. DOI: 10.1080/00224499.2016.1139665.

"The largest identity group, second only to heterosexual, was 'mostly heterosexual' for each sex and across both age groups, and that group was 'larger than all the other non-heterosexual identities combined'" (abstract). "The bisexual category was the most unstable" with three quarters changing that status *in 6 years* (abstract). "[O]ver time, more bisexual and mostly heterosexual identified young adults of both sexes moved toward heterosexuality than toward homosexuality" (p 106).

Savin-Williams, R., Joyner, K., & Rieger, R. (2012). Prevalence and stability of self-reported sexual orientation identity during young adulthood. *Archives of Sexual Behavior 41:* abstract, p. 106. https://link.springer.com/article/10.1007/s10508-012-9913-y; reviewed in Diamond & Rosky (2016), p. 7, Table 1; Diamond (2014), in *APA Handbook, 1*:638.

Mostly heterosexual individuals generally do not identify as LGB and can get overlooked by popular surveys.

[23] AMERICAN PSYCHOLOGICAL ASSOCIATION'S *HANDBOOK* ON SEXUAL ORIENTATION CHANGE:

"...research on sexual minorities has long documented that many recall having undergone notable shifts in their patterns of sexual attractions, behaviors, or identities over time."
(Diamond, L., 2014, Chapter 20: Gender and same-sex sexuality, in *APA Handbook*, *1*: 636.)
"Although change in adolescence and emerging adulthood is understandable, change in adulthood contradicts the prevailing view of consistency in sexual orientation."
(Rosario, M. & Schrimshaw, E., 2014, Chapter 18: Theories and etiologies of sexual orientation, in *APA Handbook*, *1*: 562.)
"Over the course of life, individuals experience the following: (a) changes or fluctuations in sexual attractions, behaviors, and romantic partnerships;..."
Mustaky, B., Kuper, L., and Geene, G. (2014), Chapter 19: Development of sexual orientation and identity, in *APA Handbook*, v. 1, p. 619.

RESEARCH REVIEW ON CHANGE:

"[A]dvocates for sexual minorities have...[argued] that sexual orientation is a fixed, biologically based trait that cannot be chosen or changed" (p. 2) and "openly scolded" individuals who said they experienced otherwise (p. 20). "[A]rguments based on the immutability of sexual orientation are unscientific, given that scientific research does not indicate that sexual orientation is uniformly biologically determined at birth or that patterns of same-sex and other-sex attractions remain fixed over the life course" (p. 2). "We hope that our review of scientific findings and legal rulings regarding immutability will deal these arguments a final and fatal blow" (p. 3).
Diamond, L. & Rosky, C. (2016). Scrutinizing immutability: Research on sexual orientation and U.S. Legal Advocacy for sexual minorities. *Journal of Sex Research*, *00(00)*, 1-29.
REBUTTAL: Rosik, C. (2016). Research review: The quiet death of sexual orientation immutability; How science loses when political advocacy wins.http://www.learntolove.co.za/images/Quiet-Death-of-Sexual-Orientation-Immutability.pdf
Diamond is the co-editor-in-chief of the *APA Handbook of Sexuality and Psychology*. Rosky is a law professor who won the Human Rights Campaign "Equality" award. Rosik (not to be confused with Rosky) is a former president of the Alliance for Therapeutic Choice and Scientific Integrity. Diamond is a recognized expert in sexual orientation change through life experience, and Rosik is an expert in sexual orientation through therapy (an intensified life experience).

THE CAN'T CHANGE MYTH HARMS LGB PEOPLE WHO CHANGE. Many therapy ban supporters indicate sexual orientation cannot change, causing those who experience change through life experience to think they are the only one who has changed or something is wrong with them. Perpetrating the "can't change" myth is harmful. "Many of these women were rejected and stigmatized by their own lesbian communities when they embarked on these unexpected relationships" (Diamond, L., 2008, *Sexual Fluidity: Understanding Women's Love and Desire*. Cambridge, Mass.: Harvard Press, p. 114).

SOME WHO CHANGED THROUGH THERAPY express regret for the years they delayed change because they were told change was not possible through life experience or counseling.

[24]According to the American Psychological Association and abundant rigorous research internationally, MOST PEOPLE WHO EXPERIENCE SAME-SEX ATTRACTION ALSO EXPERIENCE EQUAL OR GREATER OPPOSITE-SEX ATTRACTION. THEY COMMONLY SHIFT ALONG A SCALE that ranges from exclusively homosexual to mostly homosexual to bisexual (about equally attracted to both sexes) to mostly heterosexual to exclusively heterosexual. They change mostly toward or to exclusively heterosexual. Researchers who are themselves LGB consider a change of 1 or 2 steps along that spectrum to be sexual orientation change. **Even a change of 1 or 2 steps along that spectrum toward greater opposite-sex attraction may enable someone to live their dream. Shouldn't they have the right to counseling they may need and desire to explore their capacity to make that change?**

"Hence, directly contrary to the conventional wisdom that individuals with exclusive same-sex attractions represent the prototypical 'type' of sexual-minority individual, and that those with bisexual patterns of attraction are infrequent exceptions, the opposite is true. Individuals with nonexclusive patterns of attraction are indisputably the 'norm,' and those with exclusive same-sex attractions are the exception." This pattern has been found internationally.

Diamond (2014), in *APA Handbook of Sexuality and Psychology, 1*:633; see also Diamond, L. & Rosky, C. (2016), Scrutinizing Immutability: Research on Sexual Orientation and U.S. Legal Advocacy for Sexual Minorities. *Journal of Sex Research, 00*:1-29. DOI: 10.1080/00224499.2016.1139665.

"The largest identity group, second only to heterosexual, was 'mostly heterosexual' for each sex and across both age groups, and that group was 'larger than all the other non-heterosexual identities combined'" (abstract). "The bisexual category was the most unstable" with three quarters changing that status *in 6 years* (abstract). "[O]ver time, more bisexual and mostly heterosexual identified young adults of both sexes moved toward heterosexuality than toward homosexuality" (p 106).

Savin-Williams, R., Joyner, K., & Rieger, R. (2012). Prevalence and stability of self-reported sexual orientation identity during young adulthood. *Archives of Sexual Behavior 41:* abstract, p. 106. https://link.springer.com/article/10.1007/s10508-012-9913-y; reviewed in Diamond & Rosky (2016), p. 7, Table 1; Diamond (2014), in *APA Handbook, 1*:638.

Mostly heterosexual individuals generally do not identify as LGB and can get overlooked by research or popular surveys.

[25] MANY ADOLESCENTS CHANGE SAME-SEX ATTRACTION, BEHAVIOR, AND IDENTITY.

• Most questioning adolescents become heterosexual.

Ott, M. Corliss, H., Wypij, D., Rosario, M., Austin, B. (2011) Stability and change in self-reported sexual orientation in young people: Application of mobility metrics. Archives of Sexual Behavior, 40: 519–532. doi:10.1007/s10508-010-9691-3; Author manuscript available in PMC 2012, June 1. Known as the "GUTS" study.

• 42% of all men who experienced same-sex behavior did so before age 18 and never again.

Laumann, E.O., Gagnon, J.H., Michael, R.T., and Michaels, S. (1994). *The Social Organization of Sexuality: Sexual Practices in the United States*. Chicago and London: The University of Chicago Press.

• 48% of boys who were only attracted to the same sex at age 16 were only attracted to the opposite sex at age 17.

Udry, J.R., & Chantala, K. (2005). Risk factors differ according to same- sex and opposite-sex interest. Journal of Biosocial Science, 37, 481–497. http://dx.doi.org/10.1017/S0021932004006765

A question has been raised as to whether the boys may have been jokesters in giving these responses. But their rates of attraction change are compatible with rates of behavior change given by adults in the Laumann et al (1994) study above.

[26] GENDER DYSPHORIA USUALLY RESOLVES NATURALLY BY LATE ADOLESCENCE:
ENDOCRINE SOCIETY AND 6 CO-SPONSORING ORGANIZATIONS:
80-95% COME TO ACCEPT THEIR INNATE SEX.
Endocrine Society Guideline is co-sponsored by 6 additional US and European organizations: American Association of Clinical Endocrinologists, American Society of Andrology, European Society for Pediatric Endocrinology, European Society of Endocrinology, Pediatric Endocrine Society, and World Professional Association for Transgender Health.
(Hembree, W., Cohen-Kettenis, P., Gooren, L., Hannema, S., Meyer, W., Murad, M., Rosenthal, S., Safer, J., Tangpricha, V., & T'Sjoen, G., 2017, Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrine Society clinical practice guildeline. *J Clin Endocrinol Metab,102*:1–35, http://dx.- doi.org/10.1210/jc.2017-01658, p.10.)
AMERICAN PSYCHIATRIC ASSOCIATION:
70-98% of boys and 50-88% of girls who are distressed by the sex of their bodies come to embrace their innate sex. Desistance rates calculated from persistence rates, DSM-5, p. 455.
(American Psychiatric Association, 201, Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), Arlington, VA: American Psychiatric Association.)
AMERICAN PSYCHOLOGICAL ASSOCIATION:
No less than 75% come to embrace their bodies.
(Bockting, W., 2014, Chapter 24: Transgender Identity Development, In Tolman, D., & Diamond, L., Co-Editors-in-Chief (2014) *APA Handbook of Sexuality and Psychology*, Washington D.C.: American Psychological Association, Volume 1, p. 744.)
RESEARCH: About 80-95% COME TO ACCEPT THEIR INNATE SEX.
(Cohen-Kettenis P, Delemarre-van de Waal, H., & Gooren L. (2008), The treatment of adolescent transsexuals: Changing insights, J Sex Med, 5:1892–1897, DOI: 10.1111/j. 1743-6109.2008.00870.x)
CRITIQUE OF ATTEMPTS TO DENY MOST COME TO ACCEPT THEIR SEX:
Zucker reviewed research on which the American Psychiatric Association, in the *Diagnostic and Statistical Manual*, based its figures of low persistence of gender incongruence. Zucker strongly criticized arguments attempting to call these figures a myth. He called their view "The Myth of Persistence".
(Zucker, K. (2018), The myth of persistence: Response to "A critical commentary on follow-up studies and 'desistance' theories about transgender and gender non-conforming children" by Temple Newhook et al. (2018), *International Journal of Transgenderism*, pp. 2-3, 11, https:// doi.org/ 10.1080/15532739.2018.1468293)

[27]AFFIRMING CHILDREN TO DRESS AND LIVE AS THE OPPOSITE SEX STOPS NATURAL RESOLUTION AND LOCKS THEM IN TO BEING TRANSGENDER FOR LIFE:
Endocrine Society Guideline and 6 co-sponsoring organizations (2017, p. 12).
American Psychological Association (*APA Handbook of Sexuality and Psychology*, 2014, 1:744, 750).

PLACING MINORS ON PUBERTY BLOCKERS DOES NOT GIVE THEM A PAUSE;
IT LOCKS THEM IN FOR LIFE.
"In other words rather than only 20% remaining with gender dysphoria, now 100% believe that their mind and body do not match after taking puberty blockers and will go on to dangerous cross sex hormones and irreversible surgical procedures."
Laidlaw, M. (2018-10-24), The gender identity phantom, http://gdworkinggroup.org/2018/10/24/the-gender-identity-phantom/ Dr. Laidlaw, endocrinologist, expert witness to CA legislators.

[28]PUBERTY BLOCKERS ARE EXPERIMENTAL—HIGH RISK:
CAUSE SUDDEN CARDIAC DEATH:
may result from what is used as a puberty blocker with youth.
Gagliano-Juca, T., Traveison, T., Kantoff, P. Nguyen, P. L., Taplin, M-E, Kibel, A., Huang, G., Bearup, R., Schram, H., Manley, R., Beleva, Y., Edwards, R., Basaria, S. (2018). Androgen Deprivation Therapy is Associated with Prolongation of QTc Interval in Men With Prostate Cancer. Journal of the Endocrine Society, 2: 485-496.
MAY AFFECT BRAIN DEVELOPMENT
(Endocrine Society Guideline with 6 co-sponsoring organizations, 2017, pp. 14-15).

[29]PUBERTY BLOCKER TREATMENT IS NOT EVIDENCE-BASED:
As yet, we have *no* science on the long term medical effects of blocking puberty. This treatment is not evidence-based as supporters claim. The National Institutes of Health in 2015 began a study of transgender youth that will be the first to track medical effects of delaying puberty and only the second to follow its psychological impacts. It will not be completed until 2020. This study is only for 5 years, not long enough to give long term/endpoint outcomes.
Olson, J., Garofalo, R., Rosenthal, St., Spack, N. (2015-2010) The Impact of Early Medical Treatment in Transgender Youth. National Institutes of Health. (Grant study description.) http://grantome.com/grant/NIH/R01-HD082554-01A1

[30]HIGH DOSE CROSS-SEX HORMONES ARE TOXIC—HIGH RISK:
WPATH, Standards of Care (2011), pp. 37-40, 50, 97-104.
RISKS FOR WOMEN:
polycythemia, weight gain, balding, sleep apnea, possible cardiovascular disease, diabetes type 2, bone density loss, and increased risk of cancers (breast, cervical, ovarian, and uterine).
RISKS FOR MEN:
gallstones, weight gain, blood clots (venous thromboembolisms), and sexual dysfunction; also possible cardiovascular disease, diabetes type 2, and breast cancer.
Hembree et al. (2017), pp. 21-25.
Testimony of Michael Laidlow, M.D., Endocrinologist, CA Senate Judiciary Committee, 6/26/2018.

CAUSE 2 TO 2.5 TIMES HIGHER RATES OF DEATH FROM HEART DISEASE OR CANCER. See footnotes 20 and 22.
CROSS-SEX HORMONES INDUCE ABNORMAL, PATHOLOGIC STATES:
"There is no such thing as 'trans puberty'. What happens is that the abnormal, pathologic state of hypogonadotropic hypogonadism is induced by puberty blocking medications. Then dangerous high dose hormones of the opposite sex are given to cause hirsutism (hair growth of the face, chest, back and abdomen) in females and gynecomastia (abnormal breast tissue growth) in males. The medications also atrophy and chemically degrade the sex organs."
Laidlaw, M. (2018-10-24), The gender identity phantom, http://gdworkinggroup.org/2018/10/24/the-gender-identity-phantom/ Dr. Laidlaw, endocrinologist, expert witness to CA legislators.

[31] CROSS-SEX HORMONES NOT EVIDENCE BASED:
WPATH Standards of Care (2011), p. 24. "To date, no controlled clinical trials of any feminizing/masculinizing hormone regimen have been conducted to evaluate safety or efficacy in producing physical transition."
Endocrine Society Guideline (with 6 co-sponsoring organizations) (2017):
See ratings (indicated by a row of circles) of referenced research throughout the Guideline indicating low and very low quality research.

[32] Endocrine Society Guideline (Hembree, et al, 2017), WPATH Standards of Care (2011). World Professional Association for Transgender Health (WPATH) (2011). Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351

[33] Dhejne C, Lichtenstein P, Boman M, Johansson ALV, La˚ngstro¨m N, et al. (2011) Long-term follow-up of transsexual persons undergoing sex reassignment surgery: Cohort study in Sweden. PLoS ONE 6(2): e16885. doi:10.1371/journal.pone.0016885. Sweden is one of the most trans-affirmative and liberal nations in the world.

[34] THESE DEVASTATING OUTCOMES ARE FROM THE BEST RESEARCH AVAILABLE:.
The Centers for Medicare & Medicaid Services (CMS), 2016 (Obama administration) reported this study (Dhejne et al, 2011) was one of only two studies that assessed long term endpoint outcomes (request for surgical reassignment reversal and morbidity/mortality). The CMS report said about this study that showed these devastating outcomes:

> *Although the data are observational, they are robust because the Swedish national database is comprehensive* (including all patients for which the government had paid for surgical services) and is notable for uniform criteria to qualify for treatment and financial coverage by the government....
>
> Dhejne et al., (2011) tracked all patients who had undergone reassignment surgery (mean age 35.1 years) over a 30 year interval and compared them to 6,480 matched controls. *The study identified increased mortality and psychiatric hospitalization compared to the matched controls. The mortality was primarily due to completed suicides (19.1-fold greater than in control Swedes), but death due to neoplasm and cardiovascular disease was increased 2 to 2.5 times as well.* We note, mortality from this patient population did not become apparent until after 10 years. *The risk for psychiatric hospitalization was 2.8 times greater than in controls even after adjustment for prior psychiatric disease (18%).* The risk for attempted suicide was greater in male-to-female patients regardless of the gender of the control. Further, *we cannot exclude therapeutic interventions as a cause of the observed excess morbidity and mortality.*

Centers for Medicare & Medicaid Services, August 30, 2016, Decision Memo for Gender Dysphoria and Gender Reassignment Surgery (CAG-00446N), https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=282.

[35]MEDICAL TRANSITIONING TREATMENT IS CONTROVERSIAL IN THE MEDICAL PROFESSION ITSELF:
ACLU of Rhode Island (March 22, 2017), blog, http://www.riaclu.org/blog/post/the-aclu-of-rhode- island-opposes-conversion-therapy
Cantor, J. (2018), American Academy of Pediatrics policy and trans-kids: Fact-checking. Sexology Today! http://www.sexologytoday.org/2018/10/american-academy-of-pediatrics-policy.html
gdworkinggroup.org
YouthTransCriticalProfessionals.org
4thWaveNow.com

[36] Sex is innate. Sexual orientation, gender identity, and nonconforming sexual expression are not innate. Identical twins have the same genes, pre-natal hormones, and brain microstructures. If a trait is determined by these factors, both twins will have the same trait in nearly 100% of sets of identical twins. Here's what research has found:
If one twin is male, the other is male also nearly 100% of time.
If one twin is female, the other is female also nearly 100% of the time.
If one twin is homosexual, other is homosexual 14% of the time.
If one twin is transsexual, the other is transsexual 28% of the time.
If one twin is gender non conforming, the other usually is not.
References:
Transsexual:
Older study reported in Bockting, W. (2014). Chapter 24: Transgender Identity Development. In Tolman, D., & Diamond, L., Co-Editors-in-Chief (2014) *APA Handbook of Sexuality and Psychology* (2 volumes). Washington D.C.: American Psychological Association, Volume 1, pp. . 739-758.
Same study updated by adding participants: Diamond, M., 2013, Transsexuality Among Twins: Identity Concordance, Transition, Rearing, and Orientation, *International Journal of Transgenderism, 14*:1, 24-38.
Figure of 20% in abstract corrected to 28% by calculation from Table 5, p. 28, as reported in Haynes, L., (September 27, 2016), The American Psychological Association Says Born-That-Way-and-Can't-Change Is Not True of Sexual Orientation and Gender Dysphoria, p. 6, https://docs.wixstatic.com/ugd/ec16e9_a50743b8ec98406aa43437c6ffe1c697.pdf
"Transsexual" was defined in the study as a person who had been living as the opposite sex. Because the study used a small convenience sample, the figure of 28% can be expected to decrease as more representative and larger samples are studied.

Homosexual:
Bailey, J., Vasey, P. Diamond, L., Breedlove, S., Vilain, E., & Epprecht, M. (2016). Sexual orientation, controversy, and science. *Psychological Science in the Public Interest, 17*:74-76. DOI: 10:1177/1529100616637616.
Pairwise concordance = 14%, calculated from probandwise concordance = 25%; 28/114 = about 25%; see bottom of Table 4 on p. 75. Pairwise concordance used to make figures between this research and M. Diamond's study comparable.
Diamond, L. & Rosky, C. (2016). Scrutinizing Immutability: Research on Sexual Orientation and U.S. Legal Advocacy for Sexual Minorities. Journal of Sex Research, 00:4. DOI: 10.1080/00224499.2016.1139665

Non conforming behavior: Bailey et al (2016), p. 76.

[37]PRENATAL HORMONES DO NOT DETERMINE SAME-SEX ATTRACTION:

"The overall body of evidence is mixed (as critiqued by Jordan-Young, 2012), again suggesting that prenatal hormones potentially contribute to same-sex sexuality in some individuals but do not determine it.....Hence, as with the genetic data, the evidence [for prenatal hormones] does not support straightforward causation" (Diamond & Rosky, 2016, p. 6).

Prenatal Hormones—The Fraternal Birth Order Effect (FBO) Theory:

- Applies to about 15% to 28 1/2% of males, no females.
- Might contribute 33%-34% of the variance— about as much as genes contribute—32% or "somewhat" (p. 76)—but does not cause homosexuality. There still have to be environmental causes.

(Bailey et al, 2016, pp. 76, 79)

Some Problems with the fraternal birth order (FBO) theory:

- Male identical twins have the same number of older brothers, but, if one is homosexual, the other usually is not.
- Some very large, rigorous studies failed to find the FBO effect.

Bailey, J., Vasey, P. Diamond, L., Breedlove, S., Vilain, E., & Epprecht, M. (2016). Sexual orientation, controversy, and science. *Psychological Science in the Public Interest, 17*:45-101. DOI: 10:1177/1529100616637616.

Diamond, L. & Rosky, C. (2016). Scrutinizing immutability: Research on sexual orientation and U.S. Legal Advocacy for Sexual Minorities. *Journal of Sex Research, 00*(00), 1-29, DOI: 10.1080/00224499.2016.1139665

38 AMERICAN PSYCHOLOGICAL ASSOCIATION AND RESEARCH SAY THERE IS NO GAY GENE:

"[W]e are far from identifying potential genes that may explain not just male homosexuality but also female homosexuality." (Rosario & Schrimshaw 2014, in *APA Handbook, 1*: 579.)

"Based on what we know about molecular genetics findings in general...we expect that any sexual-orientation genes will have small effects individually" (Bailey et al, 2016, p. 77).
In 2014, the *APA Handbook* said, "Those [genetic] contributions appear to be substantial, given genetic heritability estimates of approximately 40% to 50% for both sexes" (Rosario & Schrimshaw 2014, in *APA Handbook, 1*: 579). That level of heritability was downrated to 32% in 2016 by the reviews of both Bailey et al (p. 76) and Diamond and Rosky (p. 4). "Our best estimate of the magnitude of genetic effects is moderate—certainly not overwhelming. In contrast, the evidence for environmental influence is unequivocal" (Bailey et al, 2016, p. 76).

The genetic effect on sexual orientation is now estimated to be less than estimates of heritability "for a range of characteristics that are not widely considered immutable [unchangeable], such as being divorced, smoking, having low back pain, and feeling body dissatisfaction" (which have heritability rates of 40% to 60%, Diamond & Rosky, 2016, p. 4).

"Based on the evidence from twin studies, we believe that we can already provide a qualified answer to the question, 'Is sexual orientation genetic?' That answer is 'Probably somewhat genetic, but not mostly so'....There can be little doubt that sexual orientation is environmentally influenced" (Bailey et al., 2016, p. 76; see also Diamond & Rosky, 2016, p. 4).

"[W]e focus on one of the largest recent studies, whose findings align with the findings of other similar studies. Researchers analyzed the genomes of more than 23,000 men and women that had been collected by the company 23andMe, and found no genetic loci that were significantly associated with sexual orientation in either men or women (Drabant et al., 2012). However, the marker that came closest to statistical significance among men was located on pericentromeric chromosome 8, a region which had been identified as a possible marker for male sexual orientation in a previous genome-wide association study (Mustanski et al., 2005). As with the findings of heritability, this supports a genetic contribution to sexual orientation, but not genetic determination" (Diamond & Rosky, 2016, p. 4).

Epigenetics

"In essence, the current scientific revolution in our understanding of the human epigenome challenges the very notion of being 'born gay,' along with the notion of being 'born' with *any* complex trait. Rather, our genetic legacy is dynamic, developmental, and environmentally embedded" (Diamond & Rosky, 2016, p. 4, emphasis by the authors). The same principle would apply to the notion of being "born" with the complex traits of transgender, transsexual, or nonconforming gender identity or expression.

[39] SAME-SEX ATTRACTION OR BEHAVIOR IS NOT SIMPLY BIOLOGICALLY CAUSED, *ALWAYS* HAS PSYCHOLOGICAL CAUSES:
"The inconvenient reality....is that social behaviors are always jointly determined" by nature, nurture, and opportunity.
(Kleinplatz, P. & Diamond, L., 2014, in *APA Handbook 1:* 256-257.)
"Nurture" in psychological terms usually designates family experiences in particular.

[40] PSYCHOANALYTIC CAUSES OF SAME-SEX SEXUALITY:
"Biological explanations, however, do not entirely explain sexual orientation. Psychoanalytic contingencies are evident as main effects or in interaction with biological factors....A joint program of research by psychoanalysts and biologically oriented scientists may prove fruitful" (Rosario & Schrimshaw, 2014, in *APA Handbook of Sexuality and Psychology, 1*: 583).

Regarding family dynamics: The APA Task Force accepted uncritically studies that did not meet its own scientific standards but that supported the view that sexual orientation is not caused by psychoanalytic factors/family dynamics or trauma (pp. 82, 86). It made this view a "key" research finding on which it based its conclusions. Yet it held studies that supported change-allowing therapy to its highest standards meticulously and said no conclusions could be drawn. If the Task Force had applied its standards consistently, it would have said it could draw no conclusions as to the causes of same-sex sexuality or concluded that people change their sexual orientation through therapy. "[T]here appears to be substantial bias."
Rosik, C. (2012). Did the American Psychological Association's *Report on Appropriate Therapeutic Responses to Sexual Orientation* apply its research standards consistently? A preliminary examination. *Journal of Human Sexuality, 4*:70-85. http://media.wix.com/ugd/

[41] CHILDHOOD SEXUAL ABUSE MAY LEAD TO HAVING A SAME-SEX PARTNER FOR SOME. A THERAPY BAN MANDATES THERAPISTS TO AFFIRM FEELINGS AND BEHAVIORS VICTIMS FEEL WERE FORCED ON THEM BY PERPETRATORS. THIS IS HURTFUL.

The *APA Handbook of Sexuality and Psychology,* that the American Psychological Association has declared authoritative, says that, unlike skin color, sexual attraction is not simply biologically caused; there are psychological causes such as childhood sexual abuse. It reviews research, including a rigorous, 30 year study of documented cases of childhood sexual abuse, that shows "associative and potentially causal links" between childhood sexual abuse and same-sex sexuality. Is it more compassionate to relieve sexual abuse victims of feelings and behaviors they don't want or to tell them they have to live with them? More from the *APA Handbook of Sexuality and Psychology* (2014) on the 30 year study:

> The largest reviews of the literature in this area indicated that MSM [men who have sex with men] report rates of childhood sexual abuse that are approximately three times higher than that of the general male population (Purcell, Malow, Dolezal, & Carballo-Dieguez, 2004). One of the most methodologically rigorous studies in this area used a prospective longitudinal case-control design that involved following abused and matched nonabused children into adulthood 30 years later. It found that men with documented histories of childhood sexual abuse had 6.75 times greater odds than controls of reporting ever having same-sex sexual partners (H. W. Wilson & Widom, 2010). To help control for possible confounding factors, the authors conducted post hoc analyses controlling for number of lifetime sexual partners and sex work, but the association remained. The effect in women was smaller (odds ratio 2.11) and a statistical trend (*p* .09). (Mustanski, B., Kuper, L., and Geene, G. (2014), *APA Handbook of Sexuality and Psychology.)*

Regarding trauma: The Task Force accepted uncritically studies that did not meet its own scientific standards but that supported the view that sexual orientation is not caused by psychoanalytic factors/family dynamics or trauma (pp. 82, 86). It made this view a "key" research finding on which it based its conclusions. Yet it held studies that supported change-allowing therapy to its highest standards meticulously and said no conclusions could be drawn. If the Task Force had applied its standards consistently, it would have said it could draw no conclusions as to the causes of same-sex sexuality or concluded that people change their sexual orientation through therapy. "[T]here appears to be substantial bias."

Rosik, C. (2012). Did the American Psychological Association's *Report on Appropriate Therapeutic Responses to Sexual Orientation* apply its research standards consistently? A preliminary examination. *Journal of Human Sexuality, 4*:70-85. http://media.wix.com/ugd/

[42] 10 PROFESSIONAL ORGANIZATIONS AGREE GENDER IDENTITY INCONGRUENCE HAS PSYCHOLOGICAL CAUSES:
Endocrine Society with 6 co-sponsoring organizations—American Association of Clinical Endocrinologists, American Society of Andrology, European Society for Pediatric Endocrinology, European Society fo Endocrinology, Pediatric Endocrine Society, and World Professional Association for Transgender Health:
"Results of studies from a variety of biomedical disciplines—genetic, endocrine, and neuroanatomic—support the concept that gender identity and/or gender expression likely reflect a complex interplay of biological, environmental, and cultural factors."
Endocrine Society Guideline (2017), pp. 6-7.
The American Psychological Association's *Handbook of Sexuality and Psychology* says transgender identity is not simply biologically determined, has psychological causes, and may be pathological. Affirmative treatment may neglect individual problems gender dysphoric minors are experiencing.
APA Handbook of Sexuality and Psychology (2014), *1*: 743-744, 750.
American Psychiatric Association: "[I]n contrast to certain social constructionist theories, biological factors are seen as contributing, in interaction with social and psychological factors, to gender development." (DSM-5, p. 451) "Overall, current evidence is insufficient to label gender dysphoria without a disorder of sex development as a form of intersexuality limited to the central nervous system." (DSM-5, p. 457).
American Association of Pediatricians: Gender identity "results from a multifaceted interaction of biological traits, developmental influences, and environmental conditions." p. 2.See also p. 4. Rafferty J, AAP Committee on Psychosocial Aspects of Child and Family Health, AAP Committee on Adolescence, AAP Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness (2018), Ensuring Comprehensive Care and Support for Transgender and Gender Diverse Children and Adolescents. *Pediatrics 142(4)*: e20182162.

[43] TRANSGENDER IDENTITY MAY HAVE PATHOLOGICAL CAUSES:
The American Psychological Association's *Handbook of Sexuality and Psychology* says transgender identity has psychological causes and may be pathological. It also says affirmative treatment may neglect individual problems gender dysphoric minors are experiencing.
APA Handbook of Sexuality and Psychology (2014), *1*: 743-744, 750.

[44] "Gender dysphoria" may be "secondary to or better accounted for by other diagnoses."
WPATH(2011). Standards of Care, http://www.wpath.org/ site_page.cfm?pk_association_webpage_menu=1351, p. 24

Psychological disorders may diminish or resolve through insight from life-experience or psychotherapy. Sex change, however, treats only the symptom of gender distress—and does not treat a psychological disorder (such as gender trauma) that may be causing it—leading some to sex-change regret after the "new car smell" wears off.

Trans regret testimonies of underlying gender trauma:.sexchangeregret.com, tranzformed.org.

[45] American Psychological Association's *APA Handbook of Sexuality and Psychology* cautions that affirmative treatment may neglect treating individual problems a child is experiencing. Bockting, W. (2014). Chapter 24: Transgender Identity Development. In Tolman, D., & Dia- mond, L., Co-Editors-in-Chief (2014) *APA Handbook of Sexuality and Psychology* (2 volumes). Washington D.C.: American Psychological Association, *1*: 744, 750.

[46] WPATH(2011). Standards of Care, http://www.wpath.org/ site_page.cfm?pk_association_webpage_menu=1351, p. 24.

[47] World-wide, 90% of people who commit suicide have mental disorders.

Cavanagh, J., Carson, A., Sharpe, M. & Lawrie, S. (2003), Psychological autopsy studies of suicide: a systematic review, Psychological Medicine, 33: 395–405, Cambridge University Press, DOI: 10.1017/S0033291702006943

Among adolescents in the U.S. who attempt suicide, 96% had at least one pre-existing mental disorder.

Nock, M., Green, J., Hwang, I., McLaughlin, K., Sampson, N., Zaslvsky, A., and Kessler, R. (2013), Prevalence, correlates and treatment of lifetime suicidal behavior among adolescents: Results from the National Comorbidity Survey Replication—Adolescent Supplement (NCS-A), JAMA Psychiatry, 70(3): p. 18, Table 3, doi: 10.1001/2013.jamapsychiatry.55.

[48] WHAT CHANGE-ALLOWING THERAPY ACTUALLY IS:

Opponents use the term "conversion therapy" like a kitchen sink into which they throw all kinds of things that are not even therapy, and certainly are not change-allowing therapy—so they can make it sound like therapists are doing things they are not.

Reparative therapy is trademarked. It is not "conversion therapy" which is an ill-defined term made up by opponents.

The United States Patent and Trademark Office accurately defines what Reparative TherapyTM actually is: "Mental health therapy services, namely, voluntary psychotherapy for individuals seeking to explore underlying psychodynamic factors which may have led to the development of unwanted same-sex attractions, in which treatment interventions are directed toward resolution of underlying gender-related traumas reported by the client using evidence-based treatment interventions."

The *APA Handbook* affirmed same-sex sexual orientation is caused by *psychoanalytic* factors, may be caused by sexual abuse *trauma*, and often *changes*. The *APA Handbook* (2014) thereby corrected the APA Task Force Report (2009) that had relied on studies that did not meet its own criteria.

We use evidence-based treatments for trauma and sexual addictions and well established practices used in clinics around the world and supported by several professional organizations. Change-allowing therapy today does not try to change sexual orientation or gender identity or guarantee change. Changes are by-products of client-directed therapy.

[49] ACLU of Rhode Island (March 22, 2017), Why the ACLU of Rhode Island opposes conversion therapy, but also opposes legislation to ban it. http://www.riaclu.org/blog/post/the-aclu-of-rhode-island-opposes-conversion-therapy.

[50]**Therapists will be required to discriminate against clients based on sexual orientation. Many kinds of symptoms and recognized disorders**—from unwanted emotional and sexual ties that a sexual abuse victim may experience toward an abuser, to desire of adolescents to have sex with much younger children, to compulsive sexual thoughts, to pornography addiction or sexual addiction, and more—**could be treated only if directed toward the opposite, not same, sex.**
Jospeph Nicolosi, Jr., Ph.D. (Feb. 14, 2018). Expert testimony in Maine, audio and written,
http://www.therapyequality.org/testimony-dr-joseph-nicolosi-jr.
Joseph Nicolosi, Jr., Ph.D. (April 3, 2018). Expert testimony in California in opposition to AB 2943, Privacy and Consumer Protection Committee. http://calchannel.granicus.-com/MediaPlayer.php?view_id=7&clip_id=5330.

[51] LGB-AFFIRMATIVE THERAPY only helps individuals clarify their sexual identity self-label (in case they are interested in that, but does not help to change same-sex behavior or attraction) and offers support to cope with the suffering of not diminishing their unwanted feelings, but does not lift a finger to offer trauma treatments that are open to change (APA Task Force, 2009, p. 4).
Transgender-affirmative treatment offers body-harming treatments, not psychological intervention to resolve distress over ones innate body sex and help the client embrace their innate body.
THERE IS NO RESEARCH THAT SHOWS THAT AFFIRMATIVE THERAPY IS SAFER OR MORE EFFECTIVE THAN CHANGE-ALLOWING THERAPY.

[52] A study of happiness in a nationally representative sample of LGBT individuals reported: "Surprisingly, no significant differences [in happiness] are found between mainline Protestants (whose church doctrine often accepts same-sex relations) and evangelical Protestants (whose church doctrine often condemns same-sex relations)." (Abstract)
Barringer, M., Gay, D. (2017), Happily religious: The surprising sources of happiness among lesbian, gay, bisexual, and transgender adults, *Sociological Inquiry, 87*, 75–96, DOI: 10.1111/soin.12154

A recent study of Mormons conjointly conducted by affirmative and change-allowing researchers together found no difference between religiously conservative Mormons who identified as same-sex attracted and religiously progressive Mormons or former Mormons who identified as LGBT in measures of anxiety, depression, substance abuse, flourishing, life satisfaction, or physical health. Yet the conservative Mormons engaged in less same-sex sexual behavior, scored higher on homonegative views, and were less open about their sexual attraction. Both groups were equally resolved in how they integrated their beliefs about same-sex sexuality and their religious beliefs, but they achieved that integration by contrasting paths.
Lefevor, G., Sorrell, S., Kappers, G., Plunk, A., Schow, R., Rosik, C., & Beckstead, A. (2019), Same-Sex Attracted, Not LGBQ: The Associations of Sexual Identity Labeling on Religiousness, Sexuality, and Health Among Mormons, Journal of Homosexuality, DOI: 10.1080/00918369.2018.1564006

Another recent study conjointly conducted by affirming and change-allowing researchers found sexual minorities who live in relationship options that are consistent with conservative faiths can experience satisfaction that is real.
Lefevor, G., Beckstead, L., Schow, R., Raynes, M., Mansfield, T., Rosik, C. (2019), Satisfaction and health within four sexual identity relationship options, *Journal of Sex and Marital Therapy*, http://www.tandfonline.com/action/showCitFormats?doi=10.1080/0092623X.2018.1531333

One of the authors of the conjoint studies, Dr. Christopher Rosik, concludes from studies like these that research on psychology and religion in sexual minorities "almost always overlooks non-LGB identified and satisfied religiously conservative sexual minority folks, so it should not be generalized to them. When studies include them, as ours does, or is taken from large, representative samples, the results are not always (often not?) in keeping with the conventional APA wisdom." (Private communication, 1/30/2019)

For example, Ryan et al (2018) leaves out "non-LGB identified and satisfied religiously conservative sexual minority folks," as Rosik puts it, because they studied only LGBT identified young adults they found in gay venues.

[53] Alliance Defending Freedom (May 9, 2017). Legal Analysis of Amendment No 640 to Nevada SB 201.

[54] APA Task Force (2009), p. 14.

Public Comment on Proposed Regulations Governing the Registration of Qualified Mental Health Professionals

Agenda Item: Adoption of Final Regulations for Registration of Qualified Mental Health Professionals

Included in the agenda package:

Copy of Chapter 80 as proposed (Qualified Mental Health Professionals)

Copies of public comment on proposed regulation

Summary of comment

Staff Note:

The proposed regulation replace emergency regulations currently in effect; the emergency regulations expire on 6/17/19 and a request to the Governor's office for a six-month extension has been requested.

Regulatory Committee to review comment and recommend any changes to full Board

Board to receive recommendation of Regulation Committee and adopt final regulations

Project 5242 - Proposed

BOARD OF COUNSELING

Initial regulations for registration

CHAPTER 80

REGULATIONS GOVERNING THE REGISTRATION OF QUALIFIED MENTAL HEALTH PROFESSIONALS

Part I

General Provisions

18VAC115-80-10. Definitions.

"Accredited" means a school that is listed as accredited on the U.S. Department of Education College Accreditation database found on the U.S. Department of Education website. If education was obtained outside the United States, the board may accept a report from a credentialing service that deems the degree and coursework is equivalent to a course of study at an accredited school.

"Applicant" means a person applying for registration as a qualified mental health professional.

"Board" means the Virginia Board of Counseling.

"Collaborative mental health services" means those rehabilitative supportive services that are provided by a qualified mental health professional, as set forth in a service plan under the direction of and in collaboration with either a mental health professional licensed in Virginia or a person under supervision that has been approved by the Board of Counseling, Board of Psychology, or Board of Social Work as a prerequisite for licensure.

"DBHDS" means the Virginia Department of Behavioral Health and Developmental Services.

"Face-to-face" means the physical presence of the individuals involved in the supervisory relationship or the use of technology that provides real-time, visual, and audio contact among the individuals involved.

"Mental health professional" means a person who by education and experience is professionally qualified and licensed in Virginia to provide counseling interventions designed to facilitate an individual's achievement of human development goals and remediate mental, emotional, or behavioral disorders and associated distresses that interfere with mental health and development.

"Qualified mental health professional" or "QMHP" means a person who by education and experience is professionally qualified and registered by the board to provide collaborative mental health services for adults or children. A QMHP shall not engage in independent or autonomous practice. A QMHP shall provide such services as an employee or independent contractor of DBHDS, the Department of Corrections, or a provider licensed by DBHDS.

"Qualified mental health professional-adult" or "QMHP-A" means a registered QMHP who is trained and experienced in providing mental health services to adults who have a mental illness. A QMHP-A shall provide such services as an employee or independent contractor of DBHDS, the Department of Corrections, or a provider licensed by DBHDS.

"Qualified mental health professional-child" or "QMHP-C" means a registered QMHP who is trained and experienced in providing mental health services to children or adolescents up to the age of 22 who have a mental illness. A QMHP-C shall provide such services as an employee or independent contractor of DBHDS, the Department of Corrections, or a provider licensed by DBHDS.

"Registrant" means a QMHP registered with the board.

18VAC115-80-20. Fees required by the board.

A. The board has established the following fees applicable to the registration of qualified mental health professionals:

Registration	$50
Renewal of registration	$30
Late renewal	$20
Reinstatement of a lapsed registration	$75
Duplicate certificate of registration	$10
Returned check	$35
Reinstatement following revocation or suspension	$500

B. Unless otherwise provided, fees established by the board shall not be refundable.

18VAC115-80-30. Current name and address.

Each registrant shall furnish the board his current name and address of record. Any change of name or address of record or public address if different from the address of record shall be furnished to the board within 60 days of such change. It shall be the duty and responsibility of each registrant to inform the board of his current address.

Part II

Requirements for Registration

18VAC115-80-40. Requirements for registration as a qualified mental health professional-adult.

A. An applicant for registration shall submit:

1. A completed application on forms provided by the board and any applicable fee as prescribed in 18VAC115-80-20; and

2. A current report from the National Practitioner Data Bank (NPDB).

B. An applicant for registration as a QMHP-A shall provide evidence of:

1. A master's degree in psychology, social work, counseling, substance abuse, or marriage and family therapy from an accredited college or university with an internship or practicum of at least 500 hours of experience with persons who have mental illness;

2. A master's or bachelor's degree in human services or a related field from an accredited college with no less than 1,500 hours of supervised experience to be obtained within a five-year period immediately preceding application for registration and as specified in subsection C of this section;

3. A bachelor's degree from an accredited college in an unrelated field that includes at least 15 semester credits or 22 quarter hours in a human services field and with no less than 3,000 hours of supervised experience to be obtained within a five-year period immediately preceding application for registration and as specified in subsection C of this section;

4. A registered nurse licensed in Virginia with no less than 1,500 hours of supervised experience to be obtained within a five-year period immediately preceding application for registration and as specified in subsection C of this section; or

5. A licensed occupational therapist with no less than 1,500 hours of supervised experience to be obtained within a five-year period immediately preceding application for registration and as specified in subsection C of this section.

C. Experience required for registration.

1. To be registered as a QMHP-A, an applicant who does not have a master's degree as set forth in subdivision B 1 of this section shall provide documentation of experience in providing direct services to individuals as part of a population of adults with mental illness in a setting where mental health treatment, practice, observation, or diagnosis occurs. The services provided shall be appropriate to the practice of a QMHP-A and under the supervision of a licensed mental health professional or a person under supervision that has been approved by the Board of Counseling, Board of Psychology, or Board of Social Work as a prerequisite for licensure. Supervision obtained in another United States jurisdiction shall be provided by a mental health professional licensed in Virginia or licensed in that jurisdiction.

2. Supervision shall consist of face-to-face training in the services of a QMHP-A until the supervisor determines competency in the provision of such services, after which supervision may be indirect in which the supervisor is either on-site or immediately available for consultation with the person being trained.

3. Hours obtained in a bachelor's or master's level internship or practicum in a human services field may be counted toward completion of the required hours of experience.

4. A person receiving supervised training to qualify as a QMHP-A may register with the board. A trainee registration shall expire five years from its date of issuance.

18VAC115-80-50. Requirements for registration as a qualified mental health professional-child.

A. An applicant for registration shall submit:

1. A completed application on forms provided by the board and any applicable fee as prescribed in 18VAC115-80-20; and

2. A current report from the National Practitioner Data Bank (NPDB).

B. An applicant for registration as a QMHP-C shall provide evidence of:

1. A master's degree in psychology, social work, counseling, substance abuse, or marriage and family therapy from an accredited college or university with an internship or practicum of at least 500 hours of experience with persons who have mental illness;

2. A master's or bachelor's degree in a human services field or in special education from an accredited college with no less than 1,500 hours of supervised experience to be obtained within a five-year period immediately preceding application for registration and as specified in subsection C of this section;

3. A registered nurse licensed in Virginia with no less than 1,500 hours of supervised experience to be obtained within a five-year period immediately preceding application for registration and as specified in subsection C of this section; or

4. A licensed occupational therapist with no less than 1,500 hours of supervised experience to be obtained within a five-year period immediately preceding application for registration and as specified in subsection C of this section.

C. Experience required for registration.

1. To be registered as a QMHP-C, an applicant who does not have a master's degree as set forth in subdivision B 1 of this section shall provide documentation of 1,500 hours of experience in providing direct services to individuals as part of a population of children or adolescents with mental illness in a setting where mental health treatment, practice, observation, or diagnosis occurs. The services provided shall be appropriate to the practice of a QMHP-C and under the supervision of a licensed mental health professional or a person under supervision that has been approved by the Board of Counseling, Board of Psychology, or Board of Social Work as a prerequisite for licensure. Supervision

obtained in another United States jurisdiction shall be provided by a mental health professional licensed in Virginia or licensed in that jurisdiction.

2. Supervision shall consist of face-to-face training in the services of a QMHP-C until the supervisor determines competency in the provision of such services, after which supervision may be indirect in which the supervisor is either on-site or immediately available for consultation with the person being trained.

3. Hours obtained in a bachelor's or master's level internship or practicum in a human services field may be counted toward completion of the required hours of experience.

4. A person receiving supervised training to qualify as a QMHP-C may register with the board. A trainee registration shall expire five years from its date of issuance.

18VAC115-80-60. Registration of qualified mental health professionals with prior experience.

Until December 31, 2018, persons who have been employed as QMHPs prior to December 31, 2017, may be registered with the board by submission of a completed application, payment of the application fee, and submission of an attestation from an employer that they met the qualifications for a QMHP-A or a QMHP-C during the time of employment. Such persons may continue to renew their registrations without meeting current requirements for registration provided they do not allow their registrations to lapse or have board action to revoke or suspend, in which case they shall meet the requirements for reinstatement.

Part III

Renewal of Registration

18VAC115-80-70. Annual renewal of registration.

All registrants shall renew their registrations on or before June 30 of each year. Along with the renewal form, the registrant shall submit the renewal fee as prescribed in 18VAC115-80-20.

18VAC115-80-80. Continued competency requirements for renewal of registration.

A. Qualified mental health professionals shall be required to have completed a minimum of eight contact hours of continuing education for each annual registration renewal. Persons who hold registration both as a QMHP-A and QMHP-C shall only be required to complete eight contact hours. A minimum of one of these hours shall be in a course that emphasizes ethics.

B. Qualified mental health professionals shall complete continuing competency activities that focus on increasing knowledge or skills in areas directly related to the services provided by a QMHP.

C. The following organizations, associations, or institutions are approved by the board to provide continuing education, provided the hours are directly related to the provision of mental health services:

1. Federal, state, or local governmental agencies, public school systems, licensed health facilities, or an agency licensed by DBDHS; and

2. Entities approved for continuing education by a health regulatory board within the Department of Health Professions.

D. Attestation of completion of continuing education is not required for the first renewal following initial registration in Virginia.

E. The board may grant an extension for good cause of up to one year for the completion of continuing education requirements upon written request from the registrant prior to the renewal date. Such extension shall not relieve the registrant of the continuing education requirement.

F. The board may grant an exemption for all or part of the continuing education requirements due to circumstances beyond the control of the registrant, such as temporary disability, mandatory military service, or officially declared disasters, upon written request from the registrant prior to the renewal date.

G. All registrants shall maintain original documentation of official transcripts showing credit hours earned or certificates of participation for a period of three years following renewal.

H. The board may conduct an audit of registrants to verify compliance with the requirement for a renewal period. Upon request, a registrant shall provide documentation as follows:

1. Official transcripts showing credit hours earned; or

2. Certificates of participation.

I. Continuing education hours required by a disciplinary order shall not be used to satisfy renewal requirements.

Part IV

Standards of Practice, Disciplinary Action, and Reinstatement

18VAC115-80-90. Standards of practice.

A. The protection of the public health, safety, and welfare and the best interest of the public shall be the primary guide in determining the appropriate professional conduct of all persons whose activities are regulated by the board.

B. Persons registered by the board shall:

1. Practice in a manner that is in the best interest of the public and does not endanger the public health, safety, or welfare.

2. Practice only within the competency area for which they are qualified by training or experience and shall not provide clinical mental health services for which a license is required pursuant to Chapters 35 (§ 54.1-3500 et seq.), 36 (§ 54.1-3600 et seq.), and 37 (§ 54.1-3700 et seq.) of the Code of Virginia.

3. Report to the board known or suspected violations of the laws and regulations governing the practice of qualified mental health professionals.

4. Neither accept nor give commissions, rebates, or other forms of remuneration for the referral of clients for professional services and make appropriate consultations and referrals based on the interest of patients or clients.

5. Stay abreast of new developments, concepts, and practices that are necessary to providing appropriate services.

C. In regard to confidentiality and client records, persons registered by the board shall:

1. Not willfully or negligently breach the confidentiality between a practitioner and a client. A breach of confidentiality that is required or permitted by applicable law or beyond the control of the practitioner shall not be considered negligent or willful.

2. Disclose client records to others only in accordance with applicable law.

3. Maintain client records securely, inform all employees of the requirements of confidentiality, and provide for the destruction of records that are no longer useful in a manner that ensures client confidentiality.

4. Maintain timely, accurate, legible, and complete written or electronic records for each client, to include dates of service and identifying information to substantiate treatment plan, client progress, and termination.

D. In regard to dual relationships, persons registered by the board shall:

1. Not engage in dual relationships with clients or former clients that are harmful to the client's well-being, that would impair the practitioner's objectivity and professional judgment, or that would increase the risk of client exploitation. This prohibition includes such activities as providing services to close friends, former sexual partners, employees, or relatives or engaging in business relationships with clients.

2. Not engage in sexual intimacies or romantic relationships with current clients. For at least five years after cessation or termination of professional services, practitioners shall not engage in sexual intimacies or romantic relationships with a client or those included in collateral therapeutic services. Because sexual or romantic relationships are potentially exploitative, the practitioner shall bear the burden of demonstrating that there has been no exploitation. A client's consent to, initiation of, or participation in sexual behavior or involvement with a practitioner does not change the nature of the conduct nor lift the regulatory prohibition.

3. Recognize conflicts of interest and inform all parties of obligations, responsibilities, and loyalties to third parties.

E. Upon learning of evidence that indicates a reasonable probability that another mental health service provider, as defined in § 54.1-2400.1 of the Code of Virginia, is or may be guilty of a violation of standards of conduct as defined in statute or regulation, persons registered by the board shall advise their clients of the client's right to report such misconduct to the Department of Health Professions in accordance with § 54.1-2400.4 of the Code of Virginia.

18VAC115-80-100. Grounds for revocation, suspension, restriction, or denial of registration.

In accordance with subdivision 7 of § 54.1-2400 of the Code of Virginia, the board may revoke, suspend, restrict, or decline to issue or renew a registration based upon the following conduct:

1. Conviction of a felony, or of a misdemeanor involving moral turpitude, or violation of or aid to another in violating any provision of Chapter 35 (§ 54.1-3500 et seq.) of Title 54.1 of the Code of Virginia, any other statute applicable to the practice of qualified mental health professionals, or any provision of this chapter;

2. Procuring, attempting to procure, or maintaining a registration by fraud or misrepresentation;

3. Conducting one's practice in such a manner so as to make it a danger to the health and welfare of one's clients or to the public, or if one is unable to practice with reasonable skill and safety to clients by reason of illness or abusive use of alcohol, drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition;

4. Violating or abetting another person in the violation of any provision of any statute applicable to the practice of qualified mental health professionals or any regulation in this chapter;

5. Performance of functions outside the board-registered area of competency;

6. Performance of an act likely to deceive, defraud, or harm the public;

7. Intentional or negligent conduct that causes or is likely to cause injury to a client;

8. Action taken against a health or mental health license, certification, registration, or application in Virginia or other jurisdiction;

9. Failure to cooperate with an employee of the Department of Health Professions in the conduct of an investigation; or

10. Failure to report evidence of child abuse or neglect as required in § 63.2-1509 of the Code of Virginia or elder abuse or neglect as required in § 63.2-1606 of the Code of Virginia.

18VAC115-80-110. Late renewal and reinstatement.

A. A person whose registration has expired may renew it within one year after its expiration date by paying the late renewal fee and the registration fee as prescribed in 18VAC115-80-20 for

the year in which the registration was not renewed and by providing documentation of completion of continuing education as prescribed in 18VAC115-80-80.

B. A person who fails to renew registration after one year or more shall:

1. Apply for reinstatement;

2. Pay the reinstatement fee for a lapsed registration; and

3. Submit evidence of completion of 20 hours of continuing education consistent with requirements of 18VAC115-80-80.

C. A person whose registration has been suspended or who has been denied reinstatement by board order, having met the terms of the order, may submit a new application and fee for reinstatement of registration as prescribed in 18VAC115-80-20. Any person whose registration has been revoked by the board may, three years subsequent to such board action, submit a new application and fee for reinstatement of registration as prescribed in 18VAC115-80-20. The board in its discretion may, after an administrative proceeding, grant the reinstatement sought in this subsection.

FORMS (18VAC115-80)

The following forms are available online only at https://www.license.dhp.virginia.gov/apply/:

Qualified Mental Health Profession-Adult, Application and Instructions

Qualified Mental Health Profession-Child, Application and Instructions

Qualified Mental Health Profession-Adult, Grandfathering Application and Instructions

Qualified Mental Health Profession-Child, Grandfathering Application and Instructions

Supervised Trainee, Application and Instructions

Board of Counseling

Summary of Public Comment on Regulations

18VAC115-80-10 et seq. Regulations Governing Registration of Qualified Mental Health Professionals

Proposed regulations to replace emergency regulations were published on February 4, 2019 with comment requested until April 5, 2019. A public hearing was conducted on February 8, 2019.

The following comment was received at the public hearing:

Commenters	Comment
Dianne Simons Joni Watlings	Requested that proposed regulations be amended to allow a person to qualify for registration as a QMHP-A or QMHP-C if he/she holds licensure as an occupational therapist by the Board of Medicine with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.
Judith Coleman	Commented that she had been registered as a QMHP by the Board, but in a recent audit, DBHDS cited her agency because she did not have the proper degree.

The following comments were received by email or posted on the Virginia Regulatory Townhall:

Commenters	Comment
81 persons	Requested that proposed regulations be amended to allow a person to qualify for registration as a QMHP-A or QMHP-C if he/she holds licensure as an occupational therapist by the Board of Medicine with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.
5 persons	Requested generally that the hours of mental health experience be reduced for occupational therapists
6 persons	Commented that requirement for supervision of a trainee by a licensed mental health professional was too burdensome and will result in a reduction in the supply of QMHPs. Several suggested the Board should allow a QMHP with experience (one commenter recommended four years) to supervise a QMHP trainee.
3 persons	Commented that all graduates with human services degrees should have the same requirements for 500 hours of experience. (Proposed regulations specify 500 hours for degrees in specific to mental health, such as psychology, but 1,500 hours of experience for other "human services" degrees). One person also expressed concern about the requirement that the hours of experience be within the preceding five years prior to applying for registration.

One person	Commented that sociology should be accepted as a human services degree
One person	Questioned how the Board can monitor the level of supervision specified for training of person qualifying as a QMHP-A or QMHP-C since there is discretion on the part of the supervisor whether the training must be on-site.
Virginia Chapter, National Association of Social Workers	Amend regulation to state that the activities of a QMHP are within the scope of practice of a social worker licensed by the Board of Social Work and such licensure qualifies them for registration as a QMHP.

Comments will be considered at the Regulatory Committee of the Board on May 30, 2019; the Committee will make recommendations to the full Board for adoption of final regulations on May 31, 2019.

DRAFT

Virginia Board of Counseling

Public Hearing

Friday, February 8, 2019

Time and Place: Friday, February 8, 2019 at 9:15 a.m.
Virginia Department of Health Professions
Perimeter Center, 2nd Floor, Board Room 1
9960 Mayland Drive, Henrico, Virginia 23233

Presiding: Kevin Doyle, Ed.D., LPC, LSATP, Chairperson

Members Present:
Barry Alvarez, LMFT
Johnston Brendel, Ed.D., LPC, LMFT
Natalie Harris, LPC, LMFT
Bev-Freda L. Jackson, Ph.D., MA, Citizen Member
Vivian Sanchez-Jones, Citizen Member
Maria Stransky, LPC, CSAC, CSOTP
Terry R. Tinsley, Ph.D., LPC, LMFT, CSOTP, NCC
Holly Tracy, LPC, LMFT
Tiffinee Yancey, Ph.D., LPC

Staff Present:
Christy Evans, Discipline Case Specialist
Jaime Hoyle, Executive Director
Jennifer Lang, Deputy Executive Director
Charlotte Lenart, Licensing Manager
Brenda Maida, Licensing Specialist

Others Present:
David E. Brown, D.C., DHP Director
James Rutkowski, Assistant Attorney General
Allyson Tysinger, Senior Assistant Attorney
Elaine Yeatts, DHP Senior Policy Analyst

Purpose of the Hearing: To hear public comment related to the proposed Regulations Governing the Registration of Peer Recovery Specialists and Regulations Governing the Registration of Qualified Mental Health Professionals.

Public Comment: Dianne Simons, Ph.D., OTR/L, FAOTA VCU Assistant Professor provided written and verbal comments regarding the history, education, licensing qualification and recognition of the occupational therapy as a provider of mental health service by congressional actions and federal agencies, QMHP requirements in other states and mental health provided by occupational therapist worldwide. Ms. Simons request the Board consider amending the requirements for Part II Requirements for Registration 18VAC115-80-40 B.5. and 18VAC115-80-50 B.4 to accept licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with person with mental illness or one year of experience in a mental health setting.

Judith Coleman, QMHP-A, QMHP-C provided public comment regarding her QMHP-C registration. Ms. Coleman stated that she was approved by the Virginia Board of Counseling for QMHP-C registration; however, during a recent audit the Virginia Department of Behavioral Health & Developmental Services (DBHDS) sited her agency due to Mr. Coleman not having a human services or special education degree. Ms. Coleman stated that this type of citation was unfair as she was approved by the Virginia Board of Counseling as a QMHP-C but DBHDS states that she does not qualify.

Joni Watlings, OTR/L provided public comment regarding requirement for occupational therapist for registration as a QMHP. Ms. Watlings supports the statements of Dr. Simons and asked the Board to consider changing the wording to the regulations regarding occupational therapist as stated by Dr. Simons.

Virginia.gov Agencies | Governor

Logged in as
Elaine J. Yeatts

Agency Department of Health Professions

Board Board of Counseling

Chapter

Regulations Governing the Registration of Qualified Mental Health Professionals [under development] [18 VAC 115 - 80]

Action	Initial regulations for registration
Stage	Proposed
Comment Period	Ends 4/5/2019

All good comments for this forum Show Only Flagged

Back to List of Comments

Commenter: Shannon Bennett, Loudoun County Department of Mental Health 2/5/19 10:31 am

QMHP-E Supervision requirements

The requirement that only a licensed professional can supervise a QMHP-E's experience towards becoming a QMHP-A or QMHP-C is particularly onerous considering the current shortage of licensed mental health professionals in the state of Virginia and could lead to a shortage of QMHP's as well.

Commenter: Kristen Maisano 2/14/19 12:23 am

Internship in MH

Please consider changing ***Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C*** be changed from the current Emergency Regulations to the following replacement:

> ***Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.***

Commenter: Nicole Ail 2/15/19 10:28 am

Request for Revision of Hours Required for Mental Health OT

My name is Nicole Ail. I am currently a Masters student in occupational therapy at Shenandoah University in Winchester, Virginia . I have two more years before I complete my degree and my plans are to practice here in Virginia after I graduate. I have an interest in working in mental health and will be completing field work in mental health within the next year. Mental health plays a very

critical role in client's needs and it is essential and neccessary to provide as much care as possible, and as soon as possible, to all of those in need.

Occupational therapists have been working in the area of mental health helping clients develop the skills to live healthier, more satisfying daily lives since the profession began over 100 years ago. Occupational therapists have been recognized in federal legislation and by federal agencies as mental health providers and we need to do the same here in Virginia.

I am writing in support of the proposed changes to the emergency regulations for occupational therapists to register as qualified mental health providers for adults and children in the state of Virginia. I support a revision of ***Part II Requirements for Registration regulation 18VAC115-80-40 B.5 to be 500 hours instead of 1,500 in order to help as many in need as soon as possible. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C***

Thank you for your time, your service to the Board of Counseling and to the Commonwealth of Virginia and your thoughtful consideration of this request.

Sincerely,

Nicole Ail

224 Hackberry Drive

Stephens City, VA 22655

nail18@su.edu

Commenter: Susan Lin

2/15/19 4:27 pm

Request for Reducing Supervision Hours Required for Occupational Therapists

By the time I had graduated with my master's in occupational therapy from VCU, I had over 60 hours of supervised Level I Fieldwork in mental health settings, and then one of my internships was in mental health (3 month placement), so I felt competent to work with individuals with mental health diagnoses. Therefore, the current regulations requiring 1,500 hours of supervision by a social worker or other licensed mental health provider for occupational therapists to register as a QMHP in Virginia seem excessive.

I respectfully request that the ***Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C*** be changed from the current Emergency Regulations to the following replacement:

> ***Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.***

Thank you for considering this request.

Commenter: Rachel Isak-Peer

2/19/19 1:23 pm

QMHP

As a mental health occupational therapist that works for the Commonwealth of Virginia, I find it particularly troubling that we have not been included as a qualified professional under the current QMHP guidelines specific by the Commonwealth of Virginia. On one hand, the state is saying we

are experts in the area of psychosocial rehabilitation, living skills, vocational skills, sensory modulation and that we play a vital role in our clients' recovery process, but then the other is saying we are not qualified enough to be included in the QMHP, a basic credential.

Occupational therapy was founded in public psychiatric hospitals over a century ago, and the birth of Psychosocial Rehabilitation Programming in Virginia is rooted here at Western State Hospital, which is attributed largely to our Occupational Therapy Department! It is demeaning that we have had such difficulty being included.

Our license clearly starts we are qualified to work in mental and physical health.

Additionally, occupational therapist are the most qualified professional to supervise mental health skill building programs (MH-SIS), which solely focus on our domain: Areas of occupation (ADLS, IADLS, social participation, work and school, rest and sleep, leisure and play. With the QMHP we could finally be considered for these jobs. OTs are crossed trained, we can recognize co-occurring issues contributing to mental illness such as traumatic brain injury, or sensory processing disorders.

OTs can evaluate (and later adapt) the lived environment of home, work, school and community to identify the strengths and barriers contributing to an individual's current status.

I am asking that the Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C be changed from the current Emergency Regulations to the following replacement:

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Commenter: Stephanie Williams, Emory & Henry College 2/21/19 5:09 pm

Legislation on QMHP

Please look at changing the current wording to this: Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting. Thank you, Stephanie Williams OTD, OTR/L, CHT

Commenter: Suzy Gordon 2/21/19 7:21 pm

OTs in mental health

Hello, my name is Suzy Gordon and I am currently an occupational therapy doctoral student at Virginia Commonwealth University. I will graduate in May and be seeking a job in mental health upon graduating. Mental health is important as it plays a very critical role in client's needs and it is essential and neccessary to provide as much care as possible, and as soon as possible, to all of those in need.

Occupational therapists have been working in the area of mental health helping clients develop the skills to live healthier, more satisfying daily lives since the profession began over 100 years ago. Occupational therapists have been recognized in federal legislation and by federal agencies as mental health providers and we need to do the same here in Virginia.

I am writing in support of the proposed changes to the emergency regulations for occupational therapists to register as qualified mental health providers for adults and children in the state of

Virginia. I support a revision of ***Part II Requirements for Registration regulation 18VAC115-80-40 B.5 to be 500 hours instead of 1,500 in order to help as many in need as soon as possible. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C***

Thank you for your time, your service to the Board of Counseling and to the Commonwealth of Virginia and your thoughtful consideration of this request.

Sincerely,

Suzy Gordon, OTDS

Virginia Commonwealth University

Commenter: Jessica Shipman, independent contractor OT 2/21/19 8:44 pm

Regulation 18VAC1115-80-40 B.5

I am asking that the **Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C** be changed from the current Emergency Regulations to the following replacement:

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Commenter: Carlyn Tillage, Mary Baldwin University - MDCHS 2/21/19 9:42 pm

Occupational Therapists as QMHP

I am an occupational therapy doctorate student at Murphy Deming College of Health Sciences at Mary Baldwin University. Occupational therapy uses occupation (anything that is meaningful to a person and occupies their time i.e., showering, dressing, driving to work or the grocery store, participating in work activities, leisure pursuits, and many others) as a therapeutic intervention. My profession was founded in the mental health field, and I believe should be a QMHP in the state of Virginia.

The Accreditation Council for Occupational Therapy Education (ACOTE) sets standards for entry-level occupational therapy education, which includes requirements for coursework and at least one fieldwork supervised by a licensed professional in mental health. I personally completed coursework on mental health conditions including but not limited to major depressive disorder, anxiety, eating disorders, schizophrenia, and bipolar disorder. I learned evidence-based treatments to use with individuals diagnosed with mental health disorders, the dynamics of how to run mental health groups, how to help individuals with mental health disorders reintegrate back into the community, the importance of teaching and training living and vocational skills, and much more. At the end of that semester, I completed my fieldwork at Catawba Hospital in Virginia. When individuals are reintegrated back into the community won't they need basic living skills, won't they need vocational skills? Occupational therapists can help.

Occupational therapists are licensed by the Virginia Board of Medicine. This license states that we as occupational therapists are qualified to work in mental and physical health. Occupational therapists are more than qualified, licensed professionals to be a QMHP in the state of Virginia.

I am asking that Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C be changed to read

18VAC115-80-40 B.5. and 18VAC115-80-50 B.4. Licensure as an occupational therapist by the Board of Medicine (§ 54.1- 2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Thank you,

Carlyn Tillage, OTS

Mary Baldwin University

Murphy Deming College of Health Sciences

Commenter: Amanda McGoye, Murphy Deming College of Health Sciences 2/22/19 8:58 am

OT Certification as QMHPs

I am an occupational therapy doctorate student at Murphy Deming College of Health Sciences at Mary Baldwin University. Occupational therapy uses occupation as its core means of therapeutic intervention. Occupations are those life roles and routines that have meaning to clients and can include everyday tasks such as showering, preparing meals, and getting dressed, to more complex roles such as work, education, and leisure activities. My profession was founded in the mental health field during the era of the reconstruction aids, as meaingful occupation was used to enhance quality of life and overall well-being for servicemen returning from the war. In light of our roots and how OT presently continues to be a vital tool in mental health rehabilitation, I believe OTs should receive recongnition as QMHPs in the state of Virginia.

The Accreditation Council for Occupational Therapy Education (ACOTE) sets standards for entry-level occupational therapy education, which includes requirements for coursework and at least one fieldwork supervised by a licensed professional in mental health. I personally completed didactic coursework on mental health conditions including but not limited to major depressive disorder, anxiety, eating disorders, schizophrenia, and bipolar disorder. In addition to this course, our curriculum also requires that we complete didactic coursework specifically addressing the various psychosocial aspects of health. Through these courses I have learned evidence-based treatments to use with individuals diagnosed with mental health disorders, how to facilitate mental health treatment groups, and the valueable role that OT has in helping these clients return to community and vocational roles. At the end of that semester, I completed my fieldwork at Virginia Baptist Hospital in Lynchburg. On weekends I have also worked at Western State Hospital as part of the weekend programming staff to facilitate carry-over of the group therapy programs that occur with the weekday rehab team. I developed rapport with my clients and heard stories of how they struggled to maintain a daily routine, how they felt isolated within their community, and struggled to maintain employment, balance finances, and even cook daily meals. These struggles within this population are the core of the OT profession. We have a role. We can help.

Occupational therapists are licensed by the Virginia Board of Medicine. This license states that we as occupational therapists are qualified to work in mental and physical health. Occupational therapists are more than qualified, licensed professionals to be a QMHP in the state of Virginia.

I am asking that Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C be changed to read

18VAC115-80-40 B.5. and 18VAC115-80-50 B.4. Licensure as an occupational therapist by the Board of Medicine (§ 54.1- 2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Thank you,

Amanda McGoye, OTS

Mary Baldwin University

Murphy Deming College of Health Sciences

Commenter: Lisa Snider, Loudoun County MHSADS 2/22/19 6:41 pm

Concerns with regulations

18 VAC115-80-40	
B1/B2	All Human Service master's degrees (including psychology, sociology, social work, counseling, substance abuse, marriage and family therapy, etc.) should require the same number of experience hours, 500 hours. Given the scope of QMHP-A work and requirement of working within a DBHDS licensed program, the requirement of 1,500 hours is overly limiting and restrictive.
B2	Human Service Degrees must be defined to include sociology. Based on the grandfathering period and first year of registrations, what are the degrees those who have registered have? This information is needed to ensure there appropriate degrees are included in the regulations. Note that individuals with varying degrees have the abilities to perform the QMHP-A scope of work based on having experience and the supervision within a DBHDS licensed program.
C1	The requirement for supervision to be by a licensed mental health professional: 1. Devalues the experience and registration of a QMHP-A. 2. Places another supervision burden on LMHP's, when there is a known shortage of LMHPs in Virginia. Those providing the services, QMHP-A's, have the hands-on-experience of providing service, which is invaluable for those working towards registration. 3. Has potential consequences of costs for services increasing; and 4. Has lasting impact on Virginia's ability to ensure development of QMHP-As; thus, assuring the availability of services to Virginias for years to come. Therefore, the requirement of who must supervise a QMHP-A, with the degrees listed in B1, B2, B3, B4, B5 should be changed to be a supervisor who is: 1. A registered QMHP-A with at least 4 years of experience post qualification as a QMHP-A (note requirement for 4 years of experience as this ensures seasoned QMHP-A's have opportunity impart knowledge, skills and abilities); 2. A Licensed mental health professional in Virginia or other jurisdiction; or 3. Registered as a resident or licensed eligible mental health professional in Virginia. This change is required to ensure sustainability for providing (and individuals receiving) quality, direct mental health service in Virginia.
C2	

	It is not clear how this is should be documented or will be able to be monitored. This seems like something that belongs in the DMAS or DBHDS regulations about how services are delivered rather than something needed for registration as a QMHP-A.
18 VAC 115-80-50	
B1/B2	All qualifying Human Service master's degrees (including psychology, sociology, social work, counseling, substance abuse, marriage and family therapy, etc.) should require the same number of experience hours, 500 hours, with the ability to include internship/practicum hours. Given the scope of QMHP-C work and requirement of working within a DBHDS licensed program, the requirement of 1,500 hours is overly limiting and restrictive.
B2	Human Service Degrees must be defined to include sociology. Based on the grandfathering period and first year of registrations, what are the degrees those who have registered have? This information is needed to ensure there is appropriate degrees are included in the regulations. Note that individuals with varying degrees have the abilities to perform the QMHP-C scope of work based on having experience and the supervision within a DBHDS licensed program.
C1	The requirement for supervision to be by a licensed mental health professional: 1. Devalues the experience of a QMHP-C's. 2. Places another supervision burden on LMHP's, when there is a known shortage of LMHPs in Virginia. Those providing the services, QMHP-C's, have the hands-on-experience of providing service, which is invaluable for those working towards registration. 3. Has potential consequences of costs for services increasing; and 4. Has lasting impact on Virginia's ability to ensure development of QMHP-Cs; thus, assuring the availability of services to Virginias for years to come. Therefore, the requirement of who must supervise a QMHP-C, with the degrees listed in B1, B2, B3 and B4 should change to be a supervisor who is: 1. A registered QMHP-C with at least 4 years of experience post qualification as a QMHP-C (note requirement for 4 years of experience as this ensures seasoned QMHP-C's have opportunity to impart knowledge, skills and abilities); 2. A Licensed mental health professional in Virginia or other jurisdiction; or 3. Registered as a resident or licensed eligible mental health professional in Virginia. This change is required to ensure sustainability for providing (and children receiving) quality, direct mental health service in Virginia.
C2	It is not clear how this is should be documented or will be able to be monitored. This seems like something that belongs in the DMAS or DBHDS regulations about how services are delivered rather than something needed for registration as a QMHP-C.

Commenter: Ann Moore, Shenandoah University 2/22/19 10:47 pm

Occupational Therapist as QMHP

My name is Ann Moore. I am currently a master's student in occupational therapy at Shenandoah University in Winchester, Virginia. I have one more year before I complete my degree and my plans are to practice here in Virginia after I graduate.

Occupational therapists have been working in the area of mental health helping clients develop the skills to live healthier, more satisfying daily lives since the profession began over 100 years ago. Occupational therapists have been recognized in federal legislation and by federal agencies as mental health providers and we need to do the same here in Virginia.

I am writing in support of the proposed changes to the emergency regulations for occupational therapists to register as qualified mental health providers for adults and children in the state of Virginia. I support a revision of ***Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C***

Please consider revising the language to recognize OTs preparation at the graduate level and knowledge and practice experience in mental health. I support a change to: ***Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting***.

Thank you for your time, your service to the Board of Counseling and to the Commonwealth of Virginia and your thoughtful consideration of this request.

Sincerely,

Ann Moore

1800 Weber Ave

Chesapeake, VA 23320

amoore172@su.edu

Commenter: Michaela Payne, TCC OTA Program 2/23/19 1:17 pm

Part II Requirements for Registration regulation

Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Commenter: Tiina Shackelford, OTAS 2/23/19 4:38 pm

Changes to requirements for registration as a QMHP-C

We are asking that the ***Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C*** be changed from the current Emergency Regulations to the following replacement:

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Commenter: Kate van Emmerik, James Madison University Occupational Therapy Program 2/24/19 4:09 pm

Occupational Therapists as QMHPs

I am a first-year student in the James Madison University Occupational Therapy Program. I am writing in support of the revision of requirements for occupational therapists to become Qualified Mental Health Professionals.

Occupational therapists work with people of all ages to promote independence and functionality in their everyday lives regardless of injury, illness, or diagnoses. We take three semesters of courses that are dedicated to different specialty areas, one of which is psychosocial and mental health OT practice. We are taking two classes focusing specifically on this area of practice: Psychosocial Perspectives in Occupational Therapy and a case-based learning course with cases heavy in the psychosocial and mental health practice of occupational therapy. However, psychosocial aspects of treatment are embedded throughout the entire program.

As an occupational therapy student, I am trained to treat each individual holistically and to put their best interest and goals at the heart of my client-centered practice. We are trained as generalists, so we will be prepared to practice in a wide variety of settings as stated in ACOTE standard 5.1. Mental health settings are included in this standard. One component of our training that facilitates this readiness is our completion of "at least one fieldwork experience (either Level I or Level II) must address practice in behavioral health, or psychological and social factors influencing engagement in occupation" as stated in ACOTE standard 7.1.

Master's and Doctoral occupational therapy programs yield therapists prepared to work in mental health settings to provide care for individuals with psychosocial goals who are working towards independent and meaningful lives. Occupational therapists who hold a master's degree or higher should be able to register for the QMHP title under the same requirements as those who hold a master's degree from a psychology, social work, counseling, substance abuse, or marriage and family therapy program. Occupational therapists have been practicing in mental health since the foundation of the profession, whose founders included psychiatrist Dr. William Dunton and social worker Eleanor Clark Slagle.

Individuals receiving mental health services in Virginia would benefit from occupational therapists with QMHP certicfication. The services we provide are geared towards living independent, full lives that all individuals deserve the chance to lead.

I support a revision of ***Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C***

to be changed to:

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Commenter: Matthew Carpenter, Virginia Commonwealth University 2/24/19 6:08 pm

Occupational Therapist QMHP Regulations

I am an occupational therapy student who has completed one 480 hour fieldwork in a transitional living facility for individuals with Schizophrenia or Bipolar Disorder, a 480 hour fieldwork in long-term care for individuals with severe traumatic brain injury (some whose injuries were the self-

inflicted results of mental health issues and many of whom have developed mental health problems since their injury), and who is currently in the midst of a 560 hour Doctoral Capstone project working with individuals recovering from substance use disorder, homelessness, and a history of incarceration. My academic and experiential education has prepared me to work successfully with this population. I believe that the current emergency regulations for occupational therapists promulgated by the Board of Counseling are unduly and unnecessarily onerous. They will prohibit current and future occupational therapists like myself from pursuing QMHP registration.

I am asking that the Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C be changed from the emergency regulations that currently read:

B. 5. A licensed occupational therapist with no less than 1,500 hours of supervised experience to be obtained within a five-year period immediately preceding application for registration and as specified in subsection C of this section. (Subsection C requires that the supervision occur of a licensed mental health professional or a person under supervision that has been approved by the Boards of Counseling, Psychology, or Social Work as a pre-requisite for licensure.)

AND

B. 4. A licensed occupational therapist with no less than 1,500 hours of supervised experience to be obtained within a five-year period immediately preceding application for registration and as specified in subsection C of this section.

And that they be replaced with criteria that has the potential to expand the appropriately qualified behavioral health workforce. We suggest the following replacement:

18VAC115-80-40 B.5. and 18VAC115-80-50 B.4. Licensure as an occupational therapist by the Board of Medicine (§ 54.1- 2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Occupational therapists have been eligible for licensure as a QMHP without extra requirements in a handful of states including Oregon, Maine, and Massachusetts. Entry level Occupational Therapy degrees are currently at the minimum of a Masters level. 29 universities including Virginia Commonwealth University have already achieved accreditation at an entry level doctoral degree. Another 107 programs nationwide are in the process of developing an OTD degree. The Accreditation Council for Occupational Therapy Education (ACOTE) sets the standards for entry-level occupational therapy education programs and they include extensive requirements that include at least one mental health fieldwork experience.

Occupational Therapy is a profession that was founded by two psychiatrists, a nurse, a social worker, an architect, a crafts instructor, and a consumer who recognized the value of engagement in occupation to restore health and well-being. Mental Health is and has always been the core of occupational therapy services and intensely connected with physical health and participation in the community at-large.

Our society is in the midst of an opioid epidemic. In 2016, 64,070 Americans died from a drug overdose. This is more than the 58,220 soldiers who died in the entire Vietnam War, and is even more than the 50,682 who died in the worst year of the AIDS crisis. In 2016, in Virginia alone, 1,130 of our fellow citizens died of an opioid-related overdose. This is way too high. We need as many people working with these individuals as we can to turn this epidemic around. The current emergency regulations are preventing qualified occupational therapists from serving our population and our state.

Commenter: Taylor Reamy, James Madison University Occupational Therapy Program 2/24/19 6:45 pm

Occupational Therapists as QMHP's

I am a student of the Occupational Therapy Program at James Madison University, in which I will receive a Master's degree upon graduation. I plan to practice in Virginia after I graduate in December 2020. According to the accreditation standards for a master's degree-level educational program for occupational therapists, "at least one fieldwork experience must address practice in behavioral health, or psychological and social factors influencing engagement in occupation" as stated in ACOTE standard C.1.7. I am currently completing a psychosocial level I fieldwork in which many of my classmates are in traditional mental health settings. Throughout the rest of my time in school I will be completing two more level I fieldworks with a minimum of 40 hours in each, as well as, two level II fieldworks with about 480 hours each (both are 3 months in duration). Any of these fieldworks could be completed in a mental health setting.

As a student in an occupational therapy program, we also trained to work in a variety of different settings including practice in a mental health setting, as stated in ACOTE standard A.5.1. We take courses throughout the program that ready us for work in the psychosocial and mental health fields, as well as having psychosocial aspects built into every course that we take.

Occupational therapy as a profession was founded in the field of mental health and has continued to practice in this area for over 100 years. Occupational therapists who hold a master's level degree or higher should be able to obtain the title of QMHP under the same requirements as individuals who hold a masters degree in the fields of psychology, social work, counseling, substance abuse, or marriage and family therapy program.

Occupational therapy intervention within the field of mental health is crucial and we are trained with the knowledge and skills to help individuals seeking services to improve their lives, level of independence, and their integration into society.

I support a revision of ***Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C***

be changed to the following requirement:

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Thank you for your time and consideration of this request.

Commenter: Maria Binns Cannady-InnovAge PACE and St. Catherine University OTA Program 2/24/19 8:01 pm

Reduce Restrictions on QMHP Requirement for Occupational Therapists in Virginia

Dr Hoyle,

I am writing to ask you to reduce the restriction on QMHP requirements for Occupational Therapists in Virginia. I have been an Occupational Therapist in Virginia for over 20 years. I work with the frail elderly population at the Program of All Inclusive Care for the Elderly. I have also been an adjunct Lab Professor for St. Catherine University for 2 years. Part of my lab instruction involves teaching Occupational Therapy Assistant Students interview and treatment strategies for working with mental health conditions.

EDUCATION AND LICENSURE

? **OT education is at the graduate level.** Since 2007, a master's degree has been the educational requirement for entry into the profession. Currently 29 universities are accredited to offer **Occupational Therapy Doctorate (OTD)** degrees, including two in Virginia, Virginia Commonwealth University and Mary Baldwin University. Another 107 programs are in the development process to offer OTD degrees. The remaining 177 schools offer programs at the **Masters** level, including five Virginia schools - Emory & Henry College, Jefferson College of Health Sciences, James Madison University, Radford University, and Shenandoah University.

? The Accreditation Council for Occupational Therapy Education (ACOTE) sets standards for entry-level occupational therapy education programs and those standards include **extensive requirements for coursework and at least one fieldwork experience focused on mental health**

- OTs are required to pass a national certification exam and are **licensed in all states**. OTs in Virginia are licensed by the Board of Medicine, which must be renewed every two years.

QMHP REQUIREMENTS IN OTHER STATES

- While some states, like **Oregon, Maine and Massachusetts**have **no additional requirements for OTs to qualify for QMHP status beyond licensure**. Other states, including **Illinois**, require licensure and **one year of clinical experience in a mental health setting**. **Missouri recognizes OTs**with Master's degrees who have completed a **practicum in a psychiatric settingor who have had one year of experience in a psychiatric setting**.

MENTAL HEALTH OT WORLDWIDE

?In countries where national health insurance exists, like the UK, Canada and Australia, health care team members are paid equivalently for the provision of mental healthcare services as for physical healthcare services. In those countries **50% of the OT workforce works in mental health**. In the US the number of OT practitioners pursuing careers in mental health is under 5% because of the pay differential and the cost of education.

Again, please consider reducing these restrictions on OTs, as I feel this willl prohibit OTs from pursuing QMHP registration. We need more health care professionals in the community who are willing to treat children and adults who have a variety of mental health conditions.

Respectfully,

Maria Binns Cannady, OTR/L

Commenter: Charlea Olmstead, MOTS, James Madison University 2/25/19 8:53 am

Occupational Therapists are QMHPs by trade and should be recognized as such in legislation

Regardless of the practice setting, diagnosis, etc., occupational therapists are addressing the psychosocial needs of our patients. We are trained to treat the whole person including the brain and mind. A foundation in mental health is crucial to attend to our patients' needs, thus our coursework and education speaks to neurological structures and functions; mental health

diagnoses and dysfunctions; and neurological, cognitive, perceptual, and psychosocial assessments and interventions, to name a few.

The current legislation regarding occupational therapists as QMPHs is unduely and unneccessary. By education, trade, and definition, occupational therapists are qualified to work as mental health care providers. Furthermore, other professions acting as gatekeepers to services that are already in OT's scope of practice can create competition or tension in the workplace, among professions, and among practictioners. Lastly, the current legislation undermines our profession as occupational therapists and fails to recognize it as a graduate level degree.

For these reasons and more, I am advocating that **Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C** be changed from the current Emergency Regulations to the following replacement:

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Commenter: Taylor Neiser, MOTS James Madison University 2/25/19 2:30 pm

Occupational Therapists as QMHP

I am a Master's of Occupational Therapy student at James Madison University. I have been learning about the wonderous field of psychosocial and mental health and our role as future OT's and have felt a passion awaken in me. I came into this program with the very strong mindset of becoming a Pediatric OT. I recognized my interest and curiosity in the mental health field as well but shyed away from it until this semester when I was placed at Western State Hospital for my first Level I placement. This placement has evolved my interest in mental health to a much more involved perspective.

I am originally from Maryland but have gone to secondary school in Virginia, first at Lynchburg College and now at JMU. I feel at home in this part of the state and have plans to stay in this general area to practice. Learning about the current requirements of OT's to become QMHP strikes me as being slightly extra work that could potentially be more cost-effective instead of beneficial for all professionals involved. The professionals who must train and supervise us for the extensive 1500 hours would have even more responsibilities placed on them that would not be necessary. I believe a requirement of 500 hours would be more doable and beneficial to all involved because there are phenomenon that we as OT's must be taught in this field, but also we operate through the lens of person-first therapy, where we consider a person's values, psychosocial factors as some of the most central factors to their success. We are trained to view a person as an active agent that is also highly influenced by their psychosocial factors. We are also sensitized to the reality of many mental health conditions and are taught effective interactive skills to empathize with clients.

I feel that we as Occupational Therapists, will have the skills and tools necessary to be considered QMHP, and that the requirement of 1500 hours to be certified QMHP may be redundant while a requirement of 500 hours supervision and training may be more beneficial to all involved. We are asking that the **Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C** be changed from the current Emergency Regulations to the following replacement:

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Thank you for your time.

Taylor Neiser, MOTS

Commenter: Ariana Olazagasti, MOT, James Madison University 2/25/19 11:47 pm

Validity is being questioned in the very field that OT originated in: We deserve to be QMHPs.

Occupational Therapy originated as a mental health profession providing occupation and activity-based interventions with the idea that meaningful tasks provide more motivation and better health outcomes in clients, both physiologically and psychosocially. While our scope of practice has widened, our holistic foundation and approach to intervention remains the same; psychosocial concepts of individual's health, recovery, or rehabilitation must be addressed in order to provide true client-centered and effective care.

Occupational therapists are not only trained in mental health, but also anatomical and neurological processes associated with physiological and psychological function. As a profession that began in the very field of mental health where their validity is currently being questioned, it is imperative that Occupational Therapists be able to pursue the qualifications of QMHP with minimal barriers so that they may continue to address the current mental health crisis that is sweeping the nation. The current legislation undermines the graduate-level degree that Occupational Therapists hold, as well as the value they hold in the field of health professions, and more importantly, that of mental health.

As an MOT student at James Madison University and possible future QMHP, I stand behind the move to change **Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C** from the current Emergency Regulations to the following replacement:

"Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting."

Commenter: Jessica Margolin, Tidewater Community College OTA Program 2/26/19 7:05 am

Requirements for Registration as a QMHP-C

We are asking that the **Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C** be changed from the current Emergency Regulations to the following replacement:

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Commenter: Sydney Snyder, OTAS Tidewater Community College COTA Program 2/26/19 8:55 am

Acknowledging the changes to the requirements for registration.

Changes to requirements for registration as a QMHP-C

We are asking that the ***Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C*** be changed from the current Emergency Regulations to the following replacement:

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Commenter: Vivian Rhodes, OTAS Tidewater Community College 2/26/19 9:01 am

OT Regulations

We are asking that the ***Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C*** be changed from the current Emergency Regulations to the following replacement:

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Commenter: Sara Brockman, OTS, Virginia Commonwealth University 2/26/19 11:24 am

Requirements for Registration as a QMHP

With a strong foundation in mental health practice from our roots as a profession, we as occupational therapists believe that the emergency regulations for occupational therapists promulgated by the Board of Counseling are unduly and unnecessarily onerous. They will prohibit OTs from pursuing QMHP registration. We are asking that the **Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C** be changed from the emergency regulations that currently read:

B. 5. A licensed occupational therapist with no less than 1,500 hours of supervised experience to be obtained within a five-year period immediately preceding application for registration and as specified in subsection C of this section. (Subsection C requires that the supervision occur of a licensed mental health professional or a person under supervision that has been approved by the Boards of Counseling, Psychology, or Social Work as a pre-requisite for licensure.)
AND
B. 4. A licensed occupational therapist with no less than 1,500 hours of supervised experience to be obtained within a five-year period immediately preceding application for registration and as specified in subsection C of this section.

And that they be replaced with criteria that has the potential to expand the behavioral health workforce. We suggest the following replacement:

18VAC115-80-40 B.5. and 18VAC115-80-50 B.4. Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Commenter: Gretchen Ward, Independent Contractor, 2/26/19 11:56 am

Requirements for QMHP registration for OT

My name is Gretchen Ward, I am an occupational therapist working with children, youth, and young adults at 2 private clinics in the state of VA. I previously was employed by Grafton Integrated Health Network working in behavioral health care and have 9 years of occupational therapy experience in school based and early intervention practice. I am a member of the AOTA School Based Mental Health community of practice and serve as the Policy and Advocacy coordinator for the AOTA Children and Youth Special Interest section. I also serve as the Communications Chairperson for the Virginia Occupational Therapy Association.

Mental Health is at the core of our profession as occupational therapitsts and the holistic approach of how mental, physical, and social aspects of a person impact their well being is what sets occupational therapy apart from other health professions. Students of occupational therapy complete at least one clinical learning experience in the area of mental health and are required to learn psychosocial skills in order to complete their education. I was excited to see the Virginia was leading the way recognizing occupational therapists as qualified mental health professionals, however was dismayed when I attempted to register to find an additional requirement of 1500 hours of supervision, that is not clearly defined. This requirement is an undue burden that does not take into consideration the level of education or experience of many practicing occupational therapists.

We are asking that the **Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C** be changed from the current Emergency Regulations to the following replacement:

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

This change of requirement would account for the experience of those who have been working in mental health settings and the clinical component of the education for future occupational therapists looking to work in mental health.

Thank you for the opportunity to comment and your consideration,

Gretchen R. Ward, MS, OTR/L

9144 Kershaw Ct.

Manassas, VA 20110

Commenter: Alexa Taylor 2/26/19 4:02 pm

Occupational Therapist are QMHPs

I am currently a student of the Master's of Occupational Therapy Program at James Madison University. I plan to practice in the state of Virginia upon completion of this program. After spending the summer session discussing the history of occuaptional therapy in the field of mental health, this topic is extremely confusing that we should have to argue to stay in the field we began in. Mental health is one of the largest parts of occupaitonal therapy and it is addressed in every setting with each client based on their specific needs. It is unreasonable to require that a different profession be in charge of our qualification in this area. In each OT program, students are trained in

assessments, interventions, and mindfulness of the mental health aspects involved in each area of OT. We are trained to become professionals in this topic in order to assist our future clients. If OTs become QMHPs then there will be more resources for this mental health crisis we are currently facing. We are a holistic profession that believes in treating the mind as much as the body. This revision should be made in order to allow OTs to become QMHPs.

I support a revision of ***Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C***

be changed to the following requirement:

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Thank you for your time and consideration of this request.

Commenter: Nicole Glowatsky, Murphy Deming College of Health Sciences 2/27/19 2:39 pm

OT as QMHP

I am an occupationaly therapy doctoral student at Murphy Deming College of Health Sciences at Mary Baldwin University writing on behalf of my future profession. For over 100 years now, occupational therapy has proven an effective intervention for those with mental illness. In all OT programs across the country--both master's or doctorate level--students receive countless hours of education on psychosocial rehabilitative care for patients of all diagnoses, but especially those with mental illness. To obtain a state license to practice occupational therapy, one must display deep levels of understanding of how to provide patient-centered, individualized therapy to those with mental illness. Mental health is where our profession started; it is a setting in which the purpose of occupational therapy shines through.

I am asking that the Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C be changed from the current Emergency Regulations to the following replacement:

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Commenter: Kelli King, OTAS Tidewater Community College 2/27/19 3:40 pm

Emergency Regulations for QMHP-A and QMHP-C

We are asking that the ***Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C*** be changed from the current Emergency Regulations to the following replacement:

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

2/27/19 9:27 pm

Commenter: Rebekah Vanzo, OTS, James Madison University

Occupational Therapists are QMHPs

I am an OT student at James Madison University, and upon graduation with my Master of Occupational Therapy I intend to practice in the state of Virginia.

Mental health and well-being is undeniably an integral part of occupational therapy practice; the profession itself was founded, in part, by mental health practitioners. Additionally, ACOTE Accreditation standards C. 1. 7 indicates that "at least one fieldwork experience must address practice in behavioral health, or psychological and social factors influencing engagement in occupation." While this indicates a minimum of 40 hours of fieldwork with a mental health concentration, a student could direct their level 2 fieldwork placements to have gathered 1000 hours of fieldwork with a mental health emphasis before graduating from the program. In the JMU OT program we have an entire semester concentrated on psychosocial and mental health, with classes, fieldwork, and gathering of materials in preparation for practice all guided by psychosocial frames of reference. Psychosocial issues are continuously addressed outside of this semster also. Although trained as generalists, we are well educated and prepared to provide support and treatment for the mental health needs of our clients. Approaching all clients with a holistic perspective, even clients who are not seen in a traditional mental health setting will have their mental wellbeing considered by their occupational therapist.

The title of QMHP should be allowed to occupational therapists who graduate with a master's degree or higher under the same requirements as those who graduate in psychology, social work, counseling, substance abuse, or marriage and family therapy program. To deny us this is to deny the validity of occupational therapy as an equal graduate program and profession, and undermines the extensive work occupational therapy students undertake to ensure they can effectively address the mental health needs of their clients. It is not in the best interest of our clients to have extra barriers to gain QMHP status, as it could likely lead to increased costs of treatment due to increased cost on the therapist's part to gain this title. Across the United States there is already far too little access to quality mental health care, and it does not make sense to create even more barriers.

I support a revision of ***Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C***

to be changed to:

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting

Commenter: Felicity White, OTAS student at Tidewater Community College 2/28/19 10:18 am

OT

We are asking that the ***Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C*** be changed from the current Emergency Regulations to the following replacement:

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Commenter: Lisa Clark

2/28/19 10:19 am

OT and COTA Mental Health regulations

As occupational therapy practitioners with many years of experience in working and teaching courses in mental health OT, and who have pursued legislation to attain QMHP status through the lobbying efforts of our Virginia Occupational Therapy Association, we believe that the emergency regulations for occupational therapists promulgated by the Board of Counseling are unduly and unnecessarily onerous. They will prohibit OTs from pursuing QMHP registration. We are asking that the Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C be changed from the emergency regulations that currently read:: B. 5. A licensed occupational therapist with no less than 1,500 hours of supervised experience to be obtained within a five-year period immediately preceding application for registration and as specified in subsection C of this section. (Subsection C requires that the supervision occur of a licensed mental health professional or a person under supervision that has been approved by the Boards of Counseling, Psychology, or Social Work as a pre-requisite for licensure.) AND B. 4. A licensed occupational therapist with no less than 1,500 hours of supervised experience to be obtained within a five-year period immediately preceding application for registration and as specified in subsection C of this section. And that they be replaced with criteria that has the potential to expand the behavioral health workforce. We suggest the following replacement: 18VAC115-80-40 B.5. and 18VAC115-80-50 B.4. Licensure as an occupational therapist by the Board of Medicine (§ 54.1- 2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Commenter: Peggy Riccio

2/28/19 10:40 am

OT and COTA Mental Health regulations

TAs occupational therapy practitioners with many years of experience in working and teaching courses in mental health OT, and who have pursued legislation to attain QMHP status through the lobbying efforts of our Virginia Occupational Therapy Association, we believe that the emergency regulations for occupational therapists promulgated by the Board of Counseling are unduly and unnecessarily onerous. They will prohibit OTs from pursuing QMHP registration. We are asking that the Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C be changed from the emergency regulations that currently read:: B. 5. A licensed occupational therapist with no less than 1,500 hours of supervised experience to be obtained within a five-year period immediately preceding application for registration and as specified in subsection C of this section. (Subsection C requires that the supervision occur of a licensed mental health professional or a person under supervision that has been approved by the Boards of Counseling, Psychology, or Social Work as a pre-requisite for licensure.) AND B. 4. A licensed occupational therapist with no less than 1,500 hours of supervised experience to be obtained within a five-year period immediately preceding application for registration and as specified in subsection C of this section. And that they be replaced with criteria that has the potential to expand the behavioral health workforce. We suggest the following replacement: 18VAC115-80-40 B.5. and 18VAC115-80-50 B.4. Licensure as an occupational therapist by the Board of Medicine (§ 54.1- 2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.ype over this text and enter your comments here. You are limited to approximately 3000 words.

2/28/19 11:12 am

Commenter: Brandon Mantell, OTS James Madison University

OT as QMHP

We feel that the requirements of gaining 1,500 hours under the supervision of a social worker or other licensed mental health provider in Virginia are burdensome for a professional with a master degree or higher. In our graduate work, our studies of mental health are extensive and of high importance.

We are asking that the **Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C** be changed from the current Emergency Regulations to the following replacement:

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Commenter: Lauren Carper, James Madison University 2/28/19 1:24 pm

Occupational Therapists as QMHP

I am a Master of Occupational Therapy student from James Madison University. I plan to practice in the state of Virginia for the entirety of my career following completion of the program.

Occupational Therapy as a profession is rooted in the fields of psychology, social work, medical practice, and rehabilitation. We are trained to see individuals in a holistic manner, looking at the needs of people from both the physical and psychosocial aspect in order to truly improve a person's quality of life and/or independence. This is pulled directly from the QMHP Frequently Asked Questions page provided on the Commonwealth of Virginia Board of Counseling's website as qualifications for QMHP-A prior to December 31, 2017: "Master's degree in psychology, social work, counseling, substance abuse, or marriage and family therapy from an accredited college or university, you need: • To submit a transcript • Evidence you have had an internship or practicum of at least 500 hours of experience with persons who have a mental illness. (Verification of Internship/Practicum for QMHP form)" (VA Dept. of Health Professions, 2018). It doesn't make sense to me that other fields that Occupational Therapy is rooted and grounded in by theory, intervention, evidence-based practices, and overarching goals are only required to have a Master's degree and provide evidence of at least 500 hours of experience with persons who have a mental illness when we as Master's of Occupational Therapy students will complete our program obtaining over 1,000 hours of clinical experience. Occupational Therapists work with people who are experiencing mental health crises and difficulties in all settings, practices, and with all populations. We devote an entire semester of our graduate program with a primary focus on mental health issues and how to address those as practitioners. Even though we have one semester devoted to this, we continually learn and practice those skills in every course we take and within every fieldwork, clinical experience, and volunteer experiences we partake in throughout the program. It seems excessive to place more requirements upon OTs who wish to gain the QMHP title in order to do the same job they have already been prepared to do. These proposed requirements may take time away from much needed research in the field of Occupational Therapy to show evidence that a holistic approach to treating individuals is more effective at increasing the quality of life and decreasing the mental health crises facing our nation today than other traditional approaches to health care. The requirements also undermine the training that we have completed in our graduate program and throughout our approach to leading holistic lives filled with balance between physical and mental health.

I support a revision of ***Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C*** be changed to the following requirement:

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Commenter: Reagan Steele, OTAS Tidewater Community College 3/1/19 4:33 pm

Emergency Regulations for QMHP-A and QMHP-C

We are asking that the ***Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C*** be changed from the current Emergency Regulations to the following replacement:

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Commenter: Christiana Santos 3/4/19 1:29 pm

Regulations for QMHP

The regulations that require 1500 hours of supervision are the main area of concern for me as an occupational therapist. I work in outpatient therapy, and know of no other health professional who is available to directly supervise me on a daily basis in order to obtain these hours. I would also not be able to pay them for these hours, and therefore I have no idea how I could motivate someone to come to my setting to actively supervise me. I am unable to practice in any other location to acheive these hours, because my work hours are set. The training and supervision we receive on Fieldwork Level 2 (6 months total) during our eduction (Masters level) should qualify us for this title.

Commenter: Christiana Santos 3/4/19 1:33 pm

Regulations for QMHP

We are asking that the Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C be changed from the current Emergency Regulations to the following replacement:

- Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

3/4/19 4:43 pm

Commenter: Bob Horne, Norfolk CSB

LMHP Supervision Requirement

The requirement that an LMHP-Type provider must supervise a QMHP-E's experience towards becoming either a QMHP-A or QMHP-C will be detrimental to the public behavioral healthcare system. There is currently a shortage of licensed mental health professionals in Virginia's public behavioral healthcare system. Continuing this requirement is excessive.

Commenter: Caroline Polk 3/5/19 1:33 pm

Requirements for OTs to be Qualified MH Providers

Occupational therapists (OTs) in Virginia are now permitted to serve as Qualified Mental Healthcare Providers for adults (QMHP-A) and children (QMHP-C). Unfortunately, the proposed regulations for how an OT can become a QMHP include unduly onerous requirements that do not recognize that OTs enter the profession only after graduate-level training. Because of their training and the history of the profession, OTs are well qualified to serve as mental health providers. Given the shortage of providers for much-needed mental health care, it's vital for Virginia to take steps to expand the pool of professionals who can provide this care.

Currently, the regulations require OTs to have 1,500 hours of supervision by a social worker or other licensed mental health provider in Virginia in order to apply. I ask that the **Part II Requirements for Registration regulation 18VAC115-80-40 B.5. "Requirements for registration as a QMHP-A" and 18VAC115-80-50 B.4. "Requirements for registration as a QMHP-C"** be changed from the current Emergency Regulations to the following replacement:

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Thank you for your consideration.

Commenter: Michaela Sian Crutsinger, Murphy Deming College of Health Sciences 3/6/19 6:22 pm

QMHP-C

Please consider that the roots of occupational therapy lie in mental health. Students currently being prepared to enter the field are undergoing appropriate preparation, from acadamic work to fieldwork, to enter the workforce in the field of mental health.

We are asking that the ***Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C*** be changed from the current Emergency Regulations to the following replacement:

> ***Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.***

3/7/19 12:18 pm

Commenter: McKenna Weeks, OTS, James Madison University

Occupational Therapists as QMHP

I am a current occupational therapy student at James Madison University in Harrisonburg, VA. I have lived in Virginia all my life, and I plan to practice here after successful completion of the program.

Occupational therapy programs across the country use a structured curriculum to prepare students to practice in a variety of settings including mental health. We are trained to treat clients in a holistic manner. This allows us to plan interventions that address the person as a whole to reach a state of physical, mental, and social well-being. According to the Occupational Therapy Practice Framework 3rd edition, we are competent to consider a variety of specific and global mental functions when working with clients regardless of the practice setting. These functions include thought (control and content of thought, awareness of reality vs. delusions, logical and coherent thought), higher-level cognitive (judgment, concept formation, metacognition, executive functions, praxis, cognitive flexibility, insight), emotional (regulation and range of emotions), attention, memory, consciousness, orientation, perception, temperament and personality, and more.

At JMU, we dedicate an entire semester to learning about mental health conditions, assessments, and interventions and relate them to various psychosocial frames of reference. As graduate-level professionals that receive this education in addition to hours of clinical observation and fieldwork, I believe that we deserve to be recognized as Qualified Mental Health Professionals. Occupational therapy has proven to be a successful mental health intervention for numerous years as this is where our profession originated and continues to thrive.

For these reasons, I support a revision of ***Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C***

to be changed to the following requirement:

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Commenter: Olivia Garcia, James Madison University 3/8/19 3:09 pm

Regulation changes for QMHP

I am currently a first-year Master's student in the JMU occupational therapy program. As such, I have learned about the fascinating history of how occupational therapy came to be. The profession began in mental health and evolved into a widespread practice that can be applied to a variety of settings. The foundational concept of occupational therapy is to view a person holistically in order to provide care for the overall well-being of a client. Mental health is an essential part of occupational therapy and is woven into each setting, even those that are not strictly mental health.

In my program we spend an entire semester learning about psychosocial occupational therapy and at this time we are placed in our first level I fieldwork in relation to mental health. I believe the reason for this is because mental health is a crucial building block to all occupational therapy practices and should be considered by great therapists when treating a client for any particular reason. Therefore, recieving a QMHP certification should be more accessible to occupational therapists as it is a major part of the profession and the current regulations do not honor that as it does to other equally qualified professions.

For that reason, I am strongly advocating that **Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-**

80-50 B.4. Requirements for registration as a QMHP-C be changed from the current Emergency Regulations to the following replacement:

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Commenter: Hannah Turner, James Madison University MOTS 3/10/19 2:35 pm

OT's are QMHP's

To Whom It May Concern:

My name is Hannah Turner. I am a current Master's of Occupational Therapy student at James Madison University. I intend to spend my professional career practicing in the state of Virginia upon successful completion of our highly regarded program.

Our attention has been brought to consideration of the requirements set forth regarding OT's as registered QMHPs in the state of Virginia. These onerous prerequisites represent unjust considerations for the level training and experience of Occupational Therapy professionals in Virginia. The following points outline qualifications held by the profession as a whole that indeed support the view of OT's as QMHP's by *trade*.

Occupational Therapy holds basic foundational tenants in psychiatry and mental health. The profession considers the body AND mind holistically for treatment. We are held to high standards and attain reputable credentials qualifying us for mental health profession titles. Entry level is expected to be masters level or above with the entire profession moving toward the latter. ACOTE presents requirements for an entire semester of OT education to be focused on mental health and psychosocial efforts with at least one 12-week fieldwork experience in the mental health field of study. Occupational Therapy provides mental health services as a stronghold to our professional ideals. Medicare/Medicaid services recognize OT as a CORE component of quality mental health treatment and holistic service. Even the difficult-to-navigate world of insurance and policies view OT as a billable service for mental health diagnoses. OT is bridging the gap between physical and behavioral health. Why does the currently proposed legislation not reflect the esteem OT has gathered in the realm of mental health and psychosocial treatment? Health services administration include OT as an integral part of the interdisciplinary behavioral health workforce team. Even authorized grant money is allocated toward mental health fieldwork training annually. Other participating states have set forth far less restrictive requirements. OT is represented in approximately half of mental health efforts and services *worldwide*. As a current OTS and future practicing OT in the state of Virginia...it is my hope that my home state will choose to reflect the respect and esteem the profession of Occupational Therapy has tirelessly worked toward since the foundation of the profession itself. Occupational Therapists *are*qualified mental health professionals by trade. I support the proposed change set forth from

Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C

to the following requirement:

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Commenter: Erica Jackson, James Madison University MOT 3/13/19 6:54 pm

QMHP requirements for OT

Occupational Therapy is already recognized and practiced in mental health settings. It is a profession that was originally founded on the basis of fair treatment of those with psychiatric disorders during the Moral Treatment Era. Given this, the curriculum for an accredited Master's program like that of James Madison University dedicates classes to mental health disorders, psychosocial perspectives, neuroscience, and mental health related level 1 fieldwork. This specific fieldwork accounts for roughly 100 hours of time spent with a mental health population, plus 10 credit hours of classes primarily focused on mental health/neuroscience. All this does not include the possibility of selecting a mental health level 2 fieldwork; accounting for 12 weeks of full-time work at the facility. In addition, Occupational Therapy takes a holistic approach so all classes incorporate mental health in some manner. Given this plethora of time spent on the topic, Occupational Therapists graduate with strong background knowledge in mental health practice.

With such strong ties to mental health, Occupational Therapists are drawn towards these mental health practice settings; however, I am afraid the requirements for becoming a Qualified Mental Health Practitioner may lower the number of Occupational Therapists entering these practice areas. As the profession begins moving towards a doctorate level program, people are spending greater amounts of time and money to become registered and licensed Occupational Therapists so an additional 1,500 hour requirement seems to discredit the profession. Not only this, but supervision of these hours under another health care professional prompts concerns regarding interprofessional collaboration; an area that has been identified in the United States health care system as needing improvement.

I am not against additional requirements for becoming a certified Qualified Mental Health Practitioner; however, I strongly believe these requirements should reflect the merit of an Occupational Therapy degree. Therefore, I am advocating that **Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C** be changed from the current Emergency Regulations to the following replacement:

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Commenter: Daryl Washington Executive Director, Fairfax Falls-Church CSB 3/15/19 11:01 am

Supervision and Education Requirements

The supervision requirements continue to be too stringent. Requiring a QMHP to have been supervised by someone with a license will continue to create hiring hardships. It is appreciated that experience and supervision in other juristictions will now be allowed to count.

We often get staff that have significant experience providing services in another country. The present language does not allow for consideration of that experience. The regulatory language should be trained to allow for that experience.

Thanks

Commenter: Caroline Puglia, MOTS, James Madison University 3/16/19 1:45 pm

Occupational Therapists as QMHP

I am currently a first year student in the James Madison University Occupational Therapy Program. I am writing in support of the revision for the requirements for occupational therapists to become Qualified Mental Health Professionals.

Occupational Therapy treats their clients holistically. The psychosocial component of rehabilitation is essential, and contributes greatly to achieving independence in the client's occupations. We dedicate a semester of occupational therapy school to understanding the importance and complexities of the psychosocial aspects when working with future clients.

Occupational therapists are trained to work with individuals of mental illness and cognitive impairments. We understand how these factors impact the person's environment (socially and physically) as well as themselves as a person, and the occupational they participate in. Many work in facilities that focus on mental health such as psychiatric facilities and specific areas in hospitals. The goal of occupational therapy in this population is to help create healthy habits and routines, as well as create goals to support their independence, and well being, in society. Our field is client centered, and implements treatment plans based on the individual's specific needs. We work together with other mental health specialists such as psychologists, psychiatrists, and social workers to achieve our client's goals.

The current requirements to become a qualified mental health professional as an occupational therapist discredits the importance of mental health to the occupational therapy field. With the time and money required to become an occupational therapist, the added 1,500 hours with supervision may lower the amount of occupational therapists entering these practice fields. Mental health is a challenging field, which does require additional experience. However I strongly believe these requirements should reflect the merit of an occupational therapy degree. Therefore I am advocating that **Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C** be changed from the current Emergency Regulations to the following replacement:

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Commenter: Mikayla Moore, James Madison University 3/16/19 3:26 pm

MOTS

My name is Mikayla Moore. I am an OT student at James Madison University. Upon completion from JMU's graduate program with my Masters of Occupational Therapy, I intend to practice in the state of Virginia.

Occupational Therapy's roots are originally grounded as a mental health profession. OT also encompasses, anatomical and neurological processes to provide interventions with meaningful purposeful occupations to motivate and enhance physiological and psychosocial health outcomes in clients. Since our founding, OT's scope of practice has widened to numerous types of settings, while maintaining our holistic and evidence-based approach to client-centered services and care.

In graduate school for OT we complete an extensive semester focused on psychosocial wellness involving classes, fieldwork, assessments, guest speakers, community integration, volunteer opportunities, and case studies to enhance our knowledge and understanding of practice guided by psychosocial frames of reference. According to our ACOTE Accreditation standards, C. 1. 7 indicates that "at least one fieldwork experience must address practice in behavioral health, or psychological and social factors influencing engagement in occupation." We are required a minimum of 40 hours of fieldwork for our psychosocial concentrated setting. I personally have already dedicated over 80 hours to my mental health fieldwork setting this semester. In addition, students have the choice to direct their 12 week long, level 2 fieldwork placements with a mental health focus which add up to 1000 hours before graduating from the program. Our educational and

professional background supports the mental health needs of our clients. However, our validity is still questioned by additional requirements of 1,500 hours under supervision of a social worker or other licensed mental health provider in Virginia. Current legislation undermines graduate-level degree OTs hold, work OT students and therapists continually undertake to ensure effective practice, as well as OT's rooted values in mental health.

With the high standards addressed above, we feel that the OT's should be able to pursue the qualifications of QMHP with minimal barriers and cost demands, so that we may keep clients' best interests and continue addressing mental healthin traditional and non-traditional practice settings.

I support a revision of ***Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C***

to be changed to: ***Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting***

Commenter: Jalisa Johnson, James Madison University 3/21/19 2:47 pm

Occupational Therapists as QMHPs

My name is Jalisa Johnson. I am currently a Master of Occupational Therapy student at James Madison University, whom plans to practice and serve in the state of Virginia upon receiving licensure. One facet of occupational therapy that I cherish is our advocacy for mental health. Mental health is a fundamental aspect of occupational therapy, as it is embedded in the foundation of our profession. It globally impacts functional independence, solidifying the necessity for occupational therapy involvement, advocacy, and services. The role of occupational therapy and its importance in mental health is continually expressed within each course of my MOT program, as well as in my fieldwork placements.

All Occupational Therapists are required to take and pass a national exam and obtain licensure prior to practicing. This national exam encompasses all aspects of the human being, including the influences of mental health and management. With that being said, I believe Occupational Therapists are currently servicing as QMHPs and specific training to enhance our skills and practice is welcomed and valued. With that being said, the undue requirement of 1500 hours deserves review and amending prior to implementing this regulation.

We are asking that the **Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C** be changed from the current Emergency Regulations to the following replacement:

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Thank you for your attention and consideration.

Sincerely,

Jalisa Johnson, MS, MOTS

Commenter: Theresa McCaskill 3/21/19 4:49 pm

Qualifying Out of State Experience

The current regulations require that an applicant's experience be supervised by a Virginia licensed mental health provider or a person that is approved for supervision toward licensure in Virginia. This creates a significant recruitment barrrier, preventing employers from giving fair consideration to applicants with experience from out of state. Out of State experience should be considered based on equivalency of roles.

Commenter: Jonina Moskowitz, Virginia Beach Dept. of Human Services 3/27/19 8:58 am

Supervision Requirements - QMHP-Es

We share the concern expressed by others regarding the requirement that the work of a QMHP-E be supervised by an LMHP or someone under supervision to become licensed. Licensed clinicians are needed to provide direct clinical services and recent increased requirements for their involvement in various services has already put a strain on resources for the behavioral health care system across the Commonwealth. In addition, over-reliance on those still under supervision to become licensed for supervision of QMHP-Es has the potential to undermine the residency/supervisee process, which is intended to ensure these individuals have the experience and qualifications to safely work as independent practitioners. We do appreciate recent changes allowing for inclusion of supervised experiences from other states. However, we will continue to face difficulties hiring experienced applicants, if they relocate from states without a similar requirement or were grandfathered in another state when that implemented similar requirements.

Commenter: Anita DeBord, Cumberland Mountain CSB 3/29/19 11:20 am

QMHP regs - LMHP supervision and hours of experience

We share the concern expressed by others regarding the requirement that the work of a QMHP be supervised by an LMHP. Licensed clinicians are needed to provide direct clinical services and recent increased requirements for their involvement in various services has already put a strain on resources for the behavioral health care system. In addition, there is a shortage of LMHP's across the state, and recruitment of LMHP's in our region continues to be difficult. Requiring this level of supervision will result in an increased cost of providing services, as well as a hardship on the CSB/BHA. (C.1)

We are also concerned about the difference in the hour requirement for experience of those with a masters degree. It appears that a Masters in human services and 500 internship hours meet the requirement (B.1), and a Masters in a human services field and 1500 hour of work experience meet the requirement (B.2). This is concerning, as hours of work experience should provide a better learning experience than a brief 500 hours of an educational internship. It is also concerning that experience gained requires the experience to be within the preceding 5 years prior to application for registration (B.2), yet it does not say this on the masters/internship section (B.1). There should be a common number of hours of expeirence, which can include internship/practicum. It is challenging to recruit individuals with 1500 hours of experience, especially recent graduates. Therefore, the hour requirement should be lowered, and should be consistently applied.

Commenter: Joshua Savage, Cumberland Mountain CSB 3/29/19 1:37 pm

QMHP Regulations

1 - 18VAC115-80-40.B.1 & 2: item B.2 should be merged with B.1 with 500 hours of experience due to difficulties/shortages in finding qualified candidates for a QMHP position in Virginia.

#2 - item C1 -Supervision for a QMHP should be expanded to include an experienced QMHP due to shortage of LMHPs in throughout much of Virginia.

Commenter: Courtney Roelfs, Murphy Deming College of Health Sciences 4/1/19 11:25 am

QMHP Requirements - We are more than qualified

I am a 2nd year OT student at Murphy Deming College of Health Sciences at Mary Baldwin University. Occupational therapy was founded and has roots in mental health. Occupational therapy is all about the use of everyday, meaningful activities to achieve wellness. OT helps these individuals gain real life skills, such as how to navigate their communities, work with others, and how to gain employment, to name a few. The everyday activities that we can take for granted are milestones that these individuals need appropriate support to reach. OTs look at the whole person, and use a strengths - based approach to empower these individuals to find confidence and autonomy in themselves.

As a student, I have spent many hours learning evidence-based treatment models and how to run groups with these individuals. We have learned in all our classes to consider the individual from a holistic model. With the prevalence of mental health issues at the forefront of our social landscape, OTs from all practice settings are well versed and knowledgeable in this area. I have worked for the past six months in a psychiatric rehab facility, and volunteered extensively in a local jail with individuals with mental illness. Additionally, I will complete at 12 week clinical rotation at a state run mental health hospital. This equates to 480 hours supervised by a licensed OT. I will also, as part of my doctoral education, complete 16 weeks working with individuals with mental illness gain opportunities to paid employment. This equates to 640 hours under a licensed OT. As a student, I have learned that sometimes the most meaningful thing to a person is just being able to live their life. OTs help people live their best life and give them the supports they need to make it work.

There is a shortage of mental health workers across the board. By making the requirement to become a QMHP even harder, this will undoubtedly lead to even less people working in mental health. The consequences of this could be devasting – the incidence of mental illness is constantly growing. We are at pivotal time in this country, where mental health is talked about more than ever – however, there is not enough professionals to meet the growing need. OT is needed, and we are more than qualified to provide rehabilitative services to help these individuals get back to being productive participants in their environments.

Occupational therapists are licensed by the Virginia Board of Medicine. This license states that we as occupational therapists are qualified to work in mental and physical health. Occupational therapists are more than qualified, licensed professionals to be a QMHP in the state of Virginia.

I am asking that Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C be changed to read

18VAC115-80-40 B.5. and 18VAC115-80-50 B.4. Licensure as an occupational therapist by the Board of Medicine (§ 54.1- 2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Thank you.

Sincerely,

Courtney Roelfs, OTS, Murphy Deming College of Health Sciences, Class of 2020

Commenter: Elizabeth Davidson Hoover 4/1/19 2:40 pm

OT as QMHPs

OTs started out as a profession working with mental health patients. OTs are more than qualified to work as mental health professionals especially once they have taken a level 2 internship in that area. There is no need for forced additional supervision by social workers or psychologists. (there is mutual collaboration in treatment team meetings). If the Virginia Board continues to impose these restrictions on OTs then we are going to greatly reduce the number of qualified OTs working in mental health and lose that as an area of our practice.

Commenter: Rabia Mirza, Virginia Commonwealth University 4/2/19 6:15 pm

OTs as QMHPs

Dear Jaime Hoyle,

My name is Rabia Mirza and I am a 2nd year occupational therapy doctoral student at Virginia Commonwealth University. As occupational therapists, we are educated to provide services and support mental health and wellness, rehabilitation, habilitation, and recovery-oriented approaches. Our education also includes at least one clinical fieldwork experience focused on psychosocial issues. This semester, I am completing clinicals in a residential treatment program for individuals with serious mental illness. My practicum during my final semester of school is going to be extensive involvement with an organization that follows a clubhouse model that aids individuals impacted by addiction, incarceration and homelessness. By the conclusion of my education, well over 600 hours will have been dedicated to psychoeducation and clinical involvement in a setting focusing on psychosocial challenges.

What initially drew me to this profession was its strong emphasis on treating our clients holistically. A client's motor and processing abilities are not the only things observed. Their contexts and environments, their belief systems, the meaningful activities they do, their personal goals, and their daily habits, routines and rituals are all considered when creating a treatment plan that works for them. This holistic approach not only focuses on physical health and wellness, but mental health and wellness as well. Occupational therapy origins began in the mental health field since the early 20th century, and to this day we provide mental health treatment and prevention services, with a focus on function and independence, for individuals across the lifespan.

Occupational therapy plays a vital role in mental health, and there is evidence that our interventions improve outcomes for those living in the community with serious mental illness. For these reasons, we are asking that the Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C be changed from the current Emergency Regulations to the following replacement:

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Thank you,

Rabia Mirza, OTS

Commenter: Clarissa Hull, OTR/L 4/4/19 1:15 pm

QMHP

I am currently working as an occupational therapist at Western State Hospital with clients who have a variety of mental health issues. During my graduate level program, I took a course in mental health and completed a 480 hour, 12 week full-time placement with UNC Chapel Hill's acute inpatient psychiatric units. As an OT at Western State Hospital I participate in evaluations, add to treatment plans, implement interventions, and assist with discharge planning to help our clients live their lives as successfully and independently as possible in the community. I feel as an occupational therapist working in mental health I am qualified to be a QMHP and should not have to obtain any further qualifications, as I have gained an array of knowledge through schooling, fieldwork placements, learning experiences, continuing education, and most importantly at work over the past 1.5 years.

I am asking that the ***Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C*** be changed from the current Emergency Regulations to the following replacement:

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

I would add that someone with a bachelor's degree in occupational therapy, who has since been grandfathered in and working for many years in mental health, would also deserve a QMHP distinction.

Thank you for your time and consideration with this matter.

Clarissa Hull, MS, OTR/L

Commenter: Nouran Amin, Virginia Commonwealth University 4/4/19 9:24 pm

OTs being QMHPs

I am a doctoral student in Occupational Therapy at Virginia Commonwealth University and I am writing to you to ask you to reconsider the supervision requirements outlined in the emergency regulations by the Virginia Board of Counseling for occupational therapists seeking registration as a Qualified Mental Health Provider (QMHP). As a student, I have taken courses that thoroughly covered various aspects of mental health. I have also gone through multiple clinical experiences in various settings that treat mental health conditions across the lifespan, ranging from acute conditions to community reintegration. Those clinical experiences are required for accreditation of the programs we go through, and part of the requirements include at least one experience serving clients in a mental health-based setting.

Occupational therapy is a holistic practice that emphasizes the client's lived experience, and mental health is a significant aspect of that. The practice itself was founded by a team that included two psychiatrists and began in public psychiatric hospitals. The members of that team understood the value of occupation on our lives and on our ability to restore our health and mental well-being. They recognized that the mind and body are inseparable and that disrupting our abilities to engage in occupation would negatively affect both our mind and body. This form of therapy bridges between different traditional healthcare and mental health services and is key in maintaining wellbeing for our clients.

Occupational therapy has been included as a core component of quality mental health services by the Center for Medicare and Medicaid services, and must be offered at any community mental health center that bills under Medicare for partial hospitalization. It has also been included

as a member of the behavioral health workforce by the Health Resources Service Administration in 2018. In a bipartisan Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (HR6) occupational therapy was recognized, as the act promotes non-opioid and non-pharmacological approaches to pain management.

Occupational therapists across the state are asking that the **Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C** be changed from the emergency regulations that currently read:

B. 5. A licensed occupational therapist with no less than 1,500 hours of supervised experience to be obtained within a five-year period immediately preceding application for registration and as specified in subsection C of this section. (Subsection C requires that the supervision occur of a licensed mental health professional or a person under supervision that has been approved by the Boards of Counseling, Psychology, or Social Work as a pre-requisite for licensure.)

AND

B. 4. A licensed occupational therapist with no less than 1,500 hours of supervised experience to be obtained within a five-year period immediately preceding application for registration and as specified in subsection C of this section.

And that they be **replaced** with criteria that has the potential to expand the behavioral health workforce. We suggest the following replacement:

18VAC115-80-40 B.5. and 18VAC115-80-50 B.4. Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Thank you for your time and consideration,

Nouran Amin, OTS

You are limited to approximately 3000 words.

Commenter: Taylor Schwab, Virginia Commonwealth University 4/4/19 9:44 pm

QMHP requirements for Occupational Therapists

Dear Jamie Hoyle and Board of Counseling,

I am writing to you to address Emergency Regulations for QMHP-A and QMHP-C. The occupational therapy profession is rooted in mental health. Occupational therapy practitioners take a holistic view when treating individuals, considering the connection between mind and body, and consider the client's surrounding environment and its impact on their roles, goals, and health (including mental health). We work towards getting the client engaged in activities meaningful to them to achieve health and well-being.

Occupational therapy practitioners continue to receive significant mental health training before entering the field. Current occupational therapy training is at the graduate level. Additionally, mental health courses are required as prerequisites and specific mental health coursework is imbedded during the graduate coursework and fieldwork experiences. The The Accreditation Council for Occupational Therapy Education (ACOTE) requires occupational therapy programs to educate students on human psychology and assesses their students' ability to address a client's psychosocial needs before they enter the profession.

With the significant mental health needs in the Virginia, we should allow more qualified health professionals trained in mental health principles to enter the field without unduly regulations. The requirement of 1,500 hours puts a significant burden on both practitioning practitioners and future practitioners. Other states, including Oregon, Maine and Massachusetts have no additional requirements for OTs to qualify for QMHP status beyond licensure.

As a profession we are asking that the Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C be changed from the current Emergency Regulations to the following replacement:

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Thank you for your support in helping occupational therapists provide mental health services to our community.

Sincerely,

Taylor Schwab

Occupational Therapy Doctorate Student

Virginia Commonwealth University

Commenter: Margaret Fox, Virginia Commonwealth University 4/4/19 9:45 pm

QMHP

I am an occupational therapy student requesting a change in the qualifications required for OTs to become QMHPs. For over one hundred years, OTs have worked with individuals experiencing barriers to the things they need and want to do. OTs recognize that you cannot just treat a physical symptom without also considering the individual's emotional and mental state. In fact, this connection between the mind and the body is foundational to the effectiveness of OT practice and was central to the establishment the profession. As OTs, we use occupations, or activities of personal meaning, to facilitate healing, skill building, and successful engagement with life. We utilize these unique skills in working with people across diagnoses and life stages, including in settings focused on mental health, through our education and related experiences. In particular, we are educated on psychiatric diagnoses, mental health settings, assessments, and treatments. We are further required to complete a semester-long clinical experience focused on mental health by the Accreditation Council for OT Education. Following a 2.5 year master's or 3 year doctorate in OT, we are qualified mental health professionals. We are uniquely qualified to help people live their best lives by preventing disability and helping people adapt to life circumstances through fostering client-centered occupations that facilitate healing and growth.

The current stringent requirements on OTs to become QMHPs in Virginia are not representative of the expansive training we receive to address individuals' mental health needs. Our unique ability to contribute to mental health teams is already recognized by Medicare, as OT services have always been included as a billable service for individuals with mental health diagnoses. In 2013, the Center for Medicare and Medicaid services additionally required community mental health centers wishing to bill under Medicare partial hospitalization to offer OT services, thus recognizing OT as a core component of quality mental health. It is also worth noting that some states do not have any additional requirements for OTs to become QMHPs beyond the standard licensure that all OTs must maintain. Comparing this to the 1,500 hours of supervised experience currently required of OTs in Virginia further elucidates why this is not a reasonable, necessary, or prudent requirement. This requirement places undue burden on other professionals to serve in supervisory positions for longer than needed and on the OTs, who must go through

approximately nine additional months of inessential training to provide services they have already been trained to administer. As currently written, requirements for OTs to become QMHPs in

Virginia therefore not only limit the scope of our practice, but also prevent many individuals from receiving the comprehensive services they need and deserve. This requirement does not serve to protect individuals but rather decreases the quality of life they could be experiencing if they had better access to the range of services they need, including OT.

I therefore request that requirements for registration as a QMHP-A and QMHP-C be changed from the current Emergency Regulations to the following replacement: ***Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.***

Thank you for your time and attention on this important matter.

Commenter: Kimberly Rahimian, Virginia Commonwealth University 4/5/19 7:57 am

QMHP and OT

Dear Jaime Hoyle,

My name is Kimberly Rahimian and I am currently a graduate student at Virginia Commonwealth University in the Occupational Therapy Doctorate program. I am writing to request that the Board of Counseling reconsider the supervision requirements proposed in the Emergency Regulations for occupational therapists seeking registration as a Qualified Mental Health Provider (QMHP).

The profession of occupational therapy has strong foundational roots in recognizing the importance of meaningful activities (occupations) to promote mental health. In order to become an occupational therapist, individuals must graduate from an accredited occupational therapy program at the master's or doctorate level, undergo rigorous fieldwork training for 24 weeks full-time, and pass the National Board Certification in Occupational Therapy (NBCOT) exam. Additionally, occupational therapy is recognized federally as part of recovery-oriented, quality mental health services and professions. Occupational therapists are highly trained health care professionals, who are qualified to play a vital role in addressing several different aspects of mental health, including evaluation, developing a plan of care, and intervention.

Occupational therapists should not have to undergo additional burdensome requirements to become a QMHP. I am asking that the Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C be changed from the current Emergency Regulations to the following replacement:

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Sincerely,

Kimberly M. Rahimian, OTS

Commenter: Sara Brockman, VCU 4/5/19 3:09 pm

QMHP and OT

I am writing in regards to the current regulations for occupational therapists to become Qualified Mental Healthcare Providers for adults (QMHP-A) and children (QMHP-C). I am requesting that the current burdensome requirements be changed due to the qualifications practicing occupational therapists hold upon graduating from accredited programs and the benefits they received working in.

As a student of Virginia Commonwealth University's Occupational Therapy Doctorate program, I know first hand the ways in which an education from an accredited OT program prepares you for work in mental health settings. From learning about our profession's roots in mental health on the first day of class to participating in a psychosocial fieldwork in my second year of the program, I have absorbed knowledge and experience that promotes a deeper understanding of the lived experience of those dealing with a mental health issue. Using evidence-based practice as well as empathetic listening - two important skills developed in OT school - I feel equipped to work with individuals with various psychosocial diagnoses and know that with a year of mentorship after of school, I would excel in this setting.

Unfortunately, only 5% of all practicing OTs work in mental health settings, as the pay differential is so great that it can hardly compensate for the cost of a masters or doctoral level education. This is unfair to the individuals who are struggling with mental health disorders and who need OT services now. With a QMHP certification, occupational therapists will better be able to negotiate for fair compensation and will further promote occupational therapy as a profession that belongs in the mental health sphere.

Therefore, I am asking that the **Part II Requirements for Registration regulation 18VAC115- 80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C** be changed from the current Emergency Regulations to the following replacement:

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Thank you for your time and consideration of this important issue facing our profession and, in turn, the individuals in our community who benefit from mental health-based occupational therapy services.

Sincerely,
Sara Brockman

Commenter: Katherine Howe, Virginia Commonwealth University 4/5/19 5:21 pm

OT requirements for QMHP

I would like to speak to the the proposed regulations for Occupational Therapists to become Qualified Mental Healthcare Providers for adults (QMHP-A) and children (QMHP-C). The current proposal would require an Occupational Therapist to have 1,500 hours of supervision by a social worker or other licensed mental health provider in Virginia. There are several important reasons why this requirement is excessive and unnecessary.

The profession of Occupational Therapy began in mental health settings. It was officially founded by a team which included two psychiatrists, a nurse, a social worker, an architect, a crafts instructor, and a consumer. With this foundation occupational therapists recognize the importance of the mind-body connection, and use occupation to address both physical and mental health.

Today, occupational therapists are required to obtain a Masters or Doctorate degree to enter the field. These programs must align with the Accreditation Council for Occupational Therapy Education (ACOTE) standards. One of the standards includes extensive requirements for coursework and at least one fieldwork experience focused on mental health. As a current student

of Virginia Commonwealth University's Occupational Therapy Doctorate program, I can personally attest to the significant and thorough educational focus on mental health.

Occupational Therapy continues to be recognized as a profession well suited to provide mental health services. The Center for Medicare and Medicaid Services (CMS) included Occupational Therapy as a core component of mental health in 2013. In 2015, the Substance Abuse Mental Health Services Administration (SAMHSA) included occupational therapists in staffing suggestions for new Certified Community Behavioral Health Centers. Occupational therapy education programs became eligible to receive grant funding through the Behavioral Health Workforce Education Training Grant (BHWET) which was reauthorized by Congress in 2016. Last year, the Health Resources Service Administration (HRSA) included occupational therapy as a member of a behavioral health workforce. Occupational therapy was also included in the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act.

It is also important to recognize the varying requirements for occupational therapists to become QMHPs. Some states have no additional requirements beyond licensure. Some states require one year of clinical experience in a mental health setting, while others require a practicum in a psychiatric setting.

Important information can be drawn from other countries on the involvement of occupational therapy in mental health. In the UK, Canada, and Australia health care providers are paid equally for the provision of mental healthcare services and physical healthcare services. In those countries 50% of occupational therapists work in mental health. In the U.S. the number of OT practitioners pursuing careers in mental health is under 5%. This fact holds significant relation for occupational therapy students and new graduates in pursuing careers in mental health. In addition to the pay differential and cost of education, cumbersome state requirements will likely discourage occupational therapists from entering mental health; an area of healthcare that could benefit from increased inclusion of occupational therapists.

As an occupational therapy student I have profound concern for the future of occupational therapy and the field of mental health. I am asking that the Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C be changed from the emergency regulations to the following replacement:

18VAC115-80-40 B.5. and 18VAC115-80-50 B.4. Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Thank you for your time and consideration.

Sincerely,

Katherine Howe, OTS

Commenter: Joni Watling 4/5/19 8:19 pm

QMHP and Occupational Therapy

Thank you so much for the opportunity to address the Board in person in February. There are a few things that I did not mention then that I would like to share now, on this last day of public comment.

It was almost a year ago that I left my five-year position at Fairview / University of Minnesota Medical Center's behavioral health department in Minneapolis, MN so my husband and I could relocate to Richmond, VA.
At the facility, there was a robust psychiatric inpatient program – 6 adult units, 1 young adult, 1

geriatric unit and a child/adolescent unit, with more than a dozen occupational therapists employed as part of the interdisciplinary care team. Outpatient day treatment employed another 4 occupational therapists. The OT's I mention are all in addition to the art, music, recreational & dance therapists also employed. Each unit also employed 2 social workers. Members of the interdisciplinary team included registered dieticians, nurses, psychiatrists, psychologists, chaplains and pharmacologists. Without a doubt, we all needed each other and the different perspectives each of us brought to practice and to providing culturally competent, quality, evidence-based patient care. Incidentally, at last count Regions Hospital system in St. Paul, just over the bridge from UMMC, employed more than 20 occupational therapists combined for their inpatient, outpatient & substance abuse assessment, intervention and programming needs. There are many other hospitals throughout the state with similar structure, although these institutions are by far the largest.

According to Mental Health America, Minnesota ranks #1 overall in mental health care rankings in comparison to Virginia, with an overall ranking of #33. Is this due in part to occupational therapists being the norm, and not the exception, as part of mental health treatment team? Maybe. It's hard to say, but one certainly cannot discount a cause and effect correlation. Minnesota's Occupational Therapy emphasis has always been heavily mental health oriented. The Minnesota Occupational Therapy Association holds monthly meetings & at least 90 percent of the time, the guest speaker and presentation is focused on a mental health, substance abuse or a recovery-based topic. In comparison, because there are so few OT's working in mental health here in Virginia (due to long existing norms & what has been an uptick in barriers to OT involvement due to QMHP regulations) the same cannot be said about Virginia's state association (VOTA). In particular, VOTA has strong outreach and continuing education related to school OT, in particular.

I find myself in a strange position here in Virginia. I am licensed in two states and teach mental health occupational therapy in an adjunct capacity at two different universities (Minnesota and Virginia). I have supervised dozens of fieldwork students & educated even more medical school students & nursing students about the role of occupational therapy – historically and currently in mental health and psychiatry. Here, OT seems to just be pigeonholed into a physical disability /ADL or school setting paradigm. As a result, even though students are being trained and people such as myself have skill and expertise, we experience barriers – not only due to history, but due to the onerous current QMHP requirements which require 1,500 hours of supervision – often from someone with less experience working with the mental health population than we have.

Occupational therapists want to be involved in making a positive difference in the lives of others here in Virginia. There is deep need & there is a shortage of workers in mental health. With that in mind, please change the Part II Requirements for Registration regulation to include *Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.*

Many thanks for your time and consideration.
Joni Watling, MOT, OTR/L
Doctoral Candidate University of St. Augustine for Health Sciences
Adjunct Instructor, Virginia Commonwealth University
Adjunct Instructor, University of Minnesota

Commenter: La' Shandra Russell 4/5/19 10:44 pm

LETTER TO SUPPORT VOTA'S MENTAL HEALTH LEGISLATIVE REQUEST

Good Evenining Ms. Hoyle,

My name is La' Shandra Russell and I am currently a Masters student in occupational therapy program at Shenandoah University in Leesburg, Virginia. I have less than one year before I complete my degree and my plans are to practice here in Virginia after I graduate. I have an interest in working in mental health with an interest in maternal and infant mental health. My interest in mental health practice stemmed from my experience as a fieldwork student at the Sinclair Medical Clinic in Winchester, VA where OT based mental health services is currently being offered as a part of a 5-year pilot grant program. Through this experience, I was able to see the unique perspective that OT brings to the mental health service delivery process, including addressing those physical, psychosocial and virtual barriers impacting an individual's ability to engage in occupations (activities) that are both purposeful and meaningful. Providing the individual with the opportunity to successfully engage in occupations that s/he is expected to do, wants to do and needs to do. Contributing to the individual's ability to cope with his/her stressors while engaging in occupations that supports the development of occupational and social-emotional identity. As a mom who struggled with postpartum anxiety, I have also recognized the role that OTs can serve within the area of maternal-infant mental health. Helping moms understand their sensory needs in relation to their baby and how this understanding can help guide the therapeutic process for improving mental health and developmental outcomes for both mother and baby. It is my belief that the quality of mental health is not only influenced by underlying biological process, but also through sensory experiences afforded through interactions with aspects of one's environment. As a result of the education and clinical training that OTs receive in the areas of human development, mental health, sensory integration and activity analysis, the profession of OT is in prime position to serve the mental health needs of individuals across the lifespan.

Occupational therapists have been working in the area of mental health helping clients develop the skills to live healthier, more satisfying daily lives since the profession began over 100 years ago. Occupational therapists have been recognized in federal legislation and by federal agencies as mental health providers and we need to do the same here in Virginia.

I am writing in support of the proposed changes to the emergency regulations for occupational therapists to register as qualified mental health providers for adults and children in the state of Virginia. I support a revision of ***Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C***

Please consider revising the language to recognize OTs preparation at the graduate level and knowledge and practice experience in mental health. I support a change to:

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Thank you for your time, your service to the Board of Counseling and to the Commonwealth of Virginia and your thoughtful consideration of this request.

Sincerely,

La' Shandra Russell, CLVT, OTS

Occupational Therapy Student

Shenanandoah University

Student Liaison

Virginia Occupational Therapy Association

15 Elm Street

Stafford, VA 22554

lrussell17@su.edu

Comment on QMHP Regulations

From: **Jeanine Rossi** <jrossi0821@gmail.com>
Date: Wed, Feb 13, 2019 at 7:45 PM
Subject: Requirements for OTs for QMHP-A/QMHP-C
To: <jaime.hoyle@dhp.virginia.gov>

Good evening Ms. Hoyle,

I hope this email finds you well, as an Occupational Therapist in the state of VA, I am writing regarding the requirements for registration for QMHP-C and QMHP-A.

We are asking that the ***Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C*** be changed from the current Emergency Regulations to the following replacement:

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

I appreciate your assistance in this matter and have a great evening.

My best,

Jeanine Rossi, OTR

From: **Eddy, Kristin M** <kmeddy@fcps.edu>
Date: Wed, Feb 13, 2019 at 7:52 PM
Subject: Public Comment on Emergency Regulations for QMHP-A and QMHP-C
To: jaime.hoyle@dhp.virginia.gov <jaime.hoyle@dhp.virginia.gov>

Dear Jamie Hoyle and Board of Counseling,

I am an occupational therapist practicing in the state of Virginia.

I am also a current member of VOTA and serve as the VOTA Ethics & Bylaws chairperson.

I write to you, to provide comment on the Emergency Regulations for QMHP-A and QMHP-C.

Please reconsider the supervisory requirements, which we are unduly onerous and do not recognize that occupational therapy is at the graduate level. Currently, the regulations require Occupational Therapists to have 1,500 hours of supervision by a social worker or other licensed mental health provider in Virginia in order to apply.

I am asking that the ***Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C*** be changed from the current Emergency Regulations to the following replacement:

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Sincerely,

Kristin H. Eddy, MS OTR/L

From: **Tom and Debbie Schwind** <theschwinds@hotmail.com>
Date: Wed, Feb 13, 2019 at 8:57 PM
Subject: OT and mental health supervision
To: jaime.hoyle@dhp.virginia.gov <jaime.hoyle@dhp.virginia.gov>

Dear Jaime,

As an OT practitioner in the state of Virginia with a terminal doctorate degree, I do not support the requirements that an OT needs to be supervised for 1500 hours by a social worker.

I am asking that the ***Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C*** be changed from the current Emergency Regulations to the following replacement:

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Thank you

Dr. Deborah Schwind, DHSc, M. Ed., OTR/L

From: **Graves, Jeffrey** <jeffrey.graves@dbhds.virginia.gov>
Date: Fri, Feb 15, 2019 at 2:29 PM
Subject: Occupational Therapy- QMHP-A
To: Jaime Hoyle <jaime.hoyle@dhp.virginia.gov>, <jwatling@vcu.edu>, <dfsimon@vcu.edu>

Ms. Hoyle,

The purpose of this note the express my concern over the proposed requirements for Occupational Therapists to receive the QMHP-A certification. I have worked for 6 years at Western State Hospital with persons having Serious Mental Health diagnosis such as Schizophrenia, Bipolar Disorder, Schizoaffective, etc. I also have over 15 years of experience working with persons with stroke, spinal cord injury, traumatic brain injury, autism, etc.

As OTs, we work with persons having autism, stroke, traumatic brain injury, Parkinson's, MS, Dementia and many other illnesses having an origin in the brain. Many of these diagnosis are included in the DSM V. Our education and affiliation programs provide a strong foundation for working with persons with a wide variety of illnesses. We receive education on the biological, social and cultural aspects of illness and disability. We focus on functional abilities, behavior, meaningful engagement, and independence- aspects of life fundamental to mental health. Parsing out a few diagnosis' seems an arbitrary and odd distinction to make.

Supervision by a profession other than occupational therapy to meet these requirements is, respectfully, a poor choice. Supervision should be by someone in the field with a work history in mental health. It is unlikely that Social Workers would be well supervised by psychologists who don't have a strong theoretical knowledge of the profession.

The requested criterion for qualification of OTs to meet QMHP-A are listed below.

Thanks you for taking the time to read and consider this concern. Thank you Joni and Diane for taking time to champion this concern.

Sincerely,
Jeff Graves, MS OT/L
Western State Hospital

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

From: **Godwin, Alfred K RICVAMC** <Alfred.Godwin@va.gov>
Date: Tue, Feb 19, 2019 at 1:08 PM
Subject: Requirements for QMHP
To: jaime.hoyle@dhp.virginia.gov <jaime.hoyle@dhp.virginia.gov>
Cc: Conley, Alison B RICVAMC <Alison.Conley@va.gov>

Dear Jaime Hoyle,

Hello. I write to ask the Virginia Board of Counseling to change the their QMHP requirements for occupational therapists, to more accurately reflect the mental health background and graduate level education of occupational therapists (OTs).

OTs currently graduate with either a Master of Science or a Doctoral degree, after extensive education in psychology, individual and group therapeutic interventions, and cognitive [re]training. This education provides qualified intervention to people with mental health concerns, and it brings additional resources to a mental health team. We work closely with social work, counselors, and psychologists and are licensed by the Virginia Board of Medicine.

Please consider the following:

Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C

be changed from the current Emergency Regulations to the following replacement:
Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Thank you very much for your consideration.

Sincerely,

Alfred K. Godwin, MS, OTR/L, CHT

From: **Cara K Richardson** <ckrichardson@tcc.edu>
Date: Mon, Feb 18, 2019 at 9:44 AM
Subject: mental health regulations
To: jaime.hoyle@dhp.virginia.gov <jaime.hoyle@dhp.virginia.gov>

Hello,

I teach the Occupational Therapy mental health and neuro classes to our certified occupational therapy assistant students here at Tidewater Community College. I have also interned at VCU Health inpatient psychiatry. Mental Health is part of our roots as a profession and part of our curriculum.

I am asking that the ***Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C*** be changed from the current Emergency Regulations to the following replacement:

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Best,

Cara

Cara K. Richardson
Assistant Professor, Academic Fieldwork Coordinator
OTA Program
Tidewater Community College

--------- Forwarded message ---------
From: **Patricia Blease** <patricia.blease@vcuhealth.org>
Date: Mon, Feb 18, 2019 at 5:10 PM
Subject: Occupational therapy as Qualified Mental Health Providers
To: jaime.hoyle@dhp.virginia.gov <jaime.hoyle@dhp.virginia.gov>

Ms. Hoyle,

Occupational therapy is a profession which is rooted in mental health and utilizes the engagement in occupation to restore health and well-being. The connection between mind and body and engagement in occupation to promote wellness is core to our profession. The importance of occupational therapy as a provider of mental health treatment has been recognized by several federal and congressional acts.

I have committed my professional life to pursuing occupational therapy practice in the field of mental health. I have worked the entirety of my seventeen-year career in an acute adult psychiatric inpatient unit, and plan to continue to do so. I am an occupational therapist with a Master's level education. I also completed a fieldwork placement in mental health. I am licensed by the Board of Medicine and registered through National Board

Certification for Occupational Therapy. I belong to both my state and national Occupational Therapy Associations and have chosen to follow specifically a special interest section of our national organization focused on mental health. I am a clinical instructor for level II fieldwork students, a 480-hour clinical fieldwork experience, as well as level I fieldwork students, a 42-hour clinical fieldwork. I am currently advising a Doctoral level OT student in a capstone project to promote evidence-based use of technology in the mental health setting. I teach several times a year as a guest lecturer at VCU's OT school and have been recognized as a clinical instructor since 2005. I have advanced clinical standing with VCU Health as a Clinical Level III practitioner. I complete continuing education annually to maintain my licensure, certification and evidence based clinical knowledge.

The regulations set forth by the Board of Counseling are inordinately arduous and unnecessary for occupational therapy practitioners. There are many occupational therapy practitioners and students who share my passion about this area of practice and would like to be acknowledged for the education, hard work and dedication to the field of mental health by being designated as Qualified Mental Health Providers.

It is for this reason I reach out to and ask that the ***Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C*** be changed from the current Emergency Regulations to the following replacement:

> ***Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.***

Thank you for your time and consideration,
Pat Blease, MSOTR/L

From: **Kapus, Katherine RICVAMC** <Katherine.Kapus@va.gov>
Date: Tue, Feb 19, 2019 at 1:21 PM
Subject: Requesting Changes to the QMHP Requirements for OT
To: jaime.hoyle@dhp.virginia.gov <jaime.hoyle@dhp.virginia.gov>

Dear Jaime Hoyle,

Hello. I write to ask the Virginia Board of Counseling to change the their QMHP requirements for occupational therapists, to more accurately reflect the mental health background and graduate level education of occupational therapists (OTs).

OTs currently graduate with either a Master of Science or a Doctoral degree, after extensive education in psychology, individual and group therapeutic interventions, and cognitive [re]training. This education provides qualified intervention to people with mental health concerns, and it brings additional resources to a mental health team. We work closely with social work, counselors, and psychologists and are licensed by the Virginia Board of Medicine.

Please consider the following:

1. ***Part II Requirements for Registration regulation 18VAC115-80-40 B.5.,***
2. ***Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4., and***
3. ***Requirements for registration as a QMHP-C***

be changed from the current Emergency Regulations to the following replacement:

1. ***Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and***

2. ***an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.***

Thank you very much for your consideration.

Sincerely,

Katherine Kapus, MS, OTR/L

Kind Regards,

Jaime H. Hoyle, J.D., Executive Director
Boards of Counseling, Psychology, and Social Work

Virginia Department of
Health Professions

9960 Mayland Drive, Suite 300
Richmond, VA 23233
(804) 367-4406 (office)

---------- Forwarded message ---------
From: **Conley, Alison B RICVAMC** <Alison.Conley@va.gov>
Date: Tue, Feb 19, 2019 at 2:09 PM
Subject: OT and QMHP
To: jaime.hoyle@dhp.virginia.gov <jaime.hoyle@dhp.virginia.gov>

Dear Jaime Hoyle,

I hope you are well. I am one of four occupational therapists on the mental health unit at my facility. I write to ask for your assistance with changing the Virginia Board of Counseling's QMHP requirements for occupational therapists, to be more in line with the requirements for other graduate level medical and mental health professionals. OTs have an extensive educational and practicum background in mental health and currently graduate with either a Master of Science or a Doctoral degree.

Our graduate programs require extensive education in psychology, individual and group therapeutic interventions, and cognitive [re]training. This education provides qualified intervention to people with mental health concerns, and it brings additional resources to a mental health team. We work closely with social work, counselors, and psychologists and are licensed by the Virginia Board of Medicine.

Please consider the following:

Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C

be changed from the current Emergency Regulations to the following replacement:

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Thank you very much for your consideration.

Sincerely,

Alison B. Conley, MS, OTR/L

From: **Vanderburg, Deborah RICVAMC** <Deborah.Vanderburg@va.gov>
Date: Tue, Feb 19, 2019 at 1:30 PM
Subject: OTs as QMHP
To: jaime.hoyle@dhp.virginia.gov <jaime.hoyle@dhp.virginia.gov>

Dear Jaime Hoyle,

Hello. I write to ask the Virginia Board of Counseling to change the their QMHP requirements for occupational therapists, to more accurately reflect the mental health background and graduate level education of occupational therapists (OTs). Occupational therapy is strongly rooted in the area of mental health. The first Occupational Therapists worked with "Shell Shocked" patients after WWI and were pioneers during the Moral treatment era and The Mental Hygiene movement of the 1960s.

OTs currently graduate with either a Master of Science or a Doctoral degree, after extensive education in psychology, individual and group therapeutic interventions, and cognitive [re]training. This education provides qualified intervention to people with mental health concerns, and it brings additional resources to a mental health team. We work closely with social work, counselors, and psychologists and are licensed by the Virginia Board of Medicine.

Please consider the following:

Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C

be changed from the current Emergency Regulations to the following replacement:
Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Thank you very much for your consideration.

Sincerely,

Deborah Vanderburg, MS, OTR/L

From: **Buckley, Erin A RICVAMC** <Erin.Buckley@va.gov>
Date: Tue, Feb 19, 2019 at 2:37 PM
Subject: OT supervision
To: jaime.hoyle@dhp.virginia.gov <jaime.hoyle@dhp.virginia.gov>

Dear Jaime Hoyle,

Hello, I write to ask the Virginia Board of Counseling to change the their QMHP requirements for occupational therapists, to more accurately reflect the mental health background and graduate level education of occupational therapists (OTs).

OTs currently graduate with either a Master of Science or a Doctoral degree, after extensive education in psychology, individual and group therapeutic interventions, and cognitive [re]training. This education provides qualified intervention to people with mental health concerns, and it brings additional resources to a mental health team. We work closely with social work, counselors, and psychologists and are licensed by the Virginia Board of Medicine.

Please consider the following:
Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C
be changed from the current Emergency Regulations to the following replacement:
Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Thank you very much for your consideration.

Sincerely,

Erin Buckley, MS, OTR/L

Dear Jaime Hoyle,

Hello. I write to ask the Virginia Board of Counseling to change the their QMHP requirements for occupational therapists, to more accurately reflect the mental health background and graduate level education of occupational therapists (OTs).

OTs currently graduate with either a Master of Science or a Doctoral degree, after extensive education in psychology, individual and group therapeutic interventions, and cognitive [re]training. This education provides qualified intervention to people with mental health concerns, and it brings additional resources to a mental health team. We work closely with social work, counselors, and psychologists and are licensed by the Virginia Board of Medicine.

Please consider the following:
Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C
be changed from the current Emergency Regulations to the following replacement:
Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Thank you very much for your consideration.

Sincerely,

Karen DeMarco, MS, OTR/L

From: **Pound, Dawne M RICVAMC** <Dawne.Pound@va.gov>
Date: Tue, Feb 19, 2019 at 4:04 PM
Subject: QMHP requirements
To: jaime.hoyle@dhp.virginia.gov <jaime.hoyle@dhp.virginia.gov>

Dear Jaime Hoyle,

Hello. I write to ask the Virginia Board of Counseling to change the their QMHP requirements for occupational therapists, to more accurately reflect the mental health background and graduate level education of occupational therapists (OTs).

OTs currently graduate with either a Master of Science or a Doctoral degree, after extensive education in psychology, individual and group therapeutic interventions, and cognitive [re]training. This education provides qualified intervention to people with mental health concerns, and it brings additional resources to a mental health team. We work closely with social work, counselors, and psychologists and are licensed by the Virginia Board of Medicine.

Please consider the following:

Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C

be changed from the current Emergency Regulations to the following replacement:
Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Thank you very much for your consideration.

Sincerely,

****
Dawne M. Pound, MS, OTR/L, ATP
Occupational Therapy Clinical Specialist
Spinal Cord Injury & Disorders
McGuire VA Medical Center
804.675.5000 (ext. 2599)

From: **Freeman, Mandy J RICVAMC** <Mandy.Freeman@va.gov>
Date: Wed, Feb 20, 2019 at 1:34 PM
Subject: Re: QMHP Requirements for occupational therapists
To: jaime.hoyle@dhp.virginia.gov <jaime.hoyle@dhp.virginia.gov>

Dear Jaime Hoyle,

Hello. I write to ask the Virginia Board of Counseling to change the their QMHP requirements for occupational therapists, to more accurately reflect the mental health background and graduate level education of occupational therapists (OTs).

OTs currently graduate with either a Master of Science or a Doctoral degree, after extensive education in psychology, individual and group therapeutic interventions, and cognitive [re]training. This education provides qualified intervention to people with mental health concerns, and it brings additional resources to a mental health team. We work closely with social work, counselors, and psychologists and are licensed by the Virginia Board of Medicine.

Please consider the following:

Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C

be changed from the current Emergency Regulations to the following replacement:
Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Thank you very much for your time and consideration.

Sincerely,

Mandy J. Freeman, MS, OTR/L
Occupational Therapist
McGuire VA Medical Center

Dear Jaime Hoyle,

Hello. I write to ask the Virginia Board of Counseling to change the their QMHP requirements for occupational therapists, to more accurately reflect the mental health background and graduate level education of occupational therapists (OTs).

OTs currently graduate with either a Master of Science or a Doctoral degree, after extensive education in psychology, individual and group therapeutic interventions, and cognitive [re]training. This education provides qualified intervention to people with mental health concerns, and it brings additional resources to a mental health team. We work closely with social work, counselors, and psychologists and are licensed by the Virginia Board of Medicine.

Please consider the following:

Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C

be changed from the current Emergency Regulations to the following replacement:
Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Thank you very much for your consideration.

Sincerely,

Melissa Oliver, MS OTR/L

From: **Rebecca Lesley** <rpl281@email.vccs.edu>
Date: Thu, Feb 21, 2019 at 6:24 PM
Subject:
To: <jaime.hoyle@dhp.virginia.gov>

As an OTA student, I have been enrolled in classes specifically focusing on the mental health aspects of my chosen career. We are being trained in class and hands-on to work with clients diagnosed with mental health issues. MOTs

with internship hours or setting experience would be a true asset to the mental health field, especially in light of the scarcity of mental health professionals available.

Occupational Therapy has its roots in the mental health field and has maintained its devotion to mental health clients throughout its history. It is uniquely suited to treat the factors surrounding mental health diagnoses which prevent the clients from living independent and functional lives.

As such I am asking that the ***Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C*** be changed from the current Emergency Regulations to the following replacement:

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Sincerely,

Rebecca Lesley, OTAS

From: **Cindy Bertaut** <cindybertaut@gmail.com>
Date: Fri, Feb 22, 2019 at 8:55 PM
Subject: Comments on Regulation 18VAC115-80-40 B.5
To: <jaime.hoyle@dhp.virginia.gov>

I am writing to you to comment on regulation 18VAC115-80-40 B.5.

I received my Masters Degree in Occupational Therapy in 2015 from Shenandoah University in Virginia, and live just across the Potomac River in nearby Maryland. My training in mental health during my graduate OT school studies sparked a dedicated interest in mental health practice and I have considered Occupational Therapy licensure and practice in VA.

The proposed supervisory requirements for a QMHP-A are unnecessary, given that the majority of currently practicing occupational therapists already have a graduate-level degree on par with social worker graduate degrees. Please reconsider changing the supervisory requirements for registration as a QMHP-A, under regulation 18VAC115-80-40 B.5, to "Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting."

Sincerely,

Cindy Bertaut MS, OTR/L

From: Reid, Holly Madison - reidhm <reidhm@dukes.jmu.edu>
Date: Fri, Feb 22, 2019 at 3:27 PM
Subject: QMHP Requirements for Occupational Therapists
To: jaime.hoyle@dhp.virginia.gov <jaime.hoyle@dhp.virginia.gov>

Good afternoon,

I am Holly Reid, a Master's of Occupational Therapy student at James Madison University. I am writing to express my stance on the current requirements for OTs to become Qualified Mental Health Professionals for adults and children. Like several others in this profession, I agree that a requirement of 1,500 hours of experience under the supervision of those who have similar education as occupational therapists is unnecessary.

While having experience and education in mental health is important, OT students already receive education in this area, as well as a psychosocial fieldwork experience in a mental health setting. Requiring an extra 1,500 hours of experience, especially for those who have been practicing in mental health settings for years after graduating seems arduous and time-consuming for both the OT and the professional who will supervise him or her. I agree that OTs should have experience in this areas to qualify as a QMHP-A/C, but I think this should be closer to 500 hours. I also think that therapists already practicing in a mental health setting should qualify for this title.

Thank you for your consideration.

Sincerely,
Holly Reid, MOTS
James Madison University

From: **Jillian Gomez** <jg24112@email.vccs.edu>
Date: Wed, Feb 27, 2019 at 11:22 AM
Subject: Mental Health Advocacy
To: <jaime.hoyle@dhp.virginia.gov>

We are asking that the ***Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C*** be changed from the current Emergency Regulations to the following replacement:

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

From: **Kirsten Ganslow** <kbg27104@email.vccs.edu>
Date: Wed, Feb 27, 2019 at 11:23 AM
Subject: OTAS Tidewater Community College
To: <jaime.hoyle@dhp.virginia.gov>

To whom it may concern,

We are asking that the ***Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C*** be changed from the current Emergency Regulations to the following replacement:

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Sincerely, Kirsten Ganslow

From: **Marlena Kastelan** <mek2888@email.vccs.edu>
Date: Wed, Feb 27, 2019 at 11:24 AM
Subject: mental health regulation change
To: <jaime.hoyle@dhp.virginia.gov>

We are asking that the ***Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C*** be changed from the current Emergency Regulations to the following replacement:

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

From: **Jenna Barea** <jdb294568@email.vccs.edu>
Date: Wed, Feb 27, 2019 at 11:24 AM
Subject: Mental Health Regulation
To: <jaime.hoyle@dhp.virginia.gov>

To whom it may concern,

We are asking that the ***Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C*** be changed from the current Emergency Regulations to the following replacement:

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Sincerely,

Jenna Barea, OTAS

Tidewater Community College

From: **Alix Freyer** <amf2707@email.vccs.edu>
Date: Wed, Feb 27, 2019 at 11:25 AM
Subject: Mental Health
To: <jaime.hoyle@dhp.virginia.gov>

Dear Jamie Hoyle:

We are asking that the ***Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C*** be changed from the current Emergency Regulations to the following replacement:

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Thank you very much for your time and consideration.

Sincerely:

Alix Freyer, OTAS

---------- Forwarded message ---------
From: **Olmstead, Charlea Marie - olmstecm** <olmstecm@dukes.jmu.edu>
Date: Mon, Feb 25, 2019 at 9:16 AM
Subject: Occupational Therapists as QMHPs in Virginia
To: jaime.hoyle@dhp.virginia.gov <jaime.hoyle@dhp.virginia.gov>

Ms. Hoyle,

I am emailing you regarding occupational therapists as QMHPs and the current legislation:

Regardless of the practice setting, diagnosis, etc., occupational therapists are addressing the psychosocial needs of our patients. We are trained to treat the whole person including the brain and mind. A foundation in mental health is crucial to attend to our patients' needs, thus our coursework and education speaks to neurological structures and functions; mental health diagnoses and dysfunctions; and neurological, cognitive, perceptual, and psychosocial assessments and interventions, to name a few.

The current legislation regarding occupational therapists as QMPHs is unduly and unnecessary. By education, trade, and definition, occupational therapists are qualified to work as mental health care providers. Furthermore, other professions acting as gatekeepers to services that are already in OT's scope of practice can create competition or tension in the workplace, among professions, and among practitioners. Lastly, the current legislation undermines our profession as occupational therapists and fails to recognize it as a graduate level degree.

For these reasons and more, I am advocating that Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C be changed from the current Emergency Regulations to the following replacement:

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Charlea Olmstead
Occupational Therapy Student
James Madison University 2020

---------- Forwarded message ---------
From: **Christine Gentry** <gentrych1@gmail.com>
Date: Sun, Feb 24, 2019 at 12:48 PM
Subject: QMHP for Occupational Therapists
To: <jaime.hoyle@dhp.virginia.gov>

Dear Jaime Hoyle,

Hello. I write to ask the Virginia Board of Counseling to change the their QMHP requirements for occupational therapists, to more accurately reflect the mental health background and graduate level education of occupational therapists (OTs).

OTs currently graduate with either a Master of Science or a Doctoral degree, after extensive education in psychology, individual and group therapeutic interventions, and cognitive [re]training. This education provides qualified intervention to people with mental health concerns, and it brings additional resources to a mental health team. We work closely with social work, counselors, and psychologists and are licensed by the Virginia Board of Medicine.

Please consider the following:

Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C

be changed from the current Emergency Regulations to the following replacement:
Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Thank you very much for your consideration.

Sincerely,

Christine Gentry, MA OTR/L

From: **JoAnn Kennedy** <otjoann@gmail.com>
Date: Tue, Mar 5, 2019 at 9:20 PM
Subject: Occupational Therapists as mental health practitioners
To: <jaime.hoyle@dhp.virginia.gov>

I am asking that the **Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C** be changed from the current Emergency Regulations to the following replacement:

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

For over a hundred years, the occupational therapy profession has developed a unique base of mental health theory, knowledge, and practice that is distinct from other mental health professions. We use our knowledge of neuroscience, anatomy, physiology, human development, and occupational science to provide activities that support health, wellness, and function in activities of daily living. Our interventions are much less verbally-based than psychotherapy. Rather, we use vocational, avocational, sensory, motor, and daily living activities to improve the lives of our clients. We are also experts in the use of adaptive equipment that can allow clients to function more independently in daily life. These are areas where my social work colleagues routinely ask me to support their interventions because they recognize that their clients need an approach that is complementary to mine. I do not know of any social workers who would ethically be able to supervise occupational therapists because they lack the coursework and experience in the occupational therapy field.

Entry level occupational therapists must earn a masters or doctorate degree [requiring extensive coursework in occupational therapy methods for mental health intervention and months of supervised full-time internships] to qualify for licensure in Virginia. Further regulating entry into practice by requiring other mental health professionals to supervise occupational therapists is not only unnecessary, but would be detrimental to fulfilling the state's need for more mental health professionals to serve our ailing mental health care system.

Please reconsider before finalizing regulations on mental health occupational therapy professionals,

~JoAnn Kennedy, OTD, MS, OTR/L

From: **Brognano, Erin Q** <eqbrognano@fcps.edu>
Date: Mon, Apr 1, 2019 at 8:32 AM
Subject: Public comment regarding regulations for occupational therapists as qualified mental health professionals
To: jaime.hoyle@dhp.virginia.gov <jaime.hoyle@dhp.virginia.gov>

Dear Jaime Hoyle,

I am writing to you regarding my concern as an occupational therapist about the qualifications/regulations for us to be registered as qualified mental health providers in the state of Virginia. The history of our profession as well as our education requirements, combined with work experience, make occupational therapists highly qualified as mental health providers. For example, in 2018, the Health Resources Service Administration (HRSA) included occupational therapy as members of the behavioral workforce alongside psychiatric nurses, nurse practitioners, social workers, substance use disorder prevention and treatment counselors, marriage and family therapists, and professional counselors. Occupational therapy was also included in the bipartisan Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (HR6), legislation which contained provisions related to multi-disciplinary, evidence-based, non-pharmacological based treatments for pain management and opioid abuse prevention.

As occupational therapy practitioners with many years of experience in working and teaching courses in mental health OT, and who have pursued legislation to attain QMHP status through the lobbying efforts of our Virginia Occupational Therapy Association, we believe that the emergency regulations for occupational therapists promulgated by the Board of Counseling are unduly and unnecessarily onerous. They will prohibit OTs from pursuing QMHP registration.
We are asking that the **Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C** be changed from the emergency regulations that currently read::
B. 5. A licensed occupational therapist with no less than 1,500 hours of supervised experience to be obtained within a five-year period immediately preceding application for registration and as specified in subsection C of this section. (Subsection C requires that the supervision occur of a licensed mental health professional or a person under supervision that has been approved by the Boards of Counseling, Psychology, or Social Work as a pre-requisite for licensure.)
AND
B. 4. A licensed occupational therapist with no less than 1,500 hours of supervised experience to be obtained within a five-year period immediately preceding application for registration and as specified in subsection C of this section.
And that they be replaced with criteria that has the potential to expand the behavioral health workforce. We suggest the following replacement:
18VAC115-80-40 B.5. and 18VAC115-80-50 B.4. Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Thank you for your time.

Sincerely,

Erin Q. Brognano, MS, OTR/L
Physical & Occupational Therapy Services
Fairfax County Public Schools
eqbrognano@fcps.edu
571.423.4864

From: Heidi Hutson <hhutson17@su.edu>

Date: Fri, Apr 5, 2019 at 9:25 PM

Subject: Occupational Therapists as Qualified Mental Health Professionals

Dear Ms. Hoyle,

My name is Heidi Zapanta. I am currently a Masters student in occupational therapy at Shenandoah University in Leesburg, Virginia . I will complete my degree in December of this year and my plans are to practice here in Virginia after I graduate. I have an interest in working in mental health.

I have had mental health fieldwork I experience at Western State Hospital. There are several occupational therapists serving Western State working with patients on cooking skills, independent living skills, vocational skills, and many other therapeutic activities as well. It was a privilege to witness the positive impact the work of these highly therapists has on the mental health of patients and how it prepares these patients to return to life as productive citizens of our commonwealth. Counseling has a very important place in mental health. At the same time, engaging in meaningful occupations or activities has a power that cannot be replaced by anything else. Occupational therapists are experts in assessing why an individual is having challenges engaging in important activities and making modifications to enable the individual to become more successful and also more satisfied with their lives. Occupational therapist education includes extensive training in understanding and treating mental illness using the recovery model.

Occupational therapists have been working in the area of mental health helping clients develop the skills to live healthier, more satisfying daily lives since the profession began over 100 years ago. Occupational therapists have been recognized in federal legislation and by federal agencies as mental health providers and we need to do the same here in Virginia.

I am writing in support of the proposed changes to the emergency regulations for occupational therapists to register as qualified mental health providers for adults and children in the state of Virginia. I support a revision of Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C

Please consider revising the language to recognize OTs preparation at the graduate level and knowledge and practice experience in mental health. I support a change to:

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

Thank you for your time, your service to the Board of Counseling and to the Commonwealth of Virginia and your thoughtful consideration of this request.

Sincerely,

Heidi Zapanta

Masters of Science Occupational Therapy Student

Shenandoah University class of 2019

February 18, 2019

To the Board of Counseling,

I am writing you as an Occupational Therapist (OTR/L) practicing in inpatient psychiatry at the University of Virginia Health System. I am passionate about the unique perspective that occupational therapy provides for individuals whose daily lives are impacted by mental health challenges. I use my knowledge of occupations to empower clients to participate more fully in their daily lives. I facilitate groups to equip them with life skills they can utilize when they leave the inpatient setting.

I am grateful that the University of Virginia Health System values the role of occupational therapists working in mental health. I am fortunate that our services are funded in the inpatient setting. I am aware, however that there are challenges to occupational therapists working in community based settings, where I believe this population needs us most. Enabling occupational therapists to becomes Qualified Mental Health Professionals will open doors for practice settings to hire occupational therapists as they will be able to access reimbursement for our services. I believe occupational therapists could make meaningful contributions to the interdisciplinary teams working in these settings.

The current Emergency Regulations create a barrier that will prevent many occupational therapists from attaining QMHP status, regardless of their years of education and/or experience related to mental health.

I respectfully request that the Part II Requirements for Registration regulation 18VAC115-80-40 B.5. Requirements for registration as a QMHP-A and 18VAC115-80-50 B.4. Requirements for registration as a QMHP-C be changed from the current Emergency Regulations to the following replacement:

Licensure as an occupational therapist by the Board of Medicine (§ 54.1-2900 of the Code of Virginia) with a master's or doctoral degree, and an internship or practicum of at least 500 hours with persons with mental illness or one year of experience in a mental health setting.

I believe my Master's level education, including my 500 hours spent as a fieldwork student in an inpatient psychiatric setting, has equipped me with the skills necessary to provide quality, evidence-based services for individuals with mental illness.

Thank you for your time and consideration.

Sincerely,

Savanah Howe OTR/L
38 Emerson Lane
Harrisonburg VA 22802

February 24, 2019

Melissa Leupp
145 S. Garfield St.
Arlington, VA 22204
Melissa.Leupp@apsva.us

Jaime Hoyle, Executive Director
Virginia Department of Health Professions, Board of Counseling
9960 Mayland Drive, Suite 300
Richmond, VA 23233

Dear Mr. Hoyle:
I am writing to express my concern about proposed supervision requirements for occupational therapists seeking registration as a qualified mental health provider. Occupational therapy was founded over 100 years ago by two psychiatrists and team members who recognized the value of engagement in occupations to restore and maintain mental health and well being.

Occupational therapy practitioners currently complete mental health course work and at least one fieldwork experience focused on mental health. It is interesting to note that 50% of occupational therapists in countries with national healthcare work in mental health. In the United States, less than 5% of occupational therapists work in mental health likely due to the difference in salary.

Other states have more limited or no additional requirements for occupational therapists to become mental health providers. I therefore hope that you consider requirements that more accurately reflect and respect the education level and experience of occupational therapists. An internship of at least 500 hours focusing on clients with mental illness or one year experience in mental health is a suggested replacement.

Thank you very much for your time and consideration.

Sincerely,

Melissa Leupp, MS, OTR/L

4860 Cox Road, Suite 200 Glen Allen, VA 23060
(P) 804.204.1339 (F) 804.510.0381 naswva@naswva.com » www.naswva.org

NASW VIRGINIA CHAPTER
National Association of Social Workers

Thank you for the opportunity to make public comment regarding how a change in the QMHP proposed regulations will harm the ability of Licensed Bachelor Social Workers (LBSW) and Licensed Masters Social Workers (LMSW) to engage in their scope of practice (Currently both of these licensees are called Licensed Social Worker). Under *Chapter 37 of Title 54.1 of the Code of Virginia, Social Work,* the LBSW and LMSW are authorized to practice social work which includes the provision of case management and supportive services.

The Department of Behavioral Health and Developmental Services definition of QMHP, prior to their current proposed regulations, had specifically included social workers. The DBHDS's Final Text proposed regulations for QMHP that did not contain this inclusive language. The Board of Counseling's proposed definition for the regulations for QMHP also does not include social workers. The lack of inclusion of this language disenfranchises LBSW and LMSW's from practicing within their scope of practice. The proposed regulation puts an undue burden on the LBSW and LMSW, as the proposal puts individuals with these credential (and LSW) in the position of having to acquire their QMHP. This requirement will inevitably be an obstacle to employment in the public sector of behavioral health resulting in unintended consequences for clients attempting to access care. If increased numbers of LBSW and LMSW credentialed individuals are unable to secure employment due to the proposed requirement, ultimately there will be less qualified individuals providing mental and behavioral health to the vulnerable populations in Virginia.

The Board of Counseling's proposed that a definition of the regulation stating, "Collaborative mental health services" include *"supportive services."* The Board of Health Professions *Policies and Procedures for the Evaluation of the Need to Regulate Health Occupations and Professions* delineates Criteria for three levels of regulation as noted below:

Criteria for Regulation

Registration. *Registration requires only that an individual file his name, location, and possibly background information with the State. No entry standard is typically established for a registration program.*

Statutory Certification. *Certification by the state is also known as "title protection." No scope of practice is reserved to a particular group, but only those individuals who meet certification standards (defined in terms of education and minimum competencies which can be measured) may title or call themselves by the protected title.*

> ***Licensure***. *Licensure confers a monopoly upon a specific profession whose practice is well defined. It is the most restrictive level of occupational regulation. It generally involves the delineation in statute of a scope of practice which is reserved to a select group based upon their possession of unique, identifiable, minimal competencies for safe practice. In this sense, state* licensure typically endows an occupation or profession with a monopoly in a specified scope of practice.
> *https://www.dhp.virginia.gov/bhp/guidelines/75-2.doc*

Individuals credentialed at the LBSW and LMSW levels have met the criteria for the highest level of professional regulation and therefore meet and/or exceed the above criteria. Individuals with such credentials should not be required to acquire the QMHP, which is a lower level credential specific to the regulation of "registration." Individuals who have achieved the LBSW and LMSW credentials have passed a licensing exam to ensure that they have acquired the necessary competencies to practice in their field. In passing this exam, those individuals have been awarded licensure and are registered with the state. Therefore, LBSW and LMSW individuals are well equipped to deliver services which their scope of practice allows under their license. It is the opinion of NASW Virginia Chapter that DMAS requires the specific title QMHP for billing purposes only and is not considering scope of training or level of practice beyond this.

We request that the Board of Counseling proposed regulations be amended to include language such as:

Providing documentation of a current Licensed Social Worker, License Bachelor Social Worker or Licensed Masters Social Worker from the Virginia Board of Social Work is documentation that the activities of a QMHP are in the scope of practice of their license and therefore are accepted by the Board of Counseling as sufficient evidence of meeting all the requirements for registration as a QMHP.

Respectfully Submitted,

National Association of Social Workers, Virginia Chapter
NASWVA

DRAFT Regulations Governing the Registration of Peer Recovery Specialists

Agenda Item: Adoption of Final Regulations for Registration of Peer Recovery Specialists

Included in the agenda package:

Staff Draft of Chapter 70 (Peer Recovery Specialists) – Recommendations from DBHDS staff

Staff Note:

The proposed regulation replace emergency regulations currently in effect; the emergency regulations expire on 6/17/19 and a request to the Governor's office for a six-month extension has been requested.

There were no public comments on the proposed regulations.

Regulatory Committee to review staff draft and recommend to full Board

Board to receive recommendation of Regulation Committee and adopt final regulations

DRAFT INCLUDES EDITS RECOMMENDED BY DBHDS AND DHP STAFF

BOARD OF COUNSELING

Initial regulations for registration

CHAPTER 70

REGULATIONS GOVERNING THE REGISTRATION OF PEER RECOVERY SPECIALISTS

Part I

General Provisions

18VAC115-70-10. Definitions.

"Applicant" means a person applying for registration as a peer recovery specialist.

"Board" means the Virginia Board of Counseling.

"DBHDS" means the Virginia Department of Behavioral Health and Developmental Services.

"Mental health professional" means a person who by education and experience is professionally qualified and licensed in Virginia to provide counseling interventions designed to facilitate an individual's achievement of human development goals and remediate mental, emotional, or behavioral disorders and associated distresses that interfere with mental health and development.

"Peer recovery specialist" means a person who by education and experience is professionally qualified in accordance with 12VAC35-250 to provide collaborative services to assist individuals in achieving sustained recovery from the effects of mental illness or addiction, or both.

"Registered peer recovery specialist" or "registrant" means a person who by education and experience is professionally qualified in accordance with 12VAC35-250 and registered by the board to provide collaborative services to assist individuals in achieving sustained recovery from the effects of mental illness or addiction, or both. A registered peer recovery specialist shall provide such services as an employee or independent contractor of DBHDS, a provider licensed by the DBHDS, a practitioner licensed by or holding a permit issued from the Department of Health Professions, or a facility licensed by the Department of Health.

18VAC115-70-20. Fees required by the board.

A. The board has established the following fees applicable to the registration of peer recovery specialists:

Registration	$30
Renewal of registration	$30
Late renewal	$20
Reinstatement of a lapsed registration	$60
Duplicate certificate of registration	$10
Returned check	$35
Reinstatement following revocation or suspension	$500

B. Unless otherwise provided, fees established by the board shall not be refundable.

18VAC115-70-30. Current name and address.

Each registrant shall furnish the board the registrant's current name and address of record. Any change of name or address of record or public address if different from the address of record, shall be furnished to the board within 60 days of such change. It shall be the duty and responsibility of each registrant to inform the board of the registrant's current address.

Part II

Requirements for Registration and Renewal

18VAC115-70-40. Requirements for registration as a peer recovery specialist.

A. An applicant for registration shall submit:

1. A completed application on forms provided by the board and any applicable fee as prescribed in 18VAC115-70-20; and

2. A current report from the National Practitioner Data Bank (NPDB).

B. An applicant for registration as a peer recovery specialist shall provide evidence of meeting all requirements for peer recovery specialists set by DBHDS in 12VAC35-250-30.

18VAC115-70-50. Annual renewal of registration.

All registrants shall renew their registration on or before June 30 of each year. Along with the renewal form, the registrant shall submit the renewal fee as prescribed in 18VAC115-70-20.

18VAC115-70-60. Continued competency requirements for renewal of peer recovery specialist registration.

A. Registered peer recovery specialists shall be required to have completed a minimum of eight contact hours of continuing education for each annual registration renewal. A minimum of [~~one~~ two] of these hours shall be in courses that emphasize ethics.

Registered peer recovery specialists shall complete continuing competency activities that focus on increasing knowledge or skills in one or more of the following areas:

1. Current body of mental health or substance abuse knowledge;

2. Promoting services, supports, and strategies for the recovery process;

3. Crisis intervention;

4. Values for role of peer recovery specialist;

5. Basic principles related to health and wellness;

6. Stage appropriate pathways in recovery support;

7. Ethics and boundaries;

8. Cultural sensitivity and practice;

9. Trauma and impact on recovery;

10. Community resources; or

11. Delivering peer services within agencies and organizations.

B. The following organizations, associations, or institutions are approved by the board to provide continuing education:

1. Federal, state, or local governmental agencies, public school systems, or licensed health facilities.

[2. A national or state recovery-oriented association or organization recognized by the profession.

3. A national behavioral health organization or certification body recognized by the board.

4. An agency or organization approved by DBHDS.

~~2.~~5.] The American Association for Marriage and Family Therapy and its state affiliates.

[~~3.~~6.] The American Association of State Counseling Boards.

[~~4.~~7.] The American Counseling Association and its state and local affiliates.

[~~5.~~8.] The American Psychological Association and its state affiliates.

[~~6.~~9.] The Commission on Rehabilitation Counselor Certification.

[~~7.~~10.] NAADAC, the Association for Addiction Professionals and its state and local affiliates.

[~~8.~~11.] National Association of Social Workers.

[~~9.~~12.] National Board for Certified Counselors.

~~10. A national behavioral health organization or certification body recognized by the board.~~

[~~11.~~13.] Individuals or organizations that have been approved as continuing competency sponsors by the American Association of State Counseling Boards or a counseling board in another state.

~~12. An agency or organization approved by DBHDS.~~

[14. Regionally accredited colleges or universities.]

C. Attestation of completion of continuing education is not required for the first renewal following initial registration in Virginia.

D. The board may grant an extension for good cause of up to one year for the completion of continuing education requirements upon written request from the registrant prior to the renewal date. Such an extension shall not relieve the registrant of the continuing education requirement.

E. The board may grant an exemption for all or part of the continuing education requirements due to circumstances beyond the control of the registrant such as temporary disability, mandatory military service, or officially declared disasters upon written request from the registrant prior to the renewal date.

F. All registrants shall maintain original documentation of official transcripts showing credit hours earned or certificates of participation for a period of three years following renewal.

G. The board may conduct an audit of registrants to verify compliance with the requirement for a renewal period. Upon request, a registrant shall provide documentation as follows:

1. Official transcripts showing credit hours earned; or

2. Certificates of participation.

H. Continuing education hours required by a disciplinary order shall not be used to satisfy renewal requirements.

Part III

Standards of Practice; Disciplinary Actions; Reinstatement

18VAC115-70-70. Standards of practice.

A. The protection of the public health, safety, and welfare and the best interest of the public shall be the primary guide in determining the appropriate professional conduct of all persons whose activities are regulated by the board.

B. Persons registered by the board shall:

1. Practice in a manner that is in the best interest of the public and does not endanger the public health, safety, or welfare.

2. Be able to justify all services rendered to clients as necessary.

3. Practice only within the competency area for which they are qualified by training or experience.

4. Report to the board known or suspected violations of the laws and regulations governing the practice of registered peer recovery specialists.

5. Neither accept nor give commissions, rebates, or other forms of remuneration for referral of clients for professional services and make appropriate consultations and referrals based on the best interest of clients.

6. Stay abreast of new developments, concepts, and practices that are necessary to providing appropriate services.

7. Document the need for and steps taken to terminate services when it becomes clear that the client is not benefiting from the relationship [or the client has decided to discontinue the relationship.

8. Practice in accordance with the Virginia Peer Recovery Specialist Code of Ethics of the Department of Behavioral Health and Developmental Services, as specified in 12VAC35-250] .

C. In regard to confidentiality and client records, persons registered by the board shall:

1. Not willfully or negligently breach the confidentiality between a practitioner and a client. A breach of confidentiality that is required or permitted by applicable law or beyond the control of the practitioner shall not be considered negligent or willful.

2. Disclose client records to others only in accordance with applicable law.

3. Maintain client records securely, inform all employees of the requirements of confidentiality, and provide for the destruction of records that are no longer useful in a manner that ensures client confidentiality.

4. Maintain timely, accurate, legible, and complete written or electronic records for each client, to include dates of service and identifying information to substantiate [~~treatment~~ the recovery, resiliency, and wellness] plan, client progress, and termination.

D. In regard to dual relationships, persons registered by the board shall:

1. Not engage in dual relationships with clients or former clients that are harmful to the client's well-being, that would impair the practitioner's objectivity and professional judgment, or that would increase the risk of client exploitation. This prohibition includes such activities as providing services to close friends, former sexual partners, employees, or relatives or engaging in business relationships with clients.

2. Not engage in sexual intimacies or romantic relationships with current clients. For at least five years after cessation or termination of professional services, practitioners shall not engage in sexual intimacies or romantic relationships with a client or those included in collateral therapeutic services. Because sexual or romantic relationships are potentially exploitative, the practitioner shall bear the burden of demonstrating that there has been no exploitation. A client's consent to, initiation of, or participation in sexual behavior or involvement with a practitioner does not change the nature of the conduct nor lift the regulatory prohibition.

3. Recognize conflicts of interest and inform all parties of obligations, responsibilities, and loyalties to third parties.

E. Upon learning of evidence that indicates a reasonable probability that another mental health service provider, as defined in § 54.1-2400.1 of the Code of Virginia, is or may be guilty of a violation of standards of conduct as defined in statute or regulation, persons registered by the board shall advise their clients of the client's right to report such misconduct to the Department of Health Professions in accordance with § 54.1-2400.4 of the Code of Virginia.

18VAC115-70-80. Grounds for revocation, suspension, restriction, or denial of registration.

In accordance with subdivision 7 of § 54.1-2400 of the Code of Virginia, the board may revoke, suspend, restrict, or decline to issue or renew a registration based upon the following conduct:

1. Conviction of a felony or of a misdemeanor involving moral turpitude or violation of or aid to another in violating any provision of Chapter 35 (§ 54.1-3500 et seq.) of Title 54.1 of the Code of Virginia, any other statute applicable to the practice of registered peer recovery specialists, or any provision of this chapter;

2. Procuring, attempting to procure, or maintaining a registration by fraud or misrepresentation;

3. Conducting one's practice in such a manner so as to make it a danger to the health and welfare of one's clients or to the public, or if one is unable to practice with reasonable skill and safety to clients by reason of illness or abusive use of alcohol, drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition;

4. Violating or abetting another person in the violation of any provision of any statute applicable to the practice of peer recovery specialists or [~~qualified~~] mental health professionals or any provision of this chapter;

5. Performance of functions outside the board-registered area of competency;

6. Performance of an act likely to deceive, defraud, or harm the public;

7. Intentional or negligent conduct that causes or is likely to cause injury to a client;

8. Action taken against a health or mental health license, certification, registration, or application in Virginia or other jurisdiction;

9. Failure to cooperate with an employee of the Department of Health Professions in the conduct of an investigation; or

10. Failure to report evidence of child abuse or neglect as required in § 63.2-1509 of the Code of Virginia or elder abuse or neglect as required in § 63.2-1606 of the Code of Virginia.

18VAC115-70-90. Late renewal and reinstatement.

A. A person whose registration has expired may renew it within one year after its expiration date by paying the late renewal fee and the registration fee as prescribed in 18VAC115-70-20 for the year in which the registration was not renewed and by providing documentation of completion of continuing education as prescribed in 18VAC115-70-60.

B. A person who fails to renew registration after one year or more shall:

1. Apply for reinstatement;

2. Pay the reinstatement fee for a lapsed registration; and

3. Submit evidence of current certification as a peer recovery specialist as prescribed by DBHDS in 12VAC35-250-30.

C. A person whose registration has been suspended or who has been denied reinstatement by board order, having met the terms of the order, may submit a new application and fee for reinstatement of registration as prescribed in 18VAC115-70-20. Any person whose registration has been revoked by the board may, three years subsequent to such board action, submit a new application and fee for reinstatement of registration as prescribed in 18VAC115-70-20. The board in its discretion may, after an administrative proceeding, grant the reinstatement sought in this subsection.

FORMS (18VAC115-70)

The following form is available online only at https://www.license.dhp.virginia.gov/apply/:

Registered Peer Recovery Specialists Application and Instructions

Petition for Rule-Making (Morganegg)

To amend Guidance Document 115-8 and Regulations to include criminology and criminal justice as human service or related degree and allow for supervised experience obtained in another state.

Agenda Item: Response to Petition for Rulemaking

Included in your agenda package are:

A copy of the petition received from Morgan Morganegg

Copy of Guidance Document 115-8

Copy of change in the proposed regulations replacing emergency regulations

Staff Note:

There were no comments on the petition

Action on petition:

To initiate rulemaking by adoption of a Notice of Intended Regulatory Action or a fast-track action; or

To reject the petitioner's request.

(The Board also needs to decide whether it wants to amend its guidance on approved degrees)

COMMONWEALTH OF VIRGINIA
Board of Counseling

9960 Mayland Drive, Suite 300
Richmond, Virginia 23233-1463

(804) 367-4610 (Tel)
(804) 527-4435(Fax)

Petition for Rule-making

The Code of Virginia (§ 2.2-4007) and the Public Participation Guidelines of this board require a person who wishes to petition the board to develop a new regulation or amend an existing regulation to provide certain information. Within 14 days of receiving a valid petition, the board will notify the petitioner and send a notice to the Register of Regulations identifying the petitioner, the nature of the request and the plan for responding to the petition. Following publication of the petition in the Register, a 21-day comment period will begin to allow written comment on the petition. Within 90 days after the comment period, the board will issue a written decision on the petition.

Please provide the information requested below. (Print or Type)

Petitioner's full name (Last, First, Middle initial, Suffix,) **Morganegg, Michelle E.**		
Street Address **2490 Edwardsville Rd.**	**Area Code and Telephone Number** 540-912-0115	
City **Hardy**	**State** **VA**	**Zip Code** **24101**
Email Address (optional) **m.morganegg@gmail.com**	**Fax (optional)**	

Respond to the following questions:

1. What regulation are you petitioning the board to amend? Please state the title of the regulation and the section/sections you want the board to consider amending.

A) "Can I qualify to register as a QMHP-C if I have a bachelor's degree in an unrelated field? No, QMHP-C is considered a specialty, and therefore an unrelated degree is not currently an option." I graduated with a BS in Criminology and Criminal Justice, however, I have worked with at-risk youths and youths in foster care since my graduation. This has required me to undergo extensive training specific to this field. Under your current regulations, all of my training amounts to nothing despite its relevance.

B) "Evidence of 1,500 hours of supervised experience obtained within a 5-year period" (Within VA).

I have been told directly that my hours of supervision do not, and will not, count towards licensure because they were not acquired in the state of Virginia. The Board has essentially disqualified anyone that has moved here from a different state. I began my residency here in August of 2018 and have been unable to gain employment due to the restrictions placed by the Board. This has placed a hardship on my family and had we known that this would be an issue my husband would have declined his transfer here.

2. Please summarize the substance of the change you are requesting and state the rationale or purpose for the new or amended rule.

Anyone who has not worked as a QMHP in the state of Virginia has no way to gain licensure. This is unacceptable for military families, or anyone who chose to move to Virginia from another state. Our experience is not invalid simply because we've moved from elsewhere.

3. State the legal authority of the board to take the action requested. In general, the legal authority for the adoption of regulations by the board is found in § 54.1-2400 of the Code of Virginia. If there is other legal authority for promulgation of a regulation, please provide that Code reference.

The rules were issued by this Board without consideration to all factors (new residents, degree scope vs. work experience and training). Therefore, only the Board can amend the regulations that have restricted experienced people from gaining employment.

Signature: Michelle Morgan **Date: 12/19/2018**

Board of Counseling

Approved Degrees in Human Services and Related Fields for QMHP Registration

Regulations for the Virginia Board of Counseling provide in 18VAC115-80-40 that a person may qualify as a QMHP-A with a "master's or bachelor's degree in human services or a related field from an accredited college." Section 18VAC115-80-50 provides that "a person may qualify as a QMHP-C with a "master's or bachelor's degree in human services or in special education from an accredited college."

The Board recognizes the following degrees as "human services or related fields:"

Art Therapy
Behavioral Sciences
Child Development
Child and Family Studies/Services
Cognitive Sciences
Community Mental Health
Counseling (Mental health, Vocational, Pastoral, etc.)
Counselor Education
Early Childhood Development
Education (with a focus in psychology and/or special education)
Educational Psychology
Family Development/Relations
Gerontology
Health and Human Services
Human Development
Human Services
Marriage and Family Therapy
Music Therapy
Nursing
Psychiatric Rehabilitation
Psychology
Rehabilitation Counseling
School Counseling
Social Work
Special Education
Therapeutic Recreation
Vocational Rehabilitation
Sociology – (accepted until May 31, 2021)

The Board may consider other degrees in human services or in fields related to the provision of mental health services.

18VAC115-80-50. Requirements for registration as a qualified mental health professional-child.

A. An applicant for registration shall submit:

1. A completed application on forms provided by the board and any applicable fee as prescribed in 18VAC115-80-20; and

2. A current report from the National Practitioner Data Bank (NPDB).

B. An applicant for registration as a QMHP-C shall provide evidence of:

1. A master's degree in psychology, social work, counseling, substance abuse, or marriage and family therapy from an accredited college or university with an internship or practicum of at least 500 hours of experience with persons who have mental illness;

2. A master's or bachelor's degree in a human services field or in special education from an accredited college with no less than 1,500 hours of supervised experience to be obtained within a five-year period immediately preceding application for registration and as specified in subsection C of this section;

3. A registered nurse licensed in Virginia with no less than 1,500 hours of supervised experience to be obtained within a five-year period immediately preceding application for registration and as specified in subsection C of this section; or

4. A licensed occupational therapist with no less than 1,500 hours of supervised experience to be obtained within a five-year period immediately preceding application for registration and as specified in subsection C of this section.

C. Experience required for registration.

1. To be registered as a QMHP-C, an applicant who does not have a master's degree as set forth in subdivision B 1 of this section shall provide documentation of 1,500 hours of experience in providing direct services to individuals as part of a population of children or adolescents with mental illness in a setting where mental health treatment, practice, observation, or diagnosis occurs. The services provided shall be appropriate to the practice of a QMHP-C and under the supervision of a licensed mental health professional or a person under supervision that has been approved by the Board of Counseling, Board of Psychology, or Board of Social Work as a prerequisite for licensure. Supervision obtained in another United States jurisdiction shall be provided by a mental health professional licensed in Virginia or licensed in that jurisdiction.

2. Supervision shall consist of face-to-face training in the services of a QMHP-C until the supervisor determines competency in the provision of such services, after which supervision may be indirect in which the supervisor is either on-site or immediately available for consultation with the person being trained.

3. Hours obtained in a bachelor's or master's level internship or practicum in a human services field may be counted toward completion of the required hours of experience.

4. A person receiving supervised training to qualify as a QMHP-C may register with the board. A trainee registration shall expire five years from its date of issuance.

Petition for Rule-Making (Hayter)

To amend regulations to allow LCSWs who can show clinical experience in substance abuse services and hold a CSAC be waived from taking the substance abuse licensure examination.

Agenda Item: Response to Petitions for Rulemaking

Included in your agenda package are:

A copy of the petition received from Michael Hayter

Copy of draft regulations for LSATP – Periodic review action

Staff Note:

There were no comments on the petition

Action on petition:

To initiate rulemaking by adoption of a Notice of Intended Regulatory Action or a fast-track action; or

To reject the petitioner's request.

COMMONWEALTH OF VIRGINIA
Board of Counseling

9960 Mayland Drive, Suite 300
Richmond, Virginia 23233-1463

(804) 367-4610 (Tel)
(804) 527-4435(Fax)

Petition for Rule-making

The Code of Virginia (§ 2.2-4007) and the Public Participation Guidelines of this board require a person who wishes to petition the board to develop a new regulation or amend an existing regulation to provide certain information. Within 14 days of receiving a valid petition, the board will notify the petitioner and send a notice to the Register of Regulations identifying the petitioner, the nature of the request and the plan for responding to the petition. Following publication of the petition in the Register, a 21-day comment period will begin to allow written comment on the petition. Within 90 days after the comment period, the board will issue a written decision on the petition.

Please provide the information requested below. (Print or Type)

Petitioner's full name (Last, First, Middle Initial, Suffix,) Hayter, Michael E.		
Street Address 26535 Watauga road	**Area Code and Telephone Number** 276-494-4466	
City Abingdon	**State** Virginia	**Zip Code** 24211
Email Address (optional) haytermike@yahoo.com	**Fax (optional)** 276-2186	

Respond to the following questions:

1. What regulation are you petitioning the board to amend? Please state the title of the regulation and the section/sections you want the board to consider amending.

18VAC115-60-50. Prerequisites for licensure by endorsement - Section #5 Prerequisites for licensure by endorsement. "The examination is waived for an applicant who holds a current and unrestricted license as a professional counselor within the Commonwealth of Virginia".

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July 2002

2. Please summarize the substance of the change you are requesting and state the rationale or purpose for the new or amended rule.

The LICENSED SUBSTANCE ABUSE TREATMENT PRACTITIONERS examination is waived for an applicant who holds a current and unrestricted license as a professional counselor within the Commonwealth of Virginia. The professional counselor is noted as a LPC.

Applicants who have obtained the Licensed Professional Counselor (LPC) licensure should not be exempted from taking the licensure exam for the Licensed Substance Abuse Treatment Practitioner (LASATP). Obtaining the LPC licensure does not necessarily note that they have significant enough of both mental health and substance abuse experience in their practicum experience to warrant licensure without an examination for LSATP.

Licensed Clinical Social Workers (LCSW) have extensive experience in mental health and or substance abuse clinical services in their practicum and practice. LCSW candidates must undergo the examination regardless of their clinical experiences.

LCSW licensees are also "professional counselors" in their own right and should be afforded their own opportunity to have the waiver for the LSATP as do LPCs.

I propose that LCSW holders who can show clinical experience based in substance abuse services (hold an CSAC credential already for several years) should have the waiver from the examination as LPCs do currently and be granted the LSATP licensure with appropriate payments and registration.

3. State the legal authority of the board to take the action requested. In general, the legal authority for the adoption of regulations by the board is found in § 54.1-2400 of the Code of Virginia. If there is other legal authority for promulgation of a regulation, please provide that Code reference.

VIRGINIA BOARD OF COUNSELING
Title of Regulations: 18 VAC 115-60-10 et seq.
Statutory Authority: §§ 54.1-2400 and Chapter 35 of Title 54.1 of the *Code of Virginia*

Signature: Abbey Tee LCSW, CSAC Date: 12-17-2018

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Part II

Requirements for Licensure

18VAC115-60-40. Application for licensure by examination.

Every applicant for ~~examination for~~ licensure by examination by the board shall:

1. Meet the degree program, course work and experience requirements prescribed in 18VAC115-60-60, 18VAC115-60-70 and 18VAC115-60-80;

2. Pass the examination required for initial licensure as prescribed in 18VAC115-60-90; and

~~2.~~ 3. Submit the following items to the board:

a. A completed application;

b. Official transcripts documenting the applicant's completion of the degree program and course work requirements prescribed in 18VAC115-60-60 and 18VAC115-60-70. Transcripts previously submitted for registration of supervision do not have to be resubmitted unless additional coursework was subsequently obtained;

c. Verification of supervision forms documenting fulfillment of the ~~experience~~ residency requirements of 18VAC115-60-80 and copies of all required evaluation forms, including verification of current licensure of the supervisor of any portion of the residency occurred in another jurisdiction;

d. Documentation of any other mental health or health professional license or certificate ever held in another jurisdiction; ~~and~~

e. The application processing and initial licensure fee as prescribed in 18VAC115-60-20; and

f. A current report from the U. S. Department of Health and Human Services Data Bank (NPDB).

4. Have no unresolved disciplinary action against a mental health or health professional license or certificate held in Virginia or in another jurisdiction. The board will consider history of disciplinary action on a case-by-case basis.

18VAC115-60-50. Prerequisites for licensure by endorsement.

A. Every applicant for licensure by endorsement shall submit:

1. A completed application;

2. The application processing and initial licensure fee as prescribed in 18VAC115-60-20;

3. Verification of all mental health or health professional licenses or certificates ever held in any other jurisdiction. In order to qualify for endorsement, the applicant shall have no unresolved disciplinary action against a license or certificate. The board will consider history of disciplinary action on a case-by-case basis;

4. Further documentation of one of the following:

a. A current substance abuse treatment license in good standing in another jurisdiction obtained by meeting requirements substantially equivalent to those set forth in this chapter; or

b. A mental health license in good standing in a category acceptable to the board which required completion of a master's degree in mental health to include 60 graduate semester hours in mental health; and

(1) Board-recognized national certification in substance abuse treatment;

(2) If the master's degree was in substance abuse treatment, two years of post-licensure experience in providing substance abuse treatment;

(3) If the master's degree was not in substance abuse treatment, five years of post-licensure experience in substance abuse treatment plus 12 credit hours of didactic training in the substance abuse treatment competencies set forth in 18VAC115-60-70 C; or

(4) Current substance abuse counselor certification in Virginia in good standing or a Virginia substance abuse treatment specialty licensure designation with two years of post-licensure or certification substance abuse treatment experience;

c. Documentation of education and supervised experience that met the requirements of the jurisdiction in which he was initially licensed as verified by an official transcript and a certified copy of the original application materials and evidence of post-licensure clinical practice for ~~five~~ twenty-four of the last ~~six years~~ 60 months immediately preceding his licensure application in Virginia. Clinical practice shall mean the rendering of direct clinical substance abuse treatment services or clinical supervision of such services.

5. Verification of a passing score on a substance abuse licensure examination as established by the jurisdiction in which licensure was obtained. The examination is waived for an applicant who holds a current and unrestricted license as a professional counselor within the Commonwealth of Virginia;

6. Official transcripts documenting the applicant's completion of the education requirements prescribed in 18VAC115-60-60 and 18VAC115-60-70; ~~and~~

7. An affidavit of having read and understood the regulations and laws governing the practice of substance abuse treatment in Virginia; and

8. A current report from the U. S. Department of Health and Human Services Data Bank (NPDB).

B. In lieu of transcripts verifying education and documentation verifying supervised experience, the board may accept verification from the credentials registry of the American Association of State Counseling Boards or any other board-recognized entity.

Part III

Examinations

18VAC115-60-90. General examination requirements; schedules; time limits.

A. Every applicant for initial licensure as a substance abuse treatment practitioner by examination shall pass a written examination as prescribed by the board.

B. Every applicant for licensure as a substance abuse treatment practitioner by endorsement shall have passed ~~an~~ a substance abuse examination deemed by the board to be substantially equivalent to the Virginia examination.

C. The examination is waived for an applicant who holds a current and unrestricted license as a professional counselor issued by the Board.

~~C.~~ D. A candidate approved by the board to sit for the examination shall ~~take~~ pass the examination within two years from the date of such initial board approval. If the candidate has not ~~taken~~ passed the examination ~~by the end of the two-year period prescribed in this subsection~~ within two years from the date of initial approval:

1. The initial board approval to sit for the examination shall then become invalid; and

2. ~~In order to be considered for the examination later, the~~ The applicant shall file a new application with the board, meet the requirements in effect at that time, and provide evidence of why the board should approve the re-application for examination. If approved by the board, the applicant shall pass the examination within two years of such

approval. If the examination is not passed within the additional two-year period, a new application will not be accepted.

~~D. Applicants who fail the examination twice in succession shall document completion of 45 clock hours of additional education or training acceptable to the board, addressing the areas of deficiency as reported in the examination results prior to obtaining board approval for reexamination.~~

E. The board shall establish a passing score on the written examination.

F. A candidate for examination or an applicant shall not provide clinical services unless he is under supervision approved by the board.

Review Public Comments related to proposed Guidance Document 115-11: Scopes of Practice for Person Regulations by the Board to provide Substance Abuse Treatment

Agenda Item: Review of Guidance documents

Staff Note:

The Board received comment on Guidance Document 115-11. There was no comment that the guidance was "contrary to state law or regulation," but the Board may want to consider the comment and decide whether or not to revise the document.

Included in your agenda package:

Copy of public comment on 115-11

Copy of guidance document adopted at the February meeting

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Agency Department of Health Professions

Board Board of Counseling

Edit Notice

General Notice

Scopes of practice for substance abuse treatment

Date Posted: 2/21/2019

Expiration Date: 4/17/2019

Submitted to Registrar for publication: YES

30 Day Comment Forum closed. Began on 3/18/2019 and ended 4/17/2019 [3 comments]

This document provides guidance on the scopes of practice for persons regulated by the Board to provide Substance Abuse Treatment.

To view the document, refer to Guidance Documents under the Board of Counseling

Contact Information

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Elaine J. Yeatts

Agency Department of Health Professions

Board Board of Counseling

All good comments for this forum Show Only Flagged

Back to List of Comments

Commenter: Stephen Shearer 4/5/19 5:53 pm

Clarification Paragraph

Comments on: Clarifying Information
The scope of practice for CSACs includes substance abuse counseling with individuals and groups. The Code of Virginia § 54.1-3507.1 indicates that CSACs are "qualified to be responsible for client care of persons with a primary diagnosis of substance abuse or dependence." Providing counseling to persons with a dual diagnosis is outside the scope of practice for CSACs. As such, CSACs cannot provide counseling to persons with a dual diagnosis.

The above Clarification Information states that "CSACs cannot provide counseling to persons with a dual
diagnosis." This is somewhat confusing, since most patients with a "primary diagnosis of substance abuse or dependence," if properly assessed, will also have some type cooccuring disorder. I agree that the CSAC must stay within his/her area of competency of providing appropriate care interventions to persons with a primary diagnosis of substance abuse or dependence, but this will often time occur with a person who is "with a dual diagnosis." If a clarification note is necessary, perhaps it be better to state something like "When counseling or providing other related substance use services to individuals with a primary diagnosis of substance abuse or dependency, if the person with the primary diagnosis of substance abuse or dependency is also dually diagnosed, the CSAC is not permitted to address those clinical areas that are within the individuals dual diagnosis."

It would appear that the term "dual diagnosis" is an outdated term and may be replaced with "cooccuring disorder" as a term. Also, it appears that moving from "substance abuse or dependency" to "use disorder" is a more current term.

Thank you for the opportunity to provide feedback on this this important process of providing clarification to scopes of practice.

Stephen Shearer

LADC, CADC, Certified Clinical Supervisor, Certified Employ Assistance Professional, Certified Professional in Healthcare Quality, Certified Joint Commission Professioinal.

Commenter: Lisa Snider, Loudoun County MHSADS 4/16/19 9:25 pm

Concern with not allowing counseling with dual diagnosis

Agree with the comments/concerns noted by Stephen Shearer related to "Providing counseling to persons with a dual diagnosis is outside the scope of practice for CSACs. As such, CSACs cannot provide counseling to persons with a dual diagnosis".

As stated many individuals with a substance use disorder diagnosis have a co-occurring diagnosis. If CSACs cannot provide counseling for those with a dual or co-occurring diagnosis, this presents individuals seeking substance use disorder treatment with fewer options for seeking counseling. This is a concern and places unnecessary barriers to receiving treatment.

CSACs must stay with his/her competency of providing appropriate interventions related to the individuals' substance abuse disorders. However, CSACs should not be excluded from providing services to those with a co-occurring diagnosis. Recommend the clarification to be changed to "CSACs provide individuals with a primary diagnosis of substance use disorder counseling and other related substance use recovery services. If a person with a primary substance use disorder diagnosis and another co-occurring diagnosis, the CSAC is only permitted to provide services related to the individual's substance abuse disorder diagnosis."

Commenter: Addiction Recovery Systems (ARS) 4/17/19 10:54 am

Concern with Clarifying Information Paragraph

This comment supports the previously noted concerns of Stephen Shearer and Lisa Snider regarding the Board of Counseling's "Clarifying Information" paragraph, stating, in relevant part, that "[p]roviding counseling to persons with a dual diagnosis is outside the scope of practice for CSACs. As such, CSACs cannot provide counseling to persons with a dual diagnosis."

ARS agrees with Mr. Shearer and Ms. Snider that CSACs must provide appropriate intervention services by staying within his/her area of training and competency, and we believe this understanding is consistent with the language of Virginia Code Section 54.1-3507. The code section identifies what a CSAC must be qualified to do. The only express limitation is that they "shall not engage in independent or autonomous practice." Respectfully, we believe an additional limitation that prevents CSACs from providing any services to individuals with a co-occurring diagnosis, as outlined in the clarifying note, exceeds the scope and intent of the statute.

Further, it is well accepted that individuals seeking substance abuse treatment may frequently have a co-occurring diagnosis. We find the Board of Counseling's current interpretation of Virginia Code Section 54.1-3507 to be inconsistent with the national movement of holistic mental health treatment and have concerns that this interpretation may ultimately have the unintended consequence of discouraging or preventing individuals with a co-occurring diagnosis from receiving necessary treatment.

To the extent a clarifying note is necessary, we request that the Board of Counseling consider the following:

"The Code of Virginia § 54.1-3507.1 indicates that CSACs shall be "qualified to be responsible for client care of persons with a primary diagnosis of substance abuse or treatment." If the person seeking treatment has a co-occurring diagnosis, the CSAC's intervention services shall be limited to substance abuse treatment and appropriate referral activities."

Recommended Changes by DMAS

It has been suggested that the Guidance Document include the distinction between a “Diagnostic Assessment” and the "American Society of Addiction Medicine (ASAM) multidimensional assessment", both of which are required for Medicaid ARTS reimbursement for services. The ASAM multidimensional assessment pertains to the individual's substance use disorder that determines a level of care placement or continuation of care. This is different from the Diagnostic Assessment that would be based on the DSM-V by a licensed practitioner.

CSACs are not able to diagnose but they are capable of assessing the 6 multidimensions of the ASAM Criteria and making "recommendations" for a level of care that would then have to be “signed off” or "approved" by a licensed professional that is supervising the CSAC.

The ASAM multidimensional assessment is below.

Board of Counseling

Scopes of Practice for Persons Regulated by the Board to provide Substance Abuse Treatment

The Code of Virginia § 54.1-3500 defines "counseling" as "the application of principles, standards, and methods of the counseling profession in (i) conducting assessments and diagnoses for the purpose of establishing treatment goals and objectives and (ii) planning, implementing, and evaluating treatment plans using treatment interventions to facilitate human development and to identify and remediate mental, emotional, or behavioral disorders and associated distresses that interfere with mental health."

The Code of Virginia § 54.1-3500 defines "Substance abuse treatment" as "(i) the application of specific knowledge, skills, substance abuse treatment theory, and substance abuse treatment techniques to define goals and develop a treatment plan of action regarding substance abuse or dependence prevention, education, or treatment in the substance abuse or dependence recovery process and (ii) referrals to medical, social services, psychological, psychiatric, or legal resources when such referrals are indicated."

License Required

The Code of Virginia § 54.1-3506 requires a license to engage in the practice of counseling, marriage and family therapy, or the independent practice of substance abuse treatment. The scopes of practice for Licensed Professional Counselors (LPCs) and Licensed Marriage and Family Therapists (LMFTs) include counseling and substance abuse treatment. No other license or certification is required for these licensees to perform these functions.

Scope of Practice for a Licensed Substance Abuse Treatment Practitioner (LSATP)

The scope of practice for a Licensed Substance Abuse Treatment Practitioner (LSATP) is defined in § 54.1-3507, which states that: "A licensed substance abuse treatment practitioner shall be qualified to (i) perform on an independent basis the substance abuse treatment functions of screening, intake, orientation, assessment, treatment planning, treatment, case management, substance abuse or dependence crisis intervention, client education, referral activities, recordkeeping, and consultation with other professionals; (ii) exercise independent professional judgment, based on observations and objective assessments of a client's behavior, to evaluate current functioning, to diagnose and select appropriate remedial treatment for identified problems, and to make appropriate referrals; and (iii) supervise, direct and instruct others who provide substance abuse treatment."

Scope of Practice for a Certified Substance Abuse Counselor (CSAC)

The scope of practice for a Certified Substance Abuse Counselor is defined in § 54.1-3507.1, which states that: "A certified substance abuse counselor shall be (i) qualified to perform, under appropriate supervision or direction, the substance abuse treatment functions of screening, intake, orientation, the administration of substance abuse assessment instruments, recovery and

relapse prevention planning, substance abuse treatment, case management, substance abuse or dependence crisis intervention, client education, referral activities, record keeping, and consultation with other professionals; (ii) qualified to be responsible for client care of persons with a primary diagnosis of substance abuse or dependence; and (iii) qualified to supervise, direct and instruct certified substance abuse counseling assistants. Certified substance abuse counselors shall not engage in independent or autonomous practice. "

Scope of Practice for a Certified Substance Abuse Counselor Assistant (CSAC-A)

The scope of practice for Certified Substance Abuse Counselor Assistants is defined in § 54.1-3507.2, which states that: "A certified substance abuse counseling assistant shall be qualified to perform, under appropriate supervision or direction, the substance abuse treatment functions of orientation, implementation of substance abuse treatment plans, case management, substance abuse or dependence crisis intervention, record keeping, and consultation with other professionals. Certified substance abuse counseling assistants may participate in recovery group discussions, but shall not engage in counseling with either individuals or groups or engage in independent or autonomous practice."

Scope of Practice for a Peer Recovery Specialist

Code of Virginia § 54.1-3500 defines a peer recovery specialist is "a person who by education and experience is professionally qualified in accordance with 12VAC35-20 to provide collaborative services to assist individuals in achieving sustained recovery from the effects of mental illness, addiction, or both. A registered peer recovery specialist (RPRS) shall provide such services as an employee or independent contractor of DBHDS, a provider licensed by DBHDS, a practitioner licensed by or holding a permit issued from the Department of Health Professions, or a facility licensed by the Department of Health."

A peer recovery specialist offers support and assistance in helping others in the recovery and community-integration process.

Clarifying Information

The scope of practice for CSACs includes substance abuse counseling with individuals and groups. The Code of Virginia § 54.1-3507.1 indicates that CSACs are "qualified to be responsible for client care of persons with a primary diagnosis of substance abuse or dependence." Providing counseling to persons with a dual diagnosis is outside the scope of practice for CSACs. As such, CSACs cannot provide counseling to persons with a dual diagnosis.

The Board of Counseling interprets the function of "record keeping" to include the gathering of demographic information. CSAC-As can perform this function as within their scope of practice. However, CSAC-As cannot perform the function of intake or screening. Only a CSAC, LSATP, LPC, or LMFT shall perform these functions.

Scopes of Practice for Persons Regulated by the Board of Counseling to provide Substance Abuse Treatment

	LPC	LMFT	LSATP	CSAC	CSAC-A
Provide Substance Abuse Treatment Independently	yes	yes	yes	No	No
Perform only under supervision of Licensed Mental Health Professional				Yes	Yes
Screening	Yes	Yes	Yes	Yes	No
Intake	Yes	Yes	Yes	Yes	No
Orientation	Yes	Yes	Yes	Yes	Yes
Administration of Substance Abuse Assessment Instruments	Yes	Yes	Yes	Yes	No
Recovery and relapse Prevention Planning	Yes	Yes	Yes	Yes	No
Assessment	Yes	Yes	Yes	No	No
Treatment Planning	Yes	Yes	Yes	Yes	No
Substance Abuse Treatment	Yes	Yes	Yes	Yes	No
Implementation of Substance Abuse Treatment Plans	Yes	Yes	Yes	Yes	Yes
Case Management	Yes	Yes	Yes	Yes	Yes
Substance Abuse or dependence crisis intervention	Yes	Yes	Yes	Yes	Yes
Client Education	Yes	Yes	Yes	Yes	No
Referral Activities	Yes	Yes	Yes	Yes	No
Recordkeeping	Yes	Yes	Yes	Yes	Yes
Consultation with other Professionals	Yes	Yes	Yes	Yes	Yes
Exercise Independent Professional Judgment, to evaluate current functioning	Yes	Yes	Yes	No	No
Exercise Independent Professional Judgment to diagnose and select appropriate remedial treatment for identified problems	Yes	Yes	Yes	No	No
Exercise Independent Professional judgment to make appropriate referrals	Yes	Yes	Yes	No	No
Supervise, Direct and Instruct others who provide Substance Abuse Treatment	Yes	Yes	Yes	Yes (Only CSAC-A's)	No
Provide Independent Substance Abuse Counseling	Yes	Yes	Yes	No	No
Provide counseling to persons with Dual Diagnosis	Yes	Yes	Yes	No	No
Coordinate, Facilitate, Participate in Recovery Group Discussions	Yes	Yes	Yes	Yes	Yes
Lead Recovery Group Discussions	Yes	Yes	Yes	Yes	No
Substance Abuse Counseling with Individuals	Yes	Yes	Yes	Yes	No
Substance Abuse Counseling with Groups	Yes	Yes	Yes	Yes	No

Supervision Requirements for Persons Providing Substance Abuse Treatment Pursuant to Code of Virginia 54.1-3500 et.seq.

	Independent	Authority to Supervise, Direct, or Instruct	Required to be under the Supervision of:
LMHP*	Yes	Yes	Not required
LSATP	Yes	Yes	Not required
LSATP Applicant	No (Must practice under supervision)	No	LSATP or LMHP
CSAC	No (Must practice under supervision)	Only CSAC-As and CSAC Applicants	LSATP or LMHP
CSAC Applicant	No (Must practice under supervision)	No	LSATP, LMHP, or CSAC
CSAC-A	No (Must practice under supervision)	No	LSATP, LMHP, or CSAC
CSAC-A Applicant	No (Must practice under supervision)	No	LSATP, LMHP, or CSAC

*LMHP means a Licensed Mental Health Provider and includes Licensed Professional Counselors (LPCs), Licensed Marriage and Family Therapists (LMFTs), Licensed Clinical Psychologists (LCPs), and Licensed Clinical Social Workers (LCSWs)

Periodic Review and Public Comments for the Regulations Governing the Certification of Rehabilitation Providers

Commonwealth of Virginia

REGULATIONS

GOVERNING THE CERTIFICATION OF REHABILITATION PROVIDERS

VIRGINIA BOARD OF COUNSELING

Title of Regulations: 18 VAC 115-40-10 et seq.

Statutory Authority: §§ 54.1-2400 and Chapter 35 of Title 54.1 of the *Code of Virginia*

Revised Date: February 8, 2017

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Part I. General Provisions.

18VAC115-40-10. Definitions.

A. The terms "board," "certified rehabilitation provider," and " professional judgment," when used in this chapter, shall have the meanings ascribed to them in §§54.1-3500 and 54.1-3510 of the Code of Virginia.

B. The following words and terms, when used in this chapter, shall have the following meanings unless the context indicates otherwise:

"Competency area" means an area in which a person possesses knowledge and skills and the ability to apply them in the rehabilitation setting.

"Experience" means on-the-job experience under appropriate supervision as set forth in this chapter.

"Internship" means a supervised field experience as part of a degree requirement obtained from a regionally accredited university as set forth in 18VAC115-40-22.

"Regionally accredited" means an institution accredited by one of the regional accreditation agencies recognized by the United States Secretary of Education as responsible for accrediting senior post-secondary institutions and training programs.

"Rehabilitation client" means an individual receiving rehabilitation services whose benefits are regulated by the Virginia Workers' Compensation Commission.

"Supervisee" means any individual who has met the education requirements and is under appropriate supervision and working towards certification according to the requirements of this chapter. Services provided by the supervisee shall not involve the exercise of professional judgment as defined in §54.1-3510 of the Code of Virginia.

"Supervision" means the ongoing process performed by a supervisor who monitors the performance of the person supervised and provides regular, documented, personal instruction, guidance, and education with respect to the skills and competencies of the person supervised.

"Supervisor" means one who provides case-related supervision, consultation, education, and guidance for the applicant. The supervisor must be credentialed as defined in 18VAC115-40-27.

"Training" means the educational component of on-the-job experience.

18VAC115-40-20. Fees required by the board.

A. The board has established the following fees applicable to the certification of rehabilitation providers:

Initial certification by examination: Processing and initial $115

certification	
Initial certification by endorsement: Processing and initial certification	$115
Certification renewal	$65
Duplicate certificate	$10
Late renewal	$25
Reinstatement of a lapsed certificate	$125
Replacement of or additional wall certificate	$25
Returned check	$35
Reinstatement following revocation or suspension	$600

B. Fees shall be paid to the board. All fees are nonrefundable.

Part II. Requirements for Certification.

18VAC115-40-22. Criteria for eligibility.

A. Education and experience requirements for certification are as follows:

1. Any baccalaureate degree from a regionally accredited college or university or a current registered nurse license in good standing in Virginia; and

2. Documentation of 2,000 hours of supervised experience in performing those services that will be offered to a workers' compensation claimant under § 65.2-603 of the Code of Virginia. Experience may be acquired through supervised training or experience or both. A supervised internship in rehabilitation services may count toward part of the required 2,000 hours. Any individual who does not meet the experience requirement for certification must practice under the supervision of an individual who meets the requirements of 18VAC115-40-27. Individuals shall not practice in an internship or supervisee capacity for more than five years.

B. A passing score on a board-approved examination shall be required.

C. The board may grant certification without examination to applicants certified as rehabilitation providers in other states or by nationally recognized certifying agencies, boards, associations and commissions by standards substantially equivalent to those set forth in the board's current regulation.

18VAC115-40-23 to 18VAC115-40-24. (Reserved.)

18VAC115-40-25. Application process.

The applicant shall submit to the board:

1. A completed application form;

2. The official transcript or transcripts submitted from the appropriate institutions of higher education;

3. Documentation, on the appropriate forms, of the successful completion of the supervised experience requirement of 18VAC115-40-26. Documentation of supervision obtained outside of Virginia must include verification of the supervisor's out-of-state license or certificate; and

4. A current report from the U.S. Department of Health and Human Services National Practitioner Data Bank (NPDB); and

5. Documentation of the applicant's national or out-of-state license or certificate in good standing where applicable.

18VAC115-40-26. Supervised experience requirement.

The following shall apply to the supervised experience requirement for certification:

1. On average, the supervisor and the supervisee shall consult for two hours per week in group or personal instruction. The total hours of personal instruction shall not be less than 100 hours within the 2,000 hours of experience. Group instruction shall not exceed six members in a group.

2. Half of the personal instruction contained in the total supervised experience shall be face-to-face between the supervisor and supervisee. A portion of the face-to-face instruction shall include direct observation of the supervisee-rehabilitation client interaction.

18VAC115-40-27. Supervisor requirements.

A. A supervisor shall:

1. Be a licensed professional counselor, licensed psychologist, licensed clinical social worker, licensed marriage and family therapist, licensed substance abuse treatment practitioner, licensed physician or licensed registered nurse with a minimum of one year of experience in rehabilitation service provision;

2. Be a rehabilitation provider certified by the board who has national certification in rehabilitation service provision as outlined in subsection C of 18VAC115-40-22; or

3. Have two years experience as a board certified rehabilitation provider.

B. The supervisor shall assume responsibility for the professional activities of the supervisee.

C. At the time of application for certification by examination, the supervisor shall document for the board: (i) credentials to provide supervision in accordance with this section, (ii) the applicant's total

hours of supervision, (iii) length of work experience, (iv) competence in rehabilitation service provision, and (v) any needs for additional supervision or training.

D. Supervision by any individual whose relationship to the supervisee compromises the objectivity of the supervisor is prohibited. This includes but is not limited to immediate family members (spouses, parents, siblings, children and in-laws).

Part III. Examinations.

18VAC115-40-28. General examination requirements.

Every applicant for certification as a rehabilitation provider shall take a written examination approved by the board and achieve a passing score as determined by the board.

18VAC115-40-29. (Reserved.)

Part IV. Renewal and Reinstatement.

18VAC115-40-30. Annual renewal of certificate.

Every certificate issued by the board shall expire on January 31 of each year.

1. To renew certification, the certified rehabilitation provider shall submit a renewal form and fee as prescribed in 18VAC115-40-20.

2. Failure to receive a renewal notice and form shall not excuse the certified rehabilitation provider from the renewal requirement.

18VAC115-40-35. Reinstatement.

A. A person whose certificate has expired may renew it within one year after its expiration date by paying the renewal fee and the late renewal fee prescribed in 18VAC115-40-20.

B. A person who fails to renew a certificate for one year or more shall apply for reinstatement, pay the reinstatement fee and submit evidence regarding the continued ability to perform the functions within the scope of practice of the certification.

18VAC115-40-36 to 18VAC115-40-37. (Reserved.)

18VAC115-40-38. Change of address.

A certified rehabilitation provider whose address of record or public address, if different from the address of record, has changed shall submit the new address in writing to the board within 30 days of such change.

18VAC115-40-39. (Reserved.)

Part V. Standards of Practice; Disciplinary Actions; Reinstatement.

18VAC115-40-40. Standards of practice.

A. The protection of the public health, safety and welfare, and the best interest of the public shall be the primary guide in determining the appropriate professional conduct of all persons whose activities are regulated by the board.

B. Each person certified by the board shall:

1. Provide services in a manner that is in the best interest of the public and does not endanger the public health, safety, or welfare.

2. Provide services only within the competency areas for which one is qualified by training or experience.

3. Not provide services under a false or assumed name, or impersonate another practitioner of a like, similar or different name.

4. Be aware of the areas of competence of related professions and make full use of professional, technical and administrative resources to secure for rehabilitation clients the most appropriate services.

5. Not commit any act which is a felony under the laws of this Commonwealth, other states, the District of Columbia or the United States, or any act which is a misdemeanor under such laws and involves moral turpitude.

6. Stay abreast of new developments, concepts and practices which are important to providing appropriate services.

7. State a rationale in the form of an identified objective or purpose for the provision of services to be rendered to the rehabilitation client.

8. Not engage in offering services to a rehabilitation client who is receiving services from another rehabilitation provider without attempting to inform such other providers in order to avoid confusion and conflict for the rehabilitation client.

9. Represent accurately one's competence, education, training and experience.

10. Refrain from undertaking any activity in which one's personal problems are likely to lead to inadequate or harmful services.

11. Not engage in improper direct solicitation of rehabilitation clients and shall announce services fairly and accurately in a manner which will aid the public in forming their own informed judgments, opinions and choices and which avoids fraud and misrepresentation through sensationalism, exaggeration or superficiality.

12. Recognize conflicts of interest and inform all parties of the nature and directions of loyalties and responsibilities involved.

13. Report to the board known or suspected violations of the laws and regulations governing the practice of rehabilitation providers.

14. Report to the board any unethical or incompetent practices by other rehabilitation providers that jeopardize public safety or cause a risk of harm to rehabilitation clients.

15. Provide rehabilitation clients with accurate information of what to expect in the way of tests, evaluations, billing, rehabilitation plans and schedules before rendering services.

16. Provide services and submission of reports in a timely fashion and ensure that services and reports respond to the purpose of the referral and include recommendations, if appropriate. All reports shall reflect an objective, independent opinion based on factual determinations within the provider's area of expertise and discipline. The reports of services and findings shall be distributed to appropriate parties and shall comply with all applicable legal regulations.

17. Specify, for the referral source and the rehabilitation client, at the time of initial referral, what services are to be provided and what practices are to be conducted. This shall include the identification, as well as the clarification, of services that are available by that member.

18. Assure that the rehabilitation client is aware, from the outset, if the delivery of service is being observed by a third party. Professional files, reports and records shall be maintained for three years beyond the termination of services.

19. Never engage in nonprofessional relationships with rehabilitation clients that compromise the rehabilitation client's well-being, impair the rehabilitation provider's objectivity and judgment or increase the risk of rehabilitation client exploitation.

20. Never engage in sexual intimacy with rehabilitation clients or former rehabilitation clients, as such intimacy is unethical and prohibited.

18VAC115-40-50. Grounds for revocation, suspension, probation, reprimand, censure, denial of renewal of certificate; petition for rehearing.

Action by the board to revoke, suspend, decline to issue or renew a certificate, to place such a certificate holder on probation or to censure, reprimand or fine a certified rehabilitation provider may be taken in accord with the following:

1. Procuring a license, certificate or registration by fraud or misrepresentation.

2. Violation of, or aid to another in violating, any regulation or statute applicable to the provision of rehabilitation services.

3. The denial, revocation, suspension or restriction of a registration, license or certificate to practice in another state, or a United States possession or territory or the surrender of any such registration, license or certificate while an active administrative investigation is pending.

4. Conviction of any felony, or of a misdemeanor involving moral turpitude.

5. Providing rehabilitation services without reasonable skill and safety to clients by virtue of physical or emotional illness or substance abuse.

18VAC115-40-60. [Repealed]

18VAC115-40-61. Reinstatement following disciplinary action.

A. Any person whose certificate has been revoked, suspended or denied renewal by the board under the provisions of 18VAC115-40-50 must submit a new application for reinstatement of certification.

B. The board in its discretion may, after a hearing, grant the reinstatement sought in subsection A of this section.

C. The applicant for such reinstatement, if approved, shall be certified upon payment of the appropriate fee applicable at the time of reinstatement.

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VIRGINIA REGULATORY TOWN HALL

Agency **Department of Health Professions**

Board **Board of Counseling**

Chapter **Regulations Governing the Certification of Rehabilitation Providers [18 VAC 115 - 40]**

All comments for this forum

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Commenter: IARP Virginia 8/28/18 8:55 pm

In support of the CRP Regulations

Type over this text and enter your comments here. You are limited to approximately 3000 words

August 13, 2018

Board of Health Professionals

c/o Ms. Elaine J. Yeatts

9960 Mayland Drive, Suite 300

Richmond, VA 23233

Dear Board of Health Professionals,

Please allow us to introduce ourselves. We represent the interests of the International Association of Rehabilitation Professionals (IARP) Virginia Chapter and the IARP VA Legislative Special Committee. We are seasoned professionals who have served Citizens with disabilities for decades practicing in small, mid-size and large companies across the Commonwealth. We would like to show our support for the Regulations Governing The Certification of Rehabilitation Providers (CRP) 18 VAC 115-40-10 et seq. in the interest of public safety. We are made up of professionals that were active at the inception of the regulations in the early 1990's and professionals appointed in recent years to revise the Vocational Rehabilitation Guidelines of the Virginia Workers' Compensation Commission (VWC) effective in October 2015.

The regulations were originally conceived in the early 1990's following a Joint Legislative Audit & Review Commission study ordered by Lieutenant Governor Don Beyer concerning the Virginia Workers' Compensation Commission. At that time the Citizens of the Commonwealth were endangered by rehabilitation professionals practicing without the appropriate skill set and/or experience. The Regulations Governing the CRP set forth Standards of Practice in 18 VAC 115-40-40. The Standards of Practice were drafted with the primary purpose of promoting the safety and welfare of the Citizens of the Commonwealth. Furthermore, the regulations establish education and supervision expectations that require rehabilitation professionals to hold nationally recognized designations in the field of rehabilitation or be eligibile by virtue of education and experience to test for such designations. These national certification designations also have a

Code of Ethics which expand on the protections offered by the Standards of Practice outlined in the regulations.

The regulations are also concurrent with the statutory guidelines outlined in §§ 54.1-2400 and Chapter 35 of Title 54.1 of the *Code of Virginia.* They ensure that the Citizens of the Commonwealth receive assistance from experienced professionals to advocate for their rehabilitation needs. The Citizens requiring these services are already vulnerable by virtue of their impairments and without skillful assistance would be at risk to be further disenfranchised by the rehabilitation process.

Thank you for your careful consideration of our comments and concerns. We believe our Citizens deserve the best possible opportunity to overcome the challenges of disability.

Respectfully,

Phyllis Carmichael

Phyllis Carmichael RN, MSN

IARP VA President

Linda F. Augins

Linda Augins, MA, CRP, CCM, CDMS, CRC

IARP VA Past President

Barbara Byers, MA, CRC, CVE, CCM, LPC

IARP VA President Elect

Legislative Special Committee Member

Patricia S. Eby

Patricia S. Eby, MS, RN, CNS, CRC, CDMS

IARP VA Secretary

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George Moore

George Moore, MA, CRC, LPC

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Legislative Special Committee Member

Former Committee Member Appointed by The Honorable Commissioner Larry Tarr

Cc: The Honorable Robert A. Rapaport, VWC

Commenter: International Association of Rehabilitation Professionals 9/5/18 2:40 pm

Support for VA 18 VAC 115-40-10

IARP—International Association of Rehabilitation Professionals

1000 Westgate Drive, Suite 252
St. Paul, MN 55114

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August 13, 2018

Board of Health Professionals

C/o Ms. Elaine J. Yeatts

9960 Mayland Drive, Suite 300

Richmond, VA 23233

Dear Board of Health Professionals,

This is a letter of support for VA 18 VAC 115-40-10 et seq.; the Regulations Governing The Certification of Rehabilitation Providers (CRP) in the interest of public safety. The International Association of Rehabilitation Professionals (IARP) was founded more than 30 years ago to promote the betterment of people with disabilities and the professionals who serve them. IARP represents more than 2,400 rehabilitation professionals worldwide. Our VA chapter and sent a separate letter of support for the above regulations and the national/international association also wanted to support these regulatory changes to protect the citizens of the Commonwealth of VA.

Our VA section members are seasoned rehabilitation professionals who have served the VA citizens with disabilities for decades practicing in small, mid-size and large companies across the Commonwealth. IARP VA was active at the development of the WC regulations in the early 1990's and several of our members were been appointed to revise the Vocational Rehabilitation Guidelines of the Virginia Workers' Compensation Commission (VWC) effective in October 2015.

The regulations were originally conceived in the early 1990's following a Joint Legislative Audit & Review Commission study ordered by Lieutenant Governor Don Beyer concerning the Virginia Workers' Compensation Commission. At that time the citizens of the Commonwealth were endangered by rehabilitation professionals practicing without the appropriate skill set and/or experience. The Regulations Governing the CRP set forth Standards of Practice in 18 VAC 115-40-40. The Standards of Practice were drafted with the primary purpose of promoting the safety and welfare of the Citizens of the Commonwealth of VA. Furthermore, the regulations establish education and supervision expectations that require rehabilitation professionals to hold nationally recognized designations in the field of rehabilitation or be eligible by virtue of education and experience to test for such designations. These national certification designations also have a Code of Ethics which expand on the protections offered by the Standards of Practice outlined in the regulations.

The regulations are also concurrent with the statutory guidelines outlined in §§ 54.1-2400 and Chapter 35 of Title 54.1 of the Code of Virginia. They ensure that the Citizens of the Commonwealth receive assistance from experienced professionals to advocate for their rehabilitation needs. The Citizens requiring these services are already vulnerable by virtue of their impairments and without skillful assistance would be at risk to be further

disenfranchised by the rehabilitation process.

Thank you for your careful consideration of our comments and concerns. We believe our Citizens deserve the best possible opportunity to overcome the challenges of disability.

Respectfully,

Amy Vercillo ScD, LRC (MA), CRC, CDMS
National Legislative Chair, IARP

Virginia Code

§ 32.1-127.1:03.F

Health Records Privacy

§ 32.1-127.1:03. Health records privacy

A. There is hereby recognized an individual's right of privacy in the content of his health records. Health records are the property of the health care entity maintaining them, and, except when permitted or required by this section or by other provisions of state law, no health care entity, or other person working in a health care setting, may disclose an individual's health records.

Pursuant to this subsection:

1. Health care entities shall disclose health records to the individual who is the subject of the health record, except as provided in subsections E and F and subsection B of § 8.01-413.

2. Health records shall not be removed from the premises where they are maintained without the approval of the health care entity that maintains such health records, except in accordance with a court order or subpoena consistent with subsection C of § 8.01-413 or with this section or in accordance with the regulations relating to change of ownership of health records promulgated by a health regulatory board established in Title 54.1.

3. No person to whom health records are disclosed shall redisclose or otherwise reveal the health records of an individual, beyond the purpose for which such disclosure was made, without first obtaining the individual's specific authorization to such redisclosure. This redisclosure prohibition shall not, however, prevent (i) any health care entity that receives health records from another health care entity from making subsequent disclosures as permitted under this section and the federal Department of Health and Human Services regulations relating to privacy of the electronic transmission of data and protected health information promulgated by the United States Department of Health and Human Services as required by the Health Insurance Portability and Accountability Act (HIPAA)(42 U.S.C. § 1320d et seq.) or (ii) any health care entity from furnishing health records and aggregate or other data, from which individually identifying prescription information has been removed, encoded or encrypted, to qualified researchers, including, but not limited to, pharmaceutical manufacturers and their agents or contractors, for purposes of clinical, pharmaco-epidemiological, pharmaco-economic, or other health services research.

4. Health care entities shall, upon the request of the individual who is the subject of the health record, disclose health records to other health care entities, in any available format of the requester's choosing, as provided in subsection E.

B. As used in this section:

"Agent" means a person who has been appointed as an individual's agent under a power of attorney for health care or an advance directive under the Health Care Decisions Act (§ 54.1-2981 et seq.).

"Certification" means a written representation that is delivered by hand, by first-class mail, by overnight delivery service, or by facsimile if the sender obtains a facsimile-machine-generated confirmation reflecting that all facsimile pages were successfully transmitted.

"Guardian" means a court-appointed guardian of the person.

"Health care clearinghouse" means, consistent with the definition set out in 45 C.F.R. § 160.103, a public or private entity, such as a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches, that performs either of the following functions: (i) processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction; or (ii) receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity.

"Health care entity" means any health care provider, health plan or health care clearinghouse.

"Health care provider" means those entities listed in the definition of "health care provider" in § 8.01-581.1, except that state-operated facilities shall also be considered health care providers for the purposes of this section. Health care provider shall also include all persons who are licensed, certified, registered or permitted or who hold a multistate licensure privilege issued by any of the health regulatory boards within the Department of Health Professions, except persons regulated by the Board of Funeral Directors and Embalmers or the Board of Veterinary Medicine.

"Health plan" means an individual or group plan that provides, or pays the cost of, medical care. "Health plan" includes any entity included in such definition as set out in 45 C.F.R. § 160.103.

"Health record" means any written, printed or electronically recorded material maintained by a health care entity in the course of providing health services to an individual concerning the individual and the services provided. "Health record" also includes the substance of any communication made by an individual to a health care entity in confidence during or in connection with the provision of health services or information otherwise acquired by the health care entity about an individual in confidence and in connection with the provision of health services to the individual.

"Health services" means, but shall not be limited to, examination, diagnosis, evaluation, treatment, pharmaceuticals, aftercare, habilitation or rehabilitation and mental health therapy of any kind, as well as payment or reimbursement for any such services.

"Individual" means a patient who is receiving or has received health services from a health care entity.

"Individually identifying prescription information" means all prescriptions, drug orders or any other prescription information that specifically identifies an individual.

"Parent" means a biological, adoptive or foster parent.

"Psychotherapy notes" means comments, recorded in any medium by a health care provider who is a mental health professional, documenting or analyzing the contents of conversation during a private counseling session with an individual or a group, joint, or family counseling session that are separated from the rest of the individual's health record. "Psychotherapy notes" does not include annotations relating to medication and prescription monitoring, counseling session start and stop times, treatment modalities and frequencies, clinical test results, or any summary of any symptoms, diagnosis, prognosis, functional status, treatment plan, or the individual's progress to date.

C. The provisions of this section shall not apply to any of the following:

1. The status of and release of information governed by §§ 65.2-604 and 65.2-607 of the Virginia Workers' Compensation Act;

2. Except where specifically provided herein, the health records of minors;

3. The release of juvenile health records to a secure facility or a shelter care facility pursuant to § 16.1-248.3;or

4. The release of health records to a state correctional facility pursuant to § 53.1-40.10 or a local or regional correctional facility pursuant to § 53.1-133.03.

D. Health care entities may, and, when required by other provisions of state law, shall, disclose health records:

1. As set forth in subsection E, pursuant to the written authorization of (i) the individual or (ii) in the case of a minor, (a) his custodial parent, guardian or other person authorized to consent to treatment of minors pursuant to § 54.1-2969 or (b) the minor himself, if he has consented to his own treatment pursuant to § 54.1-2969, or (iii) in emergency cases or situations where it is impractical to obtain an individual's written authorization, pursuant to the individual's oral authorization for a health care provider or health plan to discuss the individual's health records with a third party specified by the individual;

2. In compliance with a subpoena issued in accord with subsection H, pursuant to a search warrant or a grand jury subpoena, pursuant to court order upon good cause shown or in compliance with a subpoena issued pursuant to subsection C of § 8.01-413. Regardless of the manner by which health records relating to an individual are compelled to be disclosed pursuant to this subdivision, nothing in this subdivision shall be construed to prohibit any staff or employee of a health care entity from providing information about such individual to a law-enforcement officer in connection with such subpoena, search warrant, or court order;

3. In accord with subsection F of § 8.01-399 including, but not limited to, situations where disclosure is reasonably necessary to establish or collect a fee or to defend a health care entity or the health care entity's employees or staff against any accusation of wrongful conduct; also as required in the course of an investigation, audit, review or proceedings regarding a health care entity's conduct by a duly authorized law-enforcement, licensure, accreditation, or professional review entity;

4. In testimony in accordance with §§ 8.01-399 and 8.01-400.2;

5. In compliance with the provisions of § 8.01-413;

6. As required or authorized by law relating to public health activities, health oversight activities, serious threats to health or safety, or abuse, neglect or domestic violence, relating to contagious disease, public safety, and suspected child or adult abuse reporting requirements, including, but not limited to, those contained in §§ 16.1-248.3, 32.1-36, 32.1-36.1, 32.1-40, 32.1-41, 32.1-127.1:04, 32.1-276.5, 32.1-283, 32.1-283.1, 32.1-320, 37.2-710, 37.2-839, 53.1-40.10, 53.1-133.03, 54.1-2400.6, 54.1-2400.7, 54.1-2400.9, 54.1-2403.3, 54.1-2506, 54.1-2966, 54.1-2967, 54.1-2968, 54.1-3408.2, 63.2-1509, and 63.2-1606;

7. Where necessary in connection with the care of the individual;

8. In connection with the health care entity's own health care operations or the health care operations of another health care entity, as specified in 45 C.F.R. § 164.501, or in the normal course of business in accordance with accepted standards of practice within the health services setting; however, the maintenance, storage, and disclosure of the mass of prescription dispensing records maintained in a pharmacy registered or permitted in Virginia shall only be accomplished in compliance with §§ 54.1-3410, 54.1-3411, and 54.1-3412;

9. When the individual has waived his right to the privacy of the health records;

10. When examination and evaluation of an individual are undertaken pursuant to judicial or administrative law order, but only to the extent as required by such order;

11. To the guardian ad litem and any attorney representing the respondent in the course of a guardianship proceeding of an adult patient who is the respondent in a proceeding under Chapter 20 (§ 64.2-2000 et seq.) of Title 64.2;

12. To the guardian ad litem and any attorney appointed by the court to represent an individual who is or has been a patient who is the subject of a commitment proceeding under § 19.2-169.6, Article 5 (§ 37.2-814 et seq.) of Chapter 8 of Title 37.2, Article 16 (§ 16.1-335 et seq.) of Chapter 11 of Title 16.1, or a judicial authorization for treatment proceeding pursuant to Chapter 11 (§ 37.2-1100 et seq.) of Title 37.2;

13. To a magistrate, the court, the evaluator or examiner required under Article 16 (§ 16.1-335 et seq.) of Chapter 11 of Title 16.1 or § 37.2-815, a community services board or behavioral health authority or a designee of a community services board or behavioral health authority, or a law-enforcement officer participating in any proceeding under Article 16 (§ 16.1-335 et seq.) of Chapter 11 of Title 16.1, § 19.2-169.6, or Chapter 8 (§ 37.2-800 et seq.) of Title 37.2 regarding the subject of the proceeding, and to any health care provider evaluating or providing services to the person who is the subject of the proceeding or monitoring the person's adherence to a treatment plan ordered under those provisions. Health records disclosed to a law-enforcement officer shall be limited to information necessary to protect the officer, the person, or the public from physical injury or to address the health care needs of the person. Information disclosed to a law-enforcement officer shall not be used for any other purpose, disclosed to others, or retained;

14. To the attorney and/or guardian ad litem of a minor who represents such minor in any judicial or administrative proceeding, if the court or administrative hearing officer has entered an order granting the attorney or guardian ad litem this right and such attorney or guardian ad litem presents evidence to the health care entity of such order;

15. With regard to the Court-Appointed Special Advocate (CASA) program, a minor's health records in accord with § 9.1-156;

16. To an agent appointed under an individual's power of attorney or to an agent or decision maker designated in an individual's advance directive for health care or for decisions on anatomical gifts and organ, tissue or eye donation or to any other person consistent with the provisions of the Health Care Decisions Act (§ 54.1-2981 et seq.);

17. To third-party payors and their agents for purposes of reimbursement;

18. As is necessary to support an application for receipt of health care benefits from a governmental agency or as required by an authorized governmental agency reviewing such

application or reviewing benefits already provided or as necessary to the coordination of prevention and control of disease, injury, or disability and delivery of such health care benefits pursuant to § 32.1-127.1:04;

19. Upon the sale of a medical practice as provided in § 54.1-2405;or upon a change of ownership or closing of a pharmacy pursuant to regulations of the Board of Pharmacy;

20. In accord with subsection B of § 54.1-2400.1, to communicate an individual's specific and immediate threat to cause serious bodily injury or death of an identified or readily identifiable person;

21. Where necessary in connection with the implementation of a hospital's routine contact process for organ donation pursuant to subdivision B 4 of § 32.1-127;

22. In the case of substance abuse records, when permitted by and in conformity with requirements of federal law found in 42 U.S.C. § 290dd-2 and 42 C.F.R. Part 2;

23. In connection with the work of any entity established as set forth in § 8.01-581.16 to evaluate the adequacy or quality of professional services or the competency and qualifications for professional staff privileges;

24. If the health records are those of a deceased or mentally incapacitated individual to the personal representative or executor of the deceased individual or the legal guardian or committee of the incompetent or incapacitated individual or if there is no personal representative, executor, legal guardian or committee appointed, to the following persons in the following order of priority: a spouse, an adult son or daughter, either parent, an adult brother or sister, or any other relative of the deceased individual in order of blood relationship;

25. For the purpose of conducting record reviews of inpatient hospital deaths to promote identification of all potential organ, eye, and tissue donors in conformance with the requirements of applicable federal law and regulations, including 42 C.F.R. § 482.45, (i) to the health care provider's designated organ procurement organization certified by the United States Health Care Financing Administration and (ii) to any eye bank or tissue bank in Virginia certified by the Eye Bank Association of America or the American Association of Tissue Banks;

26. To the Office of the State Inspector General pursuant to Chapter 3.2 (§ 2.2-307 et seq.) of Title 2.2;

27. To an entity participating in the activities of a local health partnership authority established pursuant to Article 6.1 (§ 32.1-122.10:001 et seq.) of Chapter 4, pursuant to subdivision 1;

28. To law-enforcement officials by each licensed emergency medical services agency, (i) when the individual is the victim of a crime or (ii) when the individual has been arrested and has received emergency medical services or has refused emergency medical services and the health records consist of the prehospital patient care report required by § 32.1-116.1;

29. To law-enforcement officials, in response to their request, for the purpose of identifying or locating a suspect, fugitive, person required to register pursuant to § 9.1-901 of the Sex Offender and Crimes Against Minors Registry Act, material witness, or missing person, provided that only the following information may be disclosed: (i) name and address of the person, (ii) date and place of birth of the person, (iii) social security number of the person, (iv) blood type of the person, (v) date and time of treatment received by the person, (vi) date and time of death of the

person, where applicable, (vii) description of distinguishing physical characteristics of the person, and (viii) type of injury sustained by the person;

30. To law-enforcement officials regarding the death of an individual for the purpose of alerting law enforcement of the death if the health care entity has a suspicion that such death may have resulted from criminal conduct;

31. To law-enforcement officials if the health care entity believes in good faith that the information disclosed constitutes evidence of a crime that occurred on its premises;

32. To the State Health Commissioner pursuant to § 32.1-48.015 when such records are those of a person or persons who are subject to an order of quarantine or an order of isolation pursuant to Article 3.02 (§ 32.1-48.05 et seq.) of Chapter 2;

33. To the Commissioner of the Department of Labor and Industry or his designee by each licensed emergency medical services agency when the records consist of the prehospital patient care report required by § 32.1-116.1 and the patient has suffered an injury or death on a work site while performing duties or tasks that are within the scope of his employment;

34. To notify a family member or personal representative of an individual who is the subject of a proceeding pursuant to Article 16 (§ 16.1-335 et seq.) of Chapter 11 of Title 16.1 or Chapter 8 (§ 37.2-800 et seq.) of Title 37.2 of information that is directly relevant to such person's involvement with the individual's health care, which may include the individual's location and general condition, when the individual has the capacity to make health care decisions and (i) the individual has agreed to the notification, (ii) the individual has been provided an opportunity to object to the notification and does not express an objection, or (iii) the health care provider can, on the basis of his professional judgment, reasonably infer from the circumstances that the individual does not object to the notification. If the opportunity to agree or object to the notification cannot practicably be provided because of the individual's incapacity or an emergency circumstance, the health care provider may notify a family member or personal representative of the individual of information that is directly relevant to such person's involvement with the individual's health care, which may include the individual's location and general condition if the health care provider, in the exercise of his professional judgment, determines that the notification is in the best interests of the individual. Such notification shall not be made if the provider has actual knowledge the family member or personal representative is currently prohibited by court order from contacting the individual;

35. To a threat assessment team established by a local school board pursuant to § 22.1-79.4, by a public institution of higher education pursuant to § 23.1-805, or by a private nonprofit institution of higher education; and

36. To a regional emergency medical services council pursuant to § 32.1-116.1, for purposes limited to monitoring and improving the quality of emergency medical services pursuant to § 32.1-111.3.

Notwithstanding the provisions of subdivisions 1 through 35, a health care entity shall obtain an individual's written authorization for any disclosure of psychotherapy notes, except when disclosure by the health care entity is (i) for its own training programs in which students, trainees, or practitioners in mental health are being taught under supervision to practice or to improve their skills in group, joint, family, or individual counseling; (ii) to defend itself or its employees or staff against any accusation of wrongful conduct; (iii) in the discharge of the duty,

in accordance with subsection B of § 54.1-2400.1, to take precautions to protect third parties from violent behavior or other serious harm; (iv) required in the course of an investigation, audit, review, or proceeding regarding a health care entity's conduct by a duly authorized law-enforcement, licensure, accreditation, or professional review entity; or (v) otherwise required by law.

E. Health care records required to be disclosed pursuant to this section shall be made available electronically only to the extent and in the manner authorized by the federal Health Information Technology for Economic and Clinical Health Act (P.L. 111-5) and implementing regulations and the Health Insurance Portability and Accountability Act (42 U.S.C. § 1320d et seq.) and implementing regulations. Notwithstanding any other provision to the contrary, a health care entity shall not be required to provide records in an electronic format requested if (i) the electronic format is not reasonably available without additional cost to the health care entity, (ii) the records would be subject to modification in the format requested, or (iii) the health care entity determines that the integrity of the records could be compromised in the electronic format requested. Requests for copies of or electronic access to health records shall (a) be in writing, dated and signed by the requester; (b) identify the nature of the information requested; and (c) include evidence of the authority of the requester to receive such copies or access such records, and identification of the person to whom the information is to be disclosed; and (d) specify whether the requester would like the records in electronic format, if available, or in paper format. The health care entity shall accept a photocopy, facsimile, or other copy of the original signed by the requester as if it were an original. Within 30 days of receipt of a request for copies of or electronic access to health records, the health care entity shall do one of the following: (1) furnish such copies of or allow electronic access to the requested health records to any requester authorized to receive them in electronic format if so requested; (2) inform the requester if the information does not exist or cannot be found; (3) if the health care entity does not maintain a record of the information, so inform the requester and provide the name and address, if known, of the health care entity who maintains the record; or (4) deny the request (A) under subsection F, (B) on the grounds that the requester has not established his authority to receive such health records or proof of his identity, or (C) as otherwise provided by law. Procedures set forth in this section shall apply only to requests for health records not specifically governed by other provisions of state law.

F. Except as provided in subsection B of § 8.01-413, copies of or electronic access to an individual's health records shall not be furnished to such individual or anyone authorized to act on the individual's behalf when the individual's treating physician or the individual's treating clinical psychologist has made a part of the individual's record a written statement that, in the exercise of his professional judgment, the furnishing to or review by the individual of such health records would be reasonably likely to endanger the life or physical safety of the individual or another person, or that such health record makes reference to a person other than a health care provider and the access requested would be reasonably likely to cause substantial harm to such referenced person. If any health care entity denies a request for copies of or electronic access to health records based on such statement, the health care entity shall inform the individual of the individual's right to designate, in writing, at his own expense, another reviewing physician or clinical psychologist, whose licensure, training and experience relative to the individual's condition are at least equivalent to that of the physician or clinical psychologist upon whose opinion the denial is based. The designated reviewing physician or clinical psychologist shall make a judgment as to whether to make the health record available to the individual.

The health care entity denying the request shall also inform the individual of the individual's right to request in writing that such health care entity designate, at its own expense, a physician or clinical psychologist, whose licensure, training, and experience relative to the individual's condition are at least equivalent to that of the physician or clinical psychologist upon whose professional judgment the denial is based and who did not participate in the original decision to deny the health records, who shall make a judgment as to whether to make the health record available to the individual. The health care entity shall comply with the judgment of the reviewing physician or clinical psychologist. The health care entity shall permit copying and examination of the health record by such other physician or clinical psychologist designated by either the individual at his own expense or by the health care entity at its expense.

Any health record copied for review by any such designated physician or clinical psychologist shall be accompanied by a statement from the custodian of the health record that the individual's treating physician or clinical psychologist determined that the individual's review of his health record would be reasonably likely to endanger the life or physical safety of the individual or would be reasonably likely to cause substantial harm to a person referenced in the health record who is not a health care provider.

Further, nothing herein shall be construed as giving, or interpreted to bestow the right to receive copies of, or otherwise obtain access to, psychotherapy notes to any individual or any person authorized to act on his behalf.

G. A written authorization to allow release of an individual's health records shall substantially include the following information:

AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH RECORDS

Individual's Name _____

Health Care Entity's Name _____

Person, Agency, or Health Care Entity to whom disclosure is to be made

_____

Information or Health Records to be disclosed

_____

Purpose of Disclosure or at the Request of the Individual

_____

As the person signing this authorization, I understand that I am giving my permission to the above-named health care entity for disclosure of confidential health records. I understand that the health care entity may not condition treatment or payment on my willingness to sign this authorization unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this authorization. I also understand that I have the right to revoke this authorization at any time, but that my revocation is not effective until delivered in writing to the person who is in possession of my health records and is not effective as to health records already disclosed under this authorization. A copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original health records. I understand that health information disclosed under this authorization

might be redisclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such health information was protected by law while solely in the possession of the health care entity.

This authorization expires on (date) or (event) _____

Signature of Individual or Individual's Legal Representative if Individual is Unable to Sign

_____

Relationship or Authority of Legal Representative

_____

Date of Signature _____

H. Pursuant to this subsection:

1. Unless excepted from these provisions in subdivision 9, no party to a civil, criminal or administrative action or proceeding shall request the issuance of a subpoena duces tecum for another party's health records or cause a subpoena duces tecum to be issued by an attorney unless a copy of the request for the subpoena or a copy of the attorney-issued subpoena is provided to the other party's counsel or to the other party if pro se, simultaneously with filing the request or issuance of the subpoena. No party to an action or proceeding shall request or cause the issuance of a subpoena duces tecum for the health records of a nonparty witness unless a copy of the request for the subpoena or a copy of the attorney-issued subpoena is provided to the nonparty witness simultaneously with filing the request or issuance of the attorney-issued subpoena.

No subpoena duces tecum for health records shall set a return date earlier than 15 days from the date of the subpoena except by order of a court or administrative agency for good cause shown. When a court or administrative agency directs that health records be disclosed pursuant to a subpoena duces tecum earlier than 15 days from the date of the subpoena, a copy of the order shall accompany the subpoena.

Any party requesting a subpoena duces tecum for health records or on whose behalf the subpoena duces tecum is being issued shall have the duty to determine whether the individual whose health records are being sought is pro se or a nonparty.

In instances where health records being subpoenaed are those of a pro se party or nonparty witness, the party requesting or issuing the subpoena shall deliver to the pro se party or nonparty witness together with the copy of the request for subpoena, or a copy of the subpoena in the case of an attorney-issued subpoena, a statement informing them of their rights and remedies. The statement shall include the following language and the heading shall be in boldface capital letters:

NOTICE TO INDIVIDUAL

The attached document means that (insert name of party requesting or causing issuance of the subpoena) has either asked the court or administrative agency to issue a subpoena or a subpoena has been issued by the other party's attorney to your doctor, other health care providers (names of health care providers inserted here) or other health care entity (name of health care entity to be inserted here) requiring them to produce your health records. Your doctor, other health care

provider or other health care entity is required to respond by providing a copy of your health records. If you believe your health records should not be disclosed and object to their disclosure, you have the right to file a motion with the clerk of the court or the administrative agency to quash the subpoena. If you elect to file a motion to quash, such motion must be filed within 15 days of the date of the request or of the attorney-issued subpoena. You may contact the clerk's office or the administrative agency to determine the requirements that must be satisfied when filing a motion to quash and you may elect to contact an attorney to represent your interest. If you elect to file a motion to quash, you must notify your doctor, other health care provider(s), or other health care entity, that you are filing the motion so that the health care provider or health care entity knows to send the health records to the clerk of court or administrative agency in a sealed envelope or package for safekeeping while your motion is decided.

2. Any party filing a request for a subpoena duces tecum or causing such a subpoena to be issued for an individual's health records shall include a Notice in the same part of the request in which the recipient of the subpoena duces tecum is directed where and when to return the health records. Such notice shall be in boldface capital letters and shall include the following language:

NOTICE TO HEALTH CARE ENTITIES

A COPY OF THIS SUBPOENA DUCES TECUM HAS BEEN PROVIDED TO THE INDIVIDUAL WHOSE HEALTH RECORDS ARE BEING REQUESTED OR HIS COUNSEL. YOU OR THAT INDIVIDUAL HAS THE RIGHT TO FILE A MOTION TO QUASH (OBJECT TO) THE ATTACHED SUBPOENA. IF YOU ELECT TO FILE A MOTION TO QUASH, YOU MUST FILE THE MOTION WITHIN 15 DAYS OF THE DATE OF THIS SUBPOENA.

YOU MUST NOT RESPOND TO THIS SUBPOENA UNTIL YOU HAVE RECEIVED WRITTEN CERTIFICATION FROM THE PARTY ON WHOSE BEHALF THE SUBPOENA WAS ISSUED THAT THE TIME FOR FILING A MOTION TO QUASH HAS ELAPSED AND THAT:

NO MOTION TO QUASH WAS FILED; OR

ANY MOTION TO QUASH HAS BEEN RESOLVED BY THE COURT OR THE ADMINISTRATIVE AGENCY AND THE DISCLOSURES SOUGHT ARE CONSISTENT WITH SUCH RESOLUTION.

IF YOU RECEIVE NOTICE THAT THE INDIVIDUAL WHOSE HEALTH RECORDS ARE BEING REQUESTED HAS FILED A MOTION TO QUASH THIS SUBPOENA, OR IF YOU FILE A MOTION TO QUASH THIS SUBPOENA, YOU MUST SEND THE HEALTH RECORDS ONLY TO THE CLERK OF THE COURT OR ADMINISTRATIVE AGENCY THAT ISSUED THE SUBPOENA OR IN WHICH THE ACTION IS PENDING AS SHOWN ON THE SUBPOENA USING THE FOLLOWING PROCEDURE:

PLACE THE HEALTH RECORDS IN A SEALED ENVELOPE AND ATTACH TO THE SEALED ENVELOPE A COVER LETTER TO THE CLERK OF COURT OR ADMINISTRATIVE AGENCY WHICH STATES THAT CONFIDENTIAL HEALTH RECORDS ARE ENCLOSED AND ARE TO BE HELD UNDER SEAL PENDING A RULING ON THE MOTION TO QUASH THE SUBPOENA. THE SEALED ENVELOPE AND THE COVER LETTER SHALL BE PLACED IN AN OUTER ENVELOPE OR PACKAGE FOR TRANSMITTAL TO THE COURT OR ADMINISTRATIVE AGENCY.

3. Upon receiving a valid subpoena duces tecum for health records, health care entities shall have the duty to respond to the subpoena in accordance with the provisions of subdivisions 4, 5, 6, 7, and 8.

4. Except to deliver to a clerk of the court or administrative agency subpoenaed health records in a sealed envelope as set forth, health care entities shall not respond to a subpoena duces tecum for such health records until they have received a certification as set forth in subdivision 5 or 8 from the party on whose behalf the subpoena duces tecum was issued.

If the health care entity has actual receipt of notice that a motion to quash the subpoena has been filed or if the health care entity files a motion to quash the subpoena for health records, then the health care entity shall produce the health records, in a securely sealed envelope, to the clerk of the court or administrative agency issuing the subpoena or in whose court or administrative agency the action is pending. The court or administrative agency shall place the health records under seal until a determination is made regarding the motion to quash. The securely sealed envelope shall only be opened on order of the judge or administrative agency. In the event the court or administrative agency grants the motion to quash, the health records shall be returned to the health care entity in the same sealed envelope in which they were delivered to the court or administrative agency. In the event that a judge or administrative agency orders the sealed envelope to be opened to review the health records in camera, a copy of the order shall accompany any health records returned to the health care entity. The health records returned to the health care entity shall be in a securely sealed envelope.

5. If no motion to quash is filed within 15 days of the date of the request or of the attorney-issued subpoena, the party on whose behalf the subpoena was issued shall have the duty to certify to the subpoenaed health care entity that the time for filing a motion to quash has elapsed and that no motion to quash was filed. Any health care entity receiving such certification shall have the duty to comply with the subpoena duces tecum by returning the specified health records by either the return date on the subpoena or five days after receipt of the certification, whichever is later.

6. In the event that the individual whose health records are being sought files a motion to quash the subpoena, the court or administrative agency shall decide whether good cause has been shown by the discovering party to compel disclosure of the individual's health records over the individual's objections. In determining whether good cause has been shown, the court or administrative agency shall consider (i) the particular purpose for which the information was collected; (ii) the degree to which the disclosure of the records would embarrass, injure, or invade the privacy of the individual; (iii) the effect of the disclosure on the individual's future health care; (iv) the importance of the information to the lawsuit or proceeding; and (v) any other relevant factor.

7. Concurrent with the court or administrative agency's resolution of a motion to quash, if subpoenaed health records have been submitted by a health care entity to the court or administrative agency in a sealed envelope, the court or administrative agency shall: (i) upon determining that no submitted health records should be disclosed, return all submitted health records to the health care entity in a sealed envelope; (ii) upon determining that all submitted health records should be disclosed, provide all the submitted health records to the party on whose behalf the subpoena was issued; or (iii) upon determining that only a portion of the submitted health records should be disclosed, provide such portion to the party on whose behalf the subpoena was issued and return the remaining health records to the health care entity in a sealed envelope.

8. Following the court or administrative agency's resolution of a motion to quash, the party on whose behalf the subpoena duces tecum was issued shall have the duty to certify in writing to the subpoenaed health care entity a statement of one of the following:

a. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are consistent with such resolution; and, therefore, the health records previously delivered in a sealed envelope to the clerk of the court or administrative agency will not be returned to the health care entity;

b. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are consistent with such resolution and that, since no health records have previously been delivered to the court or administrative agency by the health care entity, the health care entity shall comply with the subpoena duces tecum by returning the health records designated in the subpoena by the return date on the subpoena or five days after receipt of certification, whichever is later;

c. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are not consistent with such resolution; therefore, no health records shall be disclosed and all health records previously delivered in a sealed envelope to the clerk of the court or administrative agency will be returned to the health care entity;

d. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are not consistent with such resolution and that only limited disclosure has been authorized. The certification shall state that only the portion of the health records as set forth in the certification, consistent with the court or administrative agency's ruling, shall be disclosed. The certification shall also state that health records that were previously delivered to the court or administrative agency for which disclosure has been authorized will not be returned to the health care entity; however, all health records for which disclosure has not been authorized will be returned to the health care entity; or

e. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are not consistent with such resolution and, since no health records have previously been delivered to the court or administrative agency by the health care entity, the health care entity shall return only those health records specified in the certification, consistent with the court or administrative agency's ruling, by the return date on the subpoena or five days after receipt of the certification, whichever is later.

A copy of the court or administrative agency's ruling shall accompany any certification made pursuant to this subdivision.

9. The provisions of this subsection have no application to subpoenas for health records requested under § 8.01-413, or issued by a duly authorized administrative agency conducting an investigation, audit, review or proceedings regarding a health care entity's conduct.

The provisions of this subsection shall apply to subpoenas for the health records of both minors and adults.

Nothing in this subsection shall have any effect on the existing authority of a court or administrative agency to issue a protective order regarding health records, including, but not limited to, ordering the return of health records to a health care entity, after the period for filing a motion to quash has passed.

A subpoena for substance abuse records must conform to the requirements of federal law found in 42 C.F.R. Part 2, Subpart E.

I. Health care entities may testify about the health records of an individual in compliance with §§ 8.01-399 and 8.01-400.2.

J. If an individual requests a copy of his health record from a health care entity, the health care entity may impose a reasonable cost-based fee, which shall include only the cost of supplies for and labor of copying the requested information, postage when the individual requests that such information be mailed, and preparation of an explanation or summary of such information as agreed to by the individual. For the purposes of this section, "individual" shall subsume a person with authority to act on behalf of the individual who is the subject of the health record in making decisions related to his health care.

K. Nothing in this section shall prohibit a health care provider who prescribes or dispenses a controlled substance required to be reported to the Prescription Monitoring Program established pursuant to Chapter 25.2 (§ 54.1-2519 et seq.) of Title 54.1 to a patient from disclosing information obtained from the Prescription Monitoring Program and contained in a patient's health care record to another health care provider when such disclosure is related to the care or treatment of the patient who is the subject of the record.

1997, c. 682;1998, c. 470;1999, cc. 812, 956, 1010;2000, cc. 810, 813, 923, 927;2001, c. 671;2002, cc. 568, 658, 835, 860;2003, cc. 471, 907, 983;2004, cc. 49, 64, 65, 66, 67, 163, 773, 1014, 1021; 2005, cc. 39, 101, 642, 697;2006, c. 433;2007, c. 497;2008, cc. 315, 782, 850, 870;2009, cc. 606, 651 , 813, 840;2010, cc. 185, 340, 406, 456, 524, 778, 825;2011, cc. 499, 668, 798, 812, 844, 871;2012, cc. 386, 402, 479;2016, c. 554;2017, cc. 457, 712, 720;2018, c. 165.

The chapters of the acts of assembly referenced in the historical citation at the end of this section may not constitute a comprehensive list of such chapters and may exclude chapters whose provisions have expired.

Credential Appeal Process FAQs

Credential Appeals FAQ's

I received a letter of ineligibility advising that board staff is unable to approve my application. What does this mean?

Board staff is only authorized to approve applications that clearly meet the requirements in the regulations governing practice. If staff is unable to make a determination regarding your degree, coursework, experience, criminal history, etc., you will receive a letter detailing the specific reasons that your application was not approved and your right to appeal the decision to an informal conference before a committee of the board.

Am I required to appeal this decision to an informal conference in order to keep my application open?

No. Your application is valid for one year from the date it was originally received by the board. Therefore, you have one year to provide additional information indicating that you have met the requirements or appeal the matter to an informal conference. Some deficiencies can be resolved within a year (e.g., missing coursework) by providing additional information or completing the missing requirements. If you plan to complete the missing requirements within a year, it is not necessary to appeal staff's decision. However, if you feel that you have met all of the requirements and you cannot otherwise satisfy the missing requirements within a year, you have the option to appeal the decision. Please keep in mind the timeframe for appeals when making your decision.

What happens if I don't appeal?

If you do not appeal the letter of ineligibility, and you do not provide additional information to satisfy the requirements, your application will expire one year from the date it was received by board staff. If your application expires, you can reapply with the board.

If I appeal the decision, when will I be scheduled for an informal conference?

The timeframe to appear at an informal conference varies. In some cases, we may be required to complete an investigation, which will delay the matter further. The time to process the case for an informal conference also depends on the amount of cases waiting to be heard by the committee. In general, this process can take approximately nine months to a year from the time you appeal to the date of the informal conference.

I don't want to appeal my case but I want the board to consider a general change in regulations. What are my options?

The Code of Virginia (§ 2.2-4007) and the Public Participation Guidelines of this board require a person who wishes to petition the board to develop a new regulation or amend an existing regulation to provide certain information. Within 14 days of receiving a valid petition, the board will notify the petitioner and send a notice to the Register of Regulations identifying the petitioner, the nature of the request and the plan for responding to the petition. Following publication of the petition in the Register, a 21-day comment period will begin to allow written comment on the petition. Within 90 days after the comment period, the board will issue a written decision on the petition. If the board has not met within that 90-day period, the decision will be issued no later than 14 days after it next meets. The petition can be found on the board's website at https://www.dhp.virginia.gov/counseling/counseling_laws_regs.htm. Please be advised that this petition is only to request that the board consider changes in regulations and does not have any effect on your application.

Informal Conference Information

How will I be notified of the informal conference date?

Within 30 days from the scheduled date, a Notice of Informal Conference will be drafted and mailed to you. The Notice will include the date and time of the conference, the allegations, and a copy of your licensure application file and/or any investigative material necessary for review. A copy of the Notice will be mailed by regular mail and the Notice with the additional application and/or investigative material will be sent by certified mail, which you may have to pick up from the post office. In order to ensure that you receive the information in a timely manner, please keep the board updated with any address changes.

Can the committee consider my prior experience in lieu of required education?

No. The regulations are specific regarding the required degree and coursework. Prior experience cannot be considered in lieu of education.

Is this appeal public information or private?

All notices of proceedings and subsequent orders are public information pursuant to Virginia Code § 54.1-2400.2(G).

What can I expect at the Informal Conference?

For more information about the informal conference process, please review the FAQ's on the agency's website at https://www.dhp.virginia.gov/Enforcement/DisciplineFAQ.htm. While these questions specifically address disciplinary proceedings, the informal conferences for credentialing matters follow the same procedures.

Executive Director’s Report

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 20100 - Behavioral Science Exec

For the Period Beginning July 1, 2018 and Ending March 31, 2019

Account Number	Account Description	Amount	Budget	Amount Under/(Over) Budget	% of Budget
5011110	Employer Retirement Contrib.	21,411.11	28,673.00	7,261.89	74.67%
5011120	Fed Old-Age Ins- Sal St Emp	12,304.98	16,224.00	3,919.02	75.84%
5011130	Fed Old-Age Ins- Wage Earners	258.91	1,120.00	861.09	23.12%
5011140	Group Insurance	2,199.44	2,779.00	579.56	79.15%
5011150	Medical/Hospitalization Ins.	51,202.50	64,872.00	13,669.50	78.93%
5011160	Retiree Medical/Hospitalizatn	1,965.29	2,482.00	516.71	79.18%
5011170	Long term Disability Ins	1,044.36	1,315.00	270.64	79.42%
	Total Employee Benefits	90,386.59	117,465.00	27,078.41	76.95%
5011200	Salaries				
5011230	Salaries, Classified	167,891.98	212,074.00	44,182.02	79.17%
5011250	Salaries, Overtime	249.87	-	(249.87)	0.00%
	Total Salaries	168,141.85	212,074.00	43,932.15	79.28%
5011300	Special Payments				
5011310	Bonuses and Incentives	350.00	-	(350.00)	0.00%
5011380	Deferred Compnstn Match Pmts	95.00	1,440.00	1,345.00	6.60%
	Total Special Payments	445.00	1,440.00	995.00	30.90%
5011400	Wages				
5011410	Wages, General	11,030.45	14,600.00	3,569.55	75.55%
	Total Wages	11,030.45	14,600.00	3,569.55	75.55%
5011600	Terminatn Personal Svce Costs				
5011660	Defined Contribution Match - Hy	1,285.35	-	(1,285.35)	0.00%
	Total Terminatn Personal Svce Costs	1,285.35	-	(1,285.35)	0.00%
5011930	Turnover/Vacancy Benefits		-	-	0.00%
	Total Personal Services	271,289.24	345,579.00	74,289.76	78.50%
5012000	Contractual Svs				
5012100	Communication Services		-		
5012160	Telecommunications Svcs (VITA)	2,979.16	5,000.00	2,020.84	59.58%
5012170	Telecomm. Svcs (Non-State)	427.50	-	(427.50)	0.00%
	Total Communication Services	3,406.66	5,000.00	1,593.34	68.13%
5012200	Employee Development Services				
5012210	Organization Memberships	125.00	-	(125.00)	0.00%
5012250	Employee Tuition Reimbursement	474.30	-	(474.30)	0.00%
	Total Employee Development Services	599.30	-	(599.30)	0.00%
5012600	Support Services				
5012630	Clerical Services	-	35,815.00	35,815.00	0.00%
	Total Support Services	-	35,815.00	35,815.00	0.00%
5012700	Technical Services				
5012780	VITA InT Int Cost Goods&Svs	689.50	-	(689.50)	0.00%
	Total Technical Services	689.50	-	(689.50)	0.00%
5012800	Transportation Services				
5012820	Travel, Personal Vehicle	5.46	-	(5.46)	0.00%
5012830	Travel, Public Carriers	32.75	-	(32.75)	0.00%

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 20100 - Behavioral Science Exec

For the Period Beginning July 1, 2018 and Ending March 31, 2019

Account Number	Account Description	Amount	Budget	Amount Under/(Over) Budget	% of Budget
5012850	Travel, Subsistence & Lodging	121.74	-	(121.74)	0.00%
5012880	Trvl, Meal Reimb- Not Rprtble	105.00	-	(105.00)	0.00%
	Total Transportation Services	264.95	-	(264.95)	0.00%
	Total Contractual Svs	4,960.41	40,815.00	35,854.59	12.15%
5013000	Supplies And Materials				
5013100	Administrative Supplies				
5013120	Office Supplies	500.37	537.00	36.63	93.18%
	Total Administrative Supplies	500.37	537.00	36.63	93.18%
5013600	Residential Supplies				
5013630	Food Service Supplies	-	19.00	19.00	0.00%
	Total Residential Supplies	-	19.00	19.00	0.00%
	Total Supplies And Materials	500.37	556.00	55.63	89.99%
5015000	Continuous Charges				
5015300	Operating Lease Payments				
5015390	Building Rentals - Non State	30,884.32	42,373.00	11,488.68	72.89%
	Total Operating Lease Payments	30,884.32	42,373.00	11,488.68	72.89%
	Total Continuous Charges	30,884.32	42,373.00	11,488.68	72.89%
5022000	Equipment				
5022200	Educational & Cultural Equip	-			
5022240	Reference Equipment	-	16.00	16.00	0.00%
	Total Educational & Cultural Equip	-	16.00	16.00	0.00%
5022600	Office Equipment				
5022610	Office Appurtenances	-	27.00	27.00	0.00%
5022620	Office Furniture	469.50	4,500.00	4,030.50	10.43%
5022630	Office Incidentals	-	34.00	34.00	0.00%
5022640	Office Machines	-	3,600.00	3,600.00	0.00%
	Total Office Equipment	469.50	8,161.00	7,691.50	5.75%
	Total Equipment	469.50	8,177.00	7,707.50	5.74%
	Total Expenditures	308,103.84	437,500.00	129,396.16	70.42%

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 20100 - Behavioral Science Exec

For the Period Beginning July 1, 2018 and Ending March 31, 2019

Account Number	Account Description	July	August	September	October	November	December	January	February	March	Total
5011000	Personal Services										
5011100	Employee Benefits										
5011110	Employer Retirement Contrib.	3,378.47	2,254.08	2,254.08	2,254.08	2,254.08	2,254.08	2,254.08	2,254.08	2,254.08	21,411.11
5011120	Fed Old-Age Ins- Sal St Emp	1,855.60	1,339.11	1,293.09	1,291.69	1,296.26	1,289.07	1,354.34	1,298.26	1,287.56	12,304.98
5011130	Fed Old-Age Ins- Wage Earners	258.91	-	-	-	-	-	-	-	-	258.91
5011140	Group Insurance	347.28	231.52	231.52	231.52	231.52	231.52	231.52	231.52	231.52	2,199.44
5011150	Medical/Hospitalization Ins.	7,954.50	5,406.00	5,406.00	5,406.00	5,406.00	5,406.00	5,406.00	5,406.00	5,406.00	51,202.50
5011160	Retiree Medical/Hospitalizatn	311.05	206.78	206.78	206.78	206.78	206.78	206.78	206.78	206.78	1,965.29
5011170	Long term Disability Ins	167.88	109.56	109.56	109.56	109.56	109.56	109.56	109.56	109.56	1,044.36
	Total Employee Benefits	14,273.69	9,547.05	9,501.03	9,499.63	9,504.20	9,497.01	9,562.28	9,506.20	9,495.50	90,386.59
5011200	Salaries										
5011230	Salaries, Classified	26,509.26	17,672.84	17,672.84	17,672.84	17,672.84	17,672.84	17,672.84	17,672.84	17,672.84	167,891.98
5011250	Salaries, Overtime	-	-	-	-	249.87	-	-	-	-	249.87
	Total Salaries	26,509.26	17,672.84	17,672.84	17,672.84	17,922.71	17,672.84	17,672.84	17,672.84	17,672.84	168,141.85
5011300	Special Payments										
5011310	Bonuses and Incentives	-	350.00	-	-	-	-	-	-	-	350.00
5011380	Deferred Compnstn Match Pmts	15.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	95.00
	Total Special Payments	15.00	360.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	445.00
5011400	Wages										-
5011410	Wages, General	3,384.45	1,080.00	828.75	810.00	870.00	776.00	1,629.25	896.00	756.00	11,030.45
	Total Wages	3,384.45	1,080.00	828.75	810.00	870.00	776.00	1,629.25	896.00	756.00	11,030.45
5011600	Terminatn Personal Svce Costs										
5011660	Defined Contribution Match - Hy	202.95	135.30	135.30	135.30	135.30	135.30	135.30	135.30	135.30	1,285.35
	Total Terminatn Personal Svce Costs	202.95	135.30	135.30	135.30	135.30	135.30	135.30	135.30	135.30	1,285.35
	Total Personal Services	44,385.35	28,795.19	28,147.92	28,127.77	28,442.21	28,091.15	29,009.67	28,220.34	28,069.64	271,289.24
5012000	Contractual Svs										-
5012100	Communication Services										-
5012160	Telecommunications Svcs (VITA)	294.56	559.41	286.68	281.64	295.57	330.41	310.74	310.74	309.41	2,979.16
5012170	Telecomm. Svcs (Non-State)	67.50	45.00	45.00	45.00	45.00	45.00	45.00	45.00	45.00	427.50
	Total Communication Services	362.06	604.41	331.68	326.64	340.57	375.41	355.74	355.74	354.41	3,406.66
5012200	Employee Development Services										

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 20100 - Behavioral Science Exec

For the Period Beginning July 1, 2018 and Ending March 31, 2019

Account Number	Account Description	July	August	September	October	November	December	January	February	March	Total
5012210	Organization Memberships	-	-	-	-	-	125.00	-	-	-	125.00
5012250	Employee Tuition Reimbursement	-	-	-	-	-	-	474.30	-	-	474.30
	Total Employee Development Services	-	-	-	-	-	125.00	474.30	-	-	599.30
5012700	Technical Services										
5012780	VITA InT Int Cost Goods&Svs	-	-	-	-	-	689.50	-	-	-	689.50
	Total Technical Services	-	-	-	-	-	689.50	-	-	-	689.50
5012800	Transportation Services										
5012820	Travel, Personal Vehicle	-	-	-	-	5.46	-	-	-	-	5.46
5012830	Travel, Public Carriers	-	-	-	-	32.75	-	-	-	-	32.75
5012850	Travel, Subsistence & Lodging	-	-	-	-	121.74	-	-	-	-	121.74
5012880	Trvl, Meal Reimb- Not Rprtble	-	-	-	-	105.00	-	-	-	-	105.00
	Total Transportation Services	-	-	-	-	264.95	-	-	-	-	264.95
	Total Contractual Svs	362.06	604.41	331.68	326.64	605.52	1,189.91	830.04	355.74	354.41	4,960.41
5013120	Office Supplies	-	205.54	-	64.69	-	106.15	31.00	-	92.99	500.37
	Total Administrative Supplies	-	205.54	-	64.69	-	106.15	31.00	-	92.99	500.37
	Total Supplies And Materials	-	205.54	-	64.69	-	106.15	31.00	-	92.99	500.37
5015000	Continuous Charges										
5015300	Operating Lease Payments										
5015390	Building Rentals - Non State	3,418.72	2,944.05	3,418.27	3,418.27	3,720.84	3,452.59	3,418.27	3,675.04	3,418.27	30,884.32
	Total Operating Lease Payments	3,418.72	2,944.05	3,418.27	3,418.27	3,720.84	3,452.59	3,418.27	3,675.04	3,418.27	30,884.32
	Total Continuous Charges	3,418.72	2,944.05	3,418.27	3,418.27	3,720.84	3,452.59	3,418.27	3,675.04	3,418.27	30,884.32
5022000	Equipment										
5022620	Office Furniture	-	469.50	-	-	-	-	-	-	-	469.50
	Total Office Equipment	-	469.50	-	-	-	-	-	-	-	469.50
	Total Equipment	-	469.50	-	-	-	-	-	-	-	469.50
	Total Expenditures	48,166.13	33,018.69	31,897.87	31,937.37	32,768.57	32,839.80	33,288.98	32,251.12	31,935.31	308,103.84

	109 Counseling
Board Cash Balance as June 30, 2018	$ 1,094,175
YTD FY19 Revenue	906,160
Less: YTD FY19 Direct and Allocated Expenditures	1,192,180
Board Cash Balance as March 31, 2019	808,155

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 10900 - Counseling

For the Period Beginning July 1, 2018 and Ending March 31, 2019

Account Number	Account Description	July	August	September	October	November	December	January	February	March	Total
4002400	Fee Revenue										
4002401	Application Fee	75,625.00	94,435.00	97,820.00	108,195.00	102,985.00	152,820.00	68,350.00	43,930.00	46,680.00	790,840.00
4002406	License & Renewal Fee	48,665.00	3,710.00	1,210.00	1,720.00	2,795.00	3,460.00	10,150.00	1,780.00	1,920.00	75,410.00
4002407	Dup. License Certificate Fee	150.00	285.00	155.00	250.00	130.00	245.00	150.00	155.00	125.00	1,645.00
4002409	Board Endorsement - Out	480.00	270.00	490.00	525.00	425.00	330.00	450.00	360.00	475.00	3,805.00
4002421	Monetary Penalty & Late Fees	6,845.00	1,335.00	355.00	450.00	245.00	45.00	310.00	440.00	240.00	10,265.00
4002430	Board Changes Fee	1,980.00	2,880.00	2,430.00	2,940.00	2,550.00	1,890.00	3,030.00	2,700.00	2,515.00	22,915.00
4002432	Misc. Fee (Bad Check Fee)	35.00	70.00	35.00	-	-	-	35.00	35.00	35.00	245.00
	Total Fee Revenue	133,780.00	102,985.00	102,495.00	114,080.00	109,130.00	158,790.00	82,475.00	49,400.00	51,990.00	905,125.00
4003000	Sales of Prop. & Commodities										
4003020	Misc. Sales-Dishonored Payments	175.00	290.00	175.00	-	-	175.00	-	65.00	155.00	1,035.00
	Total Sales of Prop. & Commodities	175.00	290.00	175.00	-	-	175.00	-	65.00	155.00	1,035.00
	Total Revenue	133,955.00	103,275.00	102,670.00	114,080.00	109,130.00	158,965.00	82,475.00	49,465.00	52,145.00	906,160.00
5011000	Personal Services										
5011100	Employee Benefits										
5011110	Employer Retirement Contrib.	1,714.37	1,143.98	1,143.98	1,143.98	1,143.98	980.57	817.16	817.16	1,213.62	10,118.80
5011120	Fed Old-Age Ins- Sal St Emp	1,529.50	1,041.64	1,027.05	1,130.58	1,044.87	936.95	715.59	708.98	902.79	9,037.95
5011140	Group Insurance	210.06	140.04	140.04	140.04	140.04	118.68	97.32	97.32	138.80	1,222.34
5011150	Medical/Hospitalization Ins.	1,010.50	687.00	687.00	687.00	687.00	687.00	687.00	687.00	1,374.00	7,193.50
5011160	Retiree Medical/Hospitalizatn	188.15	125.08	125.08	125.08	125.08	106.00	86.92	86.92	123.96	1,092.27
5011170	Long term Disability Ins	101.56	66.28	66.28	66.28	66.28	56.17	46.06	46.06	65.70	580.67
	Total Employee Benefits	4,754.14	3,204.02	3,189.43	3,292.96	3,207.25	2,885.37	2,450.05	2,443.44	3,818.87	29,245.53
5011200	Salaries										
5011230	Salaries, Classified	16,035.75	10,690.50	10,690.50	10,690.50	10,690.50	9,341.97	7,428.84	7,428.84	10,595.50	93,592.90
5011250	Salaries, Overtime	4,138.66	3,038.28	2,847.47	4,200.96	3,080.36	3,300.76	2,042.25	1,956.04	1,460.50	26,065.28
	Total Salaries	20,174.41	13,728.78	13,537.97	14,891.46	13,770.86	12,642.73	9,471.09	9,384.88	12,056.00	119,658.18
5011340	Specified Per Diem Payment	250.00	50.00	150.00	50.00	650.00	150.00	100.00	50.00	500.00	1,950.00
5011380	Deferred Compnstn Match Pmts	60.00	40.00	40.00	40.00	40.00	40.00	40.00	40.00	40.00	380.00
	Total Special Payments	310.00	90.00	190.00	90.00	690.00	190.00	140.00	90.00	540.00	2,330.00

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 10900 - Counseling

For the Period Beginning July 1, 2018 and Ending March 31, 2019

Account Number	Account Description	July	August	September	October	November	December	January	February	March	Total
5011600	Terminatn Personal Svce Costs										
5011660	Defined Contribution Match - Hy	452.04	301.36	301.36	301.36	301.36	244.28	187.20	187.20	218.86	2,495.02
	Total Terminatn Personal Svce Costs	452.04	301.36	301.36	301.36	301.36	244.28	187.20	187.20	218.86	2,495.02
	Total Personal Services	25,690.59	17,324.16	17,218.76	18,575.78	17,969.47	15,962.38	12,248.34	12,105.52	16,633.73	153,728.73
5012000	Contractual Svs										-
5012100	Communication Services										-
5012130	Messenger Services	-	-	8.67	-	-	-	-	-	-	8.67
5012140	Postal Services	1,536.28	2,861.48	1,331.91	1,028.68	904.98	1,592.55	1,348.85	763.29	1,999.94	13,367.96
5012150	Printing Services	-	-	103.68	-	-	-	-	-	-	103.68
5012160	Telecommunications Svcs (VITA)	35.32	70.64	35.32	36.68	59.10	78.33	85.26	155.75	87.02	643.42
5012190	Inbound Freight Services	-	-	-	-	-	-	-	-	4.75	4.75
	Total Communication Services	1,571.60	2,932.12	1,479.58	1,065.36	964.08	1,670.88	1,434.11	919.04	2,091.71	14,128.48
5012200	Employee Development Services										
5012210	Organization Memberships	900.00	-	-	-	-	-	500.00	-	-	1,400.00
5012260	Personnel Develpmnt Services	1,650.00	-	-	-	-	-	-	-	-	1,650.00
	Total Employee Development Services	2,550.00	-	-	-	-	-	500.00	-	-	3,050.00
5012400	Mgmnt and Informational Svcs										
5012420	Fiscal Services	16,200.83	-	473.17	372.61	240.00	27.37	88.02	117.31	209.64	17,728.95
5012440	Management Services	-	44.12	-	31.78	-	30.11	-	14.43	-	120.44
5012460	Public Infrmtnl & Relatn Svcs	12.00	12.00	20.00	12.00	12.00	4.00	4.00	16.00	14.00	106.00
5012470	Legal Services	-	195.00	-	-	-	-	-	-	-	195.00
	Total Mgmnt and Informational Svcs	16,212.83	251.12	493.17	416.39	252.00	61.48	92.02	147.74	223.64	18,150.39
5012500	Repair and Maintenance Svcs										
5012530	Equipment Repair & Maint Srvc	-	-	-	-	993.43	(166.26)	(26.28)	17.86	-	818.75
	Total Repair and Maintenance Svcs	-	-	-	-	993.43	(166.26)	(26.28)	17.86	-	818.75
5012600	Support Services										
5012630	Clerical Services	14,759.00	17,033.40	10,857.60	6,234.00	21,553.60	13,687.40	25,918.40	16,011.60	18,530.00	144,585.00
5012640	Food & Dietary Services	199.60	109.25	978.65	-	599.95	207.37	143.80	448.40	98.55	2,785.57
5012660	Manual Labor Services	-	6.11	102.19	21.34	7.79	45.29	-	44.50	-	227.22
5012670	Production Services	-	113.35	444.65	110.45	50.85	252.05	84.10	300.31	302.10	1,657.86

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 10900 - Counseling

For the Period Beginning July 1, 2018 and Ending March 31, 2019

Account Number	Account Description	July	August	September	October	November	December	January	February	March	Total
5012680	Skilled Services	1,399.52	892.36	648.61	911.11	1,240.97	450.00	1,377.75	1,008.28	607.74	8,536.34
	Total Support Services	16,358.12	18,154.47	13,031.70	7,276.90	23,453.16	14,642.11	27,524.05	17,813.09	19,538.39	157,791.99
5012800	Transportation Services										
5012820	Travel, Personal Vehicle	756.47	93.74	609.86	153.15	1,260.05	398.95	290.00	99.76	1,295.72	4,957.70
5012830	Travel, Public Carriers	-	688.40	-	38.32	78.00	-	34.13	-	-	838.85
5012850	Travel, Subsistence & Lodging	651.38	-	228.74	-	1,194.22	338.37	213.00	-	745.50	3,371.21
5012880	Trvl, Meal Reimb- Not Rprtble	244.50	-	96.25	-	411.75	142.00	100.75	-	343.50	1,338.75
	Total Transportation Services	1,652.35	782.14	934.85	191.47	2,944.02	879.32	637.88	99.76	2,384.72	10,506.51
	Total Contractual Svs	38,344.90	22,119.85	15,939.30	8,950.12	28,606.69	17,087.53	30,161.78	18,997.49	24,238.46	204,446.12
5013000	Supplies And Materials										
5013100	Administrative Supplies										-
5013120	Office Supplies	68.02	122.24	138.05	69.08	150.59	243.23	184.18	64.49	337.10	1,376.98
	Total Administrative Supplies	68.02	122.24	138.05	69.08	150.59	243.23	184.18	64.49	337.10	1,376.98
5013200	Energy Supplies										
5013230	Gasoline	-	-	-	33.83	-	-	18.94	-	-	52.77
	Total Energy Supplies	-	-	-	33.83	-	-	18.94	-	-	52.77
5013500	Repair and Maint. Supplies										
5013520	Custodial Repair & Maint Matrl	-	-	-	-	-	-	3.42	-	-	3.42
5013530	Electrcal Repair & Maint Matrl	-	-	-	-	-	-	-	0.98	-	0.98
	Total Repair and Maint. Supplies	-	-	-	-	-	-	3.42	0.98	-	4.40
5013600	Residential Supplies										
5013640	Laundry and Linen Supplies	-	-	-	-	-	-	-	3.87	-	3.87
	Total Residential Supplies	-	-	-	-	-	-	-	3.87	-	3.87
	Total Supplies And Materials	68.02	122.24	138.05	102.91	150.59	243.23	206.54	69.34	337.10	1,438.02
5015000	Continuous Charges										
5015100	Insurance-Fixed Assets										-
5015160	Property Insurance	54.87	-	-	-	-	-	-	-	-	54.87

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 10900 - Counseling

For the Period Beginning July 1, 2018 and Ending March 31, 2019

Account Number	Account Description	July	August	September	October	November	December	January	February	March	Total
	Total Insurance-Fixed Assets	54.87	-	-	-	-	-	-	-	-	54.87
5015300	Operating Lease Payments										
5015340	Equipment Rentals	43.73	42.19	41.87	43.73	41.87	41.87	41.87	48.70	48.70	394.53
5015350	Building Rentals	-	22.80	-	-	22.80	-	-	22.80	-	68.40
5015390	Building Rentals - Non State	901.10	1,044.51	900.94	900.94	980.69	909.98	900.94	968.61	900.94	8,408.65
	Total Operating Lease Payments	944.83	1,109.50	942.81	944.67	1,045.36	951.85	942.81	1,040.11	949.64	8,871.58
5015500	Insurance-Operations										
5015510	General Liability Insurance	196.94	-	-	-	-	-	-	-	-	196.94
5015540	Surety Bonds	11.62	-	-	-	-	-	-	-	-	11.62
	Total Insurance-Operations	208.56	-	-	-	-	-	-	-	-	208.56
	Total Continuous Charges	1,208.26	1,109.50	942.81	944.67	1,045.36	951.85	942.81	1,040.11	949.64	9,135.01
5022000	Equipment										
5022170	Other Computer Equipment	-	431.00	-	-	-	-	-	-	-	431.00
	Total Computer Hrdware & Sftware	-	431.00	-	-	-	-	-	-	-	431.00
	Total Equipment	-	431.00	-	-	-	-	-	-	-	431.00
	Total Expenditures	65,311.77	41,106.75	34,238.92	28,573.48	47,772.11	34,244.99	43,559.47	32,212.46	42,158.93	369,178.88
	Allocated Expenditures										
20100	Behavioral Science Exec	24,083.07	16,509.35	15,948.94	15,968.69	16,384.29	16,419.90	16,644.49	16,125.56	15,967.66	154,051.92
20200	Opt\Vet-Med\ASLP Executive Dir	-	-	-	-	-	-	-	-	-	-
20400	Nursing / Nurse Aid	-	-	-	-	-	-	-	-	-	-
20600	Funeral\LTCA\PT	-	-	-	-	-	-	-	-	-	-
30100	Data Center	36,939.81	22,604.31	22,671.33	33,652.58	9,823.21	25,671.24	25,850.38	38,117.30	24,359.20	239,689.36
30200	Human Resources	1,635.17	190.47	212.23	7,233.91	1,144.95	161.90	148.57	168.13	210.70	11,106.02
30300	Finance	9,716.19	7,911.82	7,708.93	7,658.35	8,869.67	8,494.67	10,743.53	8,990.29	9,925.71	80,019.16
30400	Director's Office	5,191.75	3,505.06	3,632.08	3,669.28	3,852.58	3,925.98	4,020.16	4,058.60	4,560.02	36,415.53
30500	Enforcement	22,855.76	17,393.62	18,205.76	18,573.58	18,337.22	18,861.53	23,659.05	25,697.84	26,895.04	190,479.41

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 10900 - Counseling

For the Period Beginning July 1, 2018 and Ending March 31, 2019

Account Number	Account Description	July	August	September	October	November	December	January	February	March	Total
30600	Administrative Proceedings	11,882.18	681.67	7,125.41	1,506.32	8,804.80	10,199.77	7,336.60	1,221.92	8,586.81	57,345.49
30700	Impaired Practitioners	-	-	-	-	-	-	-	-	-	-
30800	Attorney General	-	-	2,049.34	2,049.34	-	-	2,049.34	-	-	6,148.01
30900	Board of Health Professions	3,271.76	3,051.65	2,685.17	3,093.40	3,009.81	2,010.86	3,064.86	3,214.51	2,806.76	26,208.77
31000	SRTA	-	-	-	-	-	-	-	-	-	-
31100	Maintenance and Repairs	-	-	-	-	-	-	-	16.19	-	16.19
31300	Emp. Recognition Program	4.38	-	-	19.26	5.42	50.62	-	-	1.89	81.58
31400	Conference Center	13.23	44.46	21.83	13.36	32.07	8.77	160.15	27.85	17.31	339.02
31500	Pgm Devlpmnt & Implmentn	3,766.40	2,284.84	2,731.04	2,114.85	2,837.65	2,043.42	1,747.15	1,794.87	1,780.57	21,100.79
98700	Cash Transfers	-	-	-	-	-	-	-	-	-	-
	Total Allocated Expenditures	119,359.68	74,177.24	82,992.05	95,552.93	73,101.67	87,848.67	95,424.27	99,433.06	95,111.68	823,001.24
	Net Revenue in Excess (Shortfall) of Expenditures	$ (50,716.45)	$ (12,008.99)	$ (14,560.97)	$ (10,046.41)	$ (11,743.78)	$ 36,871.34	$ (56,508.74)	$ (82,180.52)	$ (85,125.61)	$ (286,020.12)

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 10900 - Counseling

For the Period Beginning July 1, 2018 and Ending March 31, 2019

Account Number	Account Description	Amount	Budget	Amount Under/(Over) Budget	% of Budget
4002400	Fee Revenue				
4002401	Application Fee	790,840.00	294,600.00	(496,240.00)	268.45%
4002406	License & Renewal Fee	75,410.00	1,182,950.00	1,107,540.00	6.37%
4002407	Dup. License Certificate Fee	1,645.00	825.00	(820.00)	199.39%
4002409	Board Endorsement - Out	3,805.00	1,740.00	(2,065.00)	218.68%
4002421	Monetary Penalty & Late Fees	10,265.00	13,960.00	3,695.00	73.53%
4002430	Board Changes Fee	22,915.00	-	(22,915.00)	0.00%
4002432	Misc. Fee (Bad Check Fee)	245.00	140.00	(105.00)	175.00%
	Total Fee Revenue	905,125.00	1,494,215.00	589,090.00	60.58%
4003000	Sales of Prop. & Commodities				
4003020	Misc. Sales-Dishonored Payments	1,035.00	-	(1,035.00)	0.00%
	Total Sales of Prop. & Commodities	1,035.00	-	(1,035.00)	0.00%
	Total Revenue	906,160.00	1,494,215.00	588,055.00	60.64%
5011110	Employer Retirement Contrib.	10,118.80	17,345.00	7,226.20	58.34%
5011120	Fed Old-Age Ins- Sal St Emp	9,037.95	9,814.00	776.05	92.09%
5011140	Group Insurance	1,222.34	1,681.00	458.66	72.72%
5011150	Medical/Hospitalization Ins.	7,193.50	8,244.00	1,050.50	87.26%
5011160	Retiree Medical/Hospitalizatn	1,092.27	1,501.00	408.73	72.77%
5011170	Long term Disability Ins	580.67	796.00	215.33	72.95%
	Total Employee Benefits	29,245.53	39,381.00	10,135.47	74.26%
5011200	Salaries				
5011230	Salaries, Classified	93,592.90	128,286.00	34,693.10	72.96%
5011250	Salaries, Overtime	26,065.28	-	(26,065.28)	0.00%
	Total Salaries	119,658.18	128,286.00	8,627.82	93.27%
5011300	Special Payments				
5011340	Specified Per Diem Payment	1,950.00	3,000.00	1,050.00	65.00%
5011380	Deferred Compnstn Match Pmts	380.00	1,440.00	1,060.00	26.39%
	Total Special Payments	2,330.00	4,440.00	2,110.00	52.48%
5011600	Terminatn Personal Svce Costs				
5011660	Defined Contribution Match - Hy	2,495.02	-	(2,495.02)	0.00%
	Total Terminatn Personal Svce Costs	2,495.02	-	(2,495.02)	0.00%
5011930	Turnover/Vacancy Benefits		-	-	0.00%
	Total Personal Services	153,728.73	172,107.00	18,378.27	89.32%
5012000	Contractual Svs				
5012100	Communication Services				
5012110	Express Services	-	295.00	295.00	0.00%
5012130	Messenger Services	8.67	-	(8.67)	0.00%
5012140	Postal Services	13,367.96	8,232.00	(5,135.96)	162.39%
5012150	Printing Services	103.68	120.00	16.32	86.40%
5012160	Telecommunications Svcs (VITA)	643.42	900.00	256.58	71.49%
5012190	Inbound Freight Services	4.75	-	(4.75)	0.00%

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 10900 - Counseling

For the Period Beginning July 1, 2018 and Ending March 31, 2019

Account Number	Account Description	Amount	Budget	Amount Under/(Over) Budget	% of Budget
	Total Communication Services	14,128.48	9,547.00	(4,581.48)	147.99%
5012200	**Employee Development Services**				
5012210	**Organization Memberships**	1,400.00	500.00	(900.00)	280.00%
5012260	**Personnel Develpmnt Services**	1,650.00	-	(1,650.00)	0.00%
	Total Employee Development Services	3,050.00	500.00	(2,550.00)	610.00%
5012300	**Health Services**				
5012360	**X-ray and Laboratory Services**	-	140.00	140.00	0.00%
	Total Health Services	-	140.00	140.00	0.00%
5012400	**Mgmnt and Informational Svcs**	-			
5012420	**Fiscal Services**	17,728.95	9,280.00	(8,448.95)	191.04%
5012440	**Management Services**	120.44	134.00	13.56	89.88%
5012460	**Public Infrmtnl & Relatn Svcs**	106.00	5.00	(101.00)	2120.00%
5012470	**Legal Services**	195.00	475.00	280.00	41.05%
	Total Mgmnt and Informational Svcs	18,150.39	9,894.00	(8,256.39)	183.45%
5012500	**Repair and Maintenance Svcs**				
5012530	**Equipment Repair & Maint Srvc**	818.75	-	(818.75)	0.00%
5012560	**Mechanical Repair & Maint Srvc**	-	34.00	34.00	0.00%
	Total Repair and Maintenance Svcs	818.75	34.00	(784.75)	2408.09%
5012600	**Support Services**				
5012630	**Clerical Services**	144,585.00	110,551.00	(34,034.00)	130.79%
5012640	**Food & Dietary Services**	2,785.57	1,075.00	(1,710.57)	259.12%
5012660	**Manual Labor Services**	227.22	1,170.00	942.78	19.42%
5012670	**Production Services**	1,657.86	5,380.00	3,722.14	30.82%
5012680	**Skilled Services**	8,536.34	16,764.00	8,227.66	50.92%
	Total Support Services	157,791.99	134,940.00	(22,851.99)	116.93%
5012800	**Transportation Services**				
5012820	**Travel, Personal Vehicle**	4,957.70	4,979.00	21.30	99.57%
5012830	**Travel, Public Carriers**	838.85	-	(838.85)	0.00%
5012850	**Travel, Subsistence & Lodging**	3,371.21	1,950.00	(1,421.21)	172.88%
5012880	**Trvl, Meal Reimb- Not Rprtble**	1,338.75	988.00	(350.75)	135.50%
	Total Transportation Services	10,506.51	7,917.00	(2,589.51)	132.71%
	Total Contractual Svs	204,446.12	162,972.00	(41,474.12)	125.45%
5013000	**Supplies And Materials**				
5013100	**Administrative Supplies**				
5013120	**Office Supplies**	1,376.98	597.00	(779.98)	230.65%
	Total Administrative Supplies	1,376.98	597.00	(779.98)	230.65%
5013200	**Energy Supplies**				
5013230	**Gasoline**	52.77	-	(52.77)	0.00%
	Total Energy Supplies	52.77	-	(52.77)	0.00%
5013500	**Repair and Maint. Supplies**				
5013520	**Custodial Repair & Maint Matrl**	3.42	-	(3.42)	0.00%
5013530	**Electrcal Repair & Maint Matrl**	0.98	-	(0.98)	0.00%

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 10900 - Counseling

For the Period Beginning July 1, 2018 and Ending March 31, 2019

Account Number	Account Description	Amount	Budget	Amount Under/(Over) Budget	% of Budget
	Total Repair and Maint. Supplies	4.40	-	(4.40)	0.00%
5013600	**Residential Supplies**				
5013630	**Food Service Supplies**	-	183.00	183.00	0.00%
5013640	**Laundry and Linen Supplies**	3.87	-	(3.87)	0.00%
	Total Residential Supplies	3.87	183.00	179.13	2.11%
	Total Supplies And Materials	1,438.02	780.00	(658.02)	184.36%
5015000	**Continuous Charges**				
5015100	**Insurance-Fixed Assets**				
5015160	**Property Insurance**	54.87	46.00	(8.87)	119.28%
	Total Insurance-Fixed Assets	54.87	46.00	(8.87)	119.28%
5015300	**Operating Lease Payments**				
5015340	**Equipment Rentals**	394.53	540.00	145.47	73.06%
5015350	**Building Rentals**	68.40	-	(68.40)	0.00%
5015360	**Land Rentals**	-	60.00	60.00	0.00%
5015390	**Building Rentals - Non State**	8,408.65	11,168.00	2,759.35	75.29%
	Total Operating Lease Payments	8,871.58	11,768.00	2,896.42	75.39%
5015500	**Insurance-Operations**				
5015510	**General Liability Insurance**	196.94	170.00	(26.94)	115.85%
5015540	**Surety Bonds**	11.62	11.00	(0.62)	105.64%
	Total Insurance-Operations	208.56	181.00	(27.56)	115.23%
	Total Continuous Charges	9,135.01	11,995.00	2,859.99	76.16%
5022000	**Equipment**				
5022100	**Computer Hrdware & Sftware**				
5022170	**Other Computer Equipment**	431.00	-	(431.00)	0.00%
	Total Computer Hrdware & Sftware	431.00	-	(431.00)	0.00%
5022200	**Educational & Cultural Equip**				
5022240	**Reference Equipment**	-	77.00	77.00	0.00%
	Total Educational & Cultural Equip	-	77.00	77.00	0.00%
5022600	**Office Equipment**				
5022610	**Office Appurtenances**	-	42.00	42.00	0.00%
	Total Office Equipment	-	42.00	42.00	0.00%
	Total Equipment	431.00	119.00	(312.00)	362.18%
	Total Expenditures	369,178.88	347,973.00	(21,205.88)	106.09%
	Allocated Expenditures				
20100	**Behavioral Science Exec**	154,051.92	218,750.00	64,698.08	70.42%
30100	**Data Center**	239,689.36	274,443.04	34,753.68	87.34%
30200	**Human Resources**	11,106.02	18,210.02	7,104.00	60.99%
30300	**Finance**	80,019.16	98,437.29	18,418.13	81.29%
30400	**Director's Office**	36,415.53	39,100.21	2,684.69	93.13%
30500	**Enforcement**	190,479.41	183,618.63	(6,860.77)	103.74%

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 10900 - Counseling

For the Period Beginning July 1, 2018 and Ending March 31, 2019

Account Number	Account Description	Amount	Budget	Amount Under/(Over) Budget	% of Budget
30600	Administrative Proceedings	57,345.49	53,276.14	(4,069.35)	107.64%
30700	Impaired Practitioners	-	336.22	336.22	0.00%
30800	Attorney General	6,148.01	9,991.56	3,843.55	61.53%
30900	Board of Health Professions	26,208.77	31,508.45	5,299.69	83.18%
31100	Maintenance and Repairs	16.19	4,390.85	4,374.66	0.37%
31300	Emp. Recognition Program	81.58	404.02	322.44	20.19%
31400	Conference Center	339.02	384.16	45.14	88.25%
31500	Pgm Devlpmnt & Implmentn	21,100.79	22,875.36	1,774.56	92.24%
	Total Allocated Expenditures	823,001.24	955,725.95	132,724.71	86.11%
	Net Revenue in Excess (Shortfall) of Expenditures	$ (286,020.12)	$ 190,516.05	$ 476,536.17	150.13%

Board of Counseling

May 31, 2019


Counseling Applications Received
25000
20000
15000
10000
5000
0
1590
1426
1445
1739
2089
2418
2534
2967
20639
3090
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
Counseling Applications

Virginia Department of Health Professions

Applications Received

Counseling	2019 (As of 4/30/19)	2018	2017	2016	2015	2014	2013	2012	2011	2010
CSAC	82	166	213	115	110	113	92	86	105	112
LMFT	23	62	61	61	43	45	35	32	25	31
LPC	281	703	612	524	503	458	397	270	328	322
MF Res										
Initial	16									
Add/change	19									
Subtotal	**35**	**86**	**91**	**91**	**83**	**79**	**82**	**50**	**66**	**48**
ROS										
Initial	280									
Add/change	335									
Subtotal	**615**	**1652**	**1624**	**1503**	**1487**	**1219**	**976**	**860**	**811**	**990**
CRP	1	2	5	7	3	5	6	20	12	31
CSAC-A	22	47	83	40	33	49	29	44	28	28
SA Trainee										
Initial	60									
Add/change	16									
Subtotal	**76**	**202**	**243**	**186**	**147**	**115**	**113**	**76**	**38**	**23**
LSATP	22	61	33	7	9	6	9	7	13	5
SAT Res	1	2	2	0	0	0	0	0	0	0
QMHP-A	520	8402	0	0	0	0	0	0	0	0
QMHP-C	547	7606	0	0	0	0	0	0	0	0
QMHP-Trainee	811	1398	0	0	0	0	0	0	0	0
Peer	54	250	0	0	0	0	0	0	0	0
	3090	20639	2967	2534	2418	2089	1739	1445	1426	1590

Virginia Department of Health Professions

2019 Applications Received

	January	February	March	April	
	Applications Received	**Applications Received**	**Applications Received**	**Applications Received**	**Total Applications Received**
CSAC	25	13	21	23	82
LMFT	3	9	5	6	23
LPC	64	64	78	75	281
MF Resident					0
Initial	6	5	4	1	16
Add/Change	5	4	8	2	19
Subtotal	**11**	**9**	**12**	**3**	35
ROS					0
Initial	69	76	70	65	280
Add/Change	92	75	71	97	335
Subtotal	**161**	**151**	**141**	**162**	615
QMHP-A	157	106	130	127	520
QMHP-C	184	137	108	118	547
Peer	22	5	8	19	54
CRP	0	0	0	1	1
CSAC-A	6	4	6	6	22
SA Trainee					0
Initial	15	14	14	17	60
Add/Change	1	4	4	7	16
Subtotal	**16**	**18**	**18**	**24**	**76**
LSATP	8	5	4	5	22
SAT Res	0	0	0	1	1
QMHP-Trainee	243	204	191	173	811
Total	**900**	**725**	**722**	**743**	**3090**

2019 License Issued

	January	February	March	April	
	Issued	Issued	Issued	Issued	Total Issued
CSAC					
Endorsement	2	2	5	2	11
Examination	7	6	7	11	31
Reinstatement	1	3	2	1	7
Subtotal	**10**	**11**	**14**	**14**	**49**
LMFT					
Endorsement	0	1	2	4	7
Examination	0	0	6	2	8
Reinstatement	1	0	0	0	1
Subtotal	**1**	**1**	**8**	**6**	**16**
LPC					
Endorsement	5	10	36	19	70
Examination	45	7	52	38	142
Reinstatement	2	1	1	2	6
Subtotal	**52**	**18**	**89**	**59**	**218**
MF Resident					0
Initial	7	5	8	3	23
Add/Change	5	10	6	1	22
Subtotal	**12**	**15**	**14**	**4**	**45**
ROS					0
Initial	68	63	61	61	253
Add/Change	127	134	104	118	483
Subtotal	**195**	**197**	**165**	**179**	**736**
QMHP-A					0
Application	88	84	87	72	331
Grandfather	1046	81	22	9	1158
Subtotal	**1134**	**165**	**109**	**81**	**1489**
QMHP-C					0
Application	139	107	104	83	433
Grandfather	904	86	15	8	1013
Subtotal	**1043**	**193**	**119**	**91**	1446
Peer	15	10	9	15	49
CRP	0	0	0	1	1
CSAC-A	2	7	1	2	12
SA Trainee					0
Initial	19	16	15	14	64
Add/Change	1	2	4	6	13
Subtotal	**20**	**18**	**19**	**20**	**77**
LSATP					0

2019 License Issued

	January	February	March	April	
	Issued	Issued	Issued	Issued	Total Issued
Endorsement	4	8	5	5	22
Examination	0	0	0	0	0
Reinstatement	0	0	0	0	0
Subtotal	**4**	**8**	**5**	**5**	**22**
SAT Res	0	0	0	0	0
QMHP-Trainee					0
Adult				19	19
Adult/Child				136	136
Subtotal	**329**	**279**	**216**	**155**	**979**
Total	**2817**	**922**	**768**	**632**	**5139**

CY2018 Case Categories by Counseling Profession

	CSAC	LMFT	LPC	MF Res	ROS	QMHP-A	QMHP-C	Peer	CSAC-A	SA Trainee	LSATP	QMHP-Trainee	Total
Inability to Safely Practice	4	1	7	0	3	3	2	1	0	2	0	0	**23**
Abuse/Abandonment/Neglect	2	2	6	0	3	0	3	0	0	0	0	0	**16**
Std Care, Diagnosis/Treatment	4	5	42	0	9	0	2	0	0	1	2	0	**65**
Std Care, Exceeding Scope	1	0	0	1	4	1	0	0	1	0	0	0	**8**
Inappropriate Relationship	5	2	17	0	8	8	2	1	0	2	0	0	**45**
Business Practice Issues	3	5	35	2	8	1	0	0	1	0	0	0	**55**
Confidentiality Breach	2	0	11	0	2	3	2	0	0	1	0	0	**21**
Records Release	1	2	5	1	1	0	0	0	0	1	0	0	**11**
Reinstatement	1	2	1	0	0	0	0	0	1	0	0	0	**5**
Elibilility	1	0	5	3	9	7	5	0	0	0	2	1	**33**
HIPDB	2	2	2	0	1	0	0	0	0	0	0	0	**7**
Fraud, Non-PC	0	2	5	0	1	4	8	0	0	0	0	0	**20**
Unlicensed Activity	0	0	1	0	4	0	0	0	0	0	0	0	**5**
Fraud, PC	0	0	3	0	5	4	6	0	0	0	0	0	**18**
Criminal Activity	0	0	3	2	2	0	0	0	0	0	0	0	**7**
Drug Related, PC	0	0	0	0	0	1	0	0	0	0	0	0	**1**
Total Cases Received	26	23	143	9	60	32	30	2	3	7	4	1	**340**

January through April 2019
Case Categories by Counseling Profession

	CSAC	LMFT	LPC	MF Res	ROS	QMHP-A	QMHP-C	Peer	CSAC-A	SA Trainee	LSATP	QMHP-Trainee	Total
Inability to Safely Practice	0	0	0	0	1	3	3	0	0	0	0	0	**7**
Abuse/Abandonment/Neglect	0	1	3	0	1	5	0	0	0	0	0	0	**10**
Std Care, Diagnosis/Treatment	3	4	22	0	1	5	1	0	0	0	1	0	**37**
Std Care, Exceeding Scope	0	0	0	0	0	1	0	0	0	0	0	0	**1**
Inappropriate Relationship	0	0	5	0	3	4	2	0	0	0	0	0	**14**
Business Practice Issues	1	3	12	1	1	4	3	0	0	0	0	0	**25**
Confidentiality Breach	1	1	2	0	0	1	0	0	0	0	0	0	**5**
Records Release	0	2	4	0	0	0	0	0	0	0	0	0	**6**
Reinstatement	0	0	1	0	0	0	0	0	0	0	0	0	**1**
Elibilility	0	0	1	0	6	3	4	1	1	0	0	1	**17**
HIPDB	0	1	2	0	2	2	2	0	0	1	0	0	**10**
Fraud, Non-PC	0	1	3	1	0	4	5	0	0	0	0	0	**14**
Unlicensed Activity	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Fraud, PC	1	0	0	1	0	3	4	0	0	0	0	0	**9**
Criminal Activity	0	0	0	0	0	1	0	0	0	0	0	0	**1**
Drug Related, PC	0	0	0	0	0	0	0	0	0	0	0	0	**0**
CE	0	1	3	0	0	0	0	0	0	0	0	0	**4**
No jurisdiction	0	1	1	0	0	0	0	0	0	0	0	0	**2**
Compliance	0	0	2	0	0	0	0	0	0	0	0	0	**2**
Dishonored Check	0	0	1	0	2	2	2	0	0	1	0	0	**8**
Total Cases Received	6	15	62	3	17	38	26	1	1	2	1	1	**173**

COMMONWEALTH of VIRGINIA

David E. Brown, D.C.
Director

Department of Health Professions
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463

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TEL (804) 367- 4400
FAX (804) 527- 4475

MEMORANDUM

TO: Members, Board of Counseling

FROM: David E. Brown, D.C.

DATE: May 13, 2019

SUBJECT: Revenue, Expenditures, & Cash Balance Analysis

Virginia law requires that an analysis of revenues and expenditures of each regulatory board be conducted at least biennially. If revenues and expenditures for a given board are more than 10% apart, the Board is required by law to adjust fees so that the fees are sufficient, but not excessive, to cover expenses. The action by the Board can be a fee increase, a fee decrease, or it can maintain the current fees.

The Board of Counseling ended the 2016 - 2018 biennium (July 1, 2016, through June 30, 2018) with a cash balance of $1,094,175. Current projections indicate that revenue for the 2018 - 2020 biennium (July 1, 2018, through June 30, 2020) will exceed expenditures by approximately $965,298. When combined with the Board's $1,094,175 cash balance as of June 30, 2018, the Board of Counseling projected cash balance on June 30, 2018, is $2,059,473.

To reduce the Board's projected cash surplus we recommend a one-time renewal fee decrease. Please note that these projections are based on internal agency assumptions and are, subject to change based on actions by the Governor, the General Assembly and other state agencies.

We are grateful for continued support and cooperation as we work together to manage the fiscal affairs of the Board and the Department.

Please do not hesitate to call me if you have questions.

CC: Jaime Hoyle, Executive Director
Lisa R. Hahn, Chief Operating Officer
Charles E. Giles, Budget Manager
Elaine Yeatts, Senior Policy Analyst

Discipline Report

Virginia Department of Health Professions
Board of Counseling

Discipline Reports

01/11/2019 - 05/16/2019

NEW CASES RECEIVED IN BOARD 01/11/2019 - 05/16/2019				
	Counseling	Psychology	Social Work	BSU Total
Cases Received for Board review	136	49	55	***240***

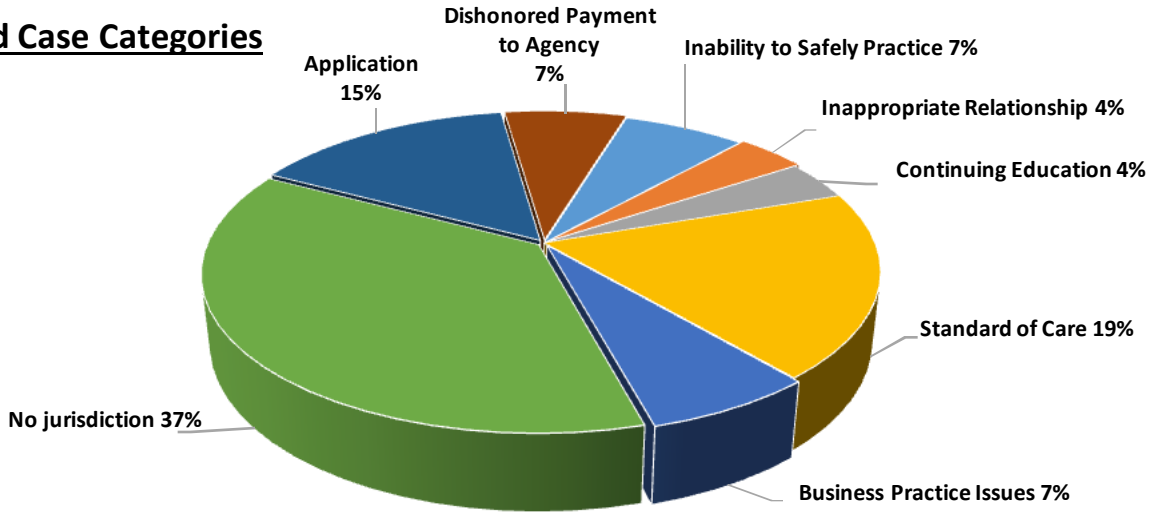
OPEN CASES (as of 05/16/2019)				
Open Case Stage	Counseling	Psychology	Social Work	BSU Total
Probable Cause Review	97	19	57	*173*
Scheduled for Informal Conferences	13	2	2	*17*
Scheduled for Formal Hearings	1	1	1	*3*
Consent Orders (offered and pending)	0	0	1	*1*
Cases with APD for processing (IFC, FH, Consent Order)	19	9	1	*29*
TOTAL CASES AT BOARD LEVEL	130	31	62	***223***
OPEN INVESTIGATIONS	74	40	32	***146***
TOTAL OPEN CASES	204	71	94	***369***

UPCOMING CONFERENCES AND HEARINGS			
	Counseling	Psychology	Social Work
Informal Conferences	07/19/2019 09/13/2019 10/11/2019	08/13/2019 12/03/2019	08/09/2019 10/25/2019 11/15/2019
Formal Hearings	Following scheduled board meetings, as necessary		

Virginia Department of
Health Professions
Board of Counseling

CASES CLOSED (01/11/2019 - 05/16/2019)	
Closed – no violation	64
Closed – undetermined	11
Closed – violation	12
Credentials/Reinstatement – Denied	7
Credentials/Reinstatement – Approved	6
TOTAL CASES CLOSED	100

Closed Case Categories



AVERAGE CASE PROCESSING TIMES (counted on closed cases)	
Average time for case closures	165
Avg. time in Enforcement (investigations)	76
Avg. time in APD (IFC/FH preparation)	58
Avg. time in Board (includes hearings, reviews, etc).	97
Avg. time with board member (probable cause review)	47

Licensing Manager’s Report

Virginia Department of

Health Professions

New License Count
Quarterly Summary

Quarter 3 - Fiscal Year 2019

Licenses issued by board and occupation during the quarter

Quarter Date Ranges	
Quarter 1	July 01 - September 30
Quarter 2	October 1 - December 31
Quarter 3	January 1 - March 31
Quarter 4	April 1 - June 30

											CURRENT
	Q1 2017	Q2 2017	Q 3 2017	Q4 2017	Q 1 2018	Q 2 2018	Q 3 2018	Q 4 2018	Q 1 2019	Q 2 2019	Q 3 2019
Audiology/Speech	150	156	69	62	159	165	61	86	181	177	92
Counseling	175	254	427	443	384	734	434	2256	3798	3447	4504
Dentistry	364	237	138	145	401	268	103	130	335	400	113
Funeral Directing	37	40	33	37	41	52	25	42	43	51	40
Long Term Care Administrators	85	79	69	66	99	80	78	78	91	107	81
Medicine	2406	1719	897	1237	2335	1656	939	1391	2495	1630	1217
Nurse Aide	2016	1625	1273	1111	1576	1520	1689	1656	2560	2060	1517
Nursing	2842	4344	2586	3293	3350	4369	2353	3152	3146	4532	3194
Optometry	34	26	15	16	51	25	17	20	53	23	31
Pharmacy	1135	1357	742	1207	1060	1367	841	1045	923	1316	196
Physical Therapy	444	431	182	176	406	459	164	196	392	457	934
Psychology	95	107	112	99	88	245	105	118	109	100	171
Social Work	207	277	353	352	343	388	335	360	360	399	430
Veterinary Medicine	246	106	62	79	244	95	76	92	328	222	106

Virginia Department of

Health Professions

New License Count
Quarterly Summary

Quarter 3 - Fiscal Year 2019

Licenses issued by board and occupation during the quarter

Quarter Date Ranges	
Quarter 1	July 01 - September 30
Quarter 2	October 1 - December 31
Quarter 3	January 1 - March 31
Quarter 4	April 1 - June 30

Board	Occupation	Q32016	Q42016	Q12017	Q22017	Q32017	Q42017	Q12018	Q22018	Q32018	Q42018	Q12019	Q2 2019	Q32019
Audiology	Audiologist	0	10	11	7	6	7	10	21	4	8	10	10	9
	Continuing Education Provider	0	0	1	0	0	0	0	0	0	0	0	0	0
	Provisional Speech-Language Pathologist	0	0	0	0	0	0	0	1	2	18	120	59	20
	School Speech Pathologist	6	7	8	23	5	4	3	12	4	2	2	12	2
	Speech Pathologist	36	54	130	126	58	51	146	131	51	58	49	9	61
	Total	42	71	150	156	69	62	159	165	61	86	181	177	92
Counseling	Certified Substance Abuse Counselor	43	0	30	7	33	24	32	57	48	31	39	28	35
	Licensed Marriage and Family Therapist	16	10	10	11	17	15	10	15	10	11	10	17	10
	Licensed Professional Counselor	131	103	124	113	128	142	112	119	137	152	173	185	159
	Marriage and Family Therapist Resident	-	-	-	3	5	10	10	22	10	23	18	23	41
	Post Graduate Trainee(ROS)													556
	Qualified Mental Health Prof-Adult	-	-	-	-	-	-	-	-	-	676	1544	1306	1408
	Qualified Mental Health Prof-Child	-	-	-	-	-	-	-	-	-	671	1227	1117	1355
	Registered Peer Recovery Specialist	-	-	-	-	-	-	-	-	-	57	29	53	34
	Registration of Supervision	-	-	-	91	182	189	131	440	154	503	510	444	0
	Rehabilitation Provider	1	1	1	2	1	0	0	2	0	2	2	1	10
	Substance Abuse Counseling Assistant	4	8	10	12	10	11	28	14	12	10	18	18	0
	Substance Abuse Trainee	-	-	-	-	-	-	61	63	48	52	73	40	57
	Substance Abuse Treatment Practitioner	5	1	0	12	0	48	0	1	14	23	14	9	17
	Substance Abuse Treatment Resident	-	-	-	3	51	4	0	1	1	45	1	0	0
	Trainee for Qualified Mental Health Prof	140	206											822
	Total	200	123	175	254	427	443	384	734	434	2256	3798	3447	4504

Virginia Department of
Health Professions

Current Count of Licenses
Quarterly Summary

Quarter 3 - Fiscal Year 2019

*Current licenses by board and occupation as of the last day of the quarter

** New Occupation

*** Veterinary Establishments are now grouped together, as the board works on designating existing establishments as "Ambulatory" or "Stationary", instead of "Full Service" or "Restricted Service".

Quarter Date Ranges	
Quarter 1	July 01 - September 30
Quarter 2	October 1 - December 31
Quarter 3	January 1 - March 31
Quarter 4	April 1 - June 30

											CURRENT
	Q12017	**Q22017**	**Q32017**	**Q42017**	**Q12018**	**Q22018**	**Q32018**	**Q42018**	**Q12019**	**Q2 2019**	**Q32019**
Audiology	4951	5056	4855	4971	5142	4770	4991	5085	5272	5384	5106
Counseling	13237	13603	13922	15791	16175	16948	17654	22731	25584	31448	35732
Dentistry	14382	14522	14657	14338	14601	14665	14835	14544	14885	15018	15144
Funeral Directing	2526	2561	2609	2513	2554	2579	2620	2532	2564	2603	3198
Long Term Care Administrators	2141	2188	2235	2065	2138	2198	2258	2114	2192	2384	2303
Medicine	66941	66733	67320	69206	69092	69230	69628	70959	69687	70070.06	70573
Nurse Aide	54044	53681	53434	53066	52653	52160	52888	53276	52466	53241	53241
Nursing	166107	166039	166796	167953	170125	169465	171385	171964	1722989	116767	174537
Optometry	1936	1955	1867	1921	1949	1805	1859	1913	1933	1954	1895
Pharmacy	37125	37844	35289	36441	37608	34789	35995	36967	38002	36034	36034
Physical Therapy	12682	11751	11652	1278	12556	12735	12939	13341	13797	38001	12611
Psychology	4994	5128	5227	5335	5368	5470	5582	5690	5497	5583	5852
Social Work	8900	9144	9340	9559	9089	9326	9468	9671	9350	9810	10113
Veterinary Medicine	7489	7565	7320	7587	7703	7105	7448	7767	7994	8097	7789
AGENCY TOTAL	397455	397810	396523	402824	406753	403245	409550	418554	422212	432338	434128

Virginia Department of
Health Professions

Current Count of Licenses
Quarterly Summary

Quarter 3 - Fiscal Year 2019

*Current licenses by board and occupation as of the last day of the quarter
** New Occupation
*** Veterinary Establishments are now grouped together, as the board works on designating existing establishments as "Ambulatory" or "Stationary", instead of "Full Service" or "Restricted Service".

Quarter Date Ranges	
Quarter 1	July 01 - September 30
Quarter 2	October 1 - December 31
Quarter 3	January 1 - March 31
Quarter 4	April 1 - June 30

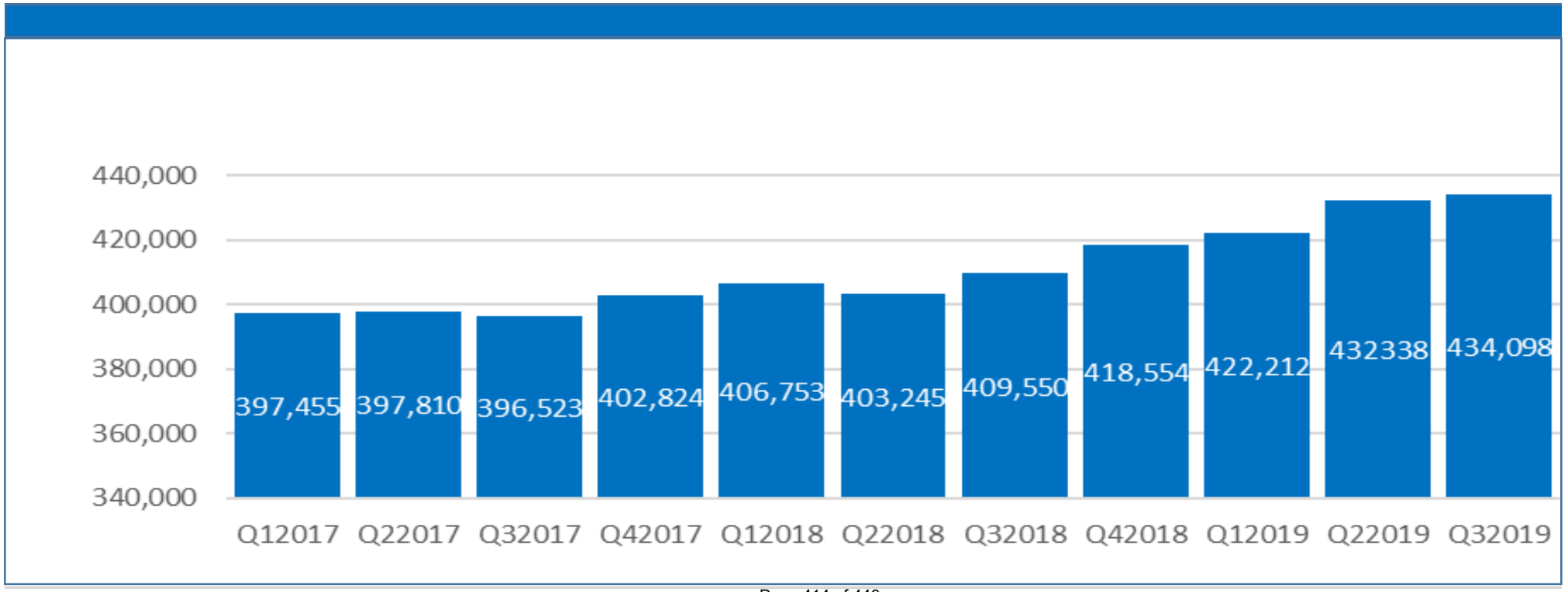
Board	Occupation	Q42016	Q12017	Q22017	Q32017	Q42017	Q12018	Q22018	Q32018	Q42018	Q12019	Q2 2019	CURRENT Q32019
Audiology and Speech Pathology	Audiologist	507	517	523	494	503	524	475	504	512	525	529	508
	Continuing Education Provider	15	15	15	15	15	15	15	15	15	12	15	15
	School Speech Pathologist	484	507	514	475	479	493	423	432	436	450	454	406
	Speech Pathologist	3796	3912	4004	3871	3974	4110	3857	4040	4122	4285	4386	4177
	Total	4802	4951	5056	4855	4971	5142	4770	4991	5085	5272	5384	5106
Counseling	Certified Substance Abuse Counselor	1734	1662	1712	1745	1784	1776	1837	1870	1911	1836	1867	1915
	Licensed Marriage and Family Therapist	870	836	856	872	885	854	864	876	889	874	895	906
	Licensed Professional Counselor	4567	4512	4653	4803	4932	4915	5062	5218	5394	5417	5590	5754
	Marriage & Family Therapist Resident	-	131	131	140	148	166	205	225	239	252	282	313
	Post Graduate Trainee (ROS)	-	-	-	-	-	-	-	-	-	-	-	8454
	Qualified Mental Health Prof-Adult**	-	-	-	-	-	-	-	-	2220	3501	5927	7331
	Qualified Mental Health Prof-Child**	-	-	-	-	-	-	-	-	1897	3012	5278	6628
	Registered Peer Recovery Specialist**	-	-	-	-	-	-	-	-	86	139	179	212
	Registration of Supervision	37125	5491	5632	5747	5831	6220	6660	7095	7445	7706	8076	0
	Rehabilitation Provider	266	270	273	250	252	258	260	235	237	239	243	222
	Substance Abuse Counseling Assistant	192	164	174	188	218	203	217	232	252	231	238	251
	Substance Abuse Trainee	-	-	-	-	1563	1609	1654	1691	1748	1765	1791	1832
	Substance Abuse Treatment Practitioner	179	170	171	176	177	171	185	208	223	216	231	249
	Substance Abuse Treatment Residents	-	1	1	1	1	3	4	4	5	5	5	5
	Trainee for Qualified Mental Health Prof**	-	-	-	-	-	-	-	-	185	391	846	1660
	Total	7808	13237	13603	13922	15791	16175	16948	17654	22731	25584	31448	35732

Virginia Department of
Health Professions

Current Count of Licenses
Fiscal Summary

Quarter 3 - Fiscal Year 2019

Current licenses by board and occupation as of the last day of the quarter



Virginia Department of

Health Professions

Application Satisfaction Survey

Quarterly Summary

Quarter 3 - Fiscal Year 2019

Applicant Satisfaction Surveys are sent to all applicants, and includes seven categories for which applicants rate their satisfaction on a scale from one to four, one and two being degrees of satisfaction, three and four being degrees of dissatisfaction. This report calculates the percentage of total responses falling into the approval range. "N/A" indicates that no response was received for that board during the specified timeframe.

Quarter Date Ranges	
Quarter 1	July 01 - September 30
Quarter 2	October 1 - December 31
Quarter 3	January 1 - March 31
Quarter 4	April 1 - June 30

												CURRENT
Board	Q42016	Q12017	Q22017	Q32017	Q42017	Q12018	Q22018	Q32018	Q42018	Q12019	Q22019	Q32019
Audiology/Speech Pathology	100.0%	100.0%	83.3%	33.3%	97.8%	100.0%	90.0%	28.6%	57.1%	92.9%	100.0%	89.8%
Counseling	77.3%	100.0%	81.7%	88.7%	94.0%	92.0%	85.9%	87.7%	98.3%	92.7%	93.5%	91.6%
Dentistry	100.0%	100.0%	100.0%	100.0%	100.0%	96.8%	97.4%	72.2%	93.2%	81.8%	92.6%	N/A
Funeral Directing	N/A	100.0%	100.0%	88.9%	100.0%	100.0%	N/A	N/A	100.0%	100.0%	100.0%	100.0%
Long Term Care Adminsitrators	100.0%	100.0%	100.0%	N/A	400.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	94.4%
Medicine	84.8%	86.2%	85.2%	86.3%	88.3%	88.4%	88.2%	89.4%	83.4%	90.5%	84.1%	90.5%
Nurse Aide	92.9%	90.5%	100.0%	96.8%	88.9%	100.0%	89.5%	88.2%	98.3%	98.3%	92.6%	97.2%
Nursing	73.3%	71.5%	74.3%	76.6%	86.7%	83.2%	89.1%	91.0%	87.3%	86.4%	90.1%	91.5%
Optometry	N/A	100.0%	100.0%	N/A	100.0%	100.0%	N/A	100.0%	100.0%	100.0%	100.0%	N/A
Pharmacy	99.1%	98.2%	100.0%	97.7%	98.4%	97.2%	93.2%	100.0%	99.5%	93.0%	94.6%	100.0%
Physical Therapy	100.0%	97.5%	100.0%	100.0%	98.9%	97.3%	100.0%	86.8%	100.0%	97.2%	94.3%	N/A
Psychology	100.0%	64.3%	91.7%	94.7%	94.9%	98.1%	91.2%	92.0%	89.6%	87.8%	93.6%	88.9%
Social Work	100.0%	97.2%	100.0%	91.2%	91.7%	91.1%	92.7%	93.1%	81.7%	82.3%	79.4%	95.8%
Veterinary Medicine	100.0%	100.0%	100.0%	100.0%	100.0%	87.3%	100.0%	100.0%	84.6%	84.8%	100.0%	100.0%
Agency	**85%**	**80%**	**86%**	**85%**	**90%**	**89%**	**90%**	91%	**91%**	**89%**	90%	93%

Workforce Expansion – Mobile Crisis Intervention & Stabilization Presentation

Mobile Crisis Intervention & Stabilization

Workforce Expansion

DHP Preliminary Workforce Report

Mobile Crisis Service Expansion

Virginia ranks 40th in terms of access to behavioral health care in the nation[1]. Virginia also ranks 41st in terms of availability of mental health providers, as measured by a ratio of population to providers.

Currently, Virginia's Medicaid-covered behavioral health services reflect a crisis-oriented approach to population needs, with an overreliance on intensive treatment services and underdeveloped opportunities for prevention and treatment in non-traditional mental health settings.

This reactionary approach is exemplified by the current inpatient psychiatric bed crisis. As the statewide Temporary Detention Order (TDO) Task Force, charged with examining the dramatic rise in admissions to state hospitals under TDO's concluded, "The best long-term solution to psychiatric crisis is strengthening the community-based system of mental health"[2]. Mobile crisis response is a solution to this challenge as the aim is to keep people safely in the community while linking and referring to other community-based supports and services.

Mobile Crisis Intervention & Stabilization Overview

A crisis services workgroup has been developed to initiate redesign of the current crisis service system. Crisis services can divert inpatient admissions. Workforce capacity is not sufficient to implement cross disability crisis services throughout the state in all regions, therefore it is essential to look at the role of QMHPs as extenders in the provision of care.

Parts of the implementation include a crisis line, triage and dispatch of mobile Crisis response teams, and subacute/short term crisis residences to maximize the use of less restrictive community based services instead of more restrictive, facility based services.

In order to implement a standardized model of care that can manage all DD, SUD and MH populations the workforce capacity has to be amended to deliver the necessary scope of services to successfully divert case from an ECO and TDO scenario.

The broad vision of the new system, which is based upon national best practice standards, is a cross disability/cross lifespan crisis service system, which consists of 1) 24/7 crisis hotline, 2) associated 24/7 mobile crisis intervention and stabilization response services in the community dispatched by this hotline when indicated, and 3) sub-acute short term crisis residences for ongoing stabilization post crisis event.

Some elements of this model exist in Virginia but there are significant limitations due to different models for populations, geographic challenges, and workforce shortages. Virginia's goal of shifting towards mobile crisis intervention and stabilization services system echoes system transformation that has been done in other states to utilize less restrictive services, community-based service delivery to meet consumer's needs. The intended system changes will shift the focus of crisis response towards preventative, community based crisis services, as opposed to a historical response of addressing crisis situations via out of community placement in restrictive settings. Thusly, the DBHDS and DMAS crisis workgroup is proposing expansion to the role of Qualified Mental Health Practitioners to meet this anticipated need.

1. Ranking the States. Secondary Ranking the States 2018. http://www.mentalhealthamerica.net/issues/ ranking-states.

2. Statewide TDO Task Force: Interim Report for the November 5, 2018 Meeting of the SJ 47 Joint Subcommittee 2018.

Crisis Intervention

Service Definition:
Brief focused assessment provided by mobile crisis team in the community, home, school, or desired secured environment to determine precipitating events leading to crisis and individual's needs by counseling, supporting, coaching, and safety planning w/goal of de-escalating current crisis to prevent further deterioration of functioning and to avert hospitalization.

Suggested service requirements applicable to QMHP:

- An LMHP, LMHP-S, LMHP-R, LMHP-RP, or a Certified Pre-Screener shall conduct a brief focused assessment. A QMHP, QMHP-A, or QMHP-C may conduct assessment under the real time supervision of an abovementioned licensed practitioner.
- An LMHP, LMHP-S, LMHP-R, LMHP-RP, or a Certified Pre-Screener, shall conduct a service specific provider intake. A QMHP, QMHP-A, or QMHP-C may facilitate a SSPI, which must be signed off by LMHP, LMHP-S, LMHP-R, or LMHP-RP within 1 business day.
- Crisis intervention shall be provided only by an LMHP, LMHP-S, LMHP-R, LMHP-RP, a Certified Pre-Screener, QMHP, QMHP-A, or QMHP-C. QMHP registrants may not provide counseling services and must remain within their scope of practice during service delivery.

Crisis Stabilization

Service Definition:
Crisis stabilization services mean the development, monitoring, coordinating and implementing of an individualized crisis plan, to ensure the stabilization of the crisis. Crisis stabilization services shall be available 24 hours a day, seven days a week, and shall be rendered by a mobile response team wherever the need presents, including, but not limited to, the individual's home, other living arrangement or other location in the community. Crisis stabilization services shall not be rendered in an acute care hospital setting or residential treatment facility, although an initial referral to a mobile response agency may be made prior to the individual's discharge from the facility.

The mobile response team based on the individualized crisis plan shall provide necessary mental and behavioral clinical interventions to stabilize the crisis, including, but not limited to: psychiatric services; medication management; psychological; community-based mental health rehabilitation services including, but not limited to, counseling, coaching, mentoring and therapeutic strategies, behavioral services and intensive in-community services, or other formal or informal community-based mental health/behavioral health rehabilitation services; advocacy and networking to provide linkages and referrals to appropriate community-based services; and assisting the individual and his or her family or caregiver in accessing other benefits or assistance programs for which they may be eligible.

The individualized crisis plan shall include a transition plan that links the individual to clinical and behavioral services, formal and informal community supports, and linkages with appropriate system partners after the crisis stabilization services are finished.

Suggested service requirements applicable to QMHP:

- An LMHP, LMHP-S, LMHP-R or LMHP-RP, a Certified Pre-Screener, or a QHMP, QMHP-A, or QMHP-C shall conduct a face-to-face service specific provider intake. If the intake is completed by the pre-screener or QMHP, it must be signed off by an LMHP, LMHP-supervisee, LMHP-resident or LMHP-RP within 1 business day.
- Crisis stabilization shall be provided only by an LMHP, LMHP-S, LMHP-R, LMHP-RP, a Certified Pre-Screener, QMHP, QMHP-A, or QMHP-C.
- Counseling, as appropriate, shall be provided by a LMHP, LMHP-S, LMHP-R or LMHPRP. QMHP registrants may not provide counseling services and must remain within their scope of practice during service delivery.
- The Individual Service Plan (ISP) will be developed by only by an LMHP, LMHP-S, LMHP-R, LMHP-RP, a Certified Pre-Screener, QMHP, QMHP-A, or QMHP-C; ISPs developed by a QMHP level practitioner must be signed off on by a licensed practitioner as noted above within 72 hours.

Mobile Crisis Intervention & Stabilization- State Comparison (Staff Requirements)

State	Staff Requirements
New Jersey	(a) Mobile response and stabilization management services shall be delivered directly by, or under the supervision of, a licensed behavioral clinician, who, at a minimum: 1. Is licensed in a behavioral health field, including, but not limited to: psychiatry, social work, counseling, psychology or psychiatric nursing; 2. Has three and one-half years applicable clinical and supervisory experience; and 3. Has the authority to directly provide, or supervise the provision of, these services within the scope of their practice, as defined by applicable New Jersey State statute and regulation. (b) The direct care staff of the mobile response agency shall, at a minimum: 1. Possess a bachelor's degree in a behavioral health or related human services field, such as social work, counseling or psychology and have a minimum of one year related field work experience; or 2. Possess a master's degree in a behavioral health or related human services field.
Minnesota	The following agencies may request DHS primary certification as a crisis response services provider: • County-operated agency • Community Mental Health Center • Indian Health Services/638 facility • Provider under contract with a county to provide crisis response services A mobile crisis intervention team must consist of: • Two or more mental health professionals or • At least one mental health professional and one mental health practitioner. Enrollable Mental Health Professionals • LP • LPCC • LICSW • LMFT • CNS • NP • Psychiatrist Mental Health Practitioner Mental health practitioners must: • Have completed at least 30 hours of crisis intervention and stabilization training during the past two years; • Be consulted by the clinical supervisor, in person or by phone, during the first three hours the practitioner provides on-site services; • Be under clinical supervision by an MHCP-enrolled mental health professional who is • employed by or under contract with the crisis response provider; and • accepts full responsibility for the services provided. The clinical supervisor must: • Be immediately available to staff by phone or in person; • Document consultations; • Review, approve, and sign the crisis assessment and treatment plan performed by mental health practitioners within one day; and • Document on-site observations in the recipient's record. MHCP strongly encourages MHCP-enrolled crisis response services providers to contract with each health plan in their service area.

State	Staff Requirements
Georgia	The following training components must be provided during orientation for all new staff: • Community-based crisis intervention training and TIP 42 training. • Cross training of BH and IDD blended MCRS staff. • DBHDD array of Adult Mental Health, Child and Adolescent Mental Health, Addictive Diseases, Intellectual & Developmental Disabilities crisis services, and community psychiatric hospitals. • DBHDD Community Behavioral Health and IDD Provider Manual service definitions. • Rapid crisis screening. • Dispatch decision tree. • Web-based data access and interface with DBHDD information system. 2. The blended Mobile Crisis Team includes minimally two staff responding; a. Of those, one (1) is a Licensed Clinical Social Worker/Licensed Professional Counselor/Licensed Marriage and Family Therapist/ Licensed Psychologist (LCSW/ LPC/LMFT/Licensed Psychologist Ph.D./Psy.D.); and b. When the screening indicates that the individual in crisis has IDD, the two-person team must also include a Behavioral Specialist (BS), BCBA, or BCaBA (dispatch of a licensed clinician is always required along with this practitioner). c. Additional staff who may be dispatched when a behavioral health need is identified include: paraprofessional/direct support staff, a registered nurse, an additional social worker (MSW), safety officer, and/or a Certified Peer Specialist (CPS, CPS-AD, CPS-Y, and CPS-P)]. d. In addition, a physician will be available to the MCRS team for consultation, if needed. Other physicians (psychiatric or medical) may consult as necessary. e. Each blended mobile crisis team must include at least one staff member with specialization in ASD; so, when there is a known or suspected indication of ASD, the following team compositions are allowed: i. A BCBA or BCBA-D who serves as the lead in a mobile crisis response for individuals with ASD and any second recognized practitioner type named herein; or ii. Licensed practitioner (as named in a. above) along with a BCBA, BCaBA or RBT. 3. All team members are required to comply with the DBHDD Policy, Professional Licensing and Certification Requirements of Practice Act, including maintaining valid/current license or certification and compliance with all DBHDD training requirements for paraprofessional, licensed or certified staff.

Supporting Data: Consumer Need in the Community & Potential Impact

According to the National Association of State Mental Health Program Directors' report entitled, "Trend in Psychiatric Inpatient Capacity, United States and Each State, 1970 – 2014", Virginia has a disproportionately high number of state hospitals compared to other states (Median = 3, Virginia has 9). There are many reasons Virginia has a disproportionately large number of state hospitals which include a historical lack of community based alternatives, a historical practice of use of more restrictive alternatives for treatment, and a financial reimbursement system which creates disincentives to treating individuals in communities. Virginia ranks #3 of all states in terms of the number of residents in state facilities per 100,000 population. In addition, Virginia ranks #6 of all the states in terms of the number of state hospital admissions and ranks #10 in terms of the per-capita rate of state hospital admissions. All these figures point to the need for the Commonwealth to develop a robust crisis system so that individuals can be safely managed in their home communities (when it is safe to do so) with the natural supports offered in their community. In order to build this robust system, it is essential for the Commonwealth to re-examine the roles/duties of QMHPs as members of mobile crisis teams to provide this community based work.

Private Hospitals

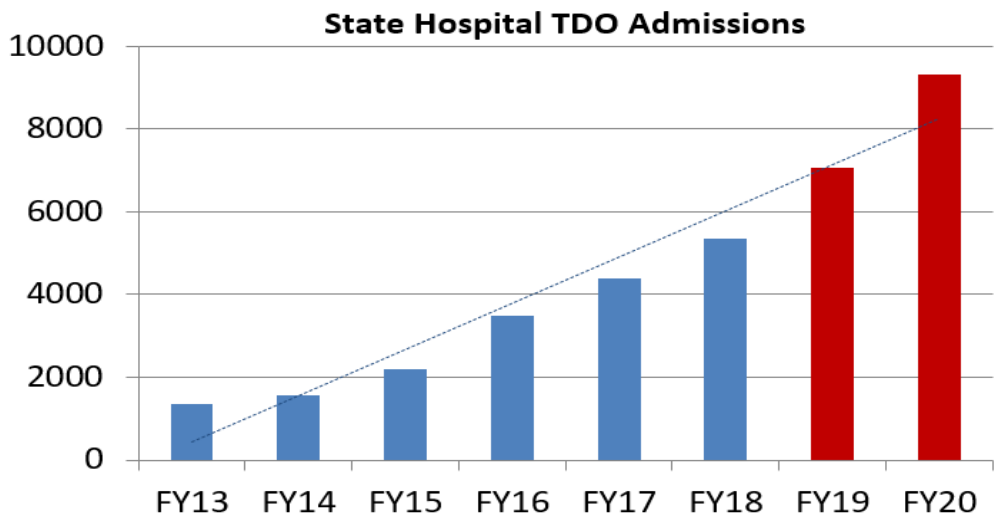
- 50+ hospitals
- approximately 1,850 beds
- 250 child & adolescent beds
- 1,600+ adult beds
- Admits approx. 49,000 persons
- Average length of stay 6.5 days

State Hospitals

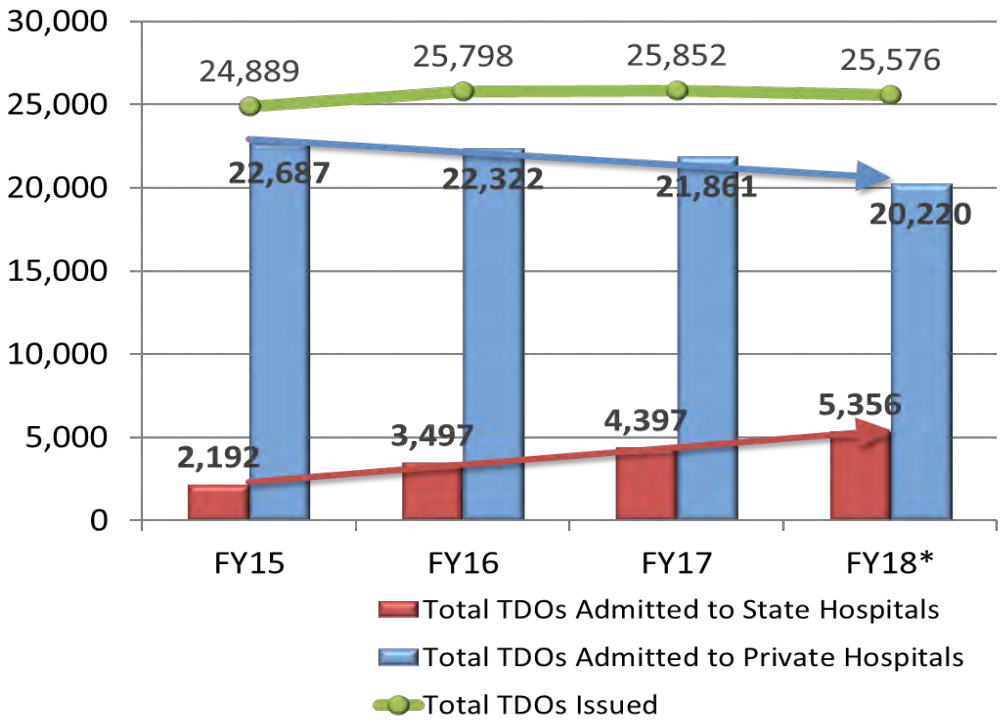
- 9 hospitals operating 1,491 beds
- 48 child and adolescent beds
- 163 geriatric beds
- 111 Maximum Security forensic beds
- Admits approx. 7,700 persons
- 35% of population has criminal justice involvement

The current crisis response system is driven by Community Service Board Emergency Services (ES). Rapid response is provided in the community, which consists of crisis intervention and pre-screening for hospitalization. The statewide data below on ES provides a snapshot of current needs:

- ES is a 1,200 member workforce which manages the most high risk, high profile service encounters for the public system of care
- ES handles over 600,000 calls annually
- ES conducts 95,000 face to face interviews annually
- ES serves over 65,000 individuals annually
- ES recommends the issuance of 25,000 TDOs annually
- Out of 95,000 evaluations ES conducts, less than ¼ of 1% of those encounters result in reportable events



- The "Last resort" legislation was passed on July 1, 2014.
- Since FY 2013, TDO admissions have increased **294%** .
- Since FY 2013, medical care costs have grown by more than **90%**.
- **In FY 2019, the trend continues as in prior years.**



Bylaws

VIRGINIA BOARD OF COUNSELING
BYLAWS

ARTICLE I: AUTHORIZATION

A. Statutory Authority

The Virginia Board of Counseling ("Board") is established and operates pursuant to §§ 54.1-2400 and 54.1-3500, et seq., of the *Code of Virginia*. Regulations promulgated by the Virginia Board of Counseling may be found in 18VAC115-20-10 et seq., Regulations Governing the Practice of Professional Counseling; 18 VAC 115-30-10 et seq., "Regulations Governing the Certification of Substance Abuse Counselors and Substance Abuse Counseling Assistants"; 18VAC115-40-10 et seq., "Regulations Governing the Certification of Rehabilitation Providers"; 18VAC115-50-10 et seq., "Regulations Governing the Practice of Marriage and Family Therapy"; 18VAC115-60-10 et seq., "Regulations Governing the Practice of Substance Abuse Treatment Practitioners", 18VAC115-80-10 et seq., "Emergency Regulations Governing the Practice of Qualified Mental Health Professionals (QMHP), and 18VAC115-70-10 et seq., "Emergency Regulations Governing the Practice of Registered Peer Recovery Specialists".

B. Duties

The Virginia Board of Counseling is charged with promulgating and enforcing regulations governing the licensure and practice of professional counselors, marriage and family therapists, and substance abuse treatment practitioners, and the certification and practice of substance abuse counselors and rehabilitation providers in the Commonwealth of Virginia, and the registration of qualified mental health professionals and registered peer recovery specialists. This includes, but is not limited to: setting fees; creating requirements for and issuing licenses, certificates, or registrations; setting standards of practice; and implementing a system of disciplinary action.

C. Mission

To ensure the delivery of safe and competent patient care by licensing health professionals, enforcing standards of practice, and providing information to healthcare practitioners and the public.

ARTICLE II: THE BOARD

A. Membership

1. The Board shall consist of twelve (12) members, appointed by the Governor as follows:
    a. Ten (10) professionals licensed in Virginia, who shall represent the various specialties recognized in the profession. The licensed professionals shall be
        i. Six (6) licensed professional counselors

        ii. Three (3) licensed marriage and family therapists, and

iii. One (1) licensed substance abuse treatment practitioner

b. Two (2) shall be citizen members.

2. The terms of the members of the Board shall be four (4) years.

3. Members of the Board of Counseling holding a voting office in any related professional association or one that takes a policy position on the regulations of the Board shall abstain from voting on issues where there may be a conflict of interest present.

B. Officers

1. The Chairperson or designee shall preserve order and conduct all proceedings according to parliamentary rules, the Virginia Freedom of Information Act, and the Administrative Process Act. Roberts Rules of Order will guide parliamentary procedure for the meetings. Except where specifically provided otherwise by the law or as otherwise ordered by the Board, the Chairperson shall appoint all committees, and shall sign as Chairperson to the certificates authorized to be signed by the Chairperson.

2. The Vice-Chairperson shall act as Chairperson in the absence of the Chairperson and assume the duties of Chairperson in the event of an unexpired term.

3. In the absences of the Chairperson and Vice-Chairperson, the Chairperson shall appoint another board member to preside at the meeting and/or formal administrative hearing.

C. Duties of Members

1. Each member shall participate in all matters before the Board.

2. Members shall attend all regular and special meetings of the Board unless prevented by illness or similar unavoidable cause. In the event of two (2) consecutive unexcused absences at any meeting of the Board or its committees, the Chairperson shall make a recommendation to the Director of the Department of Health Professions for referral to the Secretary of Health and Human Resources and Secretary of the Commonwealth.

3. The Governor may remove any Board member for cause, and the Governor shall be sole judge of the sufficiency of the cause for removal pursuant to § 2.2-108.

D. Election of Officers

1. All officers shall be elected for a term of two (2) years and may serve no more than two (2) consecutive terms.

2. The election of officers shall occur at the first scheduled Board meeting following July 1 of each odd year, and elected officers shall assume their duties at the end of the meeting.
    a. Officers shall be elected at a meeting of the Board with a quorum present.

    b. The Chairperson shall ask for nominations from the floor by office.

    c. Voting shall be by voice unless otherwise decided by a vote of the members present. The results shall be recorded in the minutes.

    d. A simple majority shall prevail with the current Chairperson casting a vote only to break a tie.

    e. Special elections to fill an unexpired term shall be held in the event of a vacancy of an officer at the subsequent Board meeting following the occurrence of an office being vacated.

    f. The election shall occur in the following order: Chairperson, Vice-Chairperson.

E. Meetings
1. The full Board shall meet quarterly, unless a meeting is not required to conduct Board business.

2. Order of Business at Meetings:
    a. Adoption of Agenda

    b. Period of Public Comment

    c. Approval of Minutes of preceding regular Board meeting and any called meeting since the last regular meeting of the Board.

    d. Reports of Officers and staff

    e. Reports of Committees

    f. Election of Officers (as needed)

    g. Unfinished Business

    h. New Business

3. The order of business may be changed at any meeting by a majority vote.

ARTICLE III: COMMITTEES

A. Duties and Frequency of Meetings.

1. Members appointed to a committee shall faithfully perform the duties assigned to the committee.

2. All standing committees shall meet as necessary to conduct the business of the Board.

B. Standing Committees

Standing committees of the Board shall consist of the following:

Regulatory/Legislative Committee
Special Conference Committee
Credentials Committee
Any other Standing Committees created by the Board.

1. Regulatory/Legislative Committee

   a. The Chairperson of the Committee shall be appointed by the Chairperson of the Board.

   b. The Regulatory/Legislative Committee shall consist of at least two (2) Board members appointed by the Chairperson of the Committee

   c. The Committee shall consider all questions bearing upon state legislation and regulation governing the professions regulated by the Board.

   d. The Committee shall recommend to the Board changes in law and regulations as it may deem advisable and, at the direction of the Board, shall take such steps as may further the desire of the Board in matters of legislation and regulation.

   e. The Chairperson of the Committee shall submit proposed changes in applicable laws and regulations in writing to the Board prior to any scheduled meeting.

2. Special Conference Committee

   a. The Special Conference Committee shall:

      i. consist of two (2) Board members.

      ii. conduct informal conferences pursuant to §§ 2.2-4019, 2.2-4021, and 54.1-2400 of the Code of Virginia as necessary to adjudicate cases in a timely manner in accordance with the agency standards for case resolution.

      iii. hold informal conferences at the request of the applicant or licensee to determine if Board requirements have been met.

b. The Chairperson of the Board shall designate another board member as an alternate on this committee in the event one of the standing committee members becomes ill or is unable to attend a scheduled conference date.

c. Should the caseload increase to the level that additional special conference committees are needed, the Chairperson of the Board may appoint additional committees.

3. Credentials Committee
   a. The Credentials Committee shall consist of at least two (2) Board members appointed by the Chairperson of the Board, with the Chairperson of the Committee to be appointed by the Chairperson of the Board.
   b. The members of the committee shall review non-routine licensure applications to determine the credentials of the applicant and the applicability of the statutes and regulations.
   c. The Committee member who conducted the initial review shall provide guidance to staff on action to be taken.
   d. The Credentials Committee shall not be required to meet collectively to conduct initial reviews.

ARTICLE IV: GENERAL DELEGATION OF AUTHORITY

The Board delegates the following functions:

1. The Executive Director shall be the custodian of all Board records. He/she shall preserve a correct list of all applicants and licensees, shall manage the correspondence of the Board, and shall perform all such other duties as naturally pertain to this position.

2. The Board delegates to Board staff the authority to issue and renew licenses or certificates and to approve supervision applications for which regulatory and statutory qualifications have been met. If there is basis, upon which the Board could refuse to issue or renew the license or certification or to deny the supervision application, the Executive Director may only issue a license, certificate, or registration upon consultation with a member of the Credentials Committee, or in accordance with delegated authority provided in a guidance document of the Board.

3. The Board delegates to the Executive Director the authority to develop and approve any and all forms used in the daily operations of Board business, to include, but not be limited to, licensure, certification, and registration applications, renewal forms, and documents used in the disciplinary process.

4. The Board delegates to the Executive Director the authority to grant an accommodation of additional testing time or other requests for accommodation to candidates for Board-required examinations

pursuant to the Americans with Disabilities Act, provided the candidate provide documentation that supports such an accommodation.

5. The Board delegates to the Executive Director authority to grant an extension for good cause of up to one (1) year for the completion of continuing education requirements upon written request from the licensee or certificate holder prior to the renewal date.

6. The Board delegates to the Executive Director authority to grant an exemption for all or part of the continuing education requirements due to circumstances beyond the control of the licensee or certificate holder, such as temporary disability, mandatory military service, or officially declared disasters.

7. The Board delegates to the Executive Director the authority to reinstate a license or certificate when the reinstatement is due to the lapse of the license or certificate rather than a disciplinary action and there is no basis upon which the Board could refuse to reinstate.

8. The Board delegates to the Executive Director the authority to sign as entered any Order or Consent Order resulting from the disciplinary process or other administrative proceeding.

9. The Board delegates to the Executive Director the authority to enter a Pre-Hearing Consent Order for Indefinite Suspension or revocation of a license, certificate, or registration.

10. The Board delegates to the Executive Director, who may consult with a Special Conference Committee member, the authority to provide guidance to the agency's Enforcement Division in situations wherein a complaint is of questionable jurisdiction and an investigation may not be necessary.

11. The Board delegates authority to the Executive Director to close non-jurisdictional cases and fee dispute cases without review by a Board member.

12. The Board delegates to the Executive Director the authority to determine if there is probable cause to initiate proceedings or action on behalf of the Board of Counseling, including the authority to close a case if staff determines probable cause does not exist, the conduct does not rise to the level of disciplinary action by the Board, or the Board does not have jurisdiction.

13. The Board delegates to the Executive Director the authority to review alleged violations of law or regulations with a Special Conference Committee member to make a determination as to whether probable cause exists to proceed with possible disciplinary action.

14. The Board delegates to the Executive Director the authority to assign the determination of probable cause for disciplinary action to a board member, or the staff counseling review coordinator, who may

offer a confidential consent agreement, offer a pre-hearing consent order, cause the scheduling of an informal conference, request additional information, or close the case.

15. In accordance with established Board guidance documents, the Board delegates to the Executive Director the determination of probable cause, for the purpose of offering a confidential consent agreement, a pre-hearing consent order, or for scheduling an informal conference.

16. The Board delegates to the Executive Director the selection of the agency subordinate who is deemed appropriately qualified to conduct a proceeding based on the qualifications of the subordinate and the type of case being convened.

17. The Board delegates to the Executive Director the convening of a quorum of the Board by telephone conference call, for the purpose of considering the summary suspension of a license or for the purpose of considering settlement proposals.

18. The Board delegates to the Chairperson, the authority to represent the Board in instances where Board "consultation" or "review" may be requested where a vote of the Board is not required and a meeting is not feasible.

19. The Board delegates authority to the Executive Director to issue an Advisory Letter to the person who is the subject of a complaint pursuant to Virginia Code § 54.1-2400.2(F), when it is determined that a probable cause review indicates a disciplinary proceeding will not be instituted.

20. The Board delegates authority to the Executive Director to delegate tasks to the Deputy Executive Director, as necessary.

ARTICLE V: AMENDMENTS

Proposed amendments to these bylaws shall be presented in writing to all Board members, the Executive Director of the Board, and the Board's legal counsel prior to any scheduled Board meeting. Amendments to the bylaws shall become effective with a favorable vote of at least two-thirds of the members present at that regular meeting.

Adopted: June 3, 2005
Revised: November 5, 2013; January 27, 2017; November 3, 2017; May 18, 2018

Delegation of Authority to Board of Nursing
RN Education and Discipline Staff

I. The Board of Nursing delegates to professional education staff the authority to:

- Approve nursing education programs with curriculum changes that relate to decreasing the number of clinical hours across the life cycle as long as the hours meet Board regulation 18VAC90-20-120 E.
- Approve quarterly reports from nursing education programs that meet all regulation requirements.
- Approve nurse aide education programs that meet requirements as determined by a review of a nurse aide education program application, an on-site review and/or a program evaluation report.
- Approve a change of location or additional locations for nurse aide education programs that meet Board of Nursing requirements.

II. The Board of Nursing delegates to professional discipline staff the authority to conduct probable cause review, issue Advisory Letters, offer Prehearing Consent Orders (PHCO's) and Confidential Consent Agreements (CCA's), or close a case, in the following circumstances:

A. Probable Cause Review – Professional discipline staff are delegated the authority to determine if there is probable cause to initiate proceedings or action on behalf of the Board of Nursing, including the authority to close a case if staff determines probable cause does not exist, the conduct does not rise to the level of disciplinary action by the Board, or the Board does not have jurisdiction. Additionally, staff may review a case with a Special Conference Committee for advice to determine if the case should be closed, a proceeding initiated, or an alternative disposition offered. Specifically, staff may:

B. Close cases in the following circumstances:

- Insufficient evidence of a violation of law or regulation, or not rising to the level of disciplinary action by the Board.

- Undetermined for reconsideration should another similar complaint be received.
- Undetermined until the lapsed/suspended/revoked licensee applies to reinstate or late renew.

C. Advisory Letters - Professional discipline staff are delegated the authority by the Board to issue an Advisory Letter to the person who was the subject of a complaint pursuant to Va. Code § 54.1-2400.2(F), when it is determined a disciplinary proceeding will not be instituted.

D. Initial and Reinstatement Applicants:

For initial and reinstatement applicants, professional staff may offer the following when there is cause for denial of licensure/certification/registration, in lieu of instituting a proceeding:

- PHCO to approve with sanction or terms consistent with that of another state
- PHCO to approve and require HPMP participation and compliance for applicants whose only causes for denial are related to impairment issues.
- PHCO to reinstate and comply with HPMP when a lapsed licensee was under a prior order to participate and comply with HPMP
- PHCO to reinstatement with same terms of probation for a probationer who allowed their license to lapse while under terms
- PHCO to Reprimand and approve, for failing to reveal a criminal conviction on a current or prior application for licensure/certification/registration (except for cases resulting in mandatory suspension). Such a PHCO may be offered at the discretion of staff considering factors such as whether the conviction would have been cause for denial, how recent was the conviction, and the explanation provided for such non-disclosure.
- PHCO to Reprimand and approve, if applicant has only one misdemeanor conviction involving moral turpitude, that conviction is less than 5 years old, and the applicant has satisfied all court requirements – consistent with Guidance Document # 90-10.

E. Disciplinary Cases: For disciplinary cases, professional discipline staff may offer the following, in lieu of instituting a proceeding.

1. General PHCOs:

- PHCOs for discipline cases for all occupations regulated by the Board of Nursing for sanctions consistent with the approved Sanction Reference Worksheet Guidelines (see Guidance Document 90-7).
- PHCO to Accept Voluntary Surrender for Indefinite Suspension during any type of investigated case when licensee indicates to the investigator the desire to surrender, or individual mails in license during course of the investigation
    1. PHCO for similar sanction consistent with another state board of nursing action
    2. PHCO for similar terms/conditions (Probation or HPMP) for cases based upon action taken by another state board of nursing.

2. Practice on Expired license/certificate/registration:

- PHCO for monetary penalty ranging from $200 – $1000 and possible Reprimand for Nurses and Massage Therapists practicing on an expired license, consistent with Guidance Document # 90-38
- Advisory Letter or PHCO for monetary penalty ranging from $50 - $150 and possible Reprimand for CNAs and/or RMAs practicing on expired certificates or registrations, consistent with Guidance Document # 90-61

3. Impairment

- Either a PHCO for Reprimand or a CCA (in lieu of scheduling an informal conference), depending on the facts of the case, for cases involving a positive urine drug screen on duty for a substance not prescribed to the licensee.
- Either PHCO to Take No Action contingent upon entry into and/or remaining in compliance with HPMP, or offer CCA with terms (i.e. quarterly reports from treating provider) for cases resulting from mandatory reports or self-reports of admission to hospitals for mental health issues where there are no practice issues. (Additionally, staff are authorized to close such cases undetermined if deemed appropriate.)
- PHCO to Take No Action contingent upon HPMP compliance in lieu of an IFC for disciplinary cases with Health Practitioner Monitoring Program (HPMP) participation and no prior Board history, no prior stay granted, the licensee is compliant with HPMP contract and no issues other than impairment.

- PHCO to Take No Action contingent upon continued HPMP compliance for cases with report received from PMP committee wherein stay of disciplinary action was vacated, but the individual was not dismissed from HPMP, and is now fully compliant with contract. (Include in the PHCO's findings of fact that stay was vacated.)
- PHCO to Accept Voluntary Surrender for Indefinite Suspension for cases involving HPMP participant that was ordered into program, but is now unable to participate due to medical reasons and HPMP committee dismisses or accepts individual's resignation

4. Standard of Care

- PHCO for Reprimand for failure to provide acceptable standard of care resulting in patient harm.
- PHCO for Reprimand for abandonment of patients by licensees in a nursing home or other healthcare facility and where this is the only alleged issue.
- PHCO for Reprimand based upon unprofessional conduct for allegations of verbal/physical abuse with mitigating circumstances**.**

5. Fraud/Financial Gain Cases

- PHCO for Monetary Penalty for cases involving fraud or underlying actions/misconduct resulting in financial gain by the licensee/applicant. This may include but is not limited to: falsifying time records to indicate worked when did not; falsifying employment and licensure applications; altering expiration dates on records/certifications (e.g., CPR cards); falsifying work/school notes, selling medications obtained by fraud, etc. [NOTE: Staff is authorized to add a Reprimand to the Monetary Penalty in the case of egregious, intentional misconduct.]
- Monetary Penalty amount imposed shall not exceed $5,000 for each violation of law or regulation, in accordance with VA Code § 54.1-2401, and shall only be imposed if the individual is not criminally prosecuted for the violation.

6. Intentional Conduct Determined Abuse / Neglect

- PHCO for Monetary Penalty, for cases of intentional conduct determined to be abuse by a licensee and that does not rise to the level of suspension or revocation. The PHCO may also include a Reprimand and/or other terms, depending on other factors in the case.

- PHCO for Monetary Penalty, for cases of intentional conduct determined to be neglect by a licensee and that does not rise to the level of suspension or revocation. The PHCO may also include a Reprimand and/or other terms, depending on other factors in the case.

[Note: Monetary Penalty amount imposed shall not exceed $5,000 for each violation of law or regulation, in accordance with VA Code § 54.1-2401, and shall only be imposed if the individual is not criminally prosecuted for the violation.]

F. Compliance

For cases involving noncompliance with prior board orders, professional discipline staff are authorized to do the following in the circumstances below, in lieu of instituting a proceeding:

- Offer PHCOs consistent with Guidance Document # 90-35 based upon noncompliance with a prior board order.
- Have authority to modify probation orders.
- Close undetermined any noncompliance case where the licensee on probation has allowed the license to lapse (not working). Board of Nursing database would be flagged so staff could offer PHCO with same terms as initial probation orders, once the license is being made current.
- Issue Orders of successful completion of HPMP, when participation was board-ordered.
- Issue Orders of successful completion of probation with terms (effective November 15, 2011, consistent with the way the Board handles successful completion of board-ordered HPMP participation).

  [NOTE: *Orders related to HPMP and Probation completion shall be scanned onto the agency website and provide consistency to the public in Board of Nursing documentation in the future*.]

G. Confidential Consent Agreements (CCA's):

Professional disciplinary staff are delegated authority to offer CCA's for those cases that meet the criteria in Va. Code §54.1-2400(14), which includes but is not limited to the following scenarios:

1. Impairment and/or HPMP:

- Pre-employment positive drug screen without evidence it has affected practice
- Possible impairment without evidence that it has affected practice (i.e. coming to work with alcohol on breath & sent home; hospitalized for psychiatric or substance abuse treatment)
- HPMP participant not eligible for a stay, but with minimal practice issues

2. Standard of Care:

- Single medication error with no patient harm.
- Standard of care violation "with little or no injury"
- Standard of care violation that may be in part due to systems issues.
- Single incident of exceeding scope of practice – accepting assignment or agreeing to do a task without adequate training obtained or competency maintained and no patient harm.
- Unintentional/inadvertent Practice Agreement violations for LNP's with Prescriptive Authority.

3. Abuse / Neglect / Misappropriation / Boundary violation:

- Single boundary violation with no patient harm (i.e., getting involved with patient finances) and not resulting in criminal conviction.
- Vague "rough handling" where there is no patient harm and does not rise to the level of abuse
- Inappropriate verbal response that does not rise to the level of verbal abuse (i.e., "shut up")

4. Miscellaneous:

- CE violations for CMT's, RMA's, LPN's, RN's, and LNP's.
- Technical probation violations (i.e., late reports, etc.) that do not rise to the level of Noncompliance cited in Guidance Document 90-35.
- A single misdemeanor conviction involving moral turpitude but unrelated to practice, with no other issues (ex. worthless check; shoplifting).