Virginia Department of Health Professions
Board of Counseling

Agenda

Full Board Meeting
November 5, 2021
10:00 a.m.
9960 Mayland Dr
2nd Floor
Richmond, VA 23233

10:00 a.m. Call to Order– Johnston Brendel, Ed.D., LPC, LMFT, Board Chair

- Welcome and Introductions
- Establishment of Quorum
- Mission of the Board Page 3

Adoption 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.

Approval of Minutes

- Board Meeting – August 20, 2021* Page 4

Agency Director's Report - David E. Brown, DC, Director, Department of Health Professions (DHP)

Presentations

- Assessment of Virginia's Licensed Behavioral Health Workforce – Debbie Oswalt, Virginia Health Care Foundation
- Virginia's Licensed Professional Counselor Workforce: 2021 - Yetty Shobo, Ph.D., Deputy Director, DHP Healthcare Workforce Data Center Page 12

Chair Report – Dr. Brendel

Legislation and Regulatory Actions – Elaine Yeatts, DHP, Senior Policy Analyst

- Chart of Regulatory Actions Page 43
- DHP Policy on Meetings Held With Electronic Participation* Page 44

Unfinished Business - Jaime Hoyle, JD, Executive Director, Boards of Counseling, Psychology and Social Work

- Counseling Compact Page 50
  - Fact Sheet for State Officials Page 77
  - FAQs Page 78
  - Universal Recognition Explained Page 82
  - What is a Counseling Compact Page 84

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New Business

- Adoption of Proposed Regulations for the Licensure of Art Therapists* - Elaine Yeatts Page 86
  - Copy of Notice on Virginia Regulatory Townhall Page 87
  - Copy of Comments Received on NOIRA Page 87
  - Copy of DRAFT regulations recommended by the Advisory Board on Art Therapy Page 100

Staff Reports

- Executive Director's Report – Jaime Hoyle
- Discipline Report – Jennifer Lang, Deputy Executive Director, Boards of Counseling, Psychology, and Social Work Page 112
- Licensing Report – Charlotte Lenart, Deputy Executive Director of Licensing, Boards of Counseling, Psychology, and Social Work Page 117

Next Meeting – February 18, 2022

Meeting Adjournment

*Indicates a Board Vote is required.
**Indicates these items will be discussed within closed session.
This information is in **DRAFT** form and is subject to change. The official agenda and packet will be approved by the public body at the meeting and will be available to the public pursuant to Virginia Code Section 2.2-3708(D).

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Virginia Department of
Health Professions
Board of Counseling

MISSION STATEMENT

Our mission is to ensure safe and competent patient care by licensing health professionals, enforcing standards of practice, and providing information to health care practitioners and the public.

DRAFT
BOARD OF COUNSELING
FULL BOARD MEETING
Friday, August 20, 2021
DRAFT MINUTES

TIME AND PLACE: Dr. Johnston Brendel, called the meeting to order at 10:04 a.m. on Friday, August 20, 2021, in Board Room 4 at the Department of Health Professions ("DHP"), 9960 Mayland Drive, Henrico, Virginia.

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

BOARD MEMBERS PRESENT:
Angela Charlton, Ph.D., LPC
Natalie Harris, LPC, LMFT
Danielle Hunt, LPC, Vice-Chairperson
Gerard Lawson, Ph.D., LPC, LSATP
Maria Stransky, LPC, CSAC, CSOTP
Terry R. Tinsley, Ph.D., LPC, LMFT, CSOTP
Vivian Sanchez-Jones, Citizen Member
Tiffinee Yancey, Ph.D., LPC

BOARD MEMBERS ABSENT:
Barry Alvarez, LMFT
Bev-Freda L. Jackson, Ph.D., MA, Citizen Member
Holly Tracy, LPC, LMFT

STAFF PRESENT:
Jaime Hoyle, JD, Executive Director
Jennifer Lang, Deputy Executive Director
Charlotte Lenart, Deputy Executive Director-Licensing

DHP STAFF PRESENT:
David E. Brown, D.C., DHP Director
Elaine Yeatts, DHP Senior Policy Analyst

BOARD COUNSEL: James Rutkowski, Assistant Attorney General

ROLL CALL - ESTABLISHMENT OF A QUORUM: Dr. Brendel congratulated and welcomed the newly appointed Board members Dr. Lawson and Dr. Charlton. Dr. Brendel also recognized Mr. Alvarez, Dr. Yancey and Ms. Harris' reappointment to the Board. Board members and staff introduced themselves and with 9 Board members present, a quorum was established.

ADOPTION OF AGENDA: The Board adopted the agenda as written.

PUBLIC COMMENT: There was no requests to provide public comment.

APPROVAL OF MINUTES: With no amendments to the May 21, 2021 board meeting minutes, the minutes stand approved as presented.

AGENCY REPORT:

Dr. Brown welcomed the new Board members and discussed the requirements for Board member participation. Dr. Brown reported that the state of emergency lapsed on June 30, 2021 that allowed Boards to hold meetings virtually. He reported that the Agency would propose legislation to allow virtual meetings.

Dr. Brown stated that the Agency closed to the public for a long period, and the Agency invested significantly to allow staff to work remotely. Dr. Brown stated that the Behavioral Science Unit was the poster child for early adoption of electronic means and seamless ability to telework. The Agency will be returning to the office (return to the new normal) on or about October 1, 2021 which employees to telework up to 3 days. The Agency wants to embrace the benefits of teleworking but same time not lose the healthy culture we have developed here at DHP.

The Agency is working on improving and increasing building security to ensure the Agency takes all appropriate steps to ensure the safe environment for staff, Board members, and public.

Dr. Brendel asked if the Agency has looked at being more efficient as it relates holding meetings electronically. Dr. Brown explained that the Code of Virginia prohibits virtual meeting, but the Agency will seek to have legislation specifically for DHP to allow virtual meetings in certain circumstances.

CHAIR REPORT:

Dr~~Ms~~. Brendel discussed the chairperson report, which provided the quarterly accomplishments. Dr. Brendel reminded everyone that the Board of Counseling is a working Board and asked each Board member to do their part in reviewing probable case reviews and to take their responsibilities seriously. The Board currently has approximately 300 probable cause cases needing review.

Dr. Brendel stated that four representatives from the Board attended the National Board for Certified Counselors (NBCC) Annual Conference. He asked the Board members to share their experiences with the Board.

Dr. Tinsley liked the discussion on Compact. He enjoyed hearing both the positive and negative consequences of a Compact and now feels as if he is more informed and is now in favor of the Compact.

Ms. Hunt indicated that one of her main take-a~~l~~ways from the

meeting was in the efficiency that the Florida Board created using Artificial Intelligence. One of the Boards mandates that the licensees provide a document to the client that outlines the expectations and appropriate behavior of the licensee.

Dr. Brendel~~'s~~ stated that he felt that Virginia was ahead of some states and behind other states in how we process~~es~~ applications. He felt that our processes for hearings are well above other states. He stated that he was always proud of saying that the Board reviewed applications in 30 days, but some Boards are reviewing complete applications within 3 days. Dr. Brendel stated that the Board falls behind ~~in the~~ on the use of technology on our website to better serve the applicants, licensees and public. Lastly, Dr. Brendel stated that the staff is incredible, hardworking, efficient and detailed oriented. Dr. Brendel stated that constantly hears praise from the community on the great customer service and efficiency, which has not always been the case.

LEGISLATION AND REGULATORY ACTIONS:

Legislation Actions:
Ms. Yeatts indicate that the Agency is working hard on several proposed ~~legislations~~ bills for the 2022 session.

Regulatory Actions:
Ms. Yeatts provided an update regulatory actions chart dated August 10, 2021.

18VAC 115-20 Regulations Governing the Practice of Professional Counseling – Unprofessional conduct-conversion therapy (Action 5225); Effective 8/18/2021.

18VAC 115-20 Regulations Governing the Practice of Professional Counseling – Periodic review (action 5230); Proposed - At Governor's Office for 245 days

18VAC 115-30 Regulations Governing the Certification of Substance Abuse Counselors – Clarification on Independent Practice (action 5692) Fast Track – At Secretary's Office for 130 days.

18VAC 115-40 Regulations Governing the Certification of Rehabilitation Providers - Periodic review (Action 5305);
Final – Published on 8/30/2021 and becomes effective on 9/29/2021.

18VAC 115-90 Regulations Governing the Licensure of Art Therapists (under development) – NOIRA – Register Date: 3/1/2021.

Petitions for Rulemaking:

First Petition:
Petition received from Jennifer Stolpe requesting education

requirements for LSATP by endorsement be reduced to 36 hours if all class hours were focused on addiction counseling.

The Board discussed the petitioner's request and is sensitive to her situation and to active military and military spouses' challenges but decided not to initiate rulemaking. Since the standard for all licensed professionals ~~related~~regulated by the Board is 60 graduate hours in counseling, a reduction to 36 hours would be problematic for this license.

Motion: *Ms. Hunt made a motion that was properly seconded, to deny the petitioners request. The motion passed unanimously.*

Second Petition:
Petition received from Dawne Sherman requesting all face-to-face client contact hours in a graduate internship in excess of 240 be allowed to count towards the 2,000 total in the residency.

The Board discussed the petitioner's request and decided it would include amendments to the internship and residency requirements in the adoption of final regulations relating to its periodic review. The amendments will specify the proportional hours that could be counted as face-to-face. However, in practice, those hours are already being applied to a residency.

For example, a person who completed 659 hours in an internship with 296 face-to-face hours was credited with 59 hours (the number in excess of required 600 hours) towards the residency and 56 hours (the number in excess of required 240 hours) was credited towards the 2,000 hours of face-to-face client contact. While the regulation does not currently specify how those excess hours are applied, an applicant is currently receiving the credit.

Motion: *Dr. Tinsley made a motion that was properly seconded, to consider the petitioner's request at the adoption final regulations of the periodic review. The motion passed with eight in favor and one opposed.*

ELECTION OF OFFICERS:

Ms. Hoyle discussed the election requirements and procedures as outlined in the By-Laws. Both Ms. Hunt and Dr. Brendel's are eligible for re-election.

Motion: *Ms. Stansky made a motion, which was properly seconded, to nominate Ms. Hunt for Vice-Chair. The motion passed with nine in favor.*

Motion: *Dr. Yancey made a motion, which was properly seconded, to nominate Dr. Brendel for Chair. The motion passed with nine in favor.*

Ms. Hoyle congratulated Ms. Hunt and Dr. Brendel on their re-election.

UNFINISHED BUSINESS:

Review/Adoption of Telehealth Guidance Document

The Board and staff discussed in depth the proposed guidance document for the use of telehealth for the practice of counseling, marriage and family therapy, and substance abuse treatment, including the use of telehealth for the supervision of residents. Board members made suggested~~ed~~ions for change to the guidance document.

It was suggested that staff incorporate the comment and concerns of the Board for the Regulatory Committee to discuss. The Regulatory Committee would then propose a draft to the full Board thereafter.

Counseling Compact

Becky Bowers-Lanier, Virginia Counselor Association (VAC) lobbyist stated that their VAC Board approved the concept of the moving forward with the compact. VAC has obtain a patron for a bill proposing legislation to enact the Counseling Interstate Compact in Virginia.

After a lengthy discussion on the pros and cons of the Compact language, the Board agreed to keep this action item on the agenda for the next Board meeting at which time the Board may want to take an official position on the Compact.

Guidance Documents 115-8 Approved Degrees in Human Services and Related Fields for QMHP Registration

The Board discussed proposed changes to Guidance Document 115-8.

Motion: *Dr. Yancey made a motion, which was properly seconded, to amended Guidance Document 115-8 to add the revised definition of human services, remove sociology from the degrees accepted and to remove the sentence "The Board may consider other degrees in human services or in Fields related to the provision of mental health services."* The motion passed unanimously.

Break:

The Board took a break at 12:13 p.m. and reconvened at 12:26 p.m.

STAFF REPORTS:

Executive Director's Report – Jaime Hoyle

Ms. Hoyle reported and answered questions on the Board's financials as presented in the agenda packet.

Ms. Hoyle talked about her take--a~~l~~ways from the NBCC Annual Conference and discussed that the Board is a composite Board,

which regulates 13 different professions that will change to 15 once the art therapy regulations become effective.

Ms. Hoyle stated her staff is awesome and works harder than any other Board.

Dr.Tinsley asked about upgrading the technology and functionality of the Board's website. Ms. Hoyle discussed the potential upgrades to the system and stated that she is in support of any technologies that would increase efficiencies that help not only applicants but also staff and would be happy to share the Florida Board's website with the administration and IT department.

Licensing Report – Charlotte Lenart, Deputy Executive Director-Licensing

Ms. Lenart gave a brief summary of the licensing report and thanked staff for their hard work and dedication.

Ms. Lenart discussed the satisfaction survey and read two comments from the survey.

Staff is receiving approximately 600 to 700 applications: 3,000 phone calls and 7,000 emails per month with a staff of 3 full time and 3 part-time employees.

Ms. Lenart advised that the Board has approximately 2,500 LPC, 225 LMFTs, 100 LSATPs and 50 CSAC are approved supervisors on the supervisory registry.

Ms. Lenart stated that the Board has denied 106 applications so far this year. Seven have since been approved and five have requested Informal Conferences.

Ms. Hoyle stated that she has been asked to reduce or eliminate overtime for staff. She discussed the staffing and the balance of the cost of overtime and staff burn-out but still process applications in the most expediently and efficient way possible.

Dr. Brendel stated that the Board is here to support and advocate for Board staff.

Discipline Report – Jennifer Lang, Deputy Executive Director

Ms. Lang's report gave a brief update on the discipline report posted in the agenda packet.

Ms. Lang stated that the discipline staff consists of herself and Christy Evans and most recently Charles "Rip" McAdams as the Board's probable cause reviewer.

Ms. Lang indicated that in the first 8 months of 2018, the Board

received 115 discipline cases and for the same period this year, the Board received 225 discipline cases. The majority of the issues relate to boundaries and fraudulently billing records. Ms. Lang is working with DBHDS to require specific training prior to hiring QMHPs.

Ms. Hoyle stated that Ms. Lang was instrumental in having all the discipline cases online and is still the only Board that has that capability.

CONSIDERATION OF SUMMARY SUSPENSION:

See Attachment A.

NEXT MEETING:

Next scheduled Quarterly Board Meeting is November 5, 2021.

ADJOURN:

The meeting adjourned at 1.26 p.m.

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

Jaime Hoyle, J.D
Executive Director

Attachment A

Summary Suspension Presentation and Consideration

RE: **Brian Artis, QMHP-A, QMHP-C**
Registration Nos: 0732004702
0733004130
Case No: 209032

Commonwealth's Representation: Erin Weaver, Assistant Attorney General, Office of the Attorney General
Emily Tatum, Adjudication Specialist, APD

Purpose of the Meeting: Ms. Weaver presented a summary of evidence in case 209032 for the Board's consideration of a summary suspension of the registrations of Brian Artis.

Closed Meeting: Dr. Tinsley moved that the Board convene in a closed meeting pursuant to § 2.2-3711(A)(27) of the *Code of Virginia* for the purpose of deliberation to reach a decision in the matter of Brian Artis. Additionally, he moved that James Rutkowski, Jaime Hoyle, Jennifer Lang, and Charlotte Lenart attend the closed session because their presence was deemed necessary and would aid the Board in its deliberations. The motion was seconded by Dr. Lawson and passed unanimously.

Reconvene: Having certified that the matters discussed in the preceding closed meeting met the requirements of § 2.2-3712 of the *Code of Virginia*, the Board reconvened in open meeting and announced the decision.

Decision: Dr. Lawson moved to summarily suspend the registrations of Brian Artis, QMHP-A, QMHP-C and offer a Consent Order for revocation in lieu of a formal hearing. The motion was seconded by Dr. Yancey and passed unanimously.

Virginia's Licensed Professional Counselor Workforce: 2021

Healthcare Workforce Data Center

July 2021

Virginia Department of Health Professions
Healthcare Workforce Data Center
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, VA 23233
804-597-4213, 804-527-4434 (fax)
E-mail: ***HWDC@dhp.virginia.gov***

Follow us on Tumblr: ***www.vahwdc.tumblr.com***
Get a copy of this report from:
http://www.dhp.virginia.gov/PublicResources/HealthcareWorkforceDataCenter/ProfessionReports/

More than 6,000 Licensed Professional Counselors voluntarily participated in this survey. *Without their efforts, the work of the center would not be possible. The Department of Health Professions, the Healthcare Workforce Data Center, and the Board of Counseling express our sincerest appreciation for your ongoing cooperation.*

Thank You!

Virginia Department of Health Professions

David E. Brown, DC
Director

Barbara Allison-Bryan, MD
Chief Deputy Director

Healthcare Workforce Data Center Staff:

Elizabeth Carter, PhD	Yetty Shobo, PhD	Rajana Siva, MBA	Christopher Coyle
Director	*Deputy Director*	*Data Analyst*	*Research Assistant*

DRAFT

Virginia Board of Counseling

Chair

Johnston Brendel, EdD, LPC, LMFT
Williamsburg

Vice-Chair

Danielle Hunt, LPC
Richmond

Members

Barry Alvarez, LMFT
Falls Church

Angela Charlton, PhD, LPC
Ashburn

Natalie Harris, LPC, LMFT
Newport News

Bev-Freda L. Jackson, PhD, MA
Arlington

Gerard Lawson, PhD, LPC, LSATP
Blacksburg

Vivian Sanchez-Jones
Roanoke

Maria Stransky, LPC, CSAC, CSOTP
Richmond

Terry R. Tinsley, PhD, LPC, LMFT, CSOTP
Gainesville

Holly Tracy, LPC, LMFT
Norfolk

Tiffinee Yancey, PhD, LPC
Suffolk

Executive Director

Jaime H. Hoyle, JD

Contents

The Licensed Professional Counselor Workforce At a Glance:

The Workforce	
Licensees[1]:	7,368
Virginia's Workforce:	6,535
FTEs:	5,263

Survey Response Rate	
All Licensees:	80%
Renewing Practitioners:	96%

Demographics	
Female:	82%
Diversity Index:	42%
Median Age:	46

Background	
Rural Childhood:	31%
HS Degree in VA:	49%
Prof. Degree in VA:	64%

Education	
Masters:	88%
Doctorate:	12%

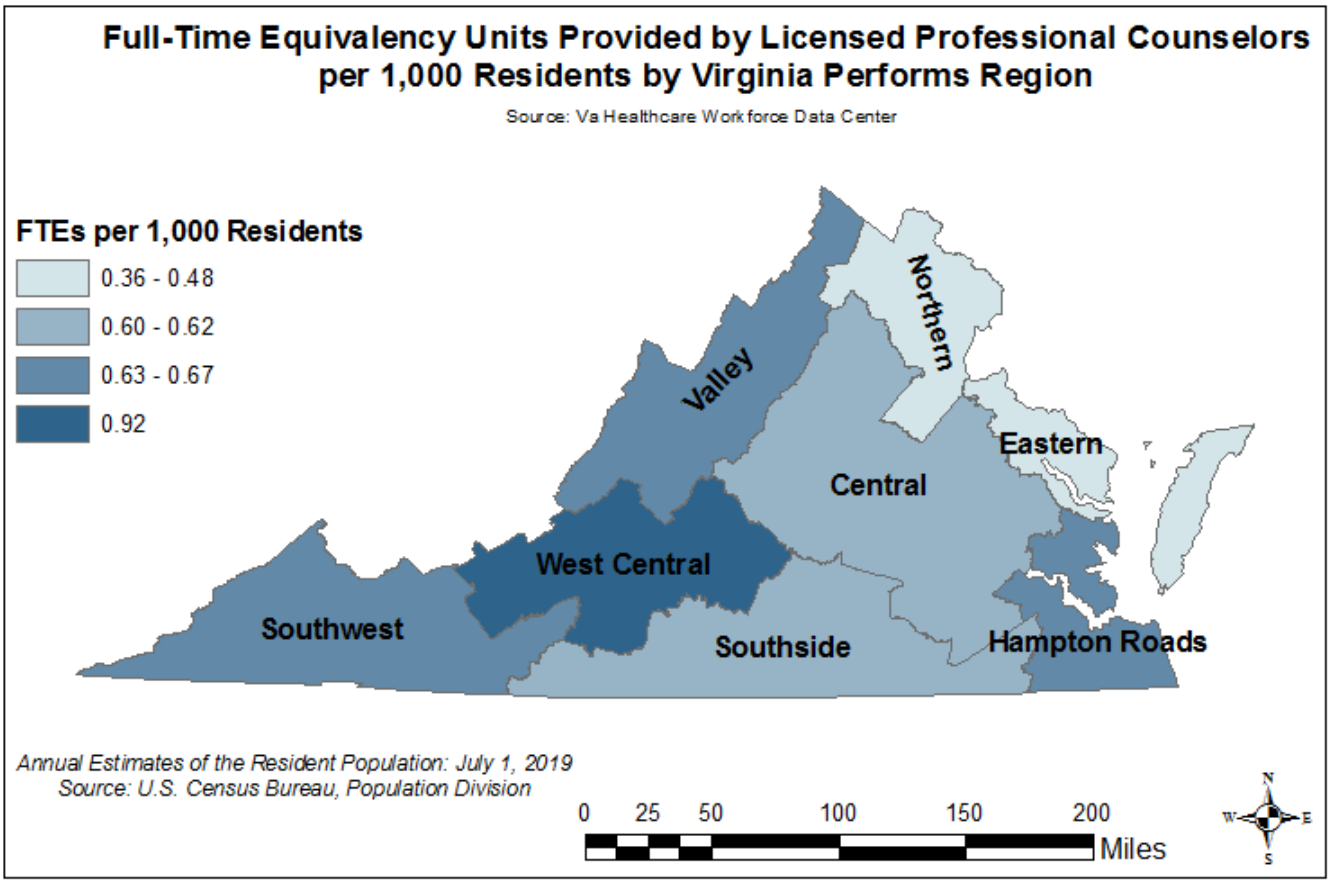
Finances	
Median Income:	$60k-$70k
Health Insurance:	61%
Under 40 w/ Ed. Debt:	68%

Current Employment	
Employed in Prof.:	94%
Hold 1 Full-Time Job:	54%
Satisfied?:	96%

Job Turnover	
Switched Jobs:	8%
Employed Over 2 Yrs.:	63%

Time Allocation	
Patient Care:	70%-79%
Administration:	10%-19%
Patient Care Role:	61%

Source: Va. Healthcare Workforce Data Center



[1] Excludes 498 temporary licenses that were issued between April 2020 and September 2020 as a result of procedural changes that were implemented by the DHP due to the coronavirus pandemic. All of these temporary licenses expired in September 2020.

Results in Brief

This report contains the results of the 2021 Licensed Professional Counselor (LPC) Workforce Survey. More than 6,000 LPCs voluntarily participated in this survey. The Virginia Department of Health Professions' Healthcare Workforce Data Center (HWDC) administers the survey during the license renewal process, which takes place every June for LPCs. These survey respondents represent 85% of the 7,368 LPCs who possessed non-temporary licenses in the state and 96% of renewing practitioners.

The HWDC estimates that 6,535 LPCs participated in Virginia's workforce during the survey period, which is defined as those LPCs who worked at least a portion of the year in the state or who live in the state and intend to work as a LPC at some point in the future. Over the past year, Virginia's LPC workforce provided 5,263 "full-time equivalency units," which the HWDC defines simply as working 2,000 hours per year.

More than 80% of all LPCs are female, including 87% of those LPCs who are under the age of 40. In a random encounter between two LPCs, there is a 42% chance that they would be of different races or ethnicities, a measure known as the diversity index. For LPCs who are under the age of 40, the diversity index increases to 48%. However, both of these values are below the comparable diversity index of 57% for Virginia's population as a whole. Nearly one-third of all LPCs grew up in rural areas, and 22% of LPCs who grew up in rural areas currently work in non-metro areas of Virginia. In total, 10% of all LPCs work in non-metro areas of the state.

More than 90% of all LPCs are currently employed in the profession, 54% hold one full-time job, and 43% work between 40 and 49 hours per week. Meanwhile, 3% of LPCs have experienced involuntary unemployment at some point over the past year, and 2% have also experienced underemployment during the same time period. More than three-quarters of all LPCs are employed in the private sector, including 61% who work in the for-profit sector. The median annual income of Virginia's LPC workforce is between $60,000 and $70,000. Nearly all LPCs are satisfied with their current work situation, including 71% of LPCs who indicated that they are "very satisfied."

Summary of Trends

In this section, all statistics for the current year are compared to the 2016 LPC workforce. The number of licensed LPCs in Virginia has increased by 61% (7,368 vs. 4,575). In addition, the size of Virginia's LPC workforce has increased by 65% (6,535 vs. 3,973), and the number of FTEs provided by this workforce has increased by 55% (5,263 vs. 3,404). Virginia's renewing LPCs are more likely to respond to this survey (96% vs. 94%).

LPCs are more likely to be female (82% vs. 79%), and the median age of this workforce has fallen (46 vs. 51). In addition, Virginia's LPC workforce has become more diverse (42% vs. 30%), and this is also the case among LPCs who are under the age of 40 (48% vs. 38%). LPCs are slightly more likely to have grown up in rural areas (31% vs. 30%), and LPCs who grew up in rural areas are more likely to work in non-metro areas of Virginia (22% vs. 21%). However, there has been no change in the overall percentage of LPCs who work in non-metro areas of the state (10%).

LPCs are more likely to hold a Master's degree as their highest professional degree (88% vs. 85%) rather than a doctoral degree (12% vs. 15%). At the same time, LPCs are more likely to carry education debt (51% vs. 39%), and the median debt amount among those LPCs who carry education debt has increased ($80k-$90k vs. $50k-$60k). The median annual income of Virginia's LPCs has also increased ($60k-$70k vs. $50k-$60k). In addition, wage and salaried LPCs are more likely to receive at least one employer-sponsored benefit (75% vs. 72%), including those LPCs who have access to health insurance (61% vs. 60%).

There has been increased turnover in Virginia's workforce as LPCs are more likely to have switched jobs (8% vs. 6%) and less likely to have worked at their primary work location for more than two years (63% vs. 71%). LPCs are more likely to work in the for-profit sector (61% vs. 54%) rather than in either the non-profit sector (17% vs. 19%) or a state/local government (19% vs. 24%). There has been no change in the percentage of LPCs who indicated that they are satisfied with their current work circumstances (96%).

A Closer Look:

Licensees		
License Status	**#**	**%**
Renewing Practitioners	6,076	77%
New Licensees	888	11%
Temporary Licensees[1]	498	6%
Non-Renewals	404	5%
All Licensees	**7,866**	**100%**
All Licensees Without Temporary	**7,368**	**94%**

Source: Va. Healthcare Workforce Data Center

HWDC surveys tend to achieve very high response rates. Nearly all renewing LPCs submitted a survey. These represent 80% of the 7,866 LPCs who held a license at some point during the survey period.

Definitions

1. **The Survey Period:** The survey was conducted in June 2021.
2. **Target Population:** All LPCs who held a Virginia license at some point between July 2020 and June 2021.
3. **Survey Population:** The survey was available to LPCs who renewed their licenses online. It was not available to those who did not renew, including LPCs newly licensed in 2021.

Response Rates			
Statistic	**Non Respondents**	**Respondents**	**Response Rate**
By Age			
Under 35	332	792	71%
35 to 39	257	981	79%
40 to 44	232	924	80%
45 to 49	169	751	82%
50 to 54	152	723	83%
55 to 59	112	562	83%
60 to 64	107	533	83%
65 and Over	222	1,017	82%
Total	**1,583**	**6,283**	**80%**
New Licenses			
Issued in Past Year	703	393	36%
Metro Status			
Non-Metro	94	485	84%
Metro	778	4,902	86%
Not in Virginia	711	895	56%

Source: Va. Healthcare Workforce Data Center

Response Rates	
Completed Surveys	**6,283**
Response Rate, All Licensees	**80%**
Response Rate, Renewals	**96%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Licensed LPCs

Number:	7,866
New:	11%
Not Renewed:	5%

Response Rates

All Licensees:	80%
Renewing Practitioners:	96%

Source: Va. Healthcare Workforce Data Center

[1] These 498 temporary licenses were issued between April 2020 and September 2020 as a result of procedural changes that were implemented by the DHP due to the coronavirus pandemic. All of these temporary licenses expired in September 2020.

At a Glance:

Workforce

Virginia's LPC Workforce:	6,535
FTEs:	5,263

Utilization Ratios

Licensees in VA Workforce:	83%
Licensees per FTE:	1.49
Workers per FTE:	1.24

Source: Va. Healthcare Workforce Data Center

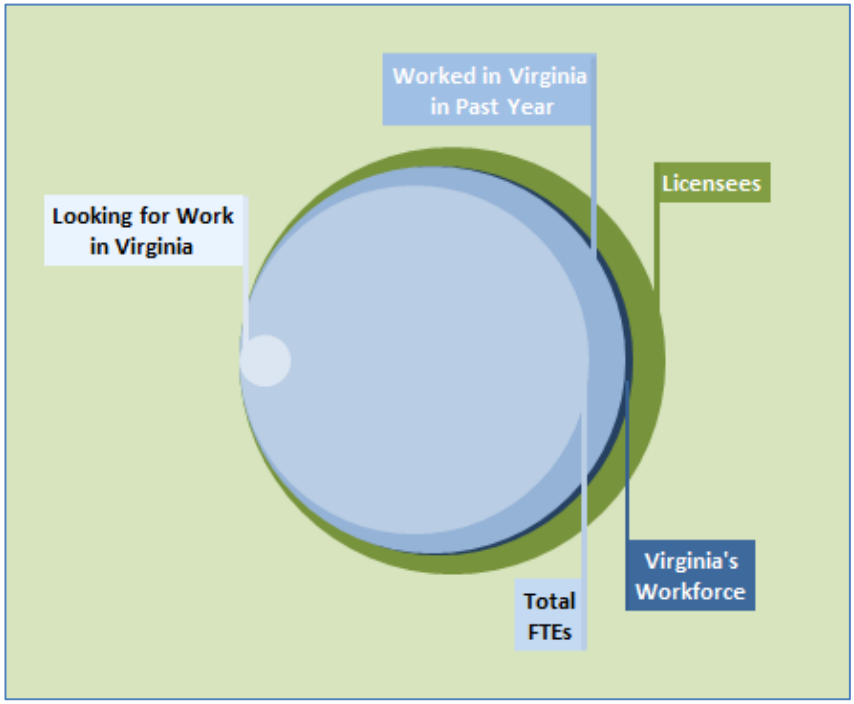
Definitions

1. **Virginia's Workforce:** A licensee with a primary or secondary work site in Virginia at any time in the past year or who indicated intent to return to Virginia's workforce at any point in the future.
2. **Full-Time Equivalency Unit (FTE):** The HWDC uses 2,000 (40 hours for 50 weeks) as its baseline measure for FTEs.
3. **Licensees in VA Workforce:** The proportion of licensees in Virginia's workforce.
4. **Licensees per FTE:** An indication of the number of licensees needed to create 1 FTE. Higher numbers indicate lower licensee participation.
5. **Workers per FTE:** An indication of the number of workers in Virginia's workforce needed to create 1 FTE. Higher numbers indicate lower utilization of available workers.

Virginia's LPC Workforce		
Status	**#**	**%**
Worked in Virginia in Past Year	6,421	98%
Looking for Work in Virginia	114	2%
Virginia's Workforce	**6,535**	**100%**
Total FTEs	**5,263**	
Licensees	**7,866**	

Source: Va. Healthcare Workforce Data Center

Weighting is used to estimate the figures in this report. Unless otherwise noted, figures refer to the Virginia Workforce only. For more information on the HWDC's methodology, visit: https://www.dhp.virginia.gov/PublicResources/HealthcareWorkforceDataCenter/



Source: Va. Healthcare Workforce Data Center

A Closer Look:

Age & Gender						
Age	Male		Female		Total	
	#	% Male	#	% Female	#	% in Age Group
Under 35	109	12%	826	88%	935	17%
35 to 39	126	14%	798	86%	923	16%
40 to 44	123	15%	723	85%	846	15%
45 to 49	95	15%	535	85%	630	11%
50 to 54	114	19%	500	82%	614	11%
55 to 59	80	17%	380	83%	460	8%
60 to 64	112	26%	320	74%	432	8%
65 and Over	231	30%	540	70%	771	14%
Total	**990**	**18%**	**4,621**	**82%**	**5,611**	**100%**

Source: Va. Healthcare Workforce Data Center

Race & Ethnicity					
Race/ Ethnicity	Virginia*	LPCs		LPCs Under 40	
	%	#	%	#	%
White	61%	4,154	74%	1,287	69%
Black	19%	976	17%	353	19%
Hispanic	10%	245	4%	107	6%
Asian	7%	75	1%	26	1%
Two or More Races	3%	122	2%	63	3%
Other Race	0%	51	1%	17	1%
Total	**100%**	**5,623**	**100%**	**1,853**	**100%**

*Population data in this chart is from the U.S. Census, Annual Estimates of the Resident Population by Sex, Race, and Hispanic Origin for the United States, States, and Counties: July 1, 2019.

Source: Va. Healthcare Workforce Data Center

At a Glance:

Gender

% Female:	82%
% Under 40 Female:	87%

Age

Median Age:	46
% Under 40:	33%
% 55 and Over:	30%

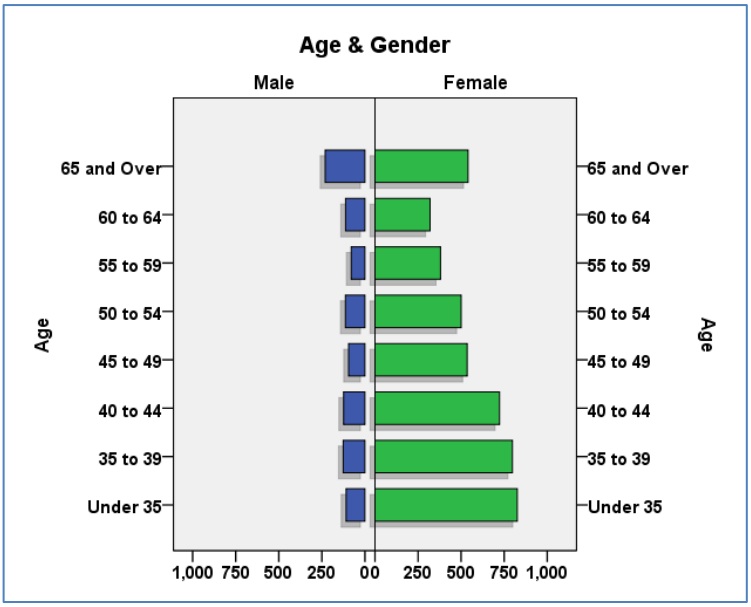
Diversity

Diversity Index:	42%
Under 40 Div. Index:	48%

Source: Va. Healthcare Workforce Data Center

In a chance encounter between two LPCs, there is a 42% chance that they would be of different races or ethnicities, a measure known as the diversity index.

One-third of all LPCs are under the age of 40, and 87% of LPCs who are under the age of 40 are female. In addition, the diversity index among LPCs who are under the age of 40 is 48%.



Source: Va. Healthcare Workforce Data Center

At a Glance:

Childhood

Urban Childhood:	14%
Rural Childhood:	31%

Virginia Background

HS in Virginia:	49%
Prof. Edu. in VA:	64%
HS or Prof. Edu. in VA:	74%

Location Choice

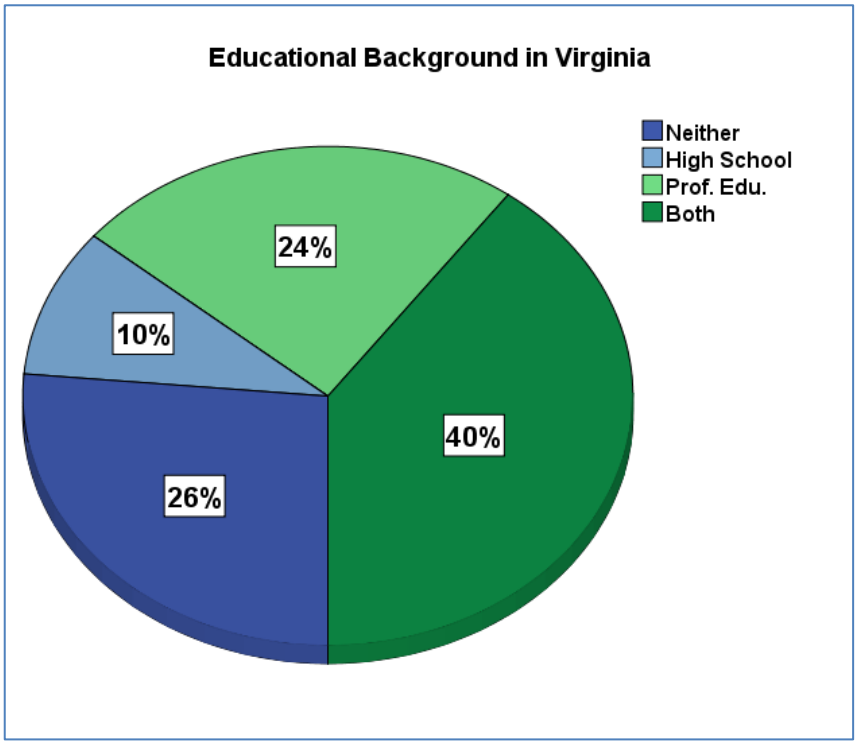
% Rural to Non-Metro:	22%
% Urban/Suburban to Non-Metro:	4%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Primary Location: USDA Rural Urban Continuum		Rural Status of Childhood Location		
Code	Description	Rural	Suburban	Urban
	Metro Counties			
1	Metro, 1 Million+	21%	62%	17%
2	Metro, 250,000 to 1 Million	41%	48%	11%
3	Metro, 250,000 or Less	45%	46%	8%
	Non-Metro Counties			
4	Urban, Pop. 20,000+, Metro Adjacent	69%	23%	8%
6	Urban, Pop. 2,500-19,999, Metro Adjacent	65%	29%	6%
7	Urban, Pop. 2,500-19,999, Non-Adjacent	87%	12%	1%
8	Rural, Metro Adjacent	63%	23%	14%
9	Rural, Non-Adjacent	46%	46%	9%
	Overall	**31%**	**55%**	**14%**

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

Nearly one-third of all LPCs grew up in self-described rural areas, and 22% of LPCs who grew up in rural areas currently work in non-metro counties. In total, 10% of all LPCs in the state currently work in non-metro counties.

Top Ten States for Licensed Professional Counselor Recruitment

Rank	All LPCs			
	High School	#	Init. Prof. Degree	#
1	Virginia	2,741	Virginia	3,527
2	New York	317	Maryland	184
3	Pennsylvania	276	Washington, D.C.	167
4	Maryland	222	Minnesota	156
5	North Carolina	208	North Carolina	137
6	Outside U.S./Canada	181	Pennsylvania	115
7	New Jersey	158	New York	109
8	Florida	147	Florida	108
9	Ohio	138	Kentucky	86
10	California	82	Texas	75

Source: Va. Healthcare Workforce Data Center

Nearly half of all LPCs received their high school degree in Virginia, while 64% received their initial professional degree in the state.

Among LPCs who have obtained their initial license in the past five years, 50% received their high school degree in Virginia, while 61% received their initial professional degree in the state.

Rank	Licensed in the Past Five Years			
	High School	#	Init. Prof. Degree	#
1	Virginia	1,320	Virginia	1,605
2	New York	144	Minnesota	129
3	Pennsylvania	116	Washington, D.C.	88
4	North Carolina	107	Maryland	84
5	Maryland	100	New York	69
6	Outside U.S./Canada	82	North Carolina	63
7	Florida	79	Florida	63
8	Ohio	68	Pennsylvania	58
9	New Jersey	61	Kentucky	53
10	Texas	42	Colorado	35

Source: Va. Healthcare Workforce Data Center

Nearly one-fifth of Virginia's licensees did not participate in the state's LPC workforce during the past year. Among licensed LPCs who did not participate in the state's LPC workforce, 90% worked at some point in the past year, including 81% who worked in a job related to the behavioral sciences.

At a Glance:

Not in VA Workforce

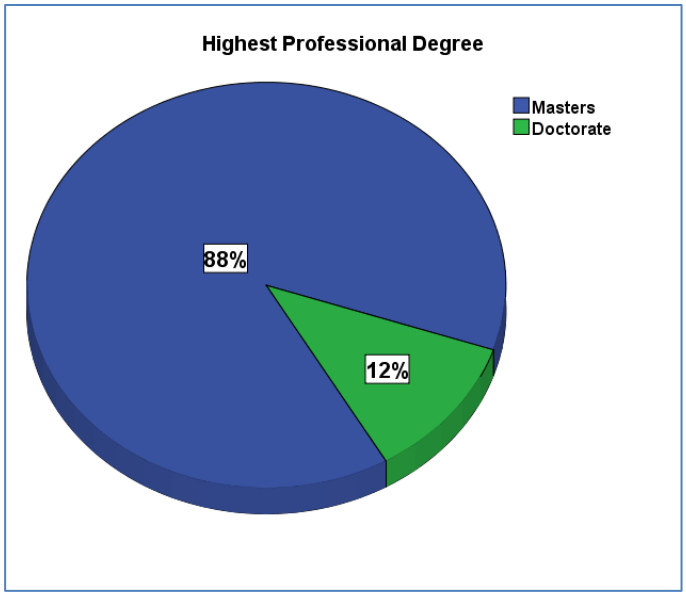
Total:	1,330
% of Licensees:	17%
Federal/Military:	6%
Va. Border State/D.C.:	22%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Highest Degree		
Degree	**#**	**%**
Bachelor's Degree	0	0%
Master's Degree	4,827	88%
Doctor of Psychology	109	2%
Other Doctorate	519	10%
Total	**5,455**	**100%**

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

More than half of all LPCs carry education debt, including 68% of those LPCs who are under the age of 40. For those LPCs with education debt, the median debt amount is between $80,000 and $90,000.

At a Glance:

Education

Masters:	88%
Doctorate/PhD:	12%

Education Debt

Carry Debt:	51%
Under Age 40 w/ Debt:	68%
Median Debt:	$80k-$90k

Source: Va. Healthcare Workforce Data Center

Education Debt				
Amount Carried	**All LPCs**		**LPCs Under 40**	
	#	**%**	**#**	**%**
None	2,376	49%	494	32%
Less than $10,000	173	4%	61	4%
$10,000-$29,999	273	6%	92	6%
$30,000-$49,999	277	6%	114	7%
$50,000-$69,999	268	6%	121	8%
$70,000-$89,999	274	6%	154	10%
$90,000-$109,999	321	7%	163	10%
$110,000-$129,999	231	5%	112	7%
$130,000-$149,999	149	3%	73	5%
$150,000 or More	472	10%	173	11%
Total	**4,814**	**100%**	**1,557**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Primary Specialty

Mental Health:	62%
Child:	7%
Substance Abuse:	5%

Secondary Specialty

Mental Health:	15%
Substance Abuse:	15%
Behavioral Disorders:	13%

Source: Va. Healthcare Workforce Data Center

More than 60% of LPCs have a primary specialty in mental health, while another 7% of LPCs have a primary specialty in children's health.

A Closer Look:

Specialties				
Specialty	Primary		Secondary	
	#	%	#	%
Mental Health	3,362	62%	692	15%
Child	383	7%	419	9%
Substance Abuse	296	5%	686	15%
Behavioral Disorders	272	5%	616	13%
Family	155	3%	368	8%
Marriage	97	2%	280	6%
School/Educational	87	2%	191	4%
Sex Offender Treatment	40	1%	54	1%
Forensic	26	0%	50	1%
Vocational/Work Environment	21	0%	40	1%
Health/Medical	12	0%	35	1%
Rehabilitation	11	0%	24	1%
Public Health	7	0%	17	0%
Neurology/Neuropsychology	6	0%	8	0%
Social	3	0%	18	0%
Gerontologic	1	0%	8	0%
Industrial-Organizational	1	0%	8	0%
Experimental or Research	0	0%	5	0%
General Practice (Non-Specialty)	399	7%	794	17%
Other Specialty Area	223	4%	406	9%
Total	**5,403**	**100%**	**4,717**	**100%**

Source: Va. Healthcare Workforce Data Center

Current Employment Situation

At a Glance:

Employment

Employed in Profession: 94%
Involuntarily Unemployed: < 1%

Positions Held

1 Full-Time: 54%
2 or More Positions: 27%

Weekly Hours:

40 to 49: 43%
60 or More: 6%
Less than 30: 19%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Current Work Status		
Status	**#**	**%**
Employed, Capacity Unknown	5	< 1%
Employed in a Behavioral Sciences-Related Capacity	5,164	94%
Employed, NOT in a Behavioral Sciences-Related Capacity	129	2%
Not Working, Reason Unknown	0	0%
Involuntarily Unemployed	15	< 1%
Voluntarily Unemployed	104	2%
Retired	73	1%
Total	**5,490**	**100%**

Source: Va. Healthcare Workforce Data Center

More than 90% of all LPCs are currently employed in the profession, 54% hold one full-time job, and 43% work between 40 and 49 hours per week.

Current Weekly Hours		
Hours	**#**	**%**
0 Hours	192	4%
1 to 9 Hours	141	3%
10 to 19 Hours	341	6%
20 to 29 Hours	519	10%
30 to 39 Hours	897	17%
40 to 49 Hours	2,293	43%
50 to 59 Hours	686	13%
60 to 69 Hours	250	5%
70 to 79 Hours	40	1%
80 or More Hours	23	0%
Total	**5,382**	**100%**

Source: Va. Healthcare Workforce Data Center

Current Positions		
Positions	**#**	**%**
No Positions	192	4%
One Part-Time Position	814	15%
Two Part-Time Positions	234	4%
One Full-Time Position	2,942	54%
One Full-Time Position & One Part-Time Position	1,029	19%
Two Full-Time Positions	40	1%
More than Two Positions	152	3%
Total	**5,403**	**100%**

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Annual Income		
Income Level	**#**	**%**
Volunteer Work Only	37	1%
Less than $20,000	247	6%
$20,000-$29,999	185	4%
$30,000-$39,999	244	6%
$40,000-$49,999	400	9%
$50,000-$59,999	593	14%
$60,000-$69,999	685	16%
$70,000-$79,999	662	15%
$80,000-$89,999	423	10%
$90,000-$99,999	236	6%
$100,000 or More	574	13%
Total	**4,285**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Earnings
Median Income: $60k-$70k

Benefits
(Salary/Wage Employees Only)
Health Insurance: 61%
Retirement: 57%

Satisfaction
Satisfied: 96%
Very Satisfied: 71%

Source: Va. Healthcare Workforce Data Center

Job Satisfaction		
Level	**#**	**%**
Very Satisfied	3,753	71%
Somewhat Satisfied	1,295	25%
Somewhat Dissatisfied	169	3%
Very Dissatisfied	46	1%
Total	**5,263**	**100%**

Source: Va. Healthcare Workforce Data Center

The typical LPC earns between $60,000 and $70,000 per year. Among LPCs who receive either an hourly wage or a salary as compensation at their primary work location, 61% have access to health insurance, and 57% have access to a retirement plan.

Employer-Sponsored Benefits			
Benefit	**#**	**%**	**% of Wage/Salary Employees**
Paid Vacation	2,382	46%	66%
Health Insurance	2,257	44%	61%
Paid Sick Leave	2,149	42%	60%
Dental Insurance	2,142	41%	59%
Retirement	2,102	41%	57%
Group Life Insurance	1,596	31%	44%
Signing/Retention Bonus	199	4%	5%
At Least One Benefit	**2,821**	**55%**	**75%**

*From any employer at time of survey.

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Employment Instability in the Past Year		
In the Past Year, Did You . . .?	**#**	**%**
Work Two or More Positions at the Same Time?	1,722	26%
Switch Employers or Practices?	546	8%
Experience Voluntary Unemployment?	238	4%
Experience Involuntary Unemployment?	181	3%
Work Part-Time or Temporary Positions, but Would Have Preferred a Full-Time/Permanent Position?	150	2%
Experience At Least One	**2,325**	**36%**

Source: Va. Healthcare Workforce Data Center

Only 3% of Virginia's LPCs experienced involuntary unemployment at some point during the past year. By comparison, Virginia's average monthly unemployment rate was 5.6% during the same time period.[2]

Location Tenure				
Tenure	**Primary**		**Secondary**	
	#	**%**	**#**	**%**
Not Currently Working at This Location	104	2%	57	4%
Less than 6 Months	284	5%	174	11%
6 Months to 1 Year	456	9%	224	15%
1 to 2 Years	1,109	21%	345	23%
3 to 5 Years	1,281	24%	352	23%
6 to 10 Years	885	17%	197	13%
More than 10 Years	1,129	22%	178	12%
Subtotal	**5,247**	**100%**	**1,528**	**100%**
Did Not Have Location	122		4,937	
Item Missing	1,166		71	
Total	**6,535**		**6,535**	

Source: Va. Healthcare Workforce Data Center

More than half of all LPCs are salaried employees, while 22% receive income from their own business or practice.

At a Glance:

Unemployment Experience

Involuntarily Unemployed: 3%
Underemployed: 2%

Turnover & Tenure

Switched Jobs: 8%
New Location: 22%
Over 2 Years: 63%
Over 2 Yrs., 2nd Location: 48%

Employment Type

Salary/Commission: 55%
Business/Practice Income: 22%

Source: Va. Healthcare Workforce Data Center

Nearly two-thirds of all LPCs have worked at their primary work location for more than two years.

Employment Type		
Primary Work Site	**#**	**%**
Salary/Commission	2,240	55%
Business/Practice Income	911	22%
Hourly Wage	569	14%
By Contract	341	8%
Unpaid	20	0%
Subtotal	**4,081**	**100%**
Did Not Have Location	122	
Item Missing	2,332	

Source: Va. Healthcare Workforce Data Center

[2] As reported by the U.S. Bureau of Labor Statistics. Over the past year, the non-seasonally adjusted monthly unemployment rate has fluctuated between a low of 3.9% and a high of 8.1%. At the time of publication, the unemployment rate for June 2021 was still preliminary.

Work Site Distribution

At a Glance:

Concentration

Top Region:	29%
Top 3 Regions:	69%
Lowest Region:	1%

Locations

2 or More (Past Year):	30%
2 or More (Now*):	28%

Source: Va. Healthcare Workforce Data Center

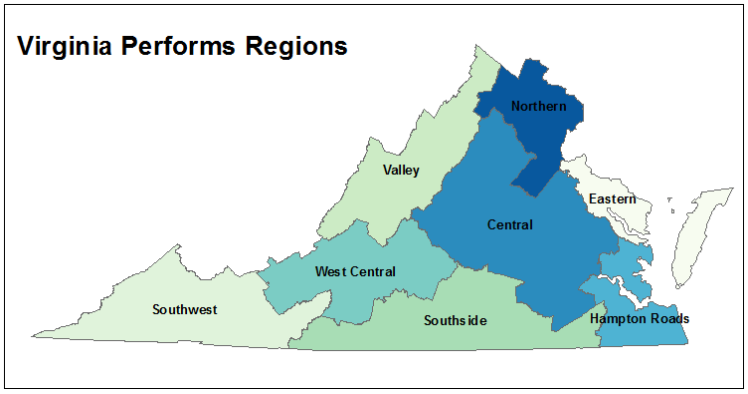
More than two-thirds of all LPCs in the state work in Northern Virginia, Central Virginia, and Hampton Roads.

A Closer Look:

Regional Distribution of Work Locations

Virginia Performs Region	Primary Location		Secondary Location	
	#	%	#	%
Northern	1,542	29%	440	28%
Central	1,043	20%	322	21%
Hampton Roads	1,030	20%	301	19%
West Central	695	13%	194	12%
Valley	348	7%	79	5%
Southwest	253	5%	57	4%
Southside	193	4%	60	4%
Eastern	60	1%	21	1%
Virginia Border State/D.C.	23	0%	22	1%
Other U.S. State	45	1%	61	4%
Outside of the U.S.	1	0%	7	0%
Total	**5,233**	**100%**	**1,564**	**100%**
Item Missing	1,181		34	

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

Number of Work Locations

Locations	Work Locations in Past Year		Work Locations Now*	
	#	%	#	%
0	113	2%	189	4%
1	3,642	68%	3,683	69%
2	823	15%	819	15%
3	709	13%	628	12%
4	36	1%	23	0%
5	12	0%	6	0%
6 or More	16	0%	5	0%
Total	**5,351**	**100%**	**5,351**	**100%**

*At the time of survey completion, June 2021.

Source: Va. Healthcare Workforce Data Center

More than one-quarter of all LPCs currently have multiple work locations, while 30% have had multiple work locations over the past year.

Establishment Type

A Closer Look:

Location Sector				
Sector	Primary Location		Secondary Location	
	#	%	#	%
For-Profit	2,971	61%	1,096	77%
Non-Profit	834	17%	182	13%
State/Local Government	946	19%	128	9%
Veterans Administration	12	0%	1	0%
U.S. Military	86	2%	11	1%
Other Federal Government	52	1%	3	0%
Total	**4,901**	**100%**	**1,421**	**100%**
Did Not Have Location	122		4,937	
Item Missing	1,512		177	

Source: Va. Healthcare Workforce Data Center

At a Glance:
(Primary Locations)

Sector

For-Profit: 61%
Federal: 3%

Top Establishments

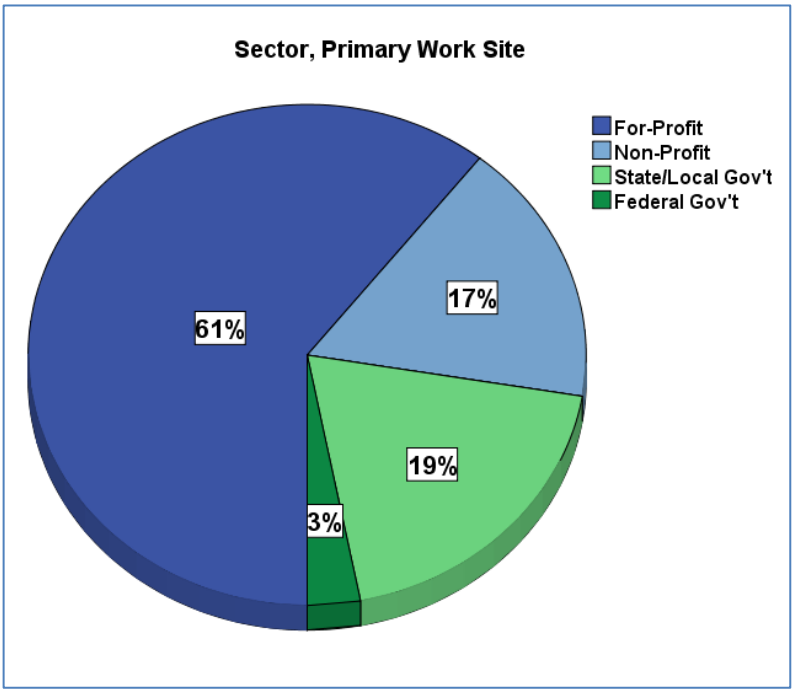
Private Practice, Group: 21%
Private Practice, Solo: 19%
Community Services Board: 14%

Payment Method

Cash/Self-Pay: 65%
Private Insurance: 55%

Source: Va. Healthcare Workforce Data Center

Nearly 80% of LPCs work in the private sector, including 61% who work in the for-profit sector. Another 19% of LPCs work for a state or local government.



Source: Va. Healthcare Workforce Data Center

Location Type				
Establishment Type	Primary Location		Secondary Location	
	#	%	#	%
Private Practice, Group	971	21%	358	26%
Private Practice, Solo	875	19%	306	22%
Community Services Board	639	14%	71	5%
Mental Health Facility, Outpatient	599	13%	163	12%
Community-Based Clinic or Health Center	417	9%	135	10%
School (Providing Care to Clients)	241	5%	25	2%
Academic Institution (Teaching Health Professions Students)	130	3%	61	4%
Corrections/Jail	90	2%	10	1%
Residential Mental Health/Substance Abuse Facility	88	2%	15	1%
Hospital, Psychiatric	68	1%	39	3%
Hospital, General	63	1%	12	1%
Administrative or Regulatory	49	1%	10	1%
Physician Office	15	0%	2	0%
Residential Intellectual/Development Disability Facility	11	0%	5	0%
Home Health Care	11	0%	2	0%
Rehabilitation Facility	11	0%	1	0%
Other Practice Setting	352	8%	149	11%
Total	**4,630**	**100%**	**1,364**	**100%**
Did Not Have a Location	122		4,937	

Source: Va. Healthcare Workforce Data Center

Group and solo private practices employ 40% of all LPCs in Virginia. Another 14% of LPCs work at community services boards.

Nearly two-thirds of all LPCs work at establishments that accept cash/self-pay as a form of payment for services rendered. This makes cash/self-pay the most commonly accepted form of payment among Virginia's LPC workforce.

Accepted Forms of Payment		
Payment	#	% of Workforce
Cash/Self-Pay	4,277	65%
Private Insurance	3,603	55%
Medicaid	2,523	39%
Medicare	535	8%

Source: Va. Healthcare Workforce Data Center

Time Allocation

At a Glance:
(Primary Locations)

Typical Time Allocation

Patient Care:	70%-79%
Administration:	10%-19%

Roles

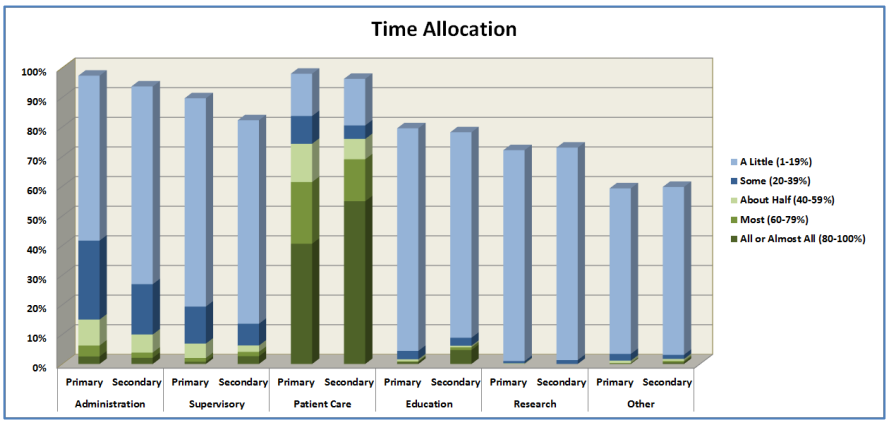
Patient Care:	61%
Administration:	6%
Supervisory:	2%

Patient Care LPCs

Median Admin. Time:	10%-19%
Avg. Admin. Time:	10%-19%

Source: Va. Healthcare Workforce Data Center

A Closer Look:



Source: Va. Healthcare Workforce Data Center

LPCs spend approximately 75% of their time treating patients. In fact, 61% of all LPCs fill a patient care role, defined as spending 60% or more of their time on patient care activities.

Time Allocation												
Time Spent	Admin.		Supervisory		Patient Care		Education		Research		Other	
	Pri. Site	Sec. Site	Pri. Site	Sec. Site	Pri. Site	Sec. Site	Pri. Site	Sec. Site	Pri. Site	Sec. Site	Pri. Site	Sec. Site
All or Almost All (80-100%)	3%	2%	1%	3%	41%	55%	1%	5%	0%	0%	0%	1%
Most (60-79%)	4%	2%	1%	1%	21%	14%	0%	1%	0%	0%	0%	0%
About Half (40-59%)	9%	6%	5%	2%	13%	7%	1%	1%	0%	0%	1%	1%
Some (20-39%)	27%	17%	12%	7%	9%	5%	3%	3%	1%	1%	2%	1%
A Little (1-19%)	56%	67%	70%	69%	14%	16%	75%	69%	71%	72%	56%	57%
None (0%)	3%	6%	10%	18%	2%	4%	20%	22%	28%	27%	41%	40%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Patients Per Week				
# of Patients	Primary Location		Secondary Location	
	#	%	#	%
None	419	9%	167	12%
1 to 24	2,972	61%	1,057	77%
25 to 49	1,338	28%	128	9%
50 to 74	78	2%	10	1%
75 or More	36	1%	8	1%
Total	**4,843**	**100%**	**1,370**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

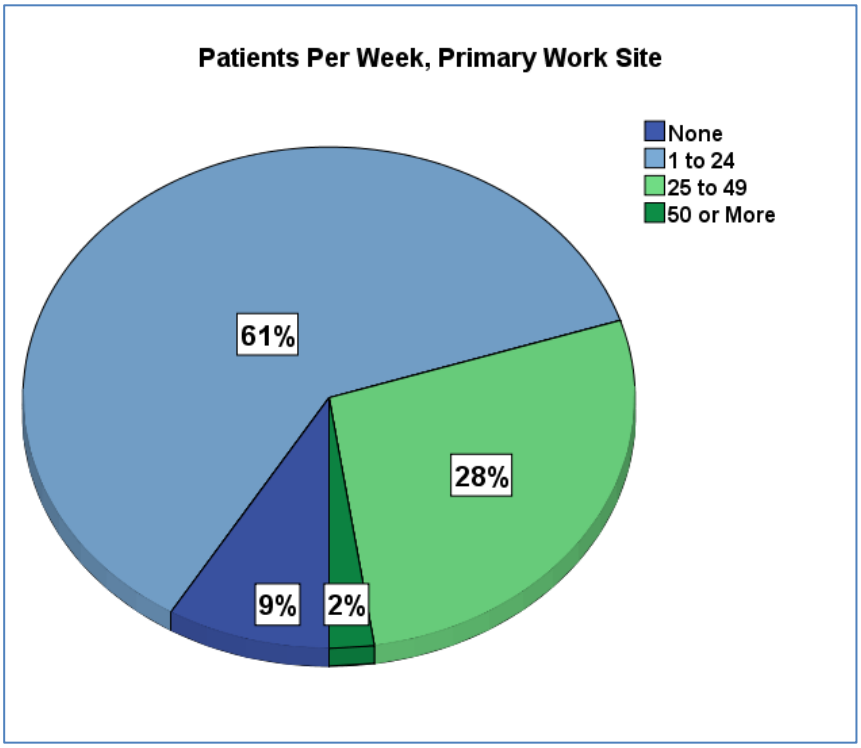
Patients Per Week

Primary Location: 1-24

Secondary Location: 1-24

Source: Va. Healthcare Workforce Data Center

More than 60% of all LPCs treat between 1 and 24 patients per week at their primary work location. Among those LPCs who also have a secondary work location, more than three-quarters treat between 1 and 24 patients per week.



Source: Va. Healthcare Workforce Data Center

At a Glance:
(Primary Locations)

Typical Patient Allocation

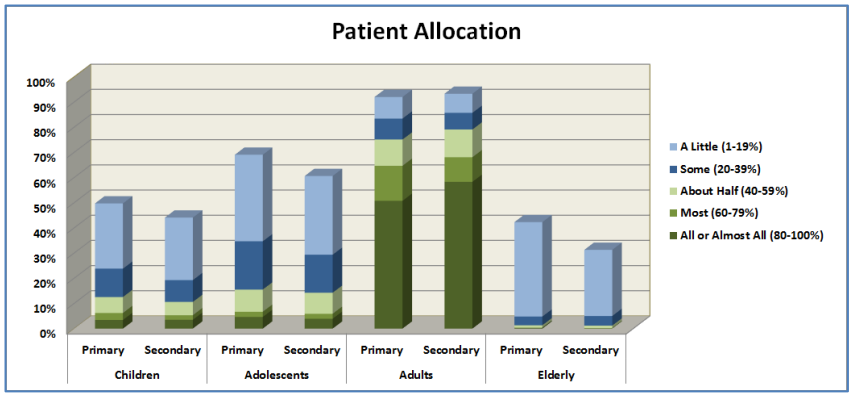
Children:	None
Adolescents:	1%-9%
Adults:	80%-89%
Elderly:	None

Roles

Children:	6%
Adolescents:	7%
Adults:	65%
Elderly:	0%

Source: Va. Healthcare Workforce Data Center

A Closer Look:



Source: Va. Healthcare Workforce Data Center

In general, approximately 85% of all patients seen by LPCs at their primary work location are adults. In addition, 65% of LPCs serve an adult patient care role, meaning that at least 60% of their patients are adults.

Patient Allocation								
Time Spent	Children		Adolescents		Adults		Elderly	
	Pri. Site	Sec. Site	Pri. Site	Sec. Site	Pri. Site	Sec. Site	Pri. Site	Sec. Site
All or Almost All (80-100%)	3%	4%	5%	4%	51%	58%	0%	0%
Most (60-79%)	3%	2%	2%	2%	14%	10%	0%	0%
About Half (40-59%)	6%	5%	9%	8%	10%	11%	1%	1%
Some (20-39%)	11%	9%	19%	15%	8%	7%	3%	4%
A Little (1-19%)	26%	25%	34%	31%	9%	8%	37%	26%
None (0%)	50%	56%	31%	39%	8%	7%	58%	69%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Retirement Expectations				
Expected Retirement Age	All LPCs		LPCs 50 and Over	
	#	%	#	%
Under Age 50	49	1%	-	-
50 to 54	114	2%	7	0%
55 to 59	300	6%	44	2%
60 to 64	838	18%	213	11%
65 to 69	1,436	31%	566	29%
70 to 74	891	19%	501	26%
75 to 79	364	8%	233	12%
80 or Over	157	3%	92	5%
I Do Not Intend to Retire	526	11%	263	14%
Total	**4,677**	**100%**	**1,919**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Retirement Expectations

All LPCs

Under 65: 28%
Under 60: 10%

LPCs 50 and Over

Under 65: 14%
Under 60: 3%

Time Until Retirement

Within 2 Years: 6%
Within 10 Years: 20%
Half the Workforce: By 2046

Source: Va. Healthcare Workforce Data Center

Among all LPCs, 28% expect to retire before the age of 65. Among those LPCs who are age 50 or over, 14% expect to retire by the age of 65.

Within the next two years, 14% of LPCs expect to increase their patient care hours, and 11% expect to pursue additional educational opportunities.

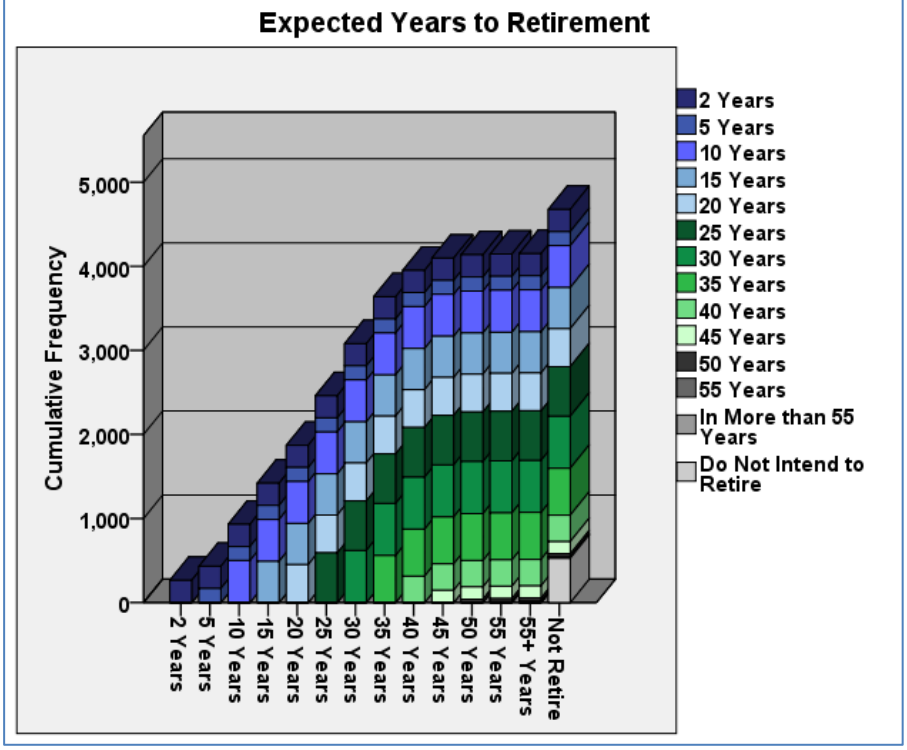
Future Plans		
Two-Year Plans:	#	%
Decrease Participation		
Decrease Patient Care Hours	595	9%
Leave Virginia	122	2%
Leave Profession	77	1%
Decrease Teaching Hours	55	1%
Increase Participation		
Increase Patient Care Hours	932	14%
Pursue Additional Education	742	11%
Increase Teaching Hours	451	7%
Return to Virginia's Workforce	49	1%

Source: Va. Healthcare Workforce Data Center

By comparing retirement expectation to age, we can estimate the maximum years to retirement for LPCs. While 6% of LPCs expect to retire in the next two years, 20% expect to retire in the next ten years. Half of the current workforce expect to retire by 2046.

Time to Retirement			
Expect to Retire Within. . .	#	%	Cumulative %
2 Years	264	6%	6%
5 Years	167	4%	9%
10 Years	499	11%	20%
15 Years	489	10%	30%
20 Years	451	10%	40%
25 Years	590	13%	53%
30 Years	619	13%	66%
35 Years	559	12%	78%
40 Years	314	7%	84%
45 Years	146	3%	88%
50 Years	39	1%	88%
55 Years	9	0%	89%
In More than 55 Years	5	0%	89%
Do Not Intend to Retire	526	11%	100%
Total	**4,677**	**100%**	

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

Using these estimates, retirement will begin to reach 10% of the current workforce starting in 2031. Retirement will peak at 13% of the current workforce around 2051 before declining to under 10% of the current workforce again around 2061.

Full-Time Equivalency Units

At a Glance:

FTEs

Total:	5,263
FTEs/1,000 Residents[3]:	0.617
Average:	0.82

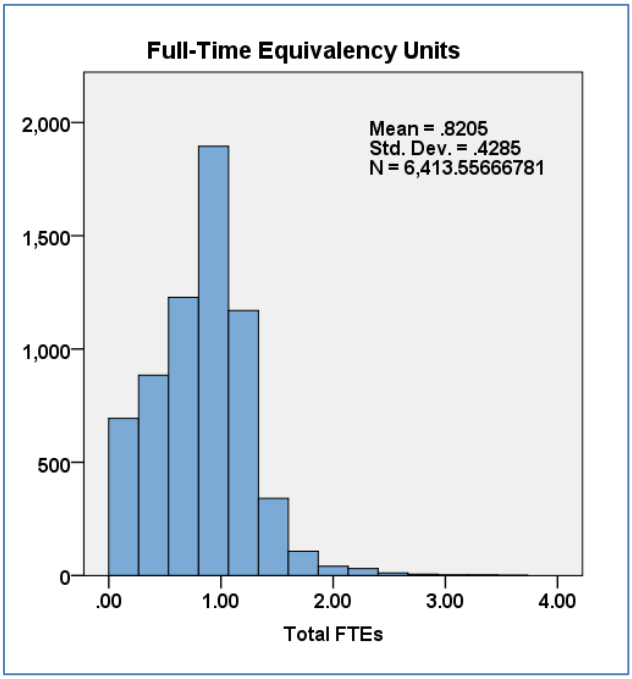
Age & Gender Effect

Age, *Partial Eta*^{2}:	Small
Gender, *Partial Eta*^{2}:	Small

Partial Eta^2 *Explained:* *Partial Eta*^{2} is a statistical measure of effect size.

Source: Va. Healthcare Workforce Data Center

A Closer Look:

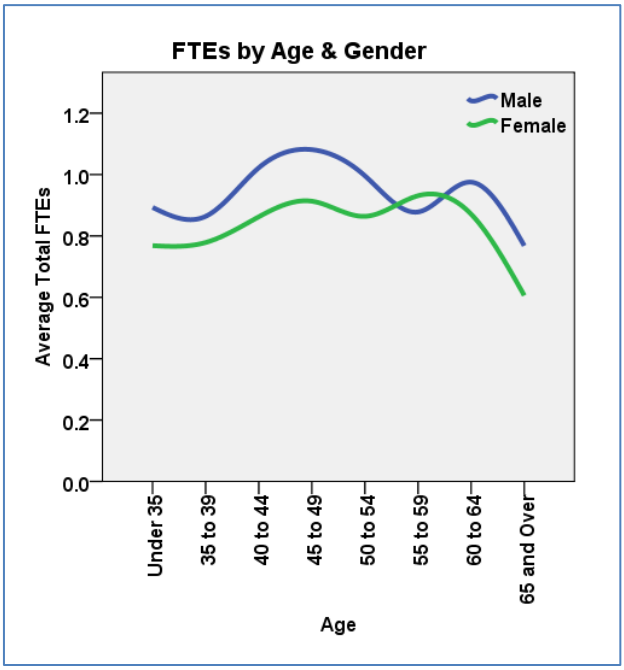


Source: Va. Healthcare Workforce Data Center

The typical (median) LPC provided 0.84 FTEs over the past year, or approximately 34 hours per week for 50 weeks. Although FTEs appear to vary by age and gender, statistical tests did not verify that a difference exists.[4]

Full-Time Equivalency Units		
Age	**Average Age**	**Median Age**
Under 35	0.77	0.80
35 to 39	0.74	0.80
40 to 44	0.88	0.84
45 to 49	0.95	1.01
50 to 54	0.83	0.81
55 to 59	0.94	0.99
60 to 64	0.90	0.91
65 and Over	0.67	0.72
Gender		
Male	0.92	1.01
Female	0.81	0.85

Source: Va. Healthcare Workforce Data Center



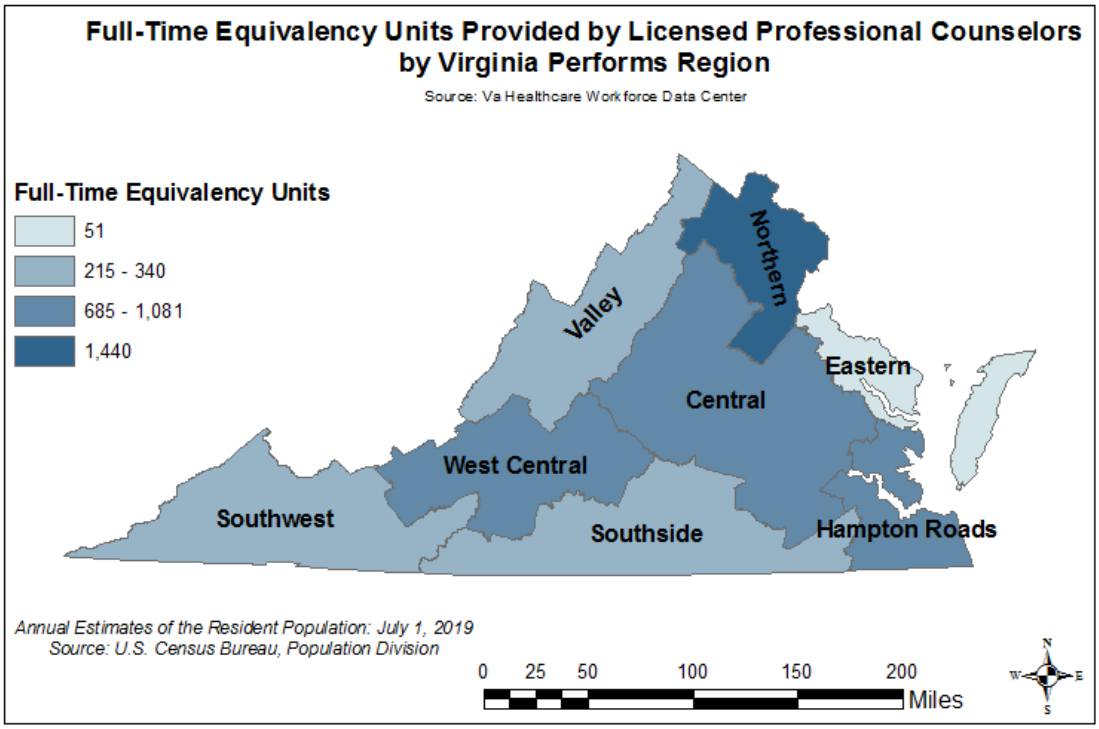
Source: Va. Healthcare Workforce Data Center

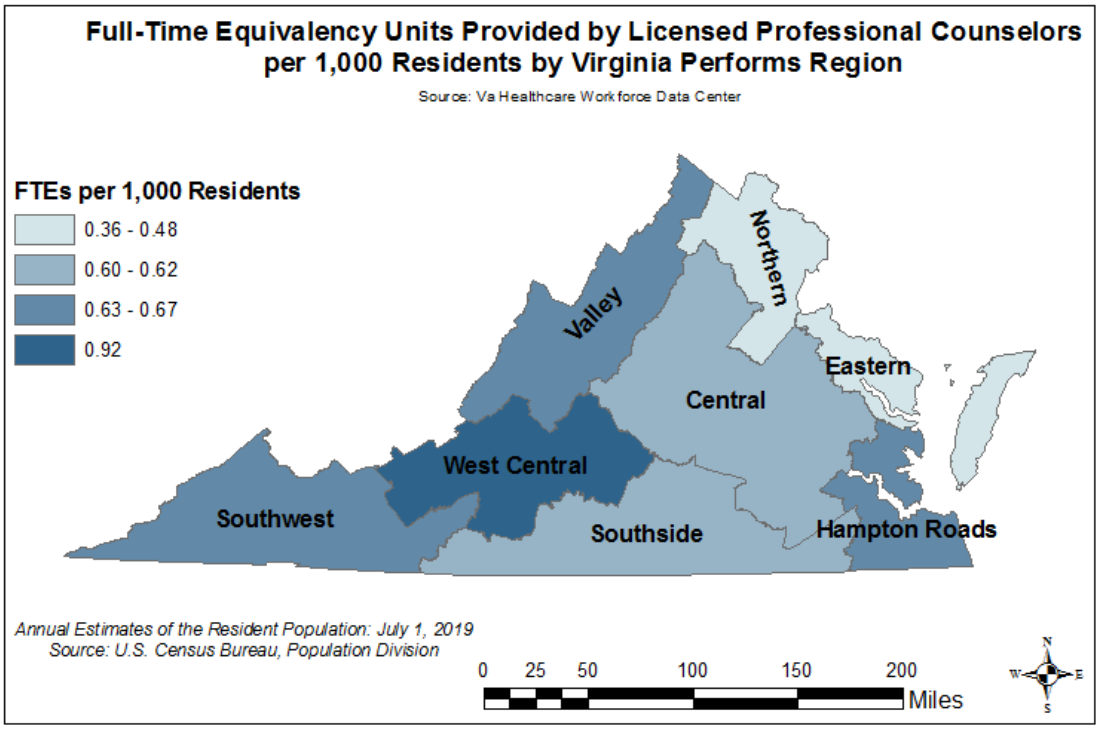
[3] Number of residents in 2019 was used as the denominator.

[4] Due to assumption violations in Mixed between-within ANOVA (Levene's Test was significant).

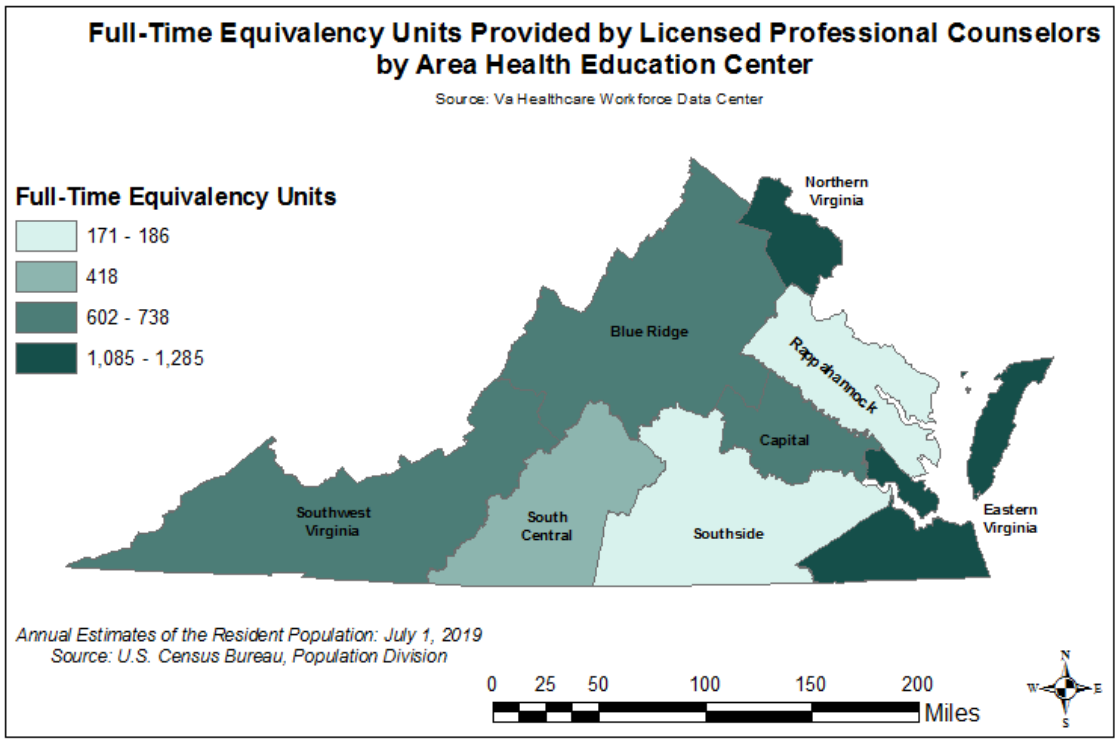
Maps

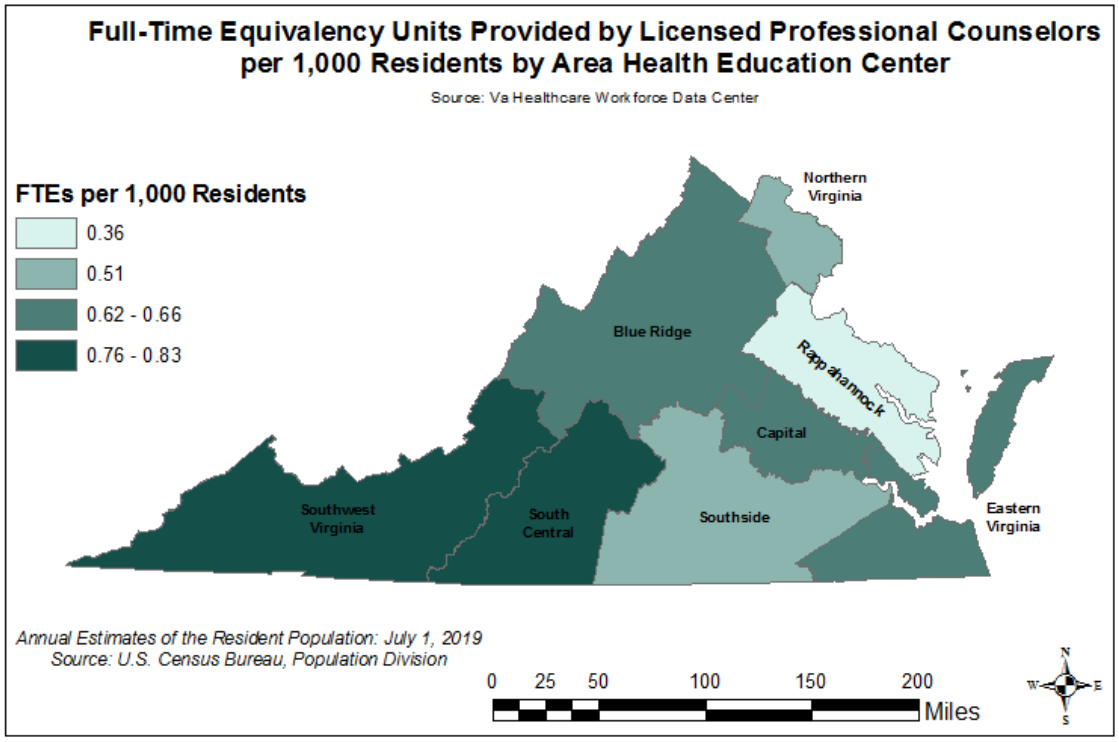
Virginia Performs Regions



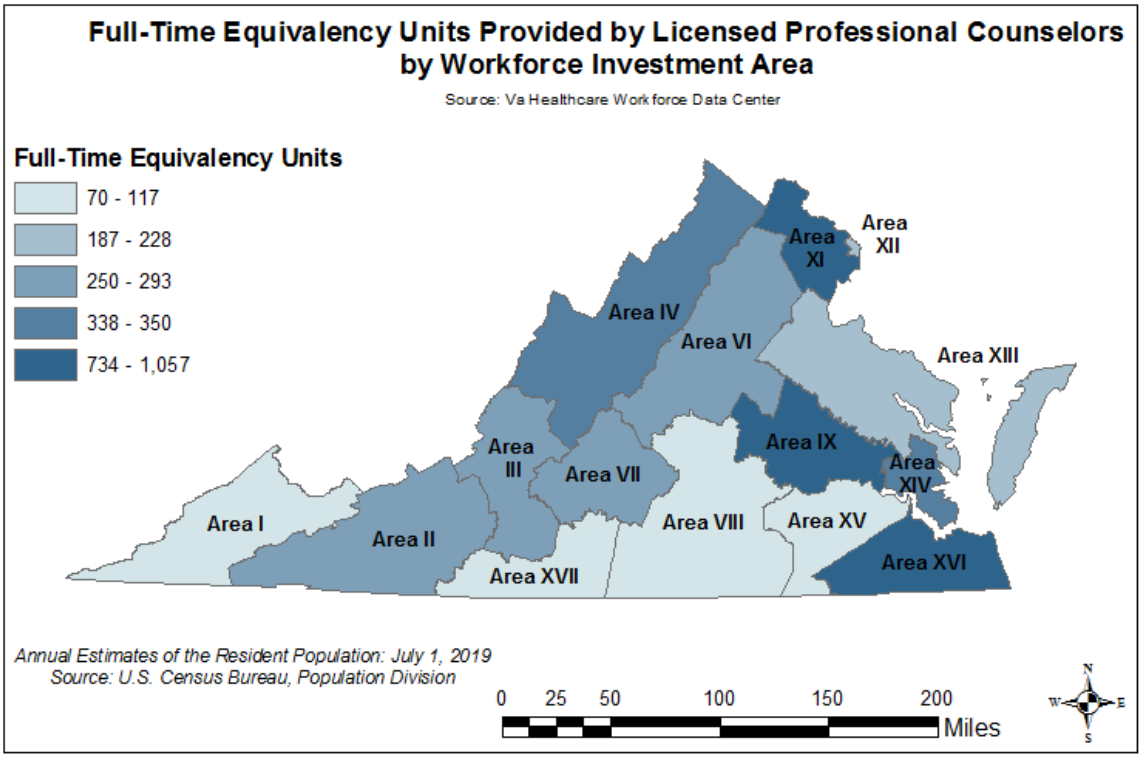


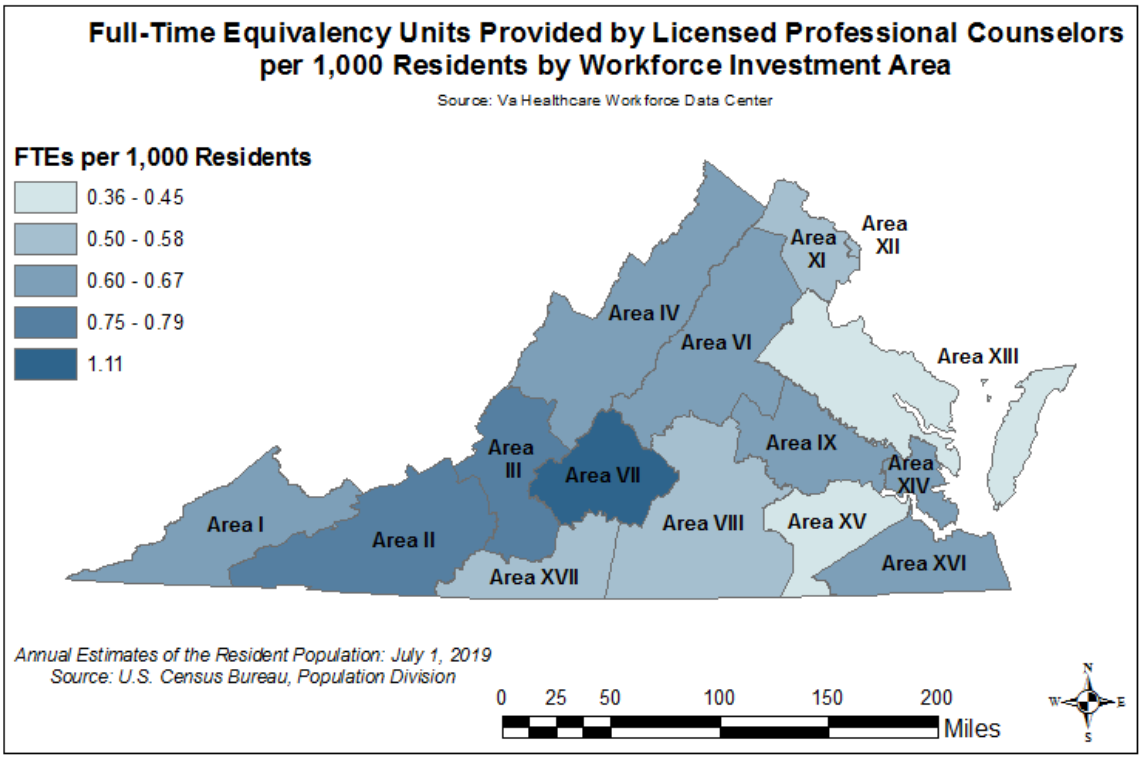
Area Health Education Center Regions



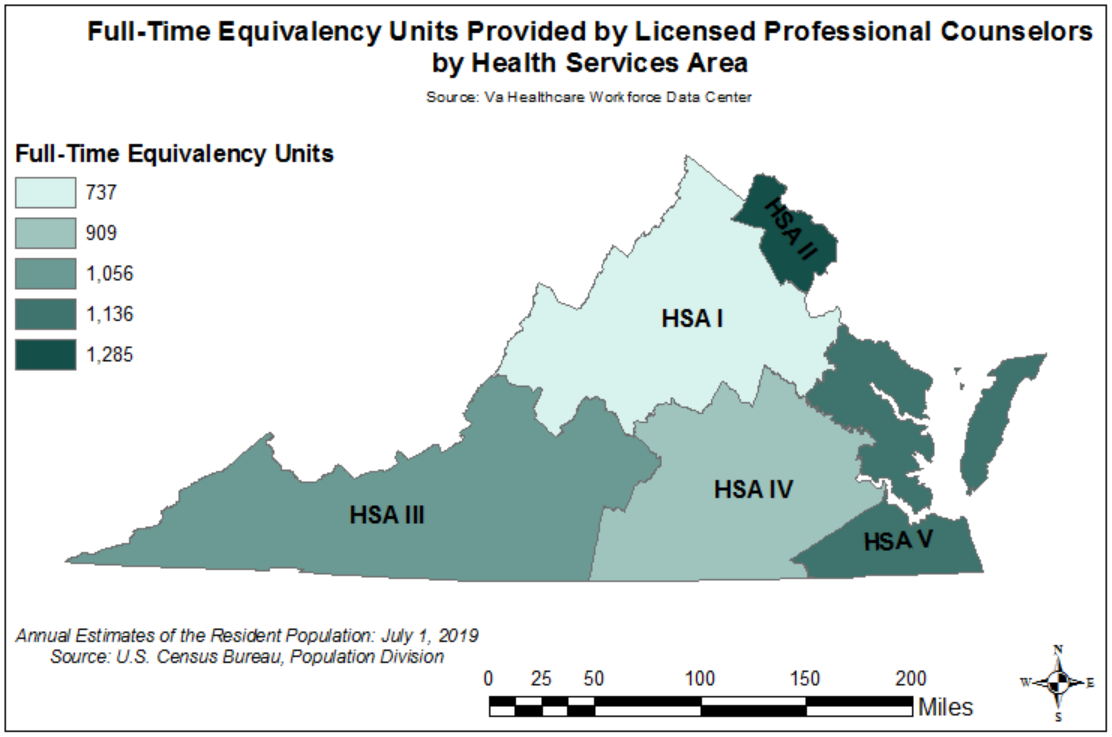


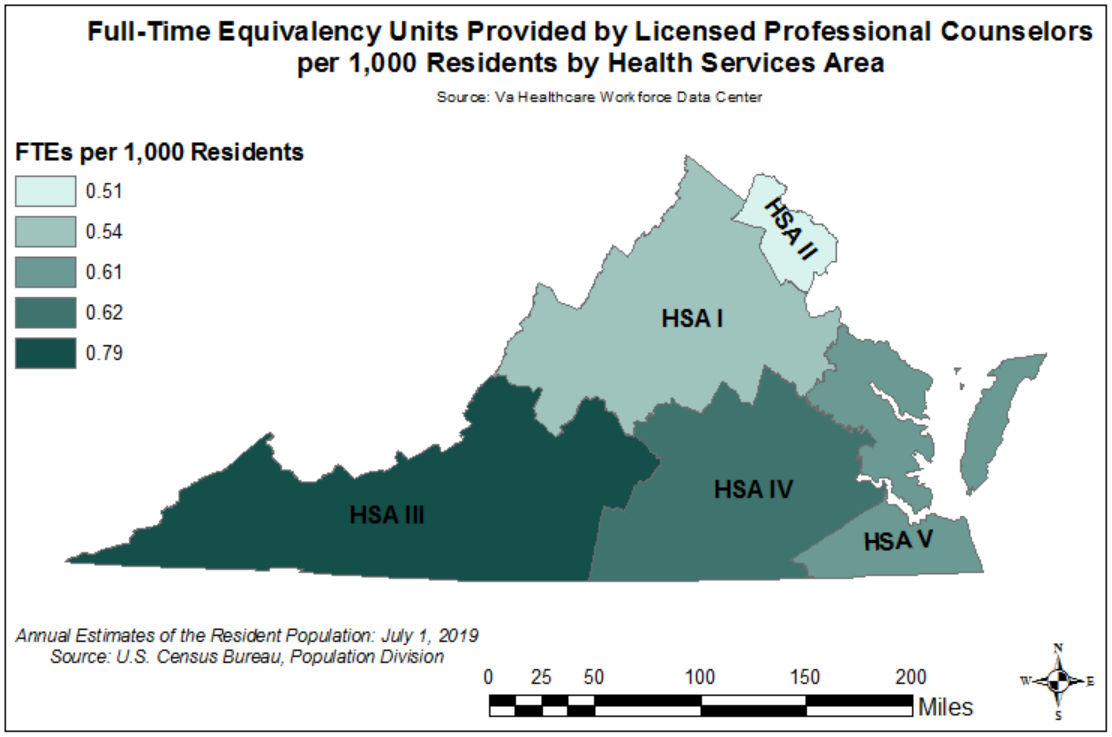
Workforce Investment Areas



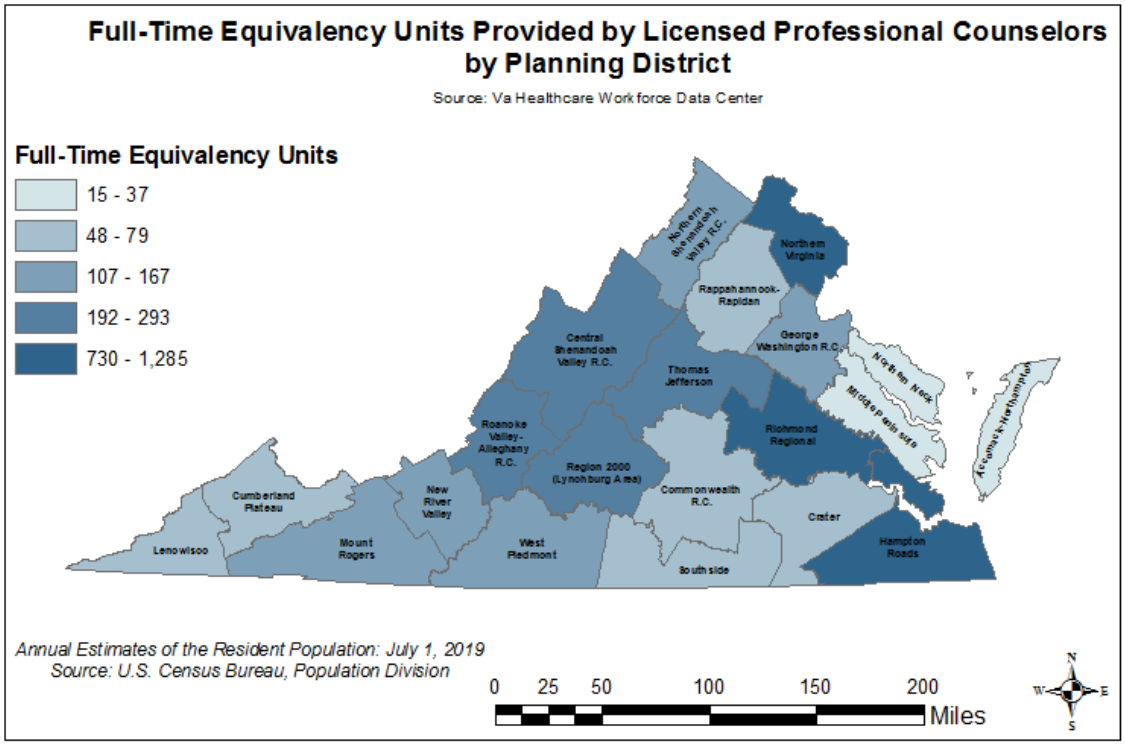


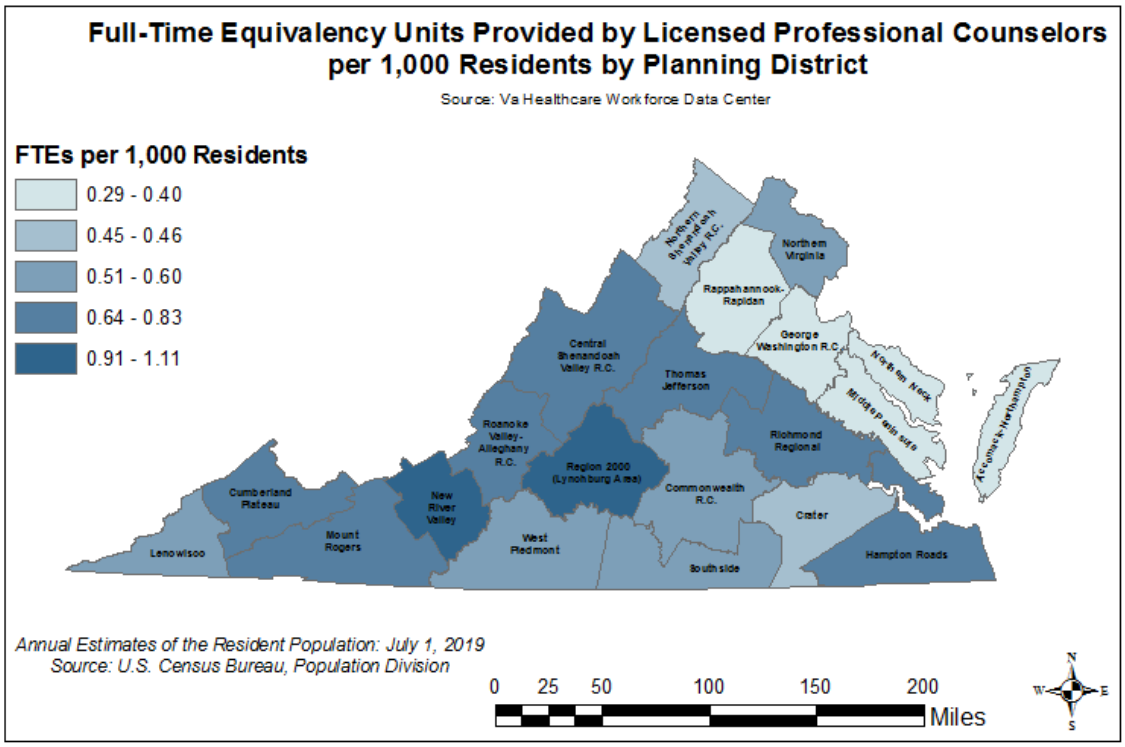
Health Services Areas





Planning Districts





Appendices

Appendix A: Weights

Rural Status	Location Weight			Total Weight	
	#	Rate	Weight	Min.	Max.
Metro, 1 Million+	4,111	85.58%	1.169	1.119	1.325
Metro, 250,000 to 1 Million	739	89.04%	1.123	1.076	1.273
Metro, 250,000 or Less	830	87.47%	1.143	1.095	1.296
Urban, Pop. 20,000+, Metro Adj.	78	91.03%	1.099	1.052	1.245
Urban, Pop. 20,000+, Non-Adj.	0	NA	NA	NA	NA
Urban, Pop. 2,500-19,999, Metro Adj.	215	85.58%	1.168	1.119	1.325
Urban, Pop. 2,500-19,999, Non-Adj.	144	86.11%	1.161	1.112	1.316
Rural, Metro Adj.	99	76.77%	1.303	1.248	1.477
Rural, Non-Adj.	43	69.77%	1.433	1.373	1.625
Virginia Border State/D.C.	856	59.23%	1.688	1.617	1.914
Other U.S. State	750	51.73%	1.933	1.852	2.191

Source: Va. Healthcare Workforce Data Center

Age	Age Weight			Total Weight	
	#	Rate	Weight	Min.	Max.
Under 35	1,124	70.46%	1.419	1.245	2.191
35 to 39	1,238	79.24%	1.262	1.107	1.948
40 to 44	1,156	79.93%	1.251	1.098	1.932
45 to 49	920	81.63%	1.225	1.075	1.891
50 to 54	875	82.63%	1.210	1.062	1.869
55 to 59	674	83.38%	1.199	1.052	1.852
60 to 64	640	83.28%	1.201	1.054	1.854
65 and Over	1,239	82.08%	1.218	1.069	1.881

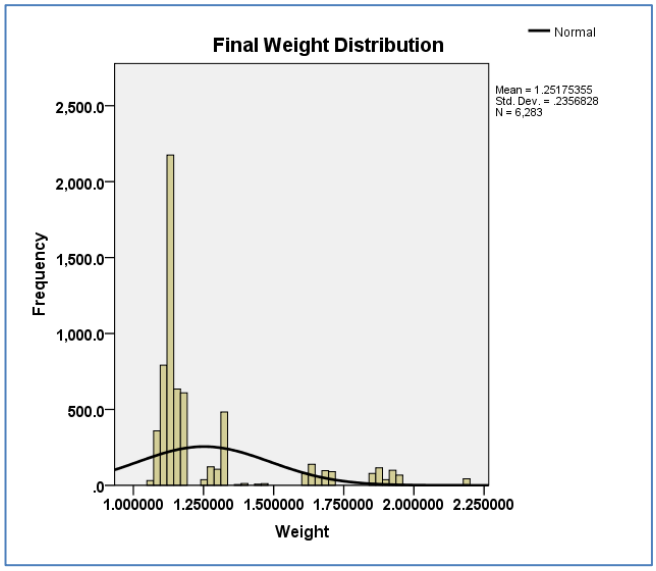
Source: Va. Healthcare Workforce Data Center

See the Methods section on the HWDC website for details on HWDC methods: https://www.dhp.virginia.gov/PublicResources/HealthcareWorkforceDataCenter/

Final weights are calculated by multiplying the two weights and the overall response rate:

Age Weight x Rural Weight x Response Rate = Final Weight.

Overall Response Rate: **0.798754**



Source: Va. Healthcare Workforce Data Center

Agenda Item: Regulatory Actions - Chart of Regulatory Actions As of October 22, 2021

Chapter		Action / Stage Information
[18 VAC 115 - 20]	Regulations Governing the Practice of Professional Counseling	Periodic review [Action 5230] Proposed - *At Governor's Office for 319 days*
[18 VAC 115 - 30]	Regulations Governing the Certification of Substance Abuse Counselors	Clarification on independent practice [Action 5692] Fast-Track - *At Secretary's Office for 204 days*
[18 VAC 115 - 40]	Regulations Governing the Certification of Rehabilitation Providers	Periodic review [Action 5305] Final - *Register Date: 8/30/21 Effective: 9/29/21*
[18 VAC 115 - 90]	Regulations Governing the Practice of Art Therapy (under development)	New chapter for licensure [Action 5656] NOIRA - *Register Date: 3/1/21* Board to adopt proposed regulations 11/5/21

Virginia Board of Counseling

Meetings Held with Electronic Participation

Purpose:

To establish a written policy for holding meetings of the Board of Counseling with electronic participation by some of its members and the public.

Policy:

This policy for conducting a meeting with electronic participation shall be in accordance with *§ 2.2-3708.2 of the Code of Virginia.*

Authority:

§ 2.2-3708.2. Meetings held through electronic communication means.

A. The following provisions apply to all public bodies:
1. Subject to the requirements of subsection C, all public bodies may conduct any meeting wherein the public business is discussed or transacted through electronic communication means if, on or before the day of a meeting, a member of the public body holding the meeting notifies the chair of the public body that:
a. Such member is unable to attend the meeting due to (i) a temporary or permanent disability or other medical condition that prevents the member's physical attendance or (ii) a family member's medical condition that requires the member to provide care for such family member, thereby preventing the member's physical attendance; or
b. Such member is unable to attend the meeting due to a personal matter and identifies with specificity the nature of the personal matter. Participation by a member pursuant to this subdivision b is limited each calendar year to two meetings or 25 percent of the meetings held per calendar year rounded up to the next whole number, whichever is greater.
2. If participation by a member through electronic communication means is approved pursuant to subdivision 1, the public body holding the meeting shall record in its minutes the remote location from which the member participated; however, the remote location need not be open to the public. If participation is approved pursuant to subdivision 1 a, the public body shall also include in its minutes the fact that the member participated through electronic communication means due to (i) a temporary or permanent disability or other medical condition that prevented the member's physical attendance or (ii) a family member's medical condition that required the member to provide care for such family member, thereby preventing the member's physical attendance. If participation is approved pursuant to subdivision 1 b, the public body shall also include in its minutes the specific nature of the personal matter cited by the member.
If a member's participation from a remote location pursuant to subdivision 1 b is disapproved because such participation would violate the policy adopted pursuant to subsection C, such disapproval shall be recorded in the minutes with specificity.

3. Any public body, or any joint meetings thereof, may meet by electronic communication means without a quorum of the public body physically assembled at one location when the Governor has declared a state of emergency in accordance with § 44-146.17 or the locality in which the public body is located has declared a local state of emergency pursuant to § 44-146.21, provided that (i) the catastrophic nature of the declared emergency makes it impracticable or unsafe to assemble a quorum in a single location and (ii) the purpose of the meeting is to provide for the continuity of operations of the public body or the discharge of its lawful purposes, duties, and responsibilities. The public body convening a meeting in accordance with this subdivision shall:
a. Give public notice using the best available method given the nature of the emergency, which notice shall be given contemporaneously with the notice provided to members of the public body conducting the meeting;
b. Make arrangements for public access to such meeting through electronic communication means, including videoconferencing if already used by the public body;
c. Provide the public with the opportunity to comment at those meetings of the public body when public comment is customarily received; and
d. Otherwise comply with the provisions of this chapter.
The nature of the emergency, the fact that the meeting was held by electronic communication means, and the type of electronic communication means by which the meeting was held shall be stated in the minutes.
The provisions of this subdivision 3 shall be applicable only for the duration of the emergency declared pursuant to § 44-146.17 or 44-146.21.
B. The following provisions apply to regional public bodies:
1. Subject to the requirements in subsection C, regional public bodies may also conduct any meeting wherein the public business is discussed or transacted through electronic communication means if, on the day of a meeting, a member of a regional public body notifies the chair of the public body that such member's principal residence is more than 60 miles from the meeting location identified in the required notice for such meeting.
2. If participation by a member through electronic communication means is approved pursuant to this subsection, the public body holding the meeting shall record in its minutes the remote location from which the member participated; however, the remote location need not be open to the public.
If a member's participation from a remote location is disapproved because such participation would violate the policy adopted pursuant to subsection C, such disapproval shall be recorded in the minutes with specificity.
C. Participation by a member of a public body in a meeting through electronic communication means pursuant to subdivisions A 1 and 2 and subsection B shall be authorized only if the following conditions are met:
1. The public body has adopted a written policy allowing for and governing participation of its members by electronic communication means, including an approval process for such participation, subject to the express limitations imposed by this section. Once adopted, the policy shall be applied strictly and uniformly, without exception, to the entire membership and without regard to the identity of the member requesting remote participation or the matters that will be considered or voted on at the meeting;
2. A quorum of the public body is physically assembled at one primary or central meeting location; and

3. The public body makes arrangements for the voice of the remote participant to be heard by all persons at the primary or central meeting location.
D. The following provisions apply to state public bodies:
1. Except as provided in subsection D of § 2.2-3707.01, state public bodies may also conduct any meeting wherein the public business is discussed or transacted through electronic communication means, provided that (i) a quorum of the public body is physically assembled at one primary or central meeting location, (ii) notice of the meeting has been given in accordance with subdivision 2, and (iii) members of the public are provided a substantially equivalent electronic communication means through which to witness the meeting. For the purposes of this subsection, "witness" means observe or listen.
If a state public body holds a meeting through electronic communication means pursuant to this subsection, it shall also hold at least one meeting annually where members in attendance at the meeting are physically assembled at one location and where no members participate by electronic communication means.
2. Notice of any regular meeting held pursuant to this subsection shall be provided at least three working days in advance of the date scheduled for the meeting. Notice, reasonable under the circumstance, of special, emergency, or continued meetings held pursuant to this section shall be given contemporaneously with the notice provided to members of the public body conducting the meeting. For the purposes of this subsection, "continued meeting" means a meeting that is continued to address an emergency or to conclude the agenda of a meeting for which proper notice was given.
The notice shall include the date, time, place, and purpose for the meeting; shall identify the primary or central meeting location and any remote locations that are open to the public pursuant to subdivision 4; shall include notice as to the electronic communication means by which members of the public may witness the meeting; and shall include a telephone number that may be used to notify the primary or central meeting location of any interruption in the telephonic or video broadcast of the meeting. Any interruption in the telephonic or video broadcast of the meeting shall result in the suspension of action at the meeting until repairs are made and public access is restored.
3. A copy of the proposed agenda and agenda packets and, unless exempt, all materials that will be distributed to members of a public body for a meeting shall be made available for public inspection at the same time such documents are furnished to the members of the public body conducting the meeting.
4. Public access to the remote locations from which additional members of the public body participate through electronic communication means shall be encouraged but not required. However, if three or more members are gathered at the same remote location, then such remote location shall be open to the public.
5. If access to remote locations is afforded, (i) all persons attending the meeting at any of the remote locations shall be afforded the same opportunity to address the public body as persons attending at the primary or central location and (ii) a copy of the proposed agenda and agenda packets and, unless exempt, all materials that will be distributed to members of the public body for the meeting shall be made available for inspection by members of the public attending the meeting at any of the remote locations at the time of the meeting.
6. The public body shall make available to the public at any meeting conducted in accordance with this subsection a public comment form prepared by the Virginia Freedom of Information Advisory Council in accordance with § 30-179.

7. Minutes of all meetings held by electronic communication means shall be recorded as required by § 2.2-3707. Votes taken during any meeting conducted through electronic communication means shall be recorded by name in roll-call fashion and included in the minutes. For emergency meetings held by electronic communication means, the nature of the emergency shall be stated in the minutes.
8. Any authorized state public body that meets by electronic communication means pursuant to this subsection shall make a written report of the following to the Virginia Freedom of Information Advisory Council by December 15 of each year:
a. The total number of meetings held that year in which there was participation through electronic communication means;
b. The dates and purposes of each such meeting;
c. A copy of the agenda for each such meeting;
d. The primary or central meeting location of each such meeting;
e. The types of electronic communication means by which each meeting was held;
f. If possible, the number of members of the public who witnessed each meeting through electronic communication means;
g. The identity of the members of the public body recorded as present at each meeting, and whether each member was present at the primary or central meeting location or participated through electronic communication means;
h. The identity of any members of the public body who were recorded as absent at each meeting and any members who were recorded as absent at a meeting but who monitored the meeting through electronic communication means;
i. If members of the public were granted access to a remote location from which a member participated in a meeting through electronic communication means, the number of members of the public at each such remote location;
j. A summary of any public comment received about the process of conducting a meeting through electronic communication means; and
k. A written summary of the public body's experience conducting meetings through electronic communication means, including its logistical and technical experience.
E. Nothing in this section shall be construed to prohibit the use of interactive audio or video means to expand public participation.

Procedures:

1. In order to conduct a meeting with electronic participation, a quorum of the board or a committee of the board must be physically present at a central location.

2. If a quorum is attained, one or more members of the board or committee may participate electronically if, on or before the day of a meeting, the member notifies the chair and the executive director that he/she is unable to attend the meeting due to: 1) a temporary or permanent disability or other medical condition that prevents the member's physical attendance; 2) a family member's medical condition that requires the member to provide care for such family member, thereby preventing the member's physical attendance; or 3) a personal matter, identifying with specificity the nature of the personal matter. Attendance by a member electronically for personal reasons is limited to two meetings per calendar year or no more than 25% of meetings held.

3. Participation by a member through electronic communication means must be approved by the board chair or president.

4. The board or committee holding the meeting shall record in its minutes the remote location from which the member participated; however, the remote location does not need to be open to the public.

5. The board or committee shall also include in its minutes the fact that the member participated through electronic communication means due to a temporary or permanent disability or other medical condition that prevented the member's physical attendance or if the member participated electronically due to a personal matter, the minutes shall state the specific nature of the personal matter cited by the member. If a member's participation from a remote location is disapproved because it would violate this policy, it must be recorded in the minutes with specificity.

6. If a board or committee holds a meeting through electronic communication, it must also hold at least one meeting annually where members are in attendance at the central location and no members participate electronically.

7. Notice of a meeting to be conducted electronically, along with the agenda, should be provided to the public contemporaneously with such information being sent to board members at least three working days in advance of such meeting. Notice of special, emergency, or continued meetings must be given contemporaneously with the notice provided to members.

8. Meeting notices and agendas shall be posted on the Virginia Regulatory Townhall (which sends notice to Commonwealth Calendar and the Board's website). They should also be provided electronically to interested parties on the Board's public participation guidelines list.

9. The notice shall include the date, time, place, and purpose for the meeting; shall identify the primary meeting location; shall include notice as to the electronic communication means by which members of the public may participate in the meeting; and shall include a telephone number that may be used to notify the primary or central meeting location of any interruption in the telephonic or video broadcast of the meeting. Any interruption in the telephonic or video broadcast of the meeting shall result in the suspension of action at the meeting until repairs are made and public access is restored.

10. The board or committee must make arrangement for the voice of the remote participant(s) to be heard by all persons at the primary or central meeting location.

11. The agenda shall include a link to a public comment form prepared by the Virginia Freedom of Information Advisory Council in accordance with § 30-179 to allow members of the public to assess their experience with participation in the electronic meeting.

Form:
Link to Public comment form from the Freedom of Information Council
http://foiacouncil.dls.virginia.gov/sample%20letters/welcome.htm

Adopted on (date): ___ _____

Counseling Compact Model Legislation

As approved by the Advisory Group on December 4, 2020

Special Note

The following language must be enacted by a state in order to officially join the Counseling Compact.

No substantive changes should be made to the model language. Substantive changes may jeopardize the enacting state's participation in the compact.

The Council of State Governments National Center for Interstate Compacts reviews state Compact legislation to ensure consistency with the model language. Please direct any inquiries to Andrew Bates at abates@csg.org.

COUNSELING COMPACT MODEL LEGISLATION

SECTION 1: PURPOSE

The purpose of this Compact is to facilitate interstate practice of Licensed Professional Counselors with the goal of improving public access to Professional Counseling services. The practice of Professional Counseling occurs in the State where the client is located at the time of the counseling services. The Compact preserves the regulatory authority of States to protect public health and safety through the current system of State licensure.

This Compact is designed to achieve the following objectives:

A. Increase public access to Professional Counseling services by providing for the mutual recognition of other Member State licenses;

B. Enhance the States' ability to protect the public's health and safety;

C. Encourage the cooperation of Member States in regulating multistate practice for Licensed Professional Counselors;

D. Support spouses of relocating Active Duty Military personnel;

E. Enhance the exchange of licensure, investigative, and disciplinary information among Member States;

F. Allow for the use of Telehealth technology to facilitate increased access to Professional Counseling services;

G. Support the uniformity of Professional Counseling licensure requirements throughout the States to promote public safety and public health benefits;

H. Invest all Member States with the authority to hold a Licensed Professional Counselor accountable for meeting all State practice laws in the State in which the client is located at the time care is rendered through the mutual recognition of Member State licenses;

I. Eliminate the necessity for licenses in multiple States; and

J. Provide opportunities for interstate practice by Licensed Professional Counselors who meet uniform licensure requirements.

SECTION 2. DEFINITIONS

As used in this Compact, and except as otherwise provided, the following definitions shall apply:

A. **"Active Duty Military"** means full-time duty status in the active uniformed service of the United States, including members of the National Guard and Reserve on active duty orders pursuant to 10 U.S.C. Chapters 1209 and 1211.

B. **"Adverse Action"** means any administrative, civil, equitable or criminal action permitted by a State's laws which is imposed by a licensing board or other authority against a Licensed Professional Counselor, including actions against an individual's license or Privilege to Practice such as revocation, suspension, probation, monitoring of the licensee, limitation on the licensee's practice, or any other Encumbrance on licensure affecting a Licensed Professional Counselor's authorization to practice, including issuance of a cease and desist action.

C. **"Alternative Program"** means a non-disciplinary monitoring or practice remediation process approved by a Professional Counseling Licensing Board to address Impaired Practitioners.

D. **"Continuing Competence/Education"** means a requirement, as a condition of license renewal, to provide evidence of participation in, and/or completion of, educational and professional activities relevant to practice or area of work.

E. **"Counseling Compact Commission" or "Commission"** means the national administrative body whose membership consists of all States that have enacted the Compact.

F. **"Current Significant Investigative Information"** means:

1. Investigative Information that a Licensing Board, after a preliminary inquiry that includes notification and an opportunity for the Licensed Professional Counselor to respond, if required by State law, has reason to believe is not groundless and, if proved true, would indicate more than a minor infraction; or

2. Investigative Information that indicates that the Licensed Professional Counselor represents an immediate threat to public health and safety regardless of whether

the Licensed Professional Counselor has been notified and had an opportunity to respond.

G. **"Data System"** means a repository of information about Licensees, including, but not limited to, continuing education, examination, licensure, investigative, Privilege to Practice and Adverse Action information.

H. **"Encumbered License"** means a license in which an Adverse Action restricts the practice of licensed Professional Counseling by the Licensee and said Adverse Action has been reported to the National Practitioners Data Bank (NPDB).

I. **"Encumbrance"** means a revocation or suspension of, or any limitation on, the full and unrestricted practice of Licensed Professional Counseling by a Licensing Board.

J. **"Executive Committee"** means a group of directors elected or appointed to act on behalf of, and within the powers granted to them by, the Commission.

K. **"Home State"** means the Member State that is the Licensee's primary State of residence.

L. **"Impaired Practitioner"** means an individual who has a condition(s) that may impair their ability to practice as a Licensed Professional Counselor without some type of intervention and may include, but are not limited to, alcohol and drug dependence, mental health impairment, and neurological or physical impairments.

M. **"Investigative Information"** means information, records, and documents received or generated by a Professional Counseling Licensing Board pursuant to an investigation.

N. **"Jurisprudence Requirement"** if required by a Member State, means the assessment of an individual's knowledge of the laws and Rules governing the practice of Professional Counseling in a State.

O. **"Licensed Professional Counselor"** means a counselor licensed by a Member State, regardless of the title used by that State, to independently assess, diagnose, and treat behavioral health conditions.

P. **"Licensee"** means an individual who currently holds an authorization from the State to practice as a Licensed Professional Counselor.

Q. **"Licensing Board"** means the agency of a State, or equivalent, that is responsible for the licensing and regulation of Licensed Professional Counselors.

R. **"Member State"** means a State that has enacted the Compact.

S. **"Privilege to Practice"** means a legal authorization, which is equivalent to a license, permitting the practice of Professional Counseling in a Remote State.

T. **"Professional Counseling"** means the assessment, diagnosis, and treatment of behavioral health conditions by a Licensed Professional Counselor.

U. **"Remote State"** means a Member State other than the Home State, where a Licensee is exercising or seeking to exercise the Privilege to Practice.

V. **"Rule"** means a regulation promulgated by the Commission that has the force of law.

W. **"Single State License"** means a Licensed Professional Counselor license issued by a Member State that authorizes practice only within the issuing State and does not include a Privilege to Practice in any other Member State.

X. **"State"** means any state, commonwealth, district, or territory of the United States of America that regulates the practice of Professional Counseling.

Y. **"Telehealth"** means the application of telecommunication technology to deliver Professional Counseling services remotely to assess, diagnose, and treat behavioral health conditions.

Z. **"Unencumbered License"** means a license that authorizes a Licensed Professional Counselor to engage in the full and unrestricted practice of Professional Counseling.

SECTION 3. STATE PARTICIPATION IN THE COMPACT

A. To Participate in the Compact, a State must currently:

1. License and regulate Licensed Professional Counselors;
2. Require Licensees to pass a nationally recognized exam approved by the Commission;
3. Require Licensees to have a 60 semester-hour (or 90 quarter-hour) master's degree in counseling or 60 semester-hours (or 90 quarter-hours) of graduate course work including the following topic areas:
    a. Professional Counseling Orientation and Ethical Practice;

b. Social and Cultural Diversity;

c. Human Growth and Development;

d. Career Development;

e. Counseling and Helping Relationships;

f. Group Counseling and Group Work;

g. Diagnosis and Treatment; Assessment and Testing;

h. Research and Program Evaluation; and

i. Other areas as determined by the Commission.

4. Require Licensees to complete a supervised postgraduate professional experience as defined by the Commission;

5. Have a mechanism in place for receiving and investigating complaints about Licensees.

B. A Member State shall:

1. Participate fully in the Commission's Data System, including using the Commission's unique identifier as defined in Rules;

2. Notify the Commission, in compliance with the terms of the Compact and Rules, of any Adverse Action or the availability of Investigative Information regarding a Licensee;

3. Implement or utilize procedures for considering the criminal history records of applicants for an initial Privilege to Practice. These procedures shall include the submission of fingerprints or other biometric-based information by applicants for the purpose of obtaining an applicant's criminal history record information from the Federal Bureau of Investigation and the agency responsible for retaining that State's criminal records;

a. A member state must fully implement a criminal background check requirement, within a time frame established by rule, by receiving the results of the Federal Bureau of Investigation record search and shall use

the results in making licensure decisions.

b. Communication between a Member State, the Commission and among Member States regarding the verification of eligibility for licensure through the Compact shall not include any information received from the Federal Bureau of Investigation relating to a federal criminal records check performed by a Member State under Public Law 92-544.

4. Comply with the Rules of the Commission;

5. Require an applicant to obtain or retain a license in the Home State and meet the Home State's qualifications for licensure or renewal of licensure, as well as all other applicable State laws;

6. Grant the Privilege to Practice to a Licensee holding a valid Unencumbered License in another Member State in accordance with the terms of the Compact and Rules; and

7. Provide for the attendance of the State's commissioner to the Counseling Compact Commission meetings.

C. Member States may charge a fee for granting the Privilege to Practice.

D. Individuals not residing in a Member State shall continue to be able to apply for a Member State's Single State License as provided under the laws of each Member State. However, the Single State License granted to these individuals shall not be recognized as granting a Privilege to Practice Professional Counseling in any other Member State.

E. Nothing in this Compact shall affect the requirements established by a Member State for the issuance of a Single State License.

F. A license issued to a Licensed Professional Counselor by a Home State to a resident in that State shall be recognized by each Member State as authorizing a Licensed Professional Counselor to practice Professional Counseling, under a Privilege to Practice, in each Member State.

SECTION 4. PRIVILEGE TO PRACTICE

A. To exercise the Privilege to Practice under the terms and provisions of the Compact, the Licensee shall:

1. Hold a license in the Home State;
2. Have a valid United States Social Security Number or National Practitioner Identifier;
3. Be eligible for a Privilege to Practice in any Member State in accordance with Section 4(D), (G) and (H);
4. Have not had any Encumbrance or restriction against any license or Privilege to Practice within the previous two (2) years;
5. Notify the Commission that the Licensee is seeking the Privilege to Practice within a Remote State(s);
6. Pay any applicable fees, including any State fee, for the Privilege to Practice;
7. Meet any Continuing Competence/Education requirements established by the Home State;
8. Meet any Jurisprudence Requirements established by the Remote State(s) in which the Licensee is seeking a Privilege to Practice; and
9. Report to the Commission any Adverse Action, Encumbrance, or restriction on license taken by any non-Member State within 30 days from the date the action is taken.

B. The Privilege to Practice is valid until the expiration date of the Home State license. The Licensee must comply with the requirements of Section 4(A) to maintain the Privilege to Practice in the Remote State.

C. A Licensee providing Professional Counseling in a Remote State under the Privilege to Practice shall adhere to the laws and regulations of the Remote State.

D. A Licensee providing Professional Counseling services in a Remote State is subject to that State’s regulatory authority. A Remote State may, in accordance with due process and that State’s laws, remove a Licensee’s Privilege to Practice in the Remote State for a

specific period of time, impose fines, and/or take any other necessary actions to protect the health and safety of its citizens. The Licensee may be ineligible for a Privilege to Practice in any Member State until the specific time for removal has passed and all fines are paid.

E. If a Home State license is encumbered, the Licensee shall lose the Privilege to Practice in any Remote State until the following occur:

1. The Home State license is no longer encumbered; and

2. Have not had any Encumbrance or restriction against any license or Privilege to Practice within the previous two (2) years.

F. Once an Encumbered License in the Home State is restored to good standing, the Licensee must meet the requirements of Section 4(A) to obtain a Privilege to Practice in any Remote State.

G. If a Licensee's Privilege to Practice in any Remote State is removed, the individual may lose the Privilege to Practice in all other Remote States until the following occur:

1. The specific period of time for which the Privilege to Practice was removed has ended;

2. All fines have been paid; and

3. Have not had any Encumbrance or restriction against any license or Privilege to Practice within the previous two (2) years.

H. Once the requirements of Section 4(G) have been met, the Licensee must meet the requirements in Section 4(A) to obtain a Privilege to Practice in a Remote State.

SECTION 5: OBTAINING A NEW HOME STATE LICENSE BASED ON A PRIVILEGE TO PRACTICE

A. A Licensed Professional Counselor may hold a Home State license, which allows for a Privilege to Practice in other Member States, in only one Member State at a time.

B. If a Licensed Professional Counselor changes primary State of residence by moving between two Member States:

1. The Licensed Professional Counselor shall file an application for obtaining a new Home State license based on a Privilege to Practice, pay all applicable fees, and notify the current and new Home State in accordance with applicable Rules adopted by the Commission.

2. Upon receipt of an application for obtaining a new Home State license by virtue of a Privilege to Practice, the new Home State shall verify that the Licensed Professional Counselor meets the pertinent criteria outlined in Section 4 via the Data System, without need for primary source verification except for:

    a. a Federal Bureau of Investigation fingerprint based criminal background check if not previously performed or updated pursuant to applicable rules adopted by the Commission in accordance with Public Law 92-544;

    b. other criminal background check as required by the new Home State; and

    c. completion of any requisite Jurisprudence Requirements of the new Home State.

3. The former Home State shall convert the former Home State license into a Privilege to Practice once the new Home State has activated the new Home State license in accordance with applicable Rules adopted by the Commission.

4. Notwithstanding any other provision of this Compact, if the Licensed Professional Counselor cannot meet the criteria in Section 4, the new Home State may apply its requirements for issuing a new Single State License.

5. The Licensed Professional Counselor shall pay all applicable fees to the new Home State in order to be issued a new Home State license.

C. If a Licensed Professional Counselor changes Primary State of Residence by moving from a Member State to a non-Member State, or from a non-Member State to a Member State, the State criteria shall apply for issuance of a Single State License in the new State.

D. Nothing in this Compact shall interfere with a Licensee’s ability to hold a Single State License in multiple States, however for the purposes of this Compact, a Licensee shall have only one Home State license.

E. Nothing in this Compact shall affect the requirements established by a Member State for the issuance of a Single State License.

SECTION 6. ACTIVE DUTY MILITARY PERSONNEL OR THEIR SPOUSES

Active Duty Military personnel, or their spouse, shall designate a Home State where the individual has a current license in good standing. The individual may retain the Home State designation during the period the service member is on active duty. Subsequent to designating a Home State, the individual shall only change their Home State through application for licensure in the new State, or through the process outlined in Section 5.

SECTION 7. COMPACT PRIVILEGE TO PRACTICE TELEHEALTH

A. Member States shall recognize the right of a Licensed Professional Counselor, licensed by a Home State in accordance with Section 3 and under Rules promulgated by the Commission, to practice Professional Counseling in any Member State via Telehealth under a Privilege to Practice as provided in the Compact and Rules promulgated by the Commission.

B. A Licensee providing Professional Counseling services in a Remote State under the Privilege to Practice shall adhere to the laws and regulations of the Remote State.

SECTION 8. ADVERSE ACTIONS

A. In addition to the other powers conferred by State law, a Remote State shall have the authority, in accordance with existing State due process law, to:

1. Take Adverse Action against a Licensed Professional Counselor’s Privilege to Practice within that Member State, and

2. Issue subpoenas for both hearings and investigations that require the attendance and testimony of witnesses as well as the production of evidence. Subpoenas issued by a Licensing Board in a Member State for the attendance and testimony of witnesses or the production of evidence from another Member State shall be enforced in the latter State by any court of competent jurisdiction, according to the practice and procedure of that court applicable to subpoenas issued in proceedings pending before it. The issuing authority shall pay any witness fees, travel expenses, mileage, and other fees required by the service statutes of the State in which the witnesses or evidence are located.

3. Only the Home State shall have the power to take Adverse Action against a Licensed Professional Counselor’s license issued by the Home State.

B. For purposes of taking Adverse Action, the Home State shall give the same priority and effect to reported conduct received from a Member State as it would if the conduct had occurred within the Home State. In so doing, the Home State shall apply its own State laws to determine appropriate action.

C. The Home State shall complete any pending investigations of a Licensed Professional Counselor who changes primary State of residence during the course of the investigations. The Home State shall also have the authority to take appropriate action(s) and shall promptly report the conclusions of the investigations to the administrator of the Data System. The administrator of the coordinated licensure information system shall promptly notify the new Home State of any Adverse Actions.

D. A Member State, if otherwise permitted by State law, may recover from the affected Licensed Professional Counselor the costs of investigations and dispositions of cases resulting from any Adverse Action taken against that Licensed Professional Counselor.

E. A Member State may take Adverse Action based on the factual findings of the Remote State, provided that the Member State follows its own procedures for taking the Adverse Action.

F. Joint Investigations:

1. In addition to the authority granted to a Member State by its respective Professional Counseling practice act or other applicable State law, any Member State may participate with other Member States in joint investigations of Licensees.

2. Member States shall share any investigative, litigation, or compliance materials in furtherance of any joint or individual investigation initiated under the Compact.

G. If Adverse Action is taken by the Home State against the license of a Licensed Professional Counselor, the Licensed Professional Counselor's Privilege to Practice in all other Member States shall be deactivated until all Encumbrances have been removed from the State license. All Home State disciplinary orders that impose Adverse Action against the license of a Licensed Professional Counselor shall include a Statement that the Licensed Professional Counselor's Privilege to Practice is deactivated in all Member States during the pendency of the order.

H. If a Member State takes Adverse Action, it shall promptly notify the administrator of the Data System. The administrator of the Data System shall promptly notify the Home State of any Adverse Actions by Remote States.

I. Nothing in this Compact shall override a Member State's decision that participation in an Alternative Program may be used in lieu of Adverse Action.

SECTION 9. ESTABLISHMENT OF COUNSELING COMPACT COMMISSION

A. The Compact Member States hereby create and establish a joint public agency known as the Counseling Compact Commission:

1. The Commission is an instrumentality of the Compact States.

2. Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the Commission is located. The Commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings.

3. Nothing in this Compact shall be construed to be a waiver of sovereign immunity.

B. Membership, Voting, and Meetings

1. Each Member State shall have and be limited to one (1) delegate selected by that Member State's Licensing Board.

2. The delegate shall be either:

   a. A current member of the Licensing Board at the time of appointment, who is a Licensed Professional Counselor or public member; or

   b. An administrator of the Licensing Board.

3. Any delegate may be removed or suspended from office as provided by the law of the State from which the delegate is appointed.

4. The Member State Licensing Board shall fill any vacancy occurring on the Commission within 60 days.

5. Each delegate shall be entitled to one (1) vote with regard to the promulgation of

Rules and creation of bylaws and shall otherwise have an opportunity to participate in the business and affairs of the Commission.

6. A delegate shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for delegates' participation in meetings by telephone or other means of communication.

7. The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the bylaws.

8. The Commission shall by Rule establish a term of office for delegates and may by Rule establish term limits.

C. The Commission shall have the following powers and duties:

1. Establish the fiscal year of the Commission;

2. Establish bylaws;

3. Maintain its financial records in accordance with the bylaws;

4. Meet and take such actions as are consistent with the provisions of this Compact and the bylaws;

5. Promulgate Rules which shall be binding to the extent and in the manner provided for in the Compact;

6. Bring and prosecute legal proceedings or actions in the name of the Commission, provided that the standing of any State Licensing Board to sue or be sued under applicable law shall not be affected;

7. Purchase and maintain insurance and bonds;

8. Borrow, accept, or contract for services of personnel, including, but not limited to, employees of a Member State;

9. Hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals appropriate authority to carry out the purposes of the Compact, and establish the Commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel, and other related personnel matters;

10. Accept any and all appropriate donations and grants of money, equipment, supplies, materials, and services, and to receive, utilize, and dispose of the same; provided that at all times the Commission shall avoid any appearance of impropriety and/or conflict of interest;

11. Lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve or use, any property, real, personal or mixed; provided that at all times the Commission shall avoid any appearance of impropriety;

12. Sell convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property real, personal, or mixed;

13. Establish a budget and make expenditures;

14. Borrow money;

15. Appoint committees, including standing committees composed of members, State regulators, State legislators or their representatives, and consumer representatives, and such other interested persons as may be designated in this Compact and the bylaws;

16. Provide and receive information from, and cooperate with, law enforcement agencies;

17. Establish and elect an Executive Committee; and

18. Perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the State regulation of Professional Counseling licensure and practice.

D. The Executive Committee

1. The Executive Committee shall have the power to act on behalf of the Commission according to the terms of this Compact.

2. The Executive Committee shall be composed of up to eleven (11) members:

   a. Seven voting members who are elected by the Commission from the current membership of the Commission; and

   b. Up to four (4) ex-officio, nonvoting members from four (4) recognized national

professional counselor organizations.

c. The ex-officio members will be selected by their respective organizations.

3. The Commission may remove any member of the Executive Committee as provided in bylaws.

4. The Executive Committee shall meet at least annually.

5. The Executive Committee shall have the following duties and responsibilities:

a. Recommend to the entire Commission changes to the Rules or bylaws, changes to this Compact legislation, fees paid by Compact Member States such as annual dues, and any Commission Compact fee charged to Licensees for the Privilege to Practice;

b. Ensure Compact administration services are appropriately provided, contractual or otherwise;

c. Prepare and recommend the budget;

d. Maintain financial records on behalf of the Commission;

e. Monitor Compact compliance of Member States and provide compliance reports to the Commission;

f. Establish additional committees as necessary; and

g. Other duties as provided in Rules or bylaws.

E. Meetings of the Commission

1. All meetings shall be open to the public, and public notice of meetings shall be given in the same manner as required under the Rulemaking provisions in Section 11.

2. The Commission or the Executive Committee or other committees of the Commission may convene in a closed, non-public meeting if the Commission or Executive Committee or other committees of the Commission must discuss:

a. Non-compliance of a Member State with its obligations under the Compact;

b. The employment, compensation, discipline or other matters, practices or procedures related to specific employees or other matters related to the Commission's internal personnel practices and procedures;

c. Current, threatened, or reasonably anticipated litigation;

d. Negotiation of contracts for the purchase, lease, or sale of goods, services, or real estate;

e. Accusing any person of a crime or formally censuring any person;

f. Disclosure of trade secrets or commercial or financial information that is privileged or confidential;

g. Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

h. Disclosure of investigative records compiled for law enforcement purposes;

i. Disclosure of information related to any investigative reports prepared by or on behalf of or for use of the Commission or other committee charged with responsibility of investigation or determination of compliance issues pursuant to the Compact; or

j. Matters specifically exempted from disclosure by federal or Member State statute.

3. If a meeting, or portion of a meeting, is closed pursuant to this provision, the Commission's legal counsel or designee shall certify that the meeting may be closed and shall reference each relevant exempting provision.

4. The Commission shall keep minutes that fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, and the reasons therefore, including a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release by a majority vote of the Commission or order of a court of competent jurisdiction.

F. Financing of the Commission

1. The Commission shall pay, or provide for the payment of, the reasonable expenses of its establishment, organization, and ongoing activities.

2. The Commission may accept any and all appropriate revenue sources, donations, and grants of money, equipment, supplies, materials, and services.

3. The Commission may levy on and collect an annual assessment from each Member State or impose fees on other parties to cover the cost of the operations and activities of the Commission and its staff, which must be in a total amount sufficient to cover its annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount shall be allocated based upon a formula to be determined by the Commission, which shall promulgate a Rule binding upon all Member States.

4. The Commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same; nor shall the Commission pledge the credit of any of the Member States, except by and with the authority of the Member State.

5. The Commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the Commission shall be subject to the audit and accounting procedures established under its bylaws. However, all receipts and disbursements of funds handled by the Commission shall be audited yearly by a certified or licensed public accountant, and the report of the audit shall be included in and become part of the annual report of the Commission.

G. Qualified Immunity, Defense, and Indemnification

1. The members, officers, executive director, employees and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided that nothing in this paragraph shall be construed to protect any such person from suit and/or liability for any damage, loss, injury, or liability caused by the intentional or willful or wanton misconduct of that person.

2. The Commission shall defend any member, officer, executive director, employee or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities; provided that nothing herein shall be construed to prohibit that person from retaining his or her own counsel; and provided further, that the actual or alleged act, error, or omission did not result from that person's intentional or willful or wanton misconduct.

3. The Commission shall indemnify and hold harmless any member, officer, executive director, employee, or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from the intentional or willful or wanton misconduct of that person.

SECTION 10. DATA SYSTEM

A. The Commission shall provide for the development, maintenance, operation, and utilization of a coordinated database and reporting system containing licensure, Adverse Action, and Investigative Information on all licensed individuals in Member States.

B. Notwithstanding any other provision of State law to the contrary, a Member State shall submit a uniform data set to the Data System on all individuals to whom this Compact is applicable as required by the Rules of the Commission, including:

1. Identifying information;

2. Licensure data;

3. Adverse Actions against a license or Privilege to Practice;

4. Non-confidential information related to Alternative Program participation;

5. Any denial of application for licensure, and the reason(s) for such denial;

6. Current Significant Investigative Information; and

7. Other information that may facilitate the administration of this Compact, as determined by the Rules of the Commission.

C. Investigative Information pertaining to a Licensee in any Member State will only be available to other Member States.

D. The Commission shall promptly notify all Member States of any Adverse Action taken against a Licensee or an individual applying for a license. Adverse Action information pertaining to a Licensee in any Member State will be available to any other Member State.

E. Member States contributing information to the Data System may designate information that may not be shared with the public without the express permission of the contributing State.

F. Any information submitted to the Data System that is subsequently required to be expunged by the laws of the Member State contributing the information shall be removed from the Data System.

SECTION 11. RULEMAKING

A. The Commission shall promulgate reasonable Rules in order to effectively and efficiently achieve the purpose of the Compact. Notwithstanding the foregoing, in the event the Commission exercises its Rulemaking authority in a manner that is beyond the scope of the purposes of the Compact, or the powers granted hereunder, then such an action by the Commission shall be invalid and have no force or effect.

B. The Commission shall exercise its Rulemaking powers pursuant to the criteria set forth in this Section and the Rules adopted thereunder. Rules and amendments shall become binding as of the date specified in each Rule or amendment.

C. If a majority of the legislatures of the Member States rejects a Rule, by enactment of a statute or resolution in the same manner used to adopt the Compact within four (4) years of the date of adoption of the Rule, then such Rule shall have no further force and effect in any Member State.

D. Rules or amendments to the Rules shall be adopted at a regular or special meeting of the Commission.

E. Prior to promulgation and adoption of a final Rule or Rules by the Commission, and at least thirty (30) days in advance of the meeting at which the Rule will be considered and voted upon, the Commission shall file a Notice of Proposed Rulemaking:

1. On the website of the Commission or other publicly accessible platform; and

2. On the website of each Member State Professional Counseling Licensing Board or other publicly accessible platform or the publication in which each State would otherwise publish proposed Rules.

F. The Notice of Proposed Rulemaking shall include:

1. The proposed time, date, and location of the meeting in which the Rule will be considered and voted upon;

2. The text of the proposed Rule or amendment and the reason for the proposed Rule;

3. A request for comments on the proposed Rule from any interested person; and

4. The manner in which interested persons may submit notice to the Commission of their intention to attend the public hearing and any written comments.

G. Prior to adoption of a proposed Rule, the Commission shall allow persons to submit written data, facts, opinions, and arguments, which shall be made available to the public.

H. The Commission shall grant an opportunity for a public hearing before it adopts a Rule or amendment if a hearing is requested by:

1. At least twenty-five (25) persons;

2. A State or federal governmental subdivision or agency; or

3. An association having at least twenty-five (25) members.

I. If a hearing is held on the proposed Rule or amendment, the Commission shall publish the place, time, and date of the scheduled public hearing. If the hearing is held via electronic means, the Commission shall publish the mechanism for access to the electronic hearing.

1. All persons wishing to be heard at the hearing shall notify the executive director of the Commission or other designated member in writing of their desire to appear and

testify at the hearing not less than five (5) business days before the scheduled date of the hearing.

2. Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.

3. All hearings will be recorded. A copy of the recording will be made available on request.

4. Nothing in this section shall be construed as requiring a separate hearing on each Rule. Rules may be grouped for the convenience of the Commission at hearings required by this section.

J. Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the Commission shall consider all written and oral comments received.

K. If no written notice of intent to attend the public hearing by interested parties is received, the Commission may proceed with promulgation of the proposed Rule without a public hearing.

L. The Commission shall, by majority vote of all members, take final action on the proposed Rule and shall determine the effective date of the Rule, if any, based on the Rulemaking record and the full text of the Rule.

M. Upon determination that an emergency exists, the Commission may consider and adopt an emergency Rule without prior notice, opportunity for comment, or hearing, provided that the usual Rulemaking procedures provided in the Compact and in this section shall be retroactively applied to the Rule as soon as reasonably possible, in no event later than ninety (90) days after the effective date of the Rule. For the purposes of this provision, an emergency Rule is one that must be adopted immediately in order to:

1. Meet an imminent threat to public health, safety, or welfare;

2. Prevent a loss of Commission or Member State funds;

3. Meet a deadline for the promulgation of an administrative Rule that is established by federal law or Rule; or

4. Protect public health and safety.

N. The Commission or an authorized committee of the Commission may direct revisions to a previously adopted Rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions shall be posted on the website of the Commission. The revision shall be subject to challenge by any person for a period of thirty (30) days after posting. The revision may be challenged only on grounds that the revision results in a material change to a Rule. A challenge shall be made in writing and delivered to the chair of the Commission prior to the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the Commission.

SECTION 12. OVERSIGHT, DISPUTE RESOLUTION, AND ENFORCEMENT

A. Oversight

1. The executive, legislative, and judicial branches of State government in each Member State shall enforce this Compact and take all actions necessary and appropriate to effectuate the Compact's purposes and intent. The provisions of this Compact and the Rules promulgated hereunder shall have standing as statutory law.

2. All courts shall take judicial notice of the Compact and the Rules in any judicial or administrative proceeding in a Member State pertaining to the subject matter of this Compact which may affect the powers, responsibilities, or actions of the Commission.

3. The Commission shall be entitled to receive service of process in any such proceeding and shall have standing to intervene in such a proceeding for all purposes. Failure to provide service of process to the Commission shall render a judgment or order void as to the Commission, this Compact, or promulgated Rules.

B. Default, Technical Assistance, and Termination

1. If the Commission determines that a Member State has defaulted in the performance of its obligations or responsibilities under this Compact or the promulgated Rules, the Commission shall:

a. Provide written notice to the defaulting State and other Member States of the nature of the default, the proposed means of curing the default and/or any other action to be taken by the Commission; and

b. Provide remedial training and specific technical assistance regarding the default.

C. If a State in default fails to cure the default, the defaulting State may be terminated from the Compact upon an affirmative vote of a majority of the Member States, and all rights, privileges and benefits conferred by this Compact may be terminated on the effective date of termination. A cure of the default does not relieve the offending State of obligations or liabilities incurred during the period of default.

D. Termination of membership in the Compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be given by the Commission to the governor, the majority and minority leaders of the defaulting State's legislature, and each of the Member States.

E. A State that has been terminated is responsible for all assessments, obligations, and liabilities incurred through the effective date of termination, including obligations that extend beyond the effective date of termination.

F. The Commission shall not bear any costs related to a State that is found to be in default or that has been terminated from the Compact, unless agreed upon in writing between the Commission and the defaulting State.

G. The defaulting State may appeal the action of the Commission by petitioning the U.S. District Court for the District of Columbia or the federal district where the Commission has its principal offices. The prevailing member shall be awarded all costs of such litigation, including reasonable attorney's fees.

H. Dispute Resolution

1. Upon request by a Member State, the Commission shall attempt to resolve disputes related to the Compact that arise among Member States and between member and non-Member States.

2. The Commission shall promulgate a Rule providing for both mediation and binding dispute resolution for disputes as appropriate.

I. Enforcement

1. The Commission, in the reasonable exercise of its discretion, shall enforce the provisions and Rules of this Compact.

2. By majority vote, the Commission may initiate legal action in the United States District Court for the District of Columbia or the federal district where the Commission has its principal offices against a Member State in default to enforce compliance with the provisions of the Compact and its promulgated Rules and bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing member shall be awarded all costs of such litigation, including reasonable attorney's fees.

3. The remedies herein shall not be the exclusive remedies of the Commission. The Commission may pursue any other remedies available under federal or State law.

SECTION 13. DATE OF IMPLEMENTATION OF THE COUNSELING COMPACT COMMISSION AND ASSOCIATED RULES, WITHDRAWAL, AND AMENDMENT

A. The Compact shall come into effect on the date on which the Compact statute is enacted into law in the tenth Member State. The provisions, which become effective at that time, shall be limited to the powers granted to the Commission relating to assembly and the promulgation of Rules. Thereafter, the Commission shall meet and exercise Rulemaking powers necessary to the implementation and administration of the Compact.

B. Any State that joins the Compact subsequent to the Commission's initial adoption of the Rules shall be subject to the Rules as they exist on the date on which the Compact becomes law in that State. Any Rule that has been previously adopted by the Commission shall have the full force and effect of law on the day the Compact becomes law in that State.

C. Any Member State may withdraw from this Compact by enacting a statute repealing the same.

1. A Member State's withdrawal shall not take effect until six (6) months after enactment of the repealing statute.

2. Withdrawal shall not affect the continuing requirement of the withdrawing State's Professional Counseling Licensing Board to comply with the investigative and Adverse Action reporting requirements of this act prior to the effective date of withdrawal.

D. Nothing contained in this Compact shall be construed to invalidate or prevent any Professional Counseling licensure agreement or other cooperative arrangement between a Member State and a non-Member State that does not conflict with the provisions of this Compact.

E. This Compact may be amended by the Member States. No amendment to this Compact shall become effective and binding upon any Member State until it is enacted into the laws of all Member States.

SECTION 14. CONSTRUCTION AND SEVERABILITY

This Compact shall be liberally construed so as to effectuate the purposes thereof. The provisions of this Compact shall be severable and if any phrase, clause, sentence or provision of this Compact is declared to be contrary to the constitution of any Member State or of the United States or the applicability thereof to any government, agency, person or circumstance is held invalid, the validity of the remainder of this Compact and the applicability thereof to any government, agency, person or circumstance shall not be affected thereby. If this Compact shall be held contrary to the constitution of any Member State, the Compact shall remain in full force and effect as to the remaining Member States and in full force and effect as to the Member State affected as to all severable matters.

SECTION 15. BINDING EFFECT OF COMPACT AND OTHER LAWS

A. A Licensee providing Professional Counseling services in a Remote State under the Privilege to Practice shall adhere to the laws and regulations, including scope of practice, of the Remote State.

B. Nothing herein prevents the enforcement of any other law of a Member State that is not inconsistent with the Compact.

C. Any laws in a Member State in conflict with the Compact are superseded to the extent of the conflict.

D. Any lawful actions of the Commission, including all Rules and bylaws properly promulgated by the Commission, are binding upon the Member States.

E. All permissible agreements between the Commission and the Member States are binding in accordance with their terms.

F. In the event any provision of the Compact exceeds the constitutional limits imposed on the legislature of any Member State, the provision shall be ineffective to the extent of the conflict with the constitutional provision in question in that Member State.

COUNSELING COMPACT

FACT SHEET: STATES AND THE COUNSELING COMPACT

The **Counseling Compact** will allow qualified professional counselors to practice in *all states that join the compact*. This will remove the need for counselors to obtain a separate license in each state in which they want to practice.

THE BASICS

- The Counseling Compact is an *interstate compact* – a constitutionally authorized, legally binding contract between states.
- The Counseling Compact is the same in form and function as other occupational licensure compacts like the Nurse Licensure Compact, the EMS Compact, the Physical Therapy Compact, and the Interstate Medical Licensure Compact.
- The Counseling Compact authorizes interstate practice, both in-person and through telehealth, by professional counselors who hold a valid, unrestricted home state license in a Compact member state.
- The practice of professional counseling takes place in the state in which the client is located at the time of the counselor-client encounter. Counselors must observe the laws and rules of the state in which they are practicing.
- The Counseling Compact takes effect upon its enactment by ten states.
- The National Center for Interstate Compacts at the Council of State Governments facilitated the development of the Counseling Compact and is providing technical assistance to states as they consider the Compact.

BENEFITS

- Preserves and strengthens state licensure systems
- Enhances public safety through a shared interstate database of licensure and disciplinary information, allowing for rapid verification of license status
- Improves access to professional counseling services
- Increases market opportunities for professional counselors by authorizing practice in member states, including via telehealth
- Enhances mobility for professional counselors
- Supports relocating military spouses
- Improves continuity of care when clients travel or relocate
- Ensures cooperation among compact member states in regulating the practice of professional counseling

DISPELLING THE MYTHS

- As with the existing licensure compacts, the Counseling Compact has no impact on a state's scope of practice – this is *not* a takeover of state regulatory authority.
- As with existing licensure compacts, the Counseling Compact leaves state-specific licensure requirements in place – this is *not* a takeover of state licensing systems.
- The Counseling Compact enhances states' authority to protect the public and regulate the counseling profession.
- The Counseling Compact will have no significant fiscal implications for states.

COUNSELING COMPACT

FREQUENTLY ASKED QUESTIONS

What is an interstate compact?

An interstate compact is a contract between two or more states creating an agreement on a particular policy issue, adopting a certain standard or cooperating on regional or national matters. Compacts are the most powerful, durable and adaptive tools for ensuring cooperative action among states. Unlike the rigid and often unfunded mandates imposed by the federal government, interstate compacts provide a state-developed structure for collaborative action and consensus-building among states and federal partners.

How many professions use an interstate compact to facilitate interstate practice?

Currently, licensure compacts exist for nurses, physicians, physical therapists, psychologists, emergency management personnel, speech-language pathologists and audiologists. Licensure compacts for occupational therapists and occupational therapy assistants, physician assistants, and advanced practice nurses are under development.

Are all occupational licensure compacts the same?

Not exactly, but most are similar in form and function. There are two types of occupational licensure compacts – the *expedited licensure* model and the *mutual recognition* model. The Interstate Medical Licensure Compact is the only expedited licensure compact. The remaining licensure compacts utilize the mutual recognition model, in which a practitioner's home state license is "mutually recognized" by other compact member states. Mutual recognition model compacts allow a practitioner to practice in the compact member states either using a multi-state license or by obtaining a "privilege to practice" (see below).

How does the Counseling Compact work?

The Counseling Compact is a mutual recognition model compact that is similar in form and function to occupational licensure compacts for nursing, physical therapy, psychology, and speech-language pathology and audiology. The Counseling Compact allows licensed professional counselors to practice in all other compact member states – either in-person or via telehealth – through a *privilege to practice*, which is equivalent to a license.

The Counseling Compact establishes an interstate commission, made up of delegates from compact member states, to administer the Compact. The Counseling Compact also creates a licensure data system for Compact member state boards to communicate and exchange information, including verification of licensure and disciplinary sanctions. An interstate commission and data system are standard features of all occupational licensure compacts.

What is a "privilege to practice"?

A privilege to practice is the authorization to practice in a compact member state other than your home state. To be eligible for a privilege to practice, you must hold an active professional counselor license in your home state (which must be a member of the compact) and meet other eligibility criteria, such as having no disciplinary action against your license for at least two years. When eligibility is verified, jurisprudence requirements are met, and all fees are paid, you receive the privilege to practice and may begin legally working in the new state.

What are the requirements for a privilege to practice?

A licensed professional counselor must notify the commission of their intent to seek the privilege to practice in another compact state, and meet the following criteria to get a privilege to practice:

- Have a Social Security Number or a National Provider Identifier
- Hold a valid license in their home state, which must be a member of the compact
- Have no encumbrances on any state license currently, and no adverse actions or restrictions against any license within the previous two years
- Pass an FBI Fingerprint-Based Criminal Background Check
- Meet any jurisprudence requirements for the member state in which they are seeking a privilege
- Complete any continuing education requirements required by their *home state* only
- Pay any fees for the privilege to practice

Privilege holders must adhere to the laws and regulations of the Compact member state in which they are practicing and report to the commission any adverse action taken by a non-member state within 30 days after the action is taken.

Does a privilege to practice allow the privilege holder to practice via telehealth in a remote state?

A privilege to practice allows the holder to provide professional counseling services in another member state under the scope of practice of the state where the client is located, whether the practice is in person or via telehealth. Privilege holders should consult laws and rules of the state in which they wish to practice in order to determine the specific telehealth requirements.

Do professional counselors have to complete continuing education requirements in states where they are practicing via privilege to practice?

No. Professional counselors utilizing the compact are only responsible for completing continuing education requirements for their home state license.

Do professional counselors need a separate privilege to practice for each state in which they want to provide counseling services?

Yes. A privilege to practice is not a multi-state license. A practitioner will need to get a privilege to practice in *each* state in which they want to provide counseling services.

A practitioner may work legally in a *member* state via either a license or a privilege to practice. A practitioner will need to hold a state-specific license to practice in *non-member* states.

Section 3 of the Counseling Compact states that a practitioner can participate in the compact with only 60 semester-hours of graduate course work in certain areas. Can a counselor participate in the compact without a master's degree?

No. It is important to remember that Section 3 describes requirements for a state to participate in the compact, not licensees. For a state to join the Counseling Compact they must have certain requirements, which most states meet.

For instance, a state must license practitioners. A state must require licensees to pass a national exam. A state must require licensees to complete a supervised post graduate professional experience.

The requirement for 60 semester-hours (or 90 quarter-hours) of graduate course work assumes an earned master's degree.

First, as noted above, the Counseling Compact requires that member states license the profession of Licensed Professional Counselors and that practitioners hold a license in a member state.

Second, the Counseling Compact is built around the current licensure requirements in the states. *All* states require an earned master's degree for licensure and the Counseling Compact reflects this reality. Further, applicants for state licensure must have an earned master's degree to sit for a national exam.

Lastly, the Counseling Compact requires licensees to complete a supervised postgraduate professional experience. "Postgraduate" presumes an earned master's degree by the practitioner.

It is important to read the compact language in its totality. Interstate compacts for occupational licensure mirror current predominant state licensure requirements and all states require an earned master's degree for licensure as a counselor. The Counseling Compact recognizes and respects this requirement and assumes it will continue.

What are the advantages of the Counseling Compact?

The Counseling Compact allows eligible professional counselors to practice in all states that join the Compact. It removes the need for practitioners to get a license in each Compact state in which they want to practice. The goal of the Counseling Compact, like all licensure compacts, is to eliminate barriers to practice and to client care by ensuring cooperation among member-state regulatory boards.

Other benefits include:

- Preserving and strengthening state licensure systems
- Enhancing public safety
- Improving access to professional counseling services
- Increasing market opportunities for professional counselors by authorizing both in-person practice and telehealth
- Enhancing mobility of professional counselors
- Supporting relocating military spouses
- Improving continuity of care when clients travel or relocate
- Encouraging cooperation among Compact member states in regulating the practice of professional counseling

How can a state/jurisdiction become a member of the Counseling Compact?

Each state's legislature must enact the Counseling Compact language into law to become a member of the Compact.

Why is the Counseling Compact important to consumers?

Through the Counseling Compact, consumers have greater access to care. The Counseling Compact allows licensed professional counselors to ensure continuity of care when clients relocate. Professional counselors also will be able to reach populations that are currently underserved, geographically isolated or lack specialty care.

Additionally, states gain a supplementary layer of oversight of professional counselors who may enter their state to practice. The Counseling Compact data system will allow member states to verify instantaneously that professional counselors based in other states have met defined standards and competencies and are in good standing with other states' regulatory boards. The Counseling Compact data system will help states better protect the public.

COUNSELING COMPACT

COUNSELING COMPACT

INTERSTATE COMPACTS VS. UNIVERSAL LICENSE RECOGNITION

As states work toward greater professional licensure portability, two key policy tools are at their disposal. This fact sheet explains these two methods and how they can work together to facilitate interstate practice.

Interstate Compacts: Borderless Practice in all Member States

The Counseling Compact is an example of an ***occupational licensure interstate compact*** – a binding agreement among states to adopt a set of uniform licensure standards for a particular profession and to recognize valid licenses for that profession issued by any state that has enacted the agreement.

The engine of a licensure compact is a shared interstate data system that allows for rapid verification of eligibility to practice. Compacts allow practitioners to obtain a "privilege to practice" in another member state in minutes, with no need to submit materials such as test scores or academic transcripts except for a jurisprudence exam if required by the new state.

The Counseling Compact, once legislatively enacted, will allow counselors licensed and based in a member state to practice full time in other member states both in person and via telehealth. Continuing education is required *only* for the home state license.

The Counseling Compact and its licensure data system will be overseen by a public Commission comprised of delegates from each member state. The Commission is empowered to issue appropriate Rules to ensure a responsive, adaptive, and sustainable Compact. Member states are bound contractually to the terms of the Compact and Rules, making the Compact a durable long-term solution to the issue of interstate license portability.

Universal License Recognition Laws: Reducing Barriers to Entry Only

Universal license recognition laws, also known as universal reciprocity, establish a state's intention to recognize *all* valid occupational and professional licenses from *all* states. These laws apply to all or most professions regulated by a state, are generally implemented on a case-by-case basis by state licensure boards and agencies, and may still require submission of documents and a standard waiting period for review.

Universal recognition laws are sound policy, but they do not allow practitioners based within the enacting state to practice in *other* states, and they do not allow for near-instant verification of licensure eligibility through a data system.

Additionally, universal recognition laws do not require states to commit contractually to a set of uniform requirements for licensure. These laws are enforced at the discretion of the enacting state, leaving room for significant differences in each state's reciprocity standards.

Furthermore, without the formal structure of a Commission and data system, universal recognition laws cannot ensure effective communication and data sharing among states, potentially jeopardizing public protection.

Can these policies coexist?

Absolutely! There are several reasons for states to pursue both licensure compacts and universal recognition laws.

- A compact is most effective when enacted by all (or nearly all) states. Until that point, universal license recognition laws reduce barriers for practitioners from nonmember states.
- Not everyone is eligible for a compact. Individuals who do not qualify for a compact at their current practice level may still be able to obtain a license by endorsement in another state.
- If a state's universal licensure recognition law is written such that it does not confer eligibility for an interstate compact, there is no conflict between these two policy tools.

Why the Counseling Compact is the gold standard for licensure portability:

Long-term reform of how states license, communicate, and share licensure data requires an enduring and adaptable legislative solution.

The Counseling Compact binds member states to a cooperative system of interstate licensure that removes barriers to practice without sacrificing public protection.

The Commission's rulemaking authority ensures swift adaptation to changes in the profession, securing the long-term viability of the Compact as a comprehensive solution to the challenges of license portability.

For more information on the Counseling Compact, please visit www.CounselingCompact.org.

For a closer look at interstate compacts and universal license recognition, please click here.

COUNSELING COMPACT

What is the Counseling Compact?

The Counseling Compact is an **interstate compact**, or a contract among states, allowing professional counselors licensed *and* residing in a compact member state to practice in other compact member states without need for multiple licenses.

This graphic covers the basics.

How does the Compact work?

Professional counselors who meet uniform licensure requirements are able to quickly obtain a **privilege to practice**, which is equivalent to a license to practice counseling in another state.

The Compact creates a shared interstate licensure **data system**, allowing for near-instant verification of licensure status. Through the data system, a privilege to practice can be obtained in a matter of minutes.

The data system also enhances public protection by ensuring that member states share investigative and disciplinary information with one another.

What are the benefits of the Compact?

The Compact will help counselors by affording them greater ease of mobility, cutting drastically the time needed for authorization to practice in a new state. The Compact will also create new market opportunities for counselors.

The Compact will help clients by improving continuity of care when clients or counselors travel or relocate.

The Compact will help the public by ensuring that member states rapidly share investigative and disciplinary information and cooperate in investigations of misconduct by practitioners, when necessary.

The Counseling Compact works together with universal license recognition laws to increase license portability.

When will the Compact go into effect?

The Compact will go into effect once enacted into law by ten (10) states. This is could occur as early as 2022.

I would like more information.

Explore the compact tool kit, or contact the project team.

Agenda Item: Regulations for Licensure of Art Therapists

Included in the agenda package:

Copy of Notice on the Virginia Regulatory Townhall

Copy of comments received on the Notice of Intended Regulatory Action (62 comments received – all in support of licensure)

Copy of DRAFT regulations as recommended by the Advisory Board on Art Therapy

Action:

Motion to adopt of Chapter 90, Regulations Governing the Practice of Art Therapy, as proposed regulations

Virginia.gov Agencies | Governor

VIRGINIA REGULATORY TOWN HALL

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Agency Department of Health Professions

Board Board of Counseling

Chapter
Regulations Governing the Practice of Art Therapy (under development) [18 VAC 115 - 90]

Action	New chapter for licensure
Stage	NOIRA
Comment Period	Ends 3/31/2021

62 comments

All good comments for this forum Show Only Flagged

Back to List of Comments

Commenter: Terri Giller 3/25/21 6:46 pm

Benefits of Art Therapy Licensure

The licensure of Art Therapists in Virginia increase accessibility of mental health services to the residents of Virginia, providing much needed services to our veterans, children, and especially in these times, those impacted by COVID-19; offering support, recovery, and healing. This new license will increase the retention of Master's level, credentialed mental health clinicians in Virginia (there are currently 2 Master's Programs for Art Therapists in VA), as well as create jobs in mental health care, drawing in skilled professionals from across the United States.

CommentID: 97421

Commenter: Anonymous 3/26/21 7:56 pm

A student's ask for assistance

As an art therapy master's degree candidate, I can speak on a few different benefits! Many of my classmates as well as myself would love to stay and practice art therapy in Virginia. That being said, the licensure protection would really help us. I know that is why many of our connections are in Maryland, because they have the LGPAT and the LCAT. The passage of this would help state retention rate for new professionals.

CommentID: 97432

Commenter: Crista Kostenko 3/26/21 9:45 pm

Support

Licensure will improve access to mental health services, help VA to retain masters level mental health clinicians, and potentially bring more Art Therapists to the state.

CommentID: 97433

Commenter: Holly Mercer Waide 3/26/21 10:41 pm

Support

The addition of individualized licensure for Art Therapy would be highly beneficial to Virginia as it will increase effective and ethical use of the practices of art therapy in our state and encourage art therapists from other locations to consider relocating to Virginia. It will also allow many of our pediatric, medical, and psychiatric hospitals to provide expressive mental health services that currently have limited or minimal access.

CommentID: 97434

Commenter: Gioia Chilton 3/26/21 11:18 pm

Support

I support this process, as an art therapist in Virginia working with active duty and veteran service members who experience traumatic brain injuries and post traumatic stress. Art therapy licensing is need to protect those in need of this specialized profession from non-qualified inept practitioners. Art therapy is licensed in Maryland, DC and many other states, Virgina should be competitive to attract jobs and residents.

CommentID: 97435

Commenter: Constantin 3/27/21 9:55 am

We need licensed art therapists in VA

With COVID-19 leaving a painful contrail of people in desperate need of mental health services we absolutely need licensed art therapist in Virginia.

Very large number of people cannot get access to a mental health services even if they have health insurance. The wait time just to get an appointment is 45 days or longer. And paying out of pocket is difficult. This licensure can open up services to help meet the demand so that health plans can cover these services.

Licensure will improve access to mental health services, help VA to retain masters level mental health clinicians, and potentially bring more Art Therapists to the state.

Most importantly it will open up a supply of therapeutic services to help meet the demand from the Virginians.

Is critical for Virginians to have access to licensed art therapy services.

CommentID: 97436

Commenter: Sarah Harris 3/27/21 10:29 am

Support!

I support this legislation, which will improve access to high-quality mental health services as well as retaining highly-qualified art therapists who practice in Virginia.

CommentID: 97438

Commenter: Kristina Arianina 3/27/21 12:40 pm

I support

I support

CommentID: 97439

Commenter: Hannah Phillips Hale, Mainstream Mental Health Services 3/27/21 2:46 pm

Please support this

Please support the Art Therapy License Bill, so that art therapists can become licensed and provide these therapeutic and healing services to more patients, clients and communities in the state of Virginia. Allowing art therapists to go through the licensure process will improve access to mental health services, help VA to retain masters level mental health clinicians, and potentially bring more Art Therapists to the state. Talk therapy does not work for everyone and the expressive/creative arts therapies can be so beneficial and life changing for many!!! I have experienced it and hope you support us, so that more people can experience it as well!!! Thank you for your consideration.

CommentID: 97440

Commenter: Mindy Van Wart 3/27/21 3:03 pm

In favor

As a grad student in art therapy, I can see how appealing and validating it is to live in one of the few states that have/will have a separate Art Therapy license for mental health workers. This license will allow future art therapists like me to focus on what we've been trained for and what we're most passionate about--being art therapists and not general counselors. With EVMS here and George Washington University nearby, Virginia is already a national hub for art therapy; it seems right to confirm and nurture this reputation by having our own licensure.

CommentID: 97442

Commenter: Tudy, Start Healing Art Therapy and Couseling 3/29/21 7:56 am

Art therapy licensure

Art therapy licensure is vital in ensuring masters level art therapists to provide services to the public who are in need of this valuable service.

CommentID: 97453

Commenter: Dana H Roebuck 3/29/21 11:58 am

Supprt for the VA Art Therapy License

As a Clinical Art Therapist from VA, who went to NY to get Art Therapy schooling and Licensure, I would love to see VA be a hub of art therapy awareness and support. Providing licensure to upcoming master's level graduates to come to/stay in VA is vital to growing the occupation and

industry. I support reciprocal licensure for Art Therapists from other states as well. Seeing trauma as having mental and emotional symptoms versus only physical symptoms will improve VA's standards of practice and care in the state to a great degree!

CommentID: 97466

Commenter: Tetiana 3/29/21 12:57 pm

Art therapy

Support!

CommentID: 97469

Commenter: Julia Willinger 3/29/21 7:32 pm

Please Support This!

Enacting a licensure process for Art Therapists in the state of Virginia is crucial toward furthering the validity of the art therapy and counseling profession and increasing access for creative therapeutic means to VA residents. I support this!

CommentID: 97487

Commenter: Rachel 3/29/21 7:50 pm

I support this!

I support this! Art therapy is an important part of mental health for many people, and this would be a great step towards ensuring that the future of art therapy is bright.

CommentID: 97488

Commenter: Madeleine Gibbons 3/29/21 7:51 pm

Support

I support this!!

CommentID: 97489

Commenter: Tyler 3/29/21 7:52 pm

Support!

I support this licensing program to be in the Commonwealth of Virginia!

CommentID: 97490

Commenter: Steph 3/29/21 7:52 pm

I support this!

I support this program to be in Virginia!

CommentID: 97491

Commenter: Adriana Noel 3/29/21 7:54 pm

Support!

I support this!

CommentID: 97492

Commenter: Elisabeth 3/29/21 8:01 pm

Support

I support this!

CommentID: 97495

Commenter: Alyssa Hayes 3/29/21 8:22 pm

SUPPORT 100%

Enacting a licensure process for Art Therapists in the state of Virginia is crucial toward furthering the validity of the art therapy and counseling profession and increasing access for creative therapeutic means to VA residents. I support this!

CommentID: 97496

Commenter: Sommer Bognar 3/29/21 8:27 pm

I support this!

I support this!

CommentID: 97497

Commenter: Erin M. 3/29/21 8:33 pm

Support

I fully support Art Therapy licensure.

CommentID: 97499

Commenter: Alana Chandler 3/29/21 8:33 pm

I Support!

An Art Therapist should be able to be licensed and viewed just as valuable as all other licensed clinicians, because we are. I support this!

CommentID: 97500

Commenter: Marlene Adams LPC ATR 3/29/21 8:45 pm

I support this

As a Registered Art Therapist I am 100% behind this!

CommentID: **97501**

Commenter: Anna McChesney 3/29/21 8:54 pm

! I support this fully

I fully support this as a clinician, business owner, colleague and citizen!

CommentID: **97502**

Commenter: Michelle Vaughan Eldridge 3/29/21 9:34 pm

We need licensed art therapists in Virginia

An art therapy license is vital for our field and our clients. In order to provide accessible mental health resources in the form of art therapy, we must obtain licensure to allow for insurance reimbursement. This is so important in order to ensure that those who need services will receive them and also, be able to afford them. In order to expand our growing population of art therapists, licensure is necessary. With the Covid-19 pandemic and increased need for mental health resources,, this is of the utmost importance.

CommentID: **97504**

Commenter: Samuel Willinger, MD 3/29/21 11:06 pm

Art therapy licensing

Many specialties in medicine and its allied fields such as dentistry, psychology , etc, have both board certification as well as state licensing .... Art therapy has been around for 40 years with a Board and journals ... A state license does yet exist ... This needs to be corrected .... It will also bring in state revenues when a fee is charged for a yearly or bi-yearly license .....

thank you for your consideration,

Samuel Willinger, MD

434-444-1732

CommentID: **97505**

Commenter: Janice D Willinger 3/29/21 11:06 pm

Support Licensure for Art Therapists in VA

Art Therapists need to be recognized as important professionals contributing to the mental health of our citizens. Please create and require a license for these dedicated therapists.

CommentID: **97506**

3/30/21 7:27 am

Commenter: Jaana Kilkki

Support for art therapy license

As a registered and board certified art therapist working with active duty military, I support the art therapy licensure. Licensing Art Therapists will create more access to mental health treatment, which is very much needed, and also make Virginia more attractive to practitioners to live and work in. It is also important to guarantee that those practicing art therapy are qualified in order to prevent harm to the public. In enacting the art therapy licensure Virginia will be in par with other states, such as MD, NY, and CT.

CommentID: **97508**

Commenter: AW 3/30/21 7:46 am

I support this

I support this

CommentID: **97509**

Commenter: Mary Roberts, PhD, LPC-ACS, ATR-BC, ATCS 3/30/21 7:54 am

I support Art Therapy Licensure

Art Therapy licensure will protect the public and increase access to non-verbal psychotherapy treatments, especially for trauma informed care. Art Therapy facilitates the creative process through healing and accessing the non-verbal brain, crucial in the treatment of our national epidemic of child abuse- neglect, emotional abuse, verbal abuse, physical abuse, and sexual abuse, and treatment of trauma for our military service members and veterans. The brain shuts down verbal processing when traumas occur and art therapy assists to access the whole brain to create healing.

CommentID: **97511**

Commenter: Heathee 3/30/21 9:01 am

Support for art therapy licensure

Support for art therapy licensure to increase access to mental health.

CommentID: **97513**

Commenter: Angelica Bigsby ATR-BC , LPC(Prince William County Community Service Board) 3/30/21 9:09 am

The need for Art Therapy licensure in Virginia

The state of Virginia must complete the process of creating art therapy license protection. There has been an increasing need for alternative therapies to help clients work towards productive and manageable lives. I work with people with serious mental illness within the local government community service board; art therapy has provided a unique lens to help clients manage their symptoms and gain insight into improving lives using evidence-based practices.

CommentID: **97514**

Commenter: Marie-Genevieve Flood 3/30/21 9:18 am

Art Therapy Licensure

I support licensure because it will improve access to mental health services.

CommentID: 97515

Commenter: Christopher Maxey 3/30/21 9:27 am

Licensure for art therapy

I strongly support art therapy licensure because it will dramatically improve access to mental health services. Mental health is too often overlooked as a critical part of care for the whole person. Art therapy is a proven technique and deserves proper licensure.

CommentID: 97517

Commenter: Seung Lee 3/30/21 9:37 am

I support this!!!

I support art therapy licensure because it will improve access to mental health services.

CommentID: 97523

Commenter: Angie 3/30/21 9:45 am

Support

Support

CommentID: 97525

Commenter: peter linn 3/30/21 9:49 am

Art Therapy Licensure

I support Art Therapy Licensure because it will improve access to Mental Health Services.

CommentID: 97526

Commenter: Jason McIntyre 3/30/21 10:36 am

Art Therapy Licensure

Licensure will improve access to mental health services in the state of Virginia.

CommentID: 97529

Commenter: Anonymous 3/30/21 10:38 am

Art therapy

I support art therapy licensure as it will improve access to mental health services.

CommentID: 97530

Commenter: Rasha W Al-Ali 3/30/21 11:07 am

Art therapy

I support Art therapy licensure

CommentID: 97534

Commenter: Natalie 3/30/21 11:10 am

Art Therapy Licensing

I support this.

CommentID: 97536

Commenter: Shakti Shukla 3/30/21 11:24 am

In support of art therapy licensure I think Raven

I support art therapy licensure because it will improve access to mental health services!

CommentID: 97538

Commenter: Rebecca Lyn Gillam; The Gil Institute for Trauma Education and Recovery 3/30/21 11:28 am

Support for Art Therapy Licensure

To whom it may concern:

As an art therapist I receive countless refers I am unable to take on as I very rarely have space in my case load. Our state would greatly benefit from more art therapist who are able to have licensure solely as an art therapist. Additionally, art therapy is a specialty that requires specific training. By creating a specific licensure process we are able to ensure that those who practice art therapy have the appropriate training.

Furthermore, art therapy provides unique oppertunities to clients heal. Providing more knowledge about art therapy could be a key to helping our states men and women heal.

CommentID: 97539

Commenter: Janessa Hill 3/30/21 11:28 am

Art Therapy License

As a Virginia resident and Art Therapy student, passing licensure for Art Therapists in Virginia would be extremely beneficial. Once I have completed my schooling, I intend to remain in Virginia and study for my license. Having such license will enable the opportunity to apply for multiple jobs

within the state and if needed, nationwide, an option unavailable if licensure is not passed. The practice of Art Therapy is quickly growing and is known to be beneficial for individuals seeking treatment. Passing licensure in Virginia will provide more opportunities for clinical work, more outreach on the benefits of Art Therapy, and will improve the standards of Art Therapists. Thank you.

CommentID: **97540**

Commenter: Steph Reed 3/30/21 11:38 am

Support

I support art therapy licensure because it will improve access to mental health services

CommentID: **97541**

Commenter: Zalene Brant, Eastern Virginia Medical school 3/30/21 11:54 am

Support

This will improve and help with virginia providing a higher quality of mental health services across the state! I fully support this and feel that it is an important part for all therapists.

CommentID: **97542**

Commenter: Gabrielle Mormile, ATR, LPC 3/30/21 11:56 am

Art Therapy licensure

I am a practicing Art Therapist and Licensed Professional Counselor in the state of Virginia. Art Therapists are often envied by LPCs and LCSWs alike because of our additional skill sets, learned from our personal experiences as Artists and our graduate level training in the application of art and creative interventions for meeting client needs. Art Therapists deserve respect and to be solidified as "eligible" practitioners without jumping through additional hoops to obtain LPC status. Some Art Therapists may choose to still pursue additional state licensure, but providers should be eligible to practice as an Art Therapist without this requirement as the education and training of an Art Therapy program and supervision, approved by the ATCB, is more than adequate to provide high quality mental health care. There is currently a high level of need and demand for Art Therapists eligible for taking insurance. It is necessary that this be addressed to ensure that families who cannot afford self-pay are also able to obtain services that meet their needs. Many mental health providers find that clients who they see require Art Therapy and attempt to practice outside of their scope because of lack of eligible Art Therapists in their localities. This puts clients at risk of harm. Allowing Art Therapists to practice fully with Art therapy license without LPC status would allow for more clients to receive the service most appropriate to their needs. I urge you to support Art Therapy licensure for the state of Virginia to ensure equitable access to all.

CommentID: **97543**

Commenter: Gretchen McKeever 3/30/21 12:38 pm

Licensing of art therapists

I strongly support the initiative to provide clear and professional licensing requirements for art therapists. Engaging in creative and artistic therapeutic practices has been essential to the trauma

recovery of people I care about. This practice of care should be fully accessible to as many people as possible to ensure the quality of care on mental health issues.

CommentID: 97544

Commenter: Claira 3/30/21 2:13 pm

Support

I support!

CommentID: 97551

Commenter: Sarah Deaver 3/30/21 2:14 pm

Support Art Tx Licensure

A professional art therapy license is long overdue Virginia. Such a license will clarify for citizens and other professionals the education and skills necessary to be an art therapist, and highly skilled master's and doctoral level licensed art therapists will provide much needed mental health services to veterans, families, and others in our state.

CommentID: 97552

Commenter: LOTUS H CUTCHINS 3/30/21 4:42 pm

I support 100%

People need different modalities for healing and I believe art therapy helps many open up in a creative way.

CommentID: 97563

Commenter: STEPHEN CUTCHINS 3/30/21 4:56 pm

please support!

Art Therapist make such a difference in peoples lives. They are very dedicated to their profession and their clients. They need to be treated as such and taken seriously in their profession so they can keep healing and making a difference in this world.

Steve

CommentID: 97564

Commenter: Elizabeth Duke 3/30/21 6:21 pm

Support for Art therapy licensure

I support Art Therapy licensure because it will improve access to mental health services which we desperately need. Thank you.

CommentID: 97567

Commenter: Susan Osborn 3/30/21 6:39 pm

Art Therapy Licensure

I support this proposal for licensure.

CommentID: 97570

Commenter: Laura Maloney SummitCounseling 3/31/21 8:10 am

Art therapy is way beyond

This is a multi leveled healing and coubseking practice that goes beyond what is offered in traditional counseling. It requires training & certification & supervision like any license does. Insurance companies will be happy bc costs in mental health will go down if we can treat people & be reiumbursed for it appropriately. It is time to think big picture health care and use what works.

CommentID: 97579

Commenter: Brittany Deutch 3/31/21 9:43 am

I SUPPORT!

I support art therapy licensure because it will improve access to mental health services in Virginia!

CommentID: 97596

Commenter: Kaitlyn Streeter 3/31/21 12:18 pm

Art Therapy Licensure Support

I support independent licensure for Art Therapists in Virginia. Art Therapists provide vital services to various populations, including those experiencing issues with mental health, substance use, neurocognitive disorders, grief, and/or trauma. Enacting this independent license is critical to expanding access to mental health services for Virginia's citizens, and could provide increased access for under-served populations.

CommentID: 97613

Commenter: Erin Blair 3/31/21 1:18 pm

Support for VA Art Therapy Licensure

I would like to proclaim my support for art therapy licensure in Virginia.

CommentID: 97618

Commenter: Cheryl Shiflett, PhD, LPC-ACS, ATR-BC, ATCS 3/31/21 1:24 pm

SUPPORT!

A professional art therapy license will clarify for Virginia residents and other health professionals the knowledge and skills necessary to be an art therapist and practice art therapy. It will provide greater access for the growing need for mental health services in our communities.

CommentID: 97619

Commenter: Leeann Allagas

3/31/21 8:02 pm

Art Therapy License in VA

As a current Registered Art Therapist, I am in support of the Art Therapy License in Virginia. In order to provide quality therapeutic services and best practices to all populations while using the skills acquired from learning to be an art therapist, it is vital that we are all held to a certain standard of care. With an official license, the public, possible future clients, and our colleagues will recognize Art Therapy as a viable mental health and wellness resource.

CommentID: 97666

Commonwealth of Virginia

REGULATIONS

GOVERNING THE PRACTICE OF ART THERAPY

VIRGINIA BOARD OF COUNSELING

Title of Regulations: 18 VAC 115-90-10 et seq.

Statutory Authority: §§ 54.1-2400 and Chapter 35 of Title 54.1 of the *Code of Virginia*

Date:

9960 Mayland Drive
Henrico, VA 23233

Phone: (804) 367-4610
FAX: (804) 527-4435
email: coun@dhp.virginia.gov

TABLE OF CONTENTS

Part I. General Provisions.

18VAC115-90-10. Definitions.

A. The following words and terms when used in this chapter shall have the meaning ascribed to them in § 54.1-3500 of the Code of Virginia:

"Art therapist"

"Art therapy"

"Board"

"Counseling"

B. The following words and terms when used in this chapter shall have the following meanings, unless the context clearly indicates otherwise:

"Applicant" means any individual who has submitted an official application and paid the application fee for licensure as an art therapist or art therapy associate.

"ATCB" means the Art Therapy Credentials Board, Inc.

"ATR" means a Registered Art Therapist, a credential issued by the ATCB after meeting established educational standards, successful completion of advanced specific graduate-level education in art therapy and supervised post-graduate art therapy experience.

"ATR-BC" means a Board Certified Art Therapist, a credential issued by the ATCB after meeting the requirements for the ATR and passing a national examination.

"ATR-Provisional" means a Provisional Registered Art Therapist, a credential issued by the ATCB, after meeting the established educational standards, successful completion of advanced specific graduate-level education in art therapy, and is practicing art therapy under an approved supervisor.

"Art Therapy Associate" means a person who has (i) completed a master's or doctoral degree program in art therapy, or an equivalent course of study from an accredited educational institution; (ii) satisfied the requirements for licensure set forth in regulations adopted by the board; and (iii) been issued a license to practice art therapy under an approved clinical supervisor in accordance with regulations of the board.

18VAC115-90-20. Fees required by the board.

A. The board has established the following fees applicable to licensure as an art therapist or art therapy associate:

Initial licensure as an art therapist: Application processing and initial licensure	$165
Initial licensure as an art therapy associate: Application processing and initial licensure	$55

Active annual license renewal as an art therapist	$130
Active annual license renewal as an art therapy associate	$30
Inactive annual license renewal as an art therapist	$65
Late renewal of an art therapist license	$45
Late renewal of an art therapy associate license	$10
Duplicate license	$10
Verification of licensure to another jurisdiction	$30
Reinstatement of a lapsed license	$200
Replacement of or additional wall certificate	$25
Returned check or dishonored credit card or debit card	$50
Reinstatement following revocation or suspension	$600

B. All fees are nonrefundable.

Part II. Requirements for Licensure as an Art Therapist and Art Therapist Associate.

18VAC115-90-30. Prerequisites for licensure as an art therapist and art therapist associate.

A. Every applicant for licensure shall submit to the board:

1. A completed application;

2. The application processing fee and initial licensure fee as prescribed in 18VAC115-90-20;

3. Verification of any other mental health or health professional license, registration, or certificate ever held in Virginia or another jurisdiction; and

4. A current report from the U.S. Department of Health and Human Services National Practitioner Data Bank (NPDB).

B. An applicant shall have no unresolved disciplinary action against a mental health or health professional license, certificate, or registration held in Virginia or in another U. S. jurisdiction. The board will consider history of disciplinary action on a case-by-case basis.

18VAC115-90-40. Requirements for licensure.

In addition to pre-requisites as set forth in 18VAC115-90-30:

A. Every applicant for licensure by examination as an art therapist shall submit to the board evidence of a current ATR-BC certification from the ATCB or its successor organization as approved by the board.

B. Every applicant for licensure by endorsement as an art therapist shall submit to the board:

1. Verification of a current, unrestricted art therapy license issued from another United States jurisdiction, or if lapsed, evidence that the license is eligible for reinstatement;

2. An attestation of having read and understood the regulations and laws governing the practice of art therapy in Virginia; and either

   a. Current ATR-BC certification from the Art Therapy Credentials Board, or

   b. Documentation of passage of the examination of the ATCB and evidence of autonomous, clinical practice in art therapy, as defined in §54.1-3500 of the Code of Virginia, for 24 of the last 60 months immediately preceding his licensure application in Virginia. Clinical practice shall mean the rendering of direct clinical art therapy services, clinical supervision of clinical art therapy services, or teaching graduate-level courses in art therapy.

C. Every applicant for licensure as an art therapy associate shall submit to the board evidence of a current registration as a Registered Art Therapist (ATR) or a Provisional Registered Art Therapist (ATR-P) from the ATCB or its successor organization as approved by the board.

18VAC90-115-50. Requirements for Practice as an Art Therapy Associate.

A. Art therapy associates shall not call themselves Licensed Art Therapists, directly bill for services rendered, or in any way represent themselves as independent, autonomous practitioners. Associates shall use the title of "Art Therapy Associate" in all written communications. Clients shall be informed in writing that the associate does not have the authority for independent practice, is practicing under supervision, and shall provide the supervisor's name, professional address, and phone number.

B. Associates shall not engage in practice under supervision in areas for which they have not had the appropriate education or training.

Part III. Examinations.

18VAC115-90-60. General examination requirements; schedules; time limits.

A. Every applicant for initial licensure by examination by the board as an art therapist shall pass the Art Therapy Credentials Board examination (ATCBE) prescribed by the ATCB.

B. An applicant is required to pass the prescribed examination and obtain registration as an ATR-BC no later than five years from the date of initial issuance by the board of an art therapy associate license, unless the board has granted an extension of the associate license.

C. An art therapy associate who has not met the requirements for licensure as an art therapist with five years of issuance of licensure as an art therapy associate may submit an application for extension of licensure to the board. Such application shall include:

   1. A plan for completing the requirement to obtain licensure as an art therapist;
   2. Documentation of compliance with the continuing education requirements;

3. Documentation of compliance with requirements related to supervision, and ,
4. A letter of recommendation from the clinical supervisor of record.

An extension of an associate art therapy license shall be valid for a period of two years.

Part IV. Licensure Renewal; Reinstatement.

18VAC115-90-70. Annual renewal of licensure.

A. Every licensed art therapist who intends to continue active practice shall submit to the board on or before June 30 of each year:

1. A completed form for renewal of the license on which the licensee attests to compliance with the continuing competency requirements prescribed in this chapter; and
2. The renewal fee prescribed in 18VAC115-90-20.

B. An associate license in art therapy shall expire annually in the month the associate license was initially issued and may be renewed up to four times by submission of the renewal form and payment of the fee prescribed in 18VAC115-90-20. On the annual renewal, the art therapy associate shall attest to completion of three hours in continuing education courses that emphasize the ethics, standards of practice, or laws governing behavioral science professions in Virginia, offered by an approved provider as set forth in subsection B of 18VAC115-90-90.

C. A licensed art therapist who wishes to place his license in an inactive status may do so upon payment of the inactive renewal fee as established in 18VAC115-90-20. No person shall practice art therapy in Virginia unless he holds a current active license. A licensee who has selected an inactive status may become active by fulfilling the reactivation requirements set forth in subsection C of 18VAC115-90-110.

D. Licensees shall notify the board of a change in the address of record or the public address, if different from the address of record within 60 days. Failure to receive a renewal notice from the board shall not relieve the license holder from the renewal requirement.

E. Practice with an expired license is prohibited and may constitute grounds for disciplinary action.

18VAC115-90-80. Continued competency requirements for renewal of a license.

A. Licensed art therapists shall be required to have completed a minimum of 20 hours of continuing competency for each annual licensure renewal. A minimum of two of these hours shall be in courses that emphasize the ethics, standards of practice, or laws governing behavioral science professions in Virginia.

B. The board may grant an extension for good cause of up to one year for the completion of continuing competency requirements upon written request from the licensee prior to the renewal date. Such extension shall not relieve the licensee of the continuing competency requirement.

C. The board may grant an exemption for all or part of the continuing competency requirements due to circumstances beyond the control of the licensee such as temporary disability, mandatory military service, or officially declared disasters.

D. An art therapist who holds another license issued by a Virginia health regulatory board shall not be required to obtain more than 20 total continuing education hours in order to renew an art therapy license, except at least 10 of the required hours of continuing education shall be specifically related to art therapy.

E. Up to two hours of the 20 hours required for annual renewal may be satisfied through delivery of art therapy services, without compensation, to low-income individuals receiving health services through a local health department or a free clinic organized in whole or primarily for the delivery of those services. One hour of continuing education may be credited for three hours of providing such volunteer services, as documented by the health department or free clinic.

F. A licensed professional art therapist who was licensed by examination is exempt from meeting continuing competency requirements for the first renewal following initial licensure.

18VAC115-90-90. Continuing competency activity criteria.

A. Approved hours of continuing competency activity for an art therapist shall be approved if they meet the continued education requirements for recertification as an ATR-BC.

B. Additionally, continuing competency activity for a licensed art therapist shall be approved if they are workshops, seminars, conferences, or courses in the behavioral health field offered by an individual or organization that has been certified or approved by one of the following:

(1) The International Association of Marriage and Family Counselors and its state affiliates;
(2) The American Association for Marriage and Family Therapy and its state affiliates;
(3) The American Association of State Counseling Boards;
(4) The American Counseling Association and its state and local affiliates;
(5) The American Psychological Association and its state affiliates;
(6) The Commission on Rehabilitation Counselor Certification;
(7) NAADAC, The Association for Addiction Professionals and its state and local affiliates;
(8) National Association of Social Workers;
(9) National Board for Certified Counselors;
(10) A national behavioral health organization or certification body;
(11) 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) The American Association of Pastoral Counselors;
(13) The American Art Therapy Association and its state affiliates;
(14) The Art Therapy Credentials Board;
(15) The International Expressive Arts Therapy Association;
(16) A regionally accredited university or college; or
(17) A federal, state, or local governmental agency or licensed health facility.

18 VAC 115-90-100. Documenting compliance with continuing competency requirements.

A. All licensees are required to maintain original documentation for a period of two years following renewal.

B. After the end of each renewal period, the board may conduct a random audit of licensees to verify compliance with the requirement for that renewal period.

C. Upon request, a licensee shall provide documentation as follows:

1. To document completion of formal organized learning activities the licensee shall provide:

a. Official transcripts showing credit hours earned; or

b. Certificates of participation.

D. Continuing competency hours required by a disciplinary order shall not be used to satisfy renewal requirements.

18VAC115-90-110. Late renewal; reactivation or reinstatement.

A. A person whose license has expired may renew it within one year after its expiration date by paying the late fee prescribed in 18VAC115-90-20 as well as the license renewal fee prescribed for the year the license was not renewed and providing evidence of having met all applicable continuing competency requirements.

B. A person who fails to renew a license after one year or more and wishes to resume practice shall apply for reinstatement, pay the reinstatement fee for a lapsed license, submit verification of any mental health license he holds or has held in another jurisdiction, if applicable, and provide evidence of having met all applicable continuing competency requirements not to exceed a maximum of 80 hours. The board may require the applicant for reinstatement to submit evidence regarding the continued ability to perform the functions within the scope of practice of the license.

C. A person wishing to reactivate an inactive license shall submit (i) the renewal fee for active licensure minus any fee already paid for inactive licensure renewal; (ii) documentation of continued competency hours equal to the number of years the license has been inactive not to exceed a maximum of 80 hours; and (iii) verification of any mental health license he holds or has held in another jurisdiction, if applicable. The board may require the applicant for reactivation to submit evidence regarding the continued ability to perform the functions within the scope of practice of the license.

Part V. Standards of Practice; Unprofessional Conduct; Disciplinary Actions; Reinstatement.

18VAC115-90-120. 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. Regardless of the delivery method, whether in person, by phone or electronically, these standards shall apply to the practice of art therapy.

B. Persons licensed 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 boundaries of their competence, based on their education, training, supervised experience and appropriate professional experience and represent their education training and experience accurately to clients;

3. Stay abreast of new counseling information, concepts, applications and practices which are necessary to providing appropriate, effective professional services;

4. Be able to justify all services rendered to clients as necessary and appropriate for diagnostic or therapeutic purposes;

5. Document the need for and steps taken to terminate a counseling relationship when it becomes clear that the client is not benefiting from the relationship. Document the assistance provided in making appropriate arrangements for the continuation of treatment for clients, when necessary, following termination of a counseling relationship;

6. Make appropriate arrangements for continuation of services, when necessary, during interruptions such as vacations, unavailability, relocation, illness, and disability;

7. Disclose to clients all experimental methods of treatment and inform clients of the risks and benefits of any such treatment. Ensure that the welfare of the clients is in no way compromised in any experimentation or research involving those clients;

8. Neither accept nor give commissions, rebates, or other forms of remuneration for referral of clients for professional services;

9. Inform clients of the purposes, goals, techniques, procedures, limitations, potential risks, and benefits of services to be performed, the limitations of confidentiality, and other pertinent information when counseling is initiated, and throughout the counseling process as necessary. Provide clients with accurate information regarding the implications of diagnosis, the intended use of tests and reports, fees, and billing arrangements;

10. Select tests for use with clients that are valid, reliable and appropriate and carefully interpret the performance of individuals not represented in standardized norms;

11. Determine whether a client is receiving services from another mental health service provider, and if so, refrain from providing services to the client without having an informed consent discussion with the client and having been granted communication privileges with the other professional;

12. Use only in connection with one's practice as a mental health professional those educational and professional degrees or titles that have been earned at a college or university accredited by an

accrediting agency recognized by the U. S. Department of Education, or credentials granted by a national certifying agency, and that are counseling in nature; and

13. Advertise professional services fairly and accurately in a manner which is not false, misleading or deceptive.

C. In regard to client records, persons licensed by the board shall:

1. Maintain written or electronic clinical records for each client to include treatment dates and identifying information to substantiate diagnosis and treatment plan, client progress, and termination Client records include documentation of the artwork or any visual production produced by the client during clinical sessions;

2. Maintain client records securely, inform all employees of the requirements of confidentiality and provide for the destruction of records which are no longer useful in a manner that ensures client confidentiality;

3. Disclose or release records to others only with the clients' expressed written consent or that of the client's legally authorized representative in accordance with § 32.1-127.1:03 of the Code of Virginia;

4. Ensure confidentiality in the usage of client records and clinical materials, including artwork or any visual production produced by the client during clinical sessions, by obtaining informed consent from the client or the client's legally authorized representative before (i) videotaping, (ii) audio recording, (iii) permitting third party observation, or (iv) using identifiable client records and clinical materials in teaching, writing or public presentations; and

5. Maintain client records for a minimum of five years or as otherwise required by law from the date of termination of the counseling relationship with the following exceptions:

a. At minimum, records of a minor child shall be maintained for five years after attaining the age of majority (18 years) or ten years following termination, whichever comes later;

b. Records that are required by contractual obligation or federal law to be maintained for a longer period of time; or

c. Records that have been transferred to another mental health service provider or given to the client or his legally authorized representative.

D. In regard to dual relationships, persons licensed by the board shall:

1. Avoid dual relationships with clients that could impair professional judgment or increase the risk of harm to clients. (Examples of such relationships include, but are not limited to, familial, social, financial, business, bartering, or close personal relationships with clients.) Art therapists shall take appropriate professional precautions when a dual relationship cannot be avoided, such as informed consent, consultation, supervision, and documentation to ensure that judgment is not impaired and no exploitation occurs;

2. Not engage in any type of romantic relationships or sexual intimacies with clients or those included in a collateral relationship with the client and not provide therapy to persons with whom they have had a romantic relationship or sexual intimacy. Art therapists shall not engage in romantic relationships or sexual intimacies with former clients within a minimum of five years after terminating the counseling relationship. Art Therapists who engage in such relationship or intimacy after five years following termination shall have the responsibility to examine and document thoroughly that such relations do not have an exploitive nature, based on factors such as duration of counseling, amount of time since counseling, termination circumstances, client's personal history and mental status, or adverse impact on the client. A client's consent to, initiation of or participation in sexual behavior or involvement with a counselor does not change the nature of the conduct nor lift the regulatory prohibition;

3. Not engage in any romantic relationship or sexual intimacy or establish a counseling or psychotherapeutic relationship with a supervisee or student. Licensed Art Therapists shall avoid any nonsexual dual relationship with a supervisee or student in which there is a risk of exploitation or potential harm to the supervisee or student or the potential for interference with the supervisor's professional judgment; and

4. Recognize conflicts of interest and inform all parties of the nature and directions of loyalties and responsibilities involved.

E. Persons licensed by this board shall report to the board known or suspected violations of the laws and regulations governing the practice of art therapy.

F. Persons licensed by the board shall advise their clients of their right to report to the Department of Health Professions any information of which the licensee may become aware in his professional capacity indicating that there is a reasonable probability that a person licensed or certified as a mental health service provider, as defined in § 54.1-2400.1 of the Code of Virginia, may have engaged in unethical, fraudulent or unprofessional conduct as defined by the pertinent licensing statutes and regulations.

18VAC115-90-130. Grounds for revocation, suspension, probation, reprimand, censure, or denial of license.

A. Action by the board to revoke, suspend, deny issuance or renewal of a license, or take disciplinary action may be taken in accordance with the following:

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 professional counseling, or any provision of this chapter;

2. Procuring, attempting to procure, or maintaining a license by fraud or misrepresentation;

3. Conducting one's practice in such a manner 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 counseling with reasonable skill and safety to clients by reason of illness, abusive use of alcohol, drugs, narcotics, chemicals, or other type of material or result of any mental or physical condition;

4. Intentional or negligent conduct that causes or is likely to cause injury to a client or clients;

5. Performance of functions outside the demonstrable areas of competency;

6. Failure to comply with the continued competency requirements set forth in this chapter;

7. Violating or abetting another person in the violation of any provision of any statute applicable to the practice of counseling, or any part or portion of this chapter; or

8. Performance of an act likely to deceive, defraud, or harm the public.

B. Following the revocation or suspension of a license, the licensee may petition the board for reinstatement upon good cause shown or as a result of substantial new evidence having been obtained that would alter the determination reached.

18 VAC115-90-140. Reinstatement following disciplinary action.

A. Any person whose license 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 licensure.

B. The board in its discretion may, after an administrative proceeding, grant the reinstatement sought in subsection A of this section.

Virginia Department of
Health Professions
Board of Counseling

Discipline Reports

07/29/2021 - 10/20/2021

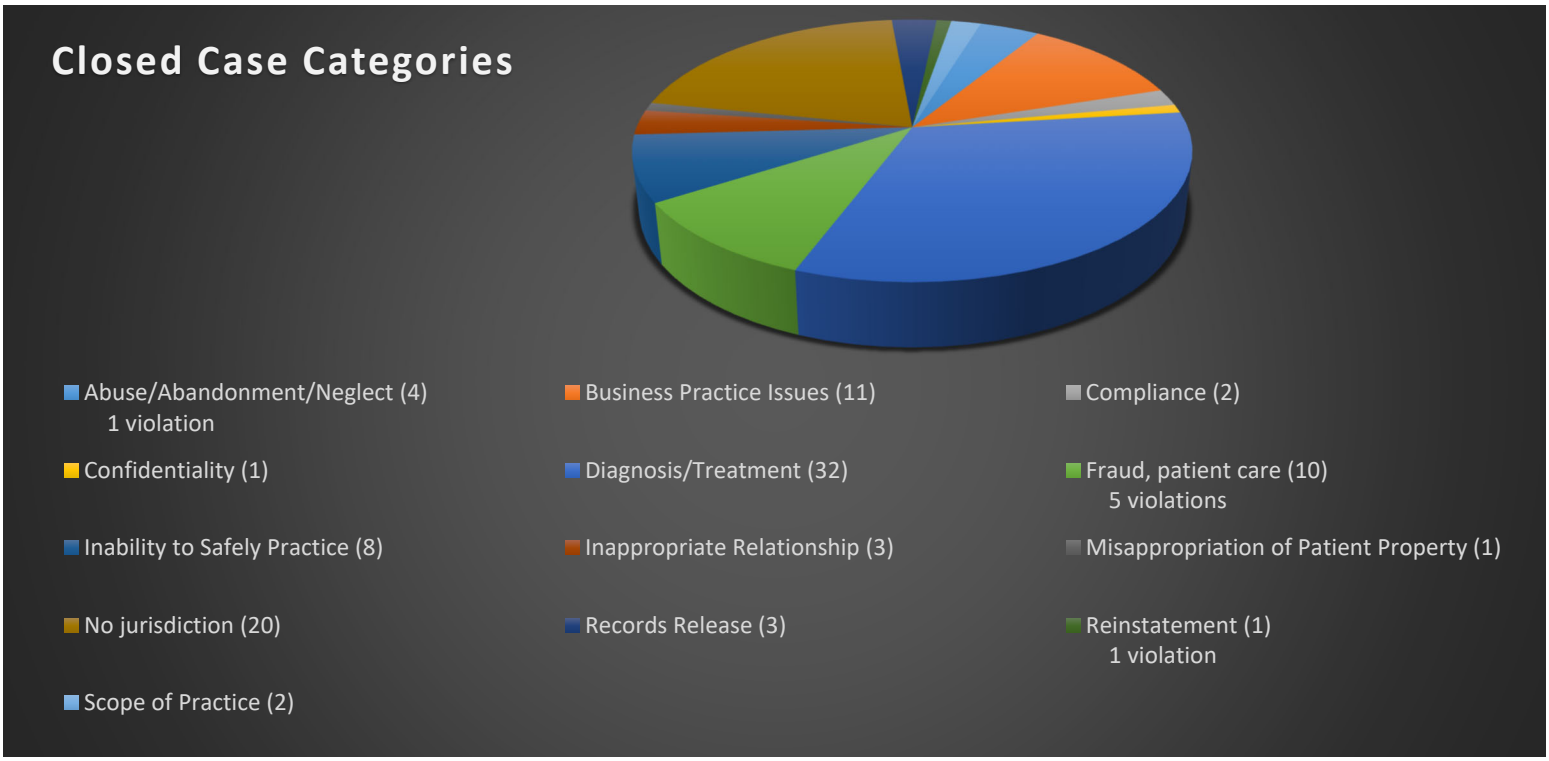
NEW CASES RECEIVED IN BOARD 07/29/2021 - 10/20/2021				
	Counseling	**Psychology**	**Social Work**	**BSU Total**
Cases **Received** for Board review	65	37	22	***124***

OPEN CASES (as of 10/20/2021)				
Open Case Stage	**Counseling**	**Psychology**	**Social Work**	**BSU Total**
Probable Cause Review	65	100	10	
Scheduled for Informal Conferences	20	4	15	
Scheduled for Formal Hearings	6	1	0	
Other (pending CCA, PHCO, hold, etc.)	15	9	6	
Cases with APD for processing (IFC, FH, Consent Order)	4	0	2	
TOTAL CASES AT BOARD LEVEL	**110**	**114**	**33**	***257***
OPEN INVESTIGATIONS	**85**	**32**	**26**	***143***
TOTAL OPEN CASES	**195**	**146**	**59**	***400***

UPCOMING CONFERENCES AND HEARINGS		
Informal Conferences	Conferences Held:	September 20, 2021 (Canceled) October 18, 2021 (Canceled)
	Scheduled Conferences:	December 10, 2021 (Special Conference Committee) January 24, 2022 (Agency Subordinate) February 25, 2022 (Special Conference Committee) March 7, 2022 (Agency Subordinate) April 11, 2022 (Agency Subordinate) April 29, 2022 (Special Conference Committee) June 24, 2022 (Special Conference Committee)
Formal Hearings	Hearings Held:	August 20, 2021
	Scheduled Hearings:	November 5, 2021 February 18, 2022

Virginia Department of
Health Professions
Board of Counseling

CASES CLOSED (07/29/2021 - 10/20/2021)	
Closed – **no violation**	86
Closed – **undetermined**	5
Closed – **violation**	7
Credentials/Reinstatement – **Denied**	0
Credentials/Reinstatement – **Approved**	0
TOTAL CASES CLOSED	**98**



AVERAGE CASE PROCESSING TIMES (counted on closed cases)	
Average time for case closures	**229**
Avg. time in Enforcement (investigations)	98
Avg. time in APD (IFC/FH preparation)	19
Avg. time in Board (includes hearings, reviews, etc).	130
Avg. time with board member (probable cause review)	29

FY2021 (July 1, 2020 – June 30, 2021)

Credential Type		Total Cases	Total Credentials	% of Cases/ Credentials
LPC	Licensed Professional Counselor	161	7200	2.24%
RIC	Licensed Resident in Counseling	47	2664	1.76%
LMFT	Licensed Marriage and Family Therapist	23	947	2.43%
RMFT	Licensed Resident in Marriage and Family Therapy	5	140	3.57%
LSATP	Licensed Substance Abuse Treatment Practitioner	10	339	2.95%
RSAT	Licensed Resident in Substance Abuse Treatment	0	12	n/a
CSAC	Certified Substance Abuse Counselor	33	1756	1.88%
CSAC-A	Certified Substance Abuse Counseling Assistant	0	232	n/a
CSAC-Trainee	Substance Abuse Trainee	8	2030	0.39%
CRP	Certified Rehabilitation Provider	0	178	n/a
QMHP-A	Qualified Mental Health Professional-Adult (Registration)	74	6598	1.12%
QMHP-C	Registered Qualified Mental Health Professional-Child (Registration)	47	4809	0.98%
QMHP-T	Registered Qualified Mental Health Professional-Trainee (Registration)	33	5704	0.58%
RPRS	Registered Peer Recovery Specialist	6	310	1.94%

LICENSING REPORT

Total as of September 1, 2021

Current Licenses, Certificates and Registrations	
Certified Substance Abuse Counselor	1,738
Substance Abuse Trainee	2,039
Substance Abuse Counseling Assistant	234
Licensed Marriage and Family Therapist	949
Marriage & Family Therapist Resident	144
Licensed Professional Counselor	7,252
Resident in Counseling	2,662
Substance Abuse Treatment Practitioner	342
Substance Abuse Treatment Residents	11
Rehabilitation Provider	178
Qualified Mental Health Prof-Adult	6,633
Qualified Mental Health Prof-Child	4,843
Trainee for Qualified Mental Health Prof	5,751
Registered Peer Recovery Specialist	315
Total	**33,091**

Licenses, Certifications and Registrations Issued

License Type	June 2021	July 2021	August 2021	September 2021*
Certified Substance Abuse Counselor	8	11	5	3
Substance Abuse Trainee	25	25	21	40
Certified Substance Abuse Counseling Assistant	3	2	3	3
Licensed Marriage and Family Therapist	10	5	7	7
Marriage & Family Therapist Resident	5	3	7	1
Pre-Education Review for LMFT	0	0	0	0
Licensed Professional Counselor	86	76	88	112
Resident in Counseling	87	64	89	87
Pre-Education Review for LPC	6	0	9	2
Substance Abuse Treatment Practitioner	3	3	5	4
Substance Abuse Treatment Residents	1	1	1	1
Pre-Education Review for LSATP	0	0	0	0
Rehabilitation Provider	0	0	0	0
Qualified Mental Health Prof-Adult	71	77	35	59
Qualified Mental Health Prof-Child	55	44	20	49
Trainee for Qualified Mental Health Prof	214	119	166	213
Registered Peer Recovery Specialist	8	11	6	16
Total	**582**	**441**	**462**	**597**

*Unofficial numbers (for informational purposes only)

Licenses, Certifications and Registration Applications Received

Applications Received	June 2021*	July 2021*	August 2021*	September 2021*
Certified Substance Abuse Counselor	13	11	7	11
Substance Abuse Trainee	23	30	23	26
Certified Substance Abuse Counseling Assistant	4	4	2	7
Licensed Marriage and Family Therapist	9	7	14	17
Marriage & Family Therapist Resident	7	4	5	6
Pre-Education Review for LMFT	0	0	3	0
Licensed Professional Counselor	111	129	121	70
Resident in Counseling	104	94	100	97
Pre-Education Review for LPC	9	1	1	2
Substance Abuse Treatment Practitioner	9	8	4	7
Substance Abuse Treatment Residents	3	3	3	0
Pre-Education Review for LSATP	0	0	0	0
Rehabilitation Provider	0	0	1	1
Qualified Mental Health Prof-Adult	122	102	109	89
Qualified Mental Health Prof-Child	89	59	82	81
Trainee for Qualified Mental Health Prof	200	182	219	220
Registered Peer Recovery Specialist	16	13	14	13
Total	**719**	**647**	**708**	**647**

*Unofficial numbers (for informational purposes only)