Virginia Department of Health Professions
Board of Counseling

Agenda

Full Board Meeting
September 16, 2022
10:15 a.m.
9960 Mayland Dr
2nd Floor, Board Room 2
Richmond, VA 23233

10:15 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

- May 13, 2022 Board Meeting Minutes* ……Page 4
- May 13, 2022 Formal Hearing Minutes (For Informational Purposes Only)……Page 8
- July 8, 2022 Informal Conference Committee (IFC) Minutes (For Informational Purposes Only)…… Page 10

Agency Director Report (Verbal) – Dr. David E. Brown, DC

Chair Report (Verbal) – Dr. Brendel

Legislation and Regulatory Actions – Erin Barrett, JD, Department of Health Professions (DHP), Senior Policy Analyst

- Regulatory Chart……Page 13
- Consideration of Petition for Rulemaking to register individuals as QMHPs based solely on experience rather than degree*……Page 14
- Consideration of petition for rulemaking to allow QMHP with 2 years of experience and supervision traiing to supervise QMHP trainees*……Page 26
- Consideration of Petition for Rulemaking to allow residents to use the title "LPC-R"*……Page 47
- Consideration of final regulations following periodic review*……Page 57
- Consideration of fast-track regulatory action to reduce regulatory burden*……Page 185
- Consideration of amendments to Guidance Document 115-1.1*…… Page 201
- Consideration of NOIRA to remove regulations duplicative of Code with regard to conversion therapy of minors*……Page 203

Presentations

- Workforce Shortage for Substance Misuse – David Cassie, Executive Director Pinacle Treatment Centers
- Virginia's Licensed Professional Counselor Workforce: 2022 – Yetty Shobo, PhD, Director, Healthcare Workforce Datat Center……Page 210

Committee Reports

- Regulatory Committee (Verbal) – Jaime Hoyle, JD, Executive Director, Boards of Counseling Psychology, and Social Work

Staff Reports

- Executive Director Report – Jaime Hoyle……Page 242
- Discipline Report - Jennifer Lang, Deputy Director, Boards of Counseling, Psychology, & Social Work……Page 257
- Licensing Report – Charlotte Lenart, Deputy Director – Licensing, Boards of Counseling, Psychology, & Social Work……Page 259

Consideration of Recommended Decisions from the Agency Subordinate*

Next Meeting – November 4, 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).

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.

Virginia Department of Health Professions
Board of Counseling

Virginia Board of Counseling
Full Board Meeting Minutes
Friday, May 13, 2022 at 10:00 a.m.
9960 Mayland Drive, Henrico, VA 23233
Board Room 2

PRESIDING OFFICER:	Johnston Brendel, Ed.D., LPC, LMFT, Chairperson
BOARD MEMBERS PRESENT:	Angela Charlton, Ph.D., LPC Barry Alvarez, LMFT Bev-Freda L. Jackson, Ph.D., MA Citizen Member Danielle Hunt, LPC, Vice-Chairperson Gerald Lawson, Ph.D., LPC, LSATP Holly Tracy, LPC, LMFT Maria Stransky, LPC, CSAC, CSOTP Tiffinee Yancey, Ph.D., LPC Terry R. Tinsley, Ph.D., LPC, LMFT, CSOTP
BOARD MEMBERS ABSENT:	Natalie Harris, LPC, LMFT Tiffinee Yancey, Ph.D., LPC Vivian Sanchez-Jones, Citizen Member
BOARD STAFF PRESENT:	Charlotte Lenart, Deputy Executive Director- Licensing Jaime Hoyle, JD, Executive Director Leoni Wells, Executive Assistant
DHP STAFF PRESENT:	Erin Barrett, Senior Policy Analyst, Department of Health Professions
BOARD COUNSEL PRESENT:	James Rutkowski, Assistant Attorney General
PUBLIC ATTENDEES:	Arnold Woodruff, Executive Director, Virginia Association for Marriage and Family Therapy (VAMFT)
CALL TO ORDER:	Dr. Brendel called the board meeting to order at 10:04 a.m.
ROLL CALL/ESTABLISHMENT OF A QUORUM:	Ms. Lenart announced that with nine members present at roll call a quorum was established.
MISSION STATEMENT:	Ms. Hoyle read the mission statement of the Department of Health Professions, which was also the mission statement of the Board.
ADOPTION OF AGENDA:	The agenda was adopted as presented.
PUBLIC COMMENT:	No public comment provided.
APPROVAL OF MINUTES:	With a small edit to attachment A, the February 18, 2022 minutes stand approved as

presented.

BOARD CHAIR REPORT:

Dr. Brendel thanked staff for everything they continue to do for the Board. Dr. Brendel asked Board members to let staff know if they would like to be a member of a committee or if they would like to step down from a committee position.

LEGISLATION & REGULATORY

General Assembly Update:
Ms. Barrett briefly discussed the history of Senate Bill 257 Counseling Compact Review bill and stated that the bill was stricken from the docket on February 24, 2022. Ms. Barrett recommended that the Board vote on whether they want to continue to support the Counseling Compact at the November meeting.

Ms. Barrett spoke about House Bill 317 which allows individuals to practice temporary for a 90-day period in Virginia while the Board reviews their application, providing they meet requirements that are set forth. This bill was an emergency action as is now in effect. Ms. Barrett indicated that the Board has a system in place to identify these individuals and to expedite their applications.

Ms. Barrett discussed House Bill 537 which will allow telehealth treatment into Virginia by certain practitioners providing behavioral health services who are providing continuity of care to their clients. The limitations are that the client-practitioners relationship has already been established and that the telehealth visits are limited to one year from the date of the last in-person evaluation.
Ms. Lenart asked if this would also apply to individuals who are licensed as residents in another state. Ms. Barrett will look into this and see how it impacts the Board.

Regulatory Actions:
Review of Public Comment on Proposed State of Implementation of Periodic Review Changes
Ms. Barrett discussed the public comment received by the Board for its periodic review. The Board received 180 comments which all related to the endorsement section of the professional counseling regulations. Ms. Barrett requested the Board consider sending these regulations back to the Regulatory Committee to make some minor edits and reorganization that would address a lot of the confusion.

Dr. Lawson commented that it appeared many of the public commenters seemed unclear about what they were responding to. He indicated that so much of this section of the regulations remained the same and it appears individuals were misled to believe that this was leading to advancing CACREP as a standard. The Board has tried to clear the path for more licensees to become licensed and has not made it any more difficult to apply by endorsement. Additionally, the commenters seem to believe this was alternative to the Compact which is not true as the periodic review started in 2019 and the Board fully supported the Counseling Compact.

COMMITTEE REPORT:

Regulatory Committee Report
Ms. Tracey Holly gave the Committee report which provided a summary of the items discussed at the meeting.

A. Consideration of Guidance Document 115-1.4, Guidance on Technology-Assisted Counseling

Motion: Mr. Alvarez moved to accept the proposed Guidance Document 115-1.4 as

presented. The motion was seconded and carried unanimously.

In addition to the guidance document, staff will post the *State of Telehealth in the U.S.* report Dr. LoriAnn Stretch completed for the Board.

B. Guidance Document 115-2 Impact of Criminal Convictions
Motion: Ms. Stransky moved to accept the revised Guidance Document 115-2 as recommended by the Committee. The motion was seconded and carried unanimously.

C. Guidance Document 115-2.1 Use of Hypnosis
Motion: Dr. Lawson moved to rescind Guidance Document 115-2.1 as recommended by the Committee. The motion was seconded and carried unanimously.

D. Guidance Document 115-1.9 Certification Accepted by CSAC Endorsement; 115-4.1 Evidence of Clinical Practice for Licensure by Endorsement; 115-4.11 Confidential Consent Agreements
Motion: Mr. Alvarez moved to reconfirm Guidance Documents 115-1.9, 115-4.1 and 115-4.11 with no amendments as recommended by the Committee. The motion was seconded and carried unanimously.

Board of Health Professions Report
Ms. Hoyle stated that the Board of Health Professions will reformat their structure to be more streamlined with less meetings and less board reports. Mr. Alvarez indicated that he attended the short Board meeting but there was no new information to provide to the Board.

EXECUTIVE DIRECTOR'S REPORT:

Ms. Hoyle reported on DHP updates. At the time, the Administration had made no decision regarding the transition, but we all hope that the Governor reappoints Dr. Brown. Ms. Hoyle discussed the new telework policy and its implementation efforts. She also stated that DHP will upgrade its licensing system soon, and the board will soon utilize BOT technology to help Board staff complete some administrative tasks in the near future and increase communication with applicants.

Ms. Hoyle discussed the budget for the board, and confirmed for board members that the board receives no general fund money, and fees generate all funds in the budget. Ms. Hoyle indicated that the budget reflects the continued growth in applications and she distributed statistics comparing the number of applications the board received over the last ten years. Ms. Hoyle reported that the Code of Virginia dictates that if the budget is 10% over or under, DHP will consider a one-time renewal fee reduction, or an increase in fees. At this point, the DHP is being conservative, as we do not know the cost of the discipline associated with the addition of the QMHPs and the eventual addition of art therapist. Currently, we are seeing an increase in discipline cases related to QMHPs, so there is reason to be cautious.

Finally, Ms. Hoyle will present to the VAMFT on June 10, 2022.

Ms. Hoyle discussed having an informal discussion with CSBs regarding QMHPs. Ms. Hoyle asked the Board if they would like to consider having a summit in the Fall to discuss QMHP education, supervision, and overall workforce issues.

Ms. Barrett suggested that the CSBs submit a petition for rulemaking to pinpoint their requests so that the Board knows exactly what they would like the Board to consider. After receiving the petition, the Board could then possibly create a workgroup to have an open discussion about the issues outlined in the petition for rulemaking. Ms. Barrett suggested this process afforded a better opportunity for conversation and dialogue with the CSBs, and at the same time maintain focus that could lead to regulatory changes.

DISCIPLINE REPORT:

Ms. Lang was not present but provided a report on the disciplinary statistics for Board of Counseling from February 3, 2022 to April 29, 2022 in the agenda packet.

LICENSING REPORT:

Ms. Lenart discussed the licensure statistics, deferred applications and Informal Conference decisions report as presented in the agenda packet.

Ms. Lenart mentioned that the Association of Marital & Family Therapy Regulatory Boards (AMFTRB) will have their annual meeting on September 13 -14, 2022. Board members that are interested in attending should contact staff. Additionally, AMFTRB is looking for additional board members, so if anyone has an interest to contact her directly.

Ms. Lenart provided a printout for the Board with information about the new National Clinical Mental Health Counseling Examination (NCMHCE) testing format. The test will be available online or in a testing center.

Ms. Lenart reminded Board members that the Board is currently in the renewal cycle. The renewal reminder email included links to the renewal FAQs and renewal chart.

Ms. Lenart indicated that staff was currently interviewing for the current vacant part-time positions and was optimistic that the Board will be able to possibly hire two new full time positions in July.

NEW BUSINESS

Mr. Lawson stated that at the last discipline hearing he was bothered by the inappropriate conduct and the need for a more descriptive informed consent form. He suggested that the Board consider creating a template or sample of an informed consent form that licensees could use in their practice. The Board agreed after a brief discussion that a template might be useful. Staff will develop a sample draft to be presented at the next Committee meeting.

NEXT MEETING DATES:

Dr. Brendel announced that a Doodle poll will be sent out to Board members so that a date can be set for the next fall meeting.

ADJOURNMENT:

Dr. Brendel adjourned the May 13, 2022 Board meeting at 12:03 p.m.

_____

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

_____

Jaime Hoyle, JD, Executive Director

VIRGINIA BOARD OF COUNSELING
FORMAL HEARING
MINUTES

May 13, 2022

Department of Health Professions
Perimeter Center, 9960 Mayland Drive
Board Room 2
Henrico, Virginia 23233

Matter: **Ophera Davis, LPC Applicant**
Attorney: n/a
Case No.: 195874

Call to Order: A panel of the Board of Counseling convened on May 13, 2022 at 12:45 p.m..

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

Board Members Present:
Barry Alvarez, LMFT
Angela Charlton, Ph.D., LPC
Bev-Freda Jackson, Ph.D., Citizen Member
Gerard Lawson, Ph.D., LPC, LSATP
Terry Tinsley, Ph.D., LPC, LMFT
Holly Tracy, LPC, LMFT

Board Staff:
Jaime Hoyle, Executive Director
Charlotte Lenart, Deputy Executive Director - Licensing
Christy Evans, Discipline Case Specialist
Leoni Wells, Executive Assistant

Court Reporter: Holly M. Bush, Farnsworth & Taylor Reporting

Establishment of a Panel: With seven (7) members present, a panel of the board was established.

Parties on Behalf of the Commonwealth: Emily Tatum, Sr. Adjudication Specialist, APD

Discussion: Ms. Davis appeared before the board in person, in accordance with the board's Notice of Formal Hearing dated April 11, 2022. Ms. Davis was not represented by legal counsel.

The Board received evidence and sworn testimony regarding the allegations contained in the Notice dated.

Closed Session: Upon a motion by Dr. Lawson, and duly seconded by Mr. Alvarez, the Board voted to convene 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. Additionally, he moved that James Rutkowski, Jaime Hoyle, Charlotte Lenart, Christy Evans, and Leoni Wells attend the closed meeting because their presence was deemed necessary and would aid the Board in its deliberation.

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

Decision and Vote: Dr. Lawson moved that the Board of Counseling deny Ms. Davis' application for licensure as a professional counselor. The basis for this decision will be set forth in a final Board Order which will be sent to Ms. Davis at the address of record. The motion was seconded by Ms. Tracy and carried unanimously.

Adjournment: The Board adjourned at 1:35 p.m.

The decision shall be effective upon the entry by the Board of a written Order stating the findings, conclusions and decisions of this formal hearing panel.

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Johnston Brendel
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5/19/2022

Johnston Brendel, Ed.D., LPC, LMFT, Chairperson
Virginia Board of Counseling

Date

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Jaime Hoyle
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5/19/2022

Jaime Hoyle, Executive Director
Virginia Board of Counseling

Date

VIRGINIA BOARD OF COUNSELING
SPECIAL CONFERENCE COMMITTEE
INFORMAL CONFERENCE MINUTES – JULY 8, 2022

CALL TO ORDER: A Special Conference Committee ("Committee") of the Board of Counseling ("Board") convened on July 8, 2022 at 10:30 a.m., at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Richmond, Virginia, Board Room 1.

MEMBERS PRESENT: Danielle Hunt, LPC, Chairperson
Maria Stransky, LPC, CSAC, CSOTP

STAFF PRESENT: Jennifer Lang, Deputy Executive Director, Board of Counseling
Christine Corey, Adjudication Specialist, Administrative Proceedings Division

RESPONDENT: **Jessica Harris-Duff, Applicant for Registration as a QMHP-A**
Case No.: 217279

DISCUSSION: Jessica Harris-Duff appeared in person before the Committee, without legal counsel, and fully discussed the allegations contained in the Notice dated May 25, 2022.

CLOSED MEETING: Upon a motion by Ms. Stransky, and duly seconded by Ms. Hunt, the Committee voted to 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 Jessica Harris-Duff, Applicant for Registration as a QMHP-A. Additionally, she moved that Jennifer Lang attend the closed meeting because her presence would aid the Committee in its deliberations.

RECONVENE: Having certified that the matters discussed in the preceding closed session met the requirements of § 2.2-3712 of the *Code of Virginia*, the Committee reconvened in open session and announced its decision.

DECISION: Upon a motion by Ms. Stransky, and duly seconded by Ms. Hunt, the Committee voted to approve Jessica Harris-Duff's application for registration as a QMHP-A. The motion carried.

ADJOURN: With all business concluded, the Committee adjourned at 11:15 a.m.

As provided by law this decision shall become a Final Order thirty (30) days after service of such Order on the respondent, unless the respondent makes a written request to the Board within such time for a formal hearing on the allegations made. If service of the Order is made by mail, three (3) additional days shall be added to that period. Upon such timely request for a formal hearing, the decision of the Special Conference Committee shall be vacated.

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DANIELLE HUNT
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Danielle Hunt, LPC, Chairperson — 7/11/2022
Special Conference Committee of the Board of Counseling — Date

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Jennifer Lang
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Jennifer Lang, Deputy Executive Director — 7/11/2022
Virginia Board of Counseling — Date

VIRGINIA BOARD OF COUNSELING
SPECIAL CONFERENCE COMMITTEE
INFORMAL CONFERENCE MINUTES – JULY 8, 2022

CALL TO ORDER: A Special Conference Committee ("Committee") of the Board of Counseling ("Board") convened on July 8, 2022 at 11:32 a.m., at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Richmond, Virginia, Board Room 1.

MEMBERS PRESENT: Danielle Hunt, LPC, Chairperson
Maria Stransky, LPC, CSAC, CSOTP

STAFF PRESENT: Jennifer Lang, Deputy Executive Director, Board of Counseling
Christine Corey, Adjudication Specialist, Administrative Proceedings Division

RESPONDENT: **Morgan Geisert-Klein, Applicant for licensure as a resident in counseling**
Case No.: 217240
Attorney: Nora Ciancio, Esquire

DISCUSSION: Morgan Geisert-Klein appeared in person before the Committee, with legal counsel, and fully discussed the allegations contained in the Notice dated May 25, 2022.

CLOSED MEETING: Upon a motion by Ms. Stransky, and duly seconded by Ms. Hunt, the Committee voted to 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 Morgan Geisert-Klein, Applicant for licensure as a resident in counseling. Additionally, she moved that Jennifer Lang attend the closed meeting because her presence would aid the Committee in its deliberations.

RECONVENE: Having certified that the matters discussed in the preceding closed session met the requirements of § 2.2-3712 of the *Code of Virginia*, the Committee reconvened in open session and announced its decision.

DECISION: Upon a motion by Ms. Stransky, and duly seconded by Ms. Hunt, the Committee voted to deny Morgan Geisert-Klein's application for licensure as a resident in counseling. The motion carried.

ADJOURN: With all business concluded, the Committee adjourned at 12:50 p.m.

As provided by law this decision shall become a Final Order thirty (30) days after service of such Order on the respondent, unless the respondent makes a written request to the Board within such time for a formal hearing on the allegations made. If service of the Order is made by mail, three (3) additional days shall be added to that period. Upon such timely request for a formal hearing, the decision of the Special Conference Committee shall be vacated.

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DANIELLE HUNT
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Danielle Hunt, LPC, Chairperson
Special Conference Committee of the Board of Counseling

7/11/2022
Date

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Jennifer Lang
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Jennifer Lang, Deputy Executive Director
Virginia Board of Counseling

7/11/2022
Date

VIRGINIA BOARD OF COUNSELING
SPECIAL CONFERENCE COMMITTEE
INFORMAL CONFERENCE MINUTES – JULY 8, 2022

CALL TO ORDER: A Special Conference Committee ("Committee") of the Board of Counseling ("Board") convened on July 8, 2022 at 1:04 p.m., at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Richmond, Virginia, Board Room 1.

MEMBERS PRESENT: Danielle Hunt, LPC, Chairperson
Maria Stransky, LPC, CSAC, CSOTP

STAFF PRESENT: Jennifer Lang, Deputy Executive Director, Board of Counseling
Emily Tatum, Adjudication Specialist, Administrative Proceedings Division

RESPONDENT: **Felicea Robinson, Applicant for licensure as a resident in counseling**
Case No.: 216836

DISCUSSION: Felicea Robinson appeared in person before the Committee, without legal counsel, and fully discussed the allegations contained in the Notice dated June 9, 2022.

CLOSED MEETING: Upon a motion by Ms. Stransky, and duly seconded by Ms. Hunt, the Committee voted to 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 Felicea Robinson, Applicant for licensure as a resident in counseling. Additionally, she moved that Jennifer Lang attend the closed meeting because her presence would aid the Committee in its deliberations.

RECONVENE: Having certified that the matters discussed in the preceding closed session met the requirements of § 2.2-3712 of the *Code of Virginia*, the Committee reconvened in open session and announced its decision.

DECISION: Upon a motion by Ms. Stransky, and duly seconded by Ms. Hunt, the Committee voted to approve Felicea Robinson's application for licensure as a resident in counseling. The motion carried.

ADJOURN: With all business concluded, the Committee adjourned at 1:45 p.m.

As provided by law this decision shall become a Final Order thirty (30) days after service of such Order on the respondent, unless the respondent makes a written request to the Board within such time for a formal hearing on the allegations made. If service of the Order is made by mail, three (3) additional days shall be added to that period. Upon such timely request for a formal hearing, the decision of the Special Conference Committee shall be vacated.

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DANIELLE HUNT
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Danielle Hunt, LPC, Chairperson — Date: 7/11/2022
Special Conference Committee of the Board of Counseling

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Jennifer Lang
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Jennifer Lang, Deputy Executive Director — Date: 7/11/2022
Virginia Board of Counseling

Board of Counseling
Current Regulatory Actions
As of September 8, 2022

VAC	Stage	Subject Matter	Date submitted*	Office; time in office**	Notes
18VAC115-20 18VAC115-50 18VAC115-60	Final	Changes resulting from periodic review		With Board for action	Amendments resulting from periodic review to update regulations, clarify language, and increase pathways to licensure by endorsement.
18VAC115-90	Proposed	New chapter for licensure of art therapists	3/24/2022	Secretary 168 days	Initiates licensure structure for art therapists as required by statute.

* Date submitted to current location

Agenda Item: Consideration of petition for rulemaking to register individuals as QMHPs based solely on experience rather than college degree

Included in your agenda package are:

- Petition for rulemaking received by the Board
- Comments received by the Board regarding the petition

Action items:

- Motion to initiate rulemaking in response to the petition; OR
- Motion to take no action, with specific reason(s) why.

Virginia Department of
Health Professions
Board of Counseling

9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463
www.dhp.virginia.gov/counseling

Email: coun@dhp.virginia.gov
(804) 367-4610 (Tel)
(804) 767-6225 (Fax)

Petition for Rule-making

The Code of Virginia (§ 2.2-4007) and the Public Participation Guidelines of this board require a person who wishes to petition the board to develop a new regulation or amend an existing regulation to provide certain information. Within 14 days of receiving a valid petition, the board will notify the petitioner and send a notice to the Register of Regulations identifying the petitioner, the nature of the request and the plan for responding to the petition. Following publication of the petition in the Register, a 21-day comment period will begin to allow written comment on the petition. Within 90 days after the comment period, the board will issue a written decision on the petition. If the board has not met within that 90-day period, the decision will be issued no later than 14 days after it next meets.

Please provide the information requested below. (Print or Type)

Petitioner's full name (Last, First, Middle initial, Suffix,)
Conner, James, A

Street Address	Area Code and Telephone Number
5322 Hull Street Road, Apt 6	804-551-8005
City: Richmond	State: Virginia	Zip Code: 23224

Email Address (optional)
jamesethaneric1211@gmail.com

Respond to the following questions:

1. What regulation are you petitioning the board to amend? Please state the title of the regulation and the section/sections you want the board to consider amending.

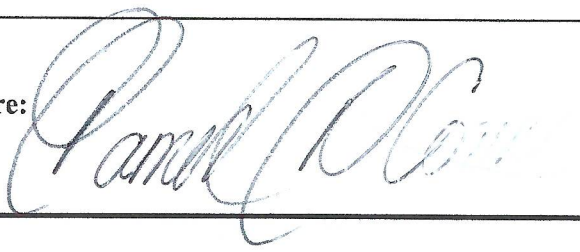
To become an QMHP you must have a college degree, I feel that for those who have the years of experience the board should provide and offering trainings so employees can be grandfathered in.

2. Please summarize the substance of the change you are requesting and state the rationale or purpose for the new or amended rule.

I'm reaching out on behalf of us who work in day supports and group homes. Since COVID-19 there have been many struggles to keep staff meaning Program Managers, Supervisors, Residential Counselors and DSP because most of us don't have our QMHP. Back in 2018 lots of us missed being grandfathered in because of different reasons, I'm advocating for those who have the years of experience and no degree or almost finishing a degree who are stepping out on FAITH asking if the board would reconsider accepting applications to be grandfathered in so we can continue providing the care to those we provide care for as we continue working on our degree. I have a sign up sheet with over 100 signatures just asking for an opportunity to keep our jobs as well not leave the residents we care behind. I can speak for me who has invested so much over the last 15 years and still receive phone calls from former clients, social workers and caseworkers as well as CSB Directors saying Mr. Conner your services have really touched lives for the better. Whether this request is granted or not I have to advocate for us who work so hard to keep our clients healthy and safe. WRIC8 News is willing to accept an interview with me to advocate for this purpose.

3. State the legal authority of the board to take the action requested. In general, the legal authority for the adoption of regulations by the board is found in § 54.1-2400 of the Code of Virginia. If there is other legal authority for promulgation of a regulation, please provide that Code reference.

I'm not excatly sure on the legal process of the regulations, but it doen't take a degree to have common sense.

Signature: 

Date: 06/10/2022

Virginia.gov Agencies | Governor

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Agency **Department of Health Professions**

Board **Board of Counseling**

Chapter

Regulations Governing the Registration of Qualified Mental Health Professionals [18 VAC 115 - 80]

31 comments

All good comments for this forum **Show Only Flagged**

Back to List of Comments

Commenter: Anonymous 7/4/22 7:44 pm

Educational requirements

Please do not remove educational requirements. The requirements keep getting reduced. It is not beneficial for the clientele these professionals are serving to continue to lower the standards.

CommentID: **122181**

Commenter: Prof. Michael Moates, MA, LP, LCMHC, LBA, LMHP 7/6/22 8:20 pm

Comment on Petition

Board of Counseling,

Thank you for taking the time to read my comment. When evaluating the request of the petitioner, the board should take two things into consideration. First, you should consider the public safety. Second, you should consider the statutory language.

I am wholeheartedly in disagreement with this petition. Here is my reasoning:

First, the Virginia legislature set the standards that the board is required to follow under statutory law. Mental Health Professional is defined in the Code of Virginia § 54.1-2400.1. Mental health service providers; duty to protect third parties; immunity. It says it "means a person who by education and experience..."

The law requires both education and professional experience to be a QMHP. Virginia is vary gracious in giving those with a bachelor's or a masters or even some without a degree in the medical field the ability to qualify.

Experience teaches you how to practice. Education teaches you the theories you need to know for safe practice. The State of Virginia already gives great latitude by expanding the opportunity.

There are many pathways to the QMHP. I would not be opposed to adding additional licenses or certifications by accredited organizations to the qualifying list to be a QMHP but removing the education requirement without adding 3rd party accountability would hurt the community. I think adding addiction counselors, behavior technicians, special education teachers, speech and language pathologists, certified employment assistance professional, and certified pastoral counselor.

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Further, I think that Virginia should recognize members of the military, law enforcement, first responders, and QMHP's from other states that are in a field similar to be able to gain the credential by reciprocity or endorsement.

Finally, I think the board should change the degree requirement from degree in xyz ... to degree at assoc. bach. mast. level with x number of hours in content area.

If anyone can be a QMHP without any accountability then the field suffers. But let make it more accessible while protecting the public.

Thank you,

Prof. Michael Moates, MA, LP, LCMHC, LBA

Adjunct College Professor

Licensed Psychologist - Master (Out of State)

Licensed Clinical Mental Health Counselor (Out of State)

Licensed Behavior Analyst - Virginia

CommentID: **122199**

Commenter: Elizabeth Engelhorn

7/7/22 10:46 am

Requirements for QMHP

I am not in favor of eliminating the educational requirements for the QMHP. In the past few years the requirements for obtaining this certification have increased, creating a new level of professionalism for this role. While it has created barriers for some, it has not been a hurdle that agencies have not been able to work with.

It does make sense to open the degrees that can be approved for the QMHP to be wider, with hours required for the certification in mental health or related field.

Elimination of the educational requirement diminishes the current status of the certification.

Thank you,

Elizabeth Engelhorn

CommentID: **122204**

Commenter: JAAS

7/10/22 10:21 am

Revision to Petition for Rulemaking

Hello Board of Regulatory Town Hall/Department of Health Profession, Board of Social Work, Therapy…

I believe that lowering the requirements to practice would put the field of Behavioral Science and Psychology in a very vulnerable position. I do not believe allowing just anyone with a claim to experience should be able to receive certification. However, I do believe that there may need to be an active (with the intent to change/revise) discussion, about establishing certifications for those who have completed their Bachelors degree, to be able to support licensed providers in a support role.

CommentID: **122227**

Commenter: Jodie Burton, DPCS

7/11/22 10:12 am

QMHP degree requirements

I am not in agreement with removing the educational requirement to obtain QMHP registration. QMHP degree requirements already expand beyond the human services fields to allow for nurses, occupational therapists, and other fields to obtain registration with appropriate experience. The approved fields of study should be reviewed for possible expansion. The list of approved human service degrees should be reviewed and expanded. While experience allows people to gain knowledge of how to provide appropriate services, education prepares them for the field within which they will gain that experience. Removing the requirement will leave the field, which is already vulnerable, increasingly vulnerable. The Board needs to consider ethical and legal considerations to removing the education degree and allowing registration for anyone with claimed experience, which may be of questionable validity.

CommentID: **122232**

Commenter: Melanie Tosh

7/11/22 12:33 pm

QMHP Education Requirement

I am not in agreement with removing the educational requirement to obtain QMHP registration. QMHP degree requirements already expand beyond the human services fields to allow for nurses, occupational therapists, and other fields to obtain registration with appropriate experience. The approved fields of study should be reviewed for possible expansion. The list of approved human service degrees should be reviewed and expanded. While experience allows people to gain knowledge of how to provide appropriate services, education prepares them for the field within which they will gain that experience. Removing the requirement will leave the field, which is already vulnerable, increasingly vulnerable. The Board needs to consider ethical and legal considerations to removing the education degree and allowing registration for anyone with claimed experience, which may be of questionable validity.

CommentID: **122233**

Commenter: Lauren Cressell

7/11/22 12:38 pm

QMHP

I am not in agreement with removing the educational requirement to obtain QMHP registration. QMHP degree requirements already expand beyond the human services fields to allow for nurses, occupational therapists, and other fields to obtain registration with appropriate experience. The approved fields of study should be reviewed for possible expansion. The list of approved human service degrees should be reviewed and expanded. While experience allows people to gain knowledge of how to provide appropriate services, education prepares them for the field within which they will gain that experience. Removing the requirement will leave the field, which is already vulnerable, increasingly vulnerable. The Board needs to consider ethical and legal considerations to removing the education degree and allowing registration for anyone with claimed experience, which may be of questionable validity.

CommentID: **122234**

Commenter: Jordan Wilson, DPCS

7/11/22 12:39 pm

Wholeheartedly Disagree

As an active QMHP, I am not in agreement with removing the educational requirement to obtain QMHP registration. QMHP degree requirements already expand beyond the human services fields to allow for nurses, occupational therapists, and other fields to obtain registration with appropriate

experience. The approved fields of study should be reviewed for possible expansion. The list of approved human service degrees should be reviewed and expanded. While experience allows people to gain knowledge of how to provide appropriate services, education prepares them for the field within which they will gain that experience. Removing the requirement will leave the field, which is already vulnerable, increasingly vulnerable. The Board needs to consider ethical and legal considerations to removing the education degree and allowing registration for anyone with claimed experience, which may be of questionable validity.

CommentID: **122235**

Commenter: Erin Motley

7/11/22 12:42 pm

QMHP Requirements

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CommentID: **122236**

Commenter: Crystal Conard

7/11/22 2:02 pm

QMHP requirements

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CommentID: **122240**

Commenter: Anonymous

7/11/22 2:04 pm

QMHP

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CommentID: **122241**

Commenter: Nickalos Turner

7/11/22 2:05 pm

QMHP Requirements

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CommentID: **122242**

Commenter: Sierra Nunn

7/11/22 3:29 pm

QMHP Requirements

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CommentID: **122244**

Commenter: Anonymous

7/11/22 3:34 pm

QMHP Requirements

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CommentID: **122245**

Commenter: Anonymous

7/11/22 3:41 pm

QMHP Education Requirements

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increasingly vulnerable. The Board needs to consider ethical and legal considerations to removing the education degree and allowing registration for anyone with claimed experience, which may be of questionable validity.

CommentID: **122246**

Commenter: C Everett

7/11/22 4:27 pm

QMHP Requirements

I am not in agreement with removing the educational requirement to obtain QMHP registration. QMHP degree requirements already expand beyond the human services fields to allow for nurses, occupational therapists, and other fields to obtain registration with appropriate experience. The approved fields of study should be reviewed for possible expansion. The list of approved human service degrees should be reviewed and expanded. While experience allows people to gain knowledge of how to provide appropriate services, education prepares them for the field within which they will gain that experience. Removing the requirement will leave the field, which is already vulnerable, increasingly vulnerable. The Board needs to consider ethical and legal considerations to removing the education degree and allowing registration for anyone with claimed experience, which may be of questionable validity.

CommentID: **122248**

Commenter: Amanda Campbell

7/11/22 8:21 pm

Very much Disagree

I am wholeheartedly opposed to eliminating the educational requirements for the QMHP. While experience is important, education is also. Eliminating these requirements leaves the field vulnerable to inconsistencies in ability to successfully complete job related tasks. Education is where the foundation of ethical boundaries is formed and without this, our individuals are at risk of being served in a manner that would be deemed unethical. It does not benefit anyone for these educational requirements to be removed. Just as someone who wants to be a doctor, a lawyer, a teacher, or a CDL driver has to have certain educational requirements, the individuals we serve deserve to have providers who have education to properly serve them. Without the educational component, we are doing our individuals a disservice.

CommentID: **122249**

Commenter: A.H. DPCS

7/11/22 10:21 pm

Not in agreement

I am not in agreement with removing the educational requirement to obtain QMHP registration. QMHP degree requirements already expand beyond the human services fields to allow for nurses, occupational therapists, and other fields to obtain registration with appropriate experience. The approved fields of study should be reviewed for possible expansion. The list of approved human service degrees should be reviewed and expanded. While experience allows people to gain knowledge of how to provide appropriate services, education prepares them for the field within which they will gain that experience. Removing the requirement will leave the field, which is already vulnerable, increasingly vulnerable. The Board needs to consider ethical and legal considerations to removing the education degree and allowing registration for anyone with claimed experience, which may be of questionable validity.

CommentID: **122250**

Commenter: Amanda Coles

7/12/22 4:51 pm

QMHP Requirements

I am not in agreement with removing the educational requirement to obtain QMHP registration. QMHP degree requirements already expand beyond the human services fields to allow for nurses, occupational therapists, and other fields to obtain registration with appropriate experience. The approved fields of study should be reviewed for possible expansion. The list of approved human service degrees should be reviewed and expanded. While experience allows people to gain knowledge of how to provide appropriate services, education prepares them for the field within which they will gain that experience. Removing the requirement will leave the field, which is already vulnerable, increasingly vulnerable. The Board needs to consider ethical and legal considerations to removing the education degree and allowing registration for anyone with claimed experience, which may be of questionable validity.

CommentID: **122256**

Commenter: R. Jones

7/13/22 3:40 pm

QMHP Requirements

I do not agree with removing the educational requirement to obtain QMHP registration. The approved fields of study should be reviewed for possible expansion but not taken completely away. Education in combination with experience prepares someone in this field to provide effective, and proper treatment to the individuals they serve. Removing the requirement will be a disservice the individuals we serve as well as create a risk of ethical and possible legal ramifications.

CommentID: **122376**

Commenter: Amy Jennings

7/15/22 4:21 pm

QMHP requirements

I am not in agreement with removing the educational requirement to obtain QMHP registration. QMHP degree requirements already expand beyond the human services fields to allow for nurses, occupational therapists, and other fields to obtain registration with appropriate experience. The approved fields of study should be reviewed for possible expansion. The list of approved human service degrees should be reviewed and expanded. While experience allows people to gain knowledge of how to provide appropriate services, education prepares them for the field within which they will gain that experience. Removing the requirement will leave the field, which is already vulnerable, increasingly vulnerable. The Board needs to consider ethical and legal considerations to removing the education degree and allowing registration for anyone with claimed experience, which may be of questionable validity.

CommentID: **122522**

Commenter: Prof. Michael Moates, MA, LP, LCMHC, LBA, LMHP

7/15/22 6:28 pm

Alternative Proposal

Something else got me thinking. I would feel comfortable with any bachelor degree even outside of human services if the individual had 1 year of experience or qualified for clinical licensure under DHP in the State of Virginia.

CommentID: **122543**

Commenter: Paula Lea

7/18/22 9:40 am

QMHPS Should Require an Educational Background

I am not in agreement with removing the educational requirement to obtain QMHP registration. QMHP degree requirements already expand beyond the human services fields to allow for nurses, occupational therapists, and

other fields to obtain registration with appropriate experience. The approved fields of study should be reviewed for possible expansion. The list of approved human service degrees should be reviewed and expanded. While experience allows people to gain knowledge of how to provide appropriate services, education prepares them for the field within which they will gain that experience. Removing the requirement will leave the field, which is already vulnerable, increasingly vulnerable. The Board needs to consider ethical and legal considerations to removing the education degree and allowing registration for anyone with claimed experience, which may be of questionable validity.

CommentID: **122697**

Commenter: Whitney Girten

7/18/22 4:15 pm

QMHP

I am not in agreement with removing the educational requirement to obtain QMHP registration. QMHP degree requirements already expand beyond the human services fields to allow for nurses, occupational therapists, and other fields to obtain registration with appropriate experience. The approved fields of study should be reviewed for possible expansion. The list of approved human service degrees should be reviewed and expanded. While experience allows people to gain knowledge of how to provide appropriate services, education prepares them for the field within which they will gain that experience. Removing the requirement will leave the field, which is already vulnerable, increasingly vulnerable. The Board needs to consider ethical and legal considerations to removing the education degree and allowing registration for anyone with claimed experience, which may be of questionable validity.

CommentID: **122732**

Commenter: Cynthia Miller, Ph.D., LPC

7/19/22 10:25 am

Oppose

Removing the requirement for a college degree in order to be a QMHP would be a mistake. While I appreciate the role of experience in helping to educate someone in a profession, experience alone is not enough. Experience might help me learn **what** to do through repetition and modeling, but it won't help me understand **why** I'm doing it. Additionally, experience won't necessarily teach me about the underlying professional and ethical foundations of a field. Experience will tell me what general norms are in my particular workplace but it won't tell me whether those norms are generally accepted in the wider field or not. Finally, removing the requirement for a college degree moves QMHPs further into the realm of paraprofessional rather than professionals. Clients receiving services from QMHPs are more vulnerable than the average population and they need helpers with the appropriate education in human development, psychopathology, and behavior to serve them well.

CommentID: **122767**

Commenter: Paige Kaiser, Virginia Tech Masters Student

7/20/22 2:38 pm

QMHP

As an individual who has worked in a mental health setting without a graduate degree and as an individual who is currently pursuing one; a graduate degree is needed in this field of work. Before my time at Virginia Tech I worked in a children's home in SC, Connie Maxwell Children's Ministries. I have been in situations where I have helped many but I wondered what more knowledge I could give. A lot of what I said was based off my own experience, not factual information. I have only been pursuing my Masters for three weeks and I can already look back and see mistakes I made. Qualified Mental Health Providers are qualified for a reason, they went through the necessary training to be able to aid people. Without the necessary training then people could be misleading people and it could make them worse. Being able to help others is based off a common philosophy among many professions. Therefore that studying and practice is required to be truly successful at being able to help others. As an individual who has experienced both sides of this, I hope that this

does not pass. Without graduate school, people are not properly qualified to work with others professionally.

CommentID: **122815**

Commenter: William

7/23/22 8:54 pm

Already a Low Bar

Mental healthcare is a complex mix of science and art. It requires a basic understanding to practice competently, even under supervision. Frankly, as a QMHP myself working on a Master's Degree, the requirements for QMHPs are already very low. There are many degrees that are accepted as "related" degrees, and with enough hours of experience any college degree meets this requirement.

I think we should be moving in the other direction. I agree with having related degrees count, but I have concerns that unrelated degrees allow entry into this field. I think we should at least require certain classes like Abnormal Psychology and some kind of undergrad Psychology research class within the context of a Bachelor's degree.

I'm not saying that nobody with a GED or high school diploma can be helpful, but there are just certain things you learn with a Bachelor's degree with classes in related fields that you need in order to understand the issues people are dealing with when you work with them.

CommentID: **122882**

Commenter: DPCS - Aaron

7/25/22 1:02 pm

QMHP

I am not in agreement with removing the educational requirement to obtain QMHP registration. QMHP degree requirements already expand beyond the human services fields to allow for nurses, occupational therapists, and other fields to obtain registration with appropriate experience. The approved fields of study should be reviewed for possible expansion. The list of approved human service degrees should be reviewed and expanded. While experience allows people to gain knowledge of how to provide appropriate services, education prepares them for the field within which they will gain that experience. Removing the requirement will leave the field, which is already vulnerable, increasingly vulnerable. The Board needs to consider ethical and legal considerations to removing the education degree and allowing registration for anyone with claimed experience, which may be of questionable validity.

CommentID: **122949**

Commenter: EHS Support Services

7/25/22 4:09 pm

QMHP

I am not in support of removing the education requirements for the QMHP registration. While experience is a valid credential in mental health evidenced by peer supports, the opportunity to be grandfathered in for experience was available prior to the start date of Jan. 3, 2018.

CommentID: **122972**

Commenter: Christopher Wagner

8/1/22 1:45 pm

Opposed to QMHP change

Opposed. This would be going backward. I get that college is expensive now, but there are plenty of college graduates who could fill these roles and the clients/patients deserve helpers with both educational background and practical experience. There are other peer support roles for those who have only personal experience.

CommentID: **124373**

Commenter: Alexandra Krens and Chloe Billy, Virginia Tech Masters Students 8/2/22 3:05 pm

QMHP requirements

Hello,

We're Alexandra Krens and Chloe Billy, two graduate students in the Virginia Tech counselor education program. We're commenting on this as part of a project focused on advocacy and legislation in the counseling profession.

We saw this petition to alter the educational requirements for Qualified Mental Health Professionals (QMHPs) and we have some concerns.

In preparation for this comment, we spoke with a former QMHP-t, and she talked about often feeling unprepared to provide clients the care they needed, and that many QMHPs that she knew felt the same. Specifically, she talked about feeling ill-equipped to handle crisis situations. If a person like her, who has an undergraduate degree in psychology, feels she doesn't have the education or knowledge to provide adequate care to clients, we should be increasing educational requirements, not decreasing them.

There are already several ways a person can become a QMHP, including being an occupational therapist or a nurse, which doesn't require an educational background in mental health specifically, and provides a good way to allow people whose expertise comes mainly from experience, but still contains an educational component, to enter the field. We're open to the idea of similar professions which still contain a mental health education component coming into the field, but don't think that those without a background should be let in.

We are aware that part of the motivation for this is the labor shortage. To help with this, we suggest that the board consider starting a program or certification process specifically for QMHPs. This would allow more people to enter the field while ensuring that they are properly equipped to help clients.

Sincerely,

Alexandra Krens and Chloe Billy

CommentID: **124586**

Agenda Item: Consideration of petition for rulemaking to allow QMHP with 2 years of experience and supervision training to supervise QMHP trainees

Included in your agenda package are:

- Petition for rulemaking received by the Board
- Comments received by the Board regarding the petition

Action items:

- Motion to initiate rulemaking in response to the petition; OR
- Motion to take no action, with specific reason(s) why.

Virginia Department of Health Professions
Board of Counseling

9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463
www.dhp.virginia.gov/counseling

Email: coun@dhp.virginia.gov
(804) 367-4610 (Tel)
(804) 767-6225 (Fax)

Petition for Rule-making

The Code of Virginia (§ 2.2-4007) and the Public Participation Guidelines of this board require a person who wishes to petition the board to develop a new regulation or amend an existing regulation to provide certain information. Within 14 days of receiving a valid petition, the board will notify the petitioner and send a notice to the Register of Regulations identifying the petitioner, the nature of the request and the plan for responding to the petition. Following publication of the petition in the Register, a 21-day comment period will begin to allow written comment on the petition. Within 90 days after the comment period, the board will issue a written decision on the petition. If the board has not met within that 90-day period, the decision will be issued no later than 14 days after it next meets.

Please provide the information requested below. (Print or Type)

Petitioner's full name (Last, First, Middle initial, Suffix,)

Faison, Jennifer - Virginia Association of Community Services Boards, Inc. (VACSB)

Street Address	Area Code and Telephone Number	
10128 West Broad Street, Suite B	804 330-3141	
City: Glen Allen	State: Virginia	Zip Code: 23060

Email Address (optional)

hpiland@vacsb.org

Respond to the following questions:

1. What regulation are you petitioning the board to amend? Please state the title of the regulation and the section/sections you want the board to consider amending.

Please see the addendum attached with this petition.

2. Please summarize the substance of the change you are requesting and state the rationale or purpose for the new or amended rule.

Please see the addendum attached with this petition.

3. State the legal authority of the board to take the action requested. In general, the legal authority for the adoption of regulations by the board is found in § 54.1-2400 of the Code of Virginia. If there is other legal authority for promulgation of a regulation, please provide that Code reference.

§ 54.1-2400

Signature: 

Date: 06/30/2022

Addendum to the Virginia Association of Community Services Boards, Inc. (VACSB) June 30, 2022 Petition to the Board of Counseling

1. What regulation are you petitioning the board to amend? Please state the title of the regulation and the section/sections you want the board to consider amending.

Title of Regulations: 18 VAC 115-80-10 et seq.

- 18VAC115-80-40. Requirements for registration as a qualified mental health professional-adult. - C. Experience required for registration.
- 18VAC115-80-50. Requirements for registration as a qualified mental health professional-child. - C. Experience required for registration.
- Board of Counseling Guidance Document: 115-8, titled Approved Degrees in Human Services and Related Fields for QMHP Registration.

2. Please summarize the substance of the change you are requesting and state the rationale or purpose for the new or amended rule.

<u>Substance of the Change</u>:

1. Supervision

To allow a seasoned (2 years of experience and specifically trained for supervision) Qualified Mental Health Professional (QMHP) to provide supervision to a QMHP-Trainee. Currently regulations only allow an LMHP to provide that supervision. The request is to allow a hybrid approach to supervision hours, where the QMHP-Trainee would receive some supervision from a seasoned QMHP who is specifically trained for this supervision, and some supervision from an LMHP. The seasoned QMHP would provide supervision through-out since the seasoned QMHP is already there working closely with the QMHP-Trainee, and at least two hours a month of supervision would be provided by an LMHP.

Recommended Trainings: The Virginia Association of Community Services Board's (VACSB's) Mental Health Council recommends two trainings be developed in partnership with relevant state agencies and providers for approval by DHP. Those trainings would be for:

1. A QMHP-Trainee to take before becoming a registered QMHP.
2. A seasoned QMHP to take before providing supervision to a QMHP-Trainee.

Recommended Replacement Language for Section C in both 18VAC115-80-40 and 18VAC115-80-50. *A QMHP-Trainee's required work experience must be supervised by an LMHP or a QMHP who is trained for supervision. There must be documentation of at least weekly supervision to address training, provide feedback and address implementation of treatment plans. At least two hours a month of supervision must be provided by a LMHP while a QMHP-Trainee is completing work experience.*

2. Allowable Degrees

Add undergraduate degrees in sociology and criminal justice to the Board of Counseling's guidance document 115-8, titled Approved Degrees in Human Services and Related Fields for QMHP Registration.

Rationale:

1. Supervision

LMHPs are in High Demand: In CSBs (and some private providers as well) there are not enough LMHPs on staff to provide supervision. Some rural CSBs only have 1-2 LMHPs on staff. Some programs have had to reduce services because they have to hire someone to provide the supervision, which is an inefficient use of resources given that there are most likely seasoned QMHPs on staff who could be trained to provide the supervision. Plus, from a business perspective, for the few LMHPs whom the CSBs do have on staff, their time is best being spent on billable therapy sessions.

QMHPs Can Provide More Specific Training: Seasoned and specially trained QMHPs can provide supervision that is more specific to what a QMHP-Trainee needs to learn and experience for the QMHP profession. The LMHP profession has different roles and responsibilities than a QMHP role. The LMHP may very well have never been trained or worked in the same job responsibilities of a QMHP.

The following are specific tasks or competencies that are unique to QMHPs. Though an LMHP can provide conceptual guidance of these areas, an experienced QMHP can provide position-specific guidance and oversight based on that QMHP's experience.

1. Coordinate care delivery
2. Engaging community resources
3. Knowledge and vetting of community resources
4. Levels of care and standards for care
5. Assess physical and psychological factors impacting the case in a variety of settings
6. Implementing recommendations from multidisciplinary care teams

Utilize QMHPs to Their Fullest Potential: The current trends in healthcare dictate that healthcare providers need to have the tools available to utilize their staff in the most efficient ways, so more people can be served and so that the provider is running a sustainable business model. One example is for staff to be able to practice to the outer edges of their scope of

practice. Allowing seasoned QMHPs to provide supervision is an example of that. With this amendment to the current regulations, CSBs and other providers would be utilizing QMHPs to their fullest potential, which can motivate QMHPs to stay in that role longer and this would be maximizing providers' investment in staffing costs. As well, this allowance for QMHP supervision would make a large impact in incentivizing QMHP-Trainees to work at a CSB to become a QMHP, because supervision will be more readily available.

CSBs are experiencing serious problems with workforce recruitment and retention, which includes the professions of LMHPs and QMHPs. The goal of this request is to alleviate some of the barriers to registration for QMHP-Trainees and give more time back to the LMHPs to do the work they are licensed and trained to do without changes in adequate supervision to QMHP-Trainees.

2. Allowable Degrees

The pool of candidates from which CSBs and other providers could draw would be enhanced if a degree in sociology is added back to the Board of Counseling's guidance document. Removing a sociology degree has created a situation where fewer applicants are eligible for employment. As well, adding a degree in criminal justice to the list of approved degrees would be beneficial because CSBs serve legal-involved populations, provide substance use disorder services and mental health programs for mandated clients. CSBs estimate that only half of the applicants for QMHP/QMHP-Trainee positions meet the requirements because many applicants have qualifying experience, but don't meet the field of study requirement. Many of those candidates being turned away have a sociology or criminal justice degree. It takes the CSBs an average of 3-6 months to fill QMHP or QMHP-Trainee level positions.

Commonwealth of Virginia

Barrett, Erin <erin.barrett@dhp.virginia.gov>

Fwd: QMHP requirements

1 message

Hoyle, Jaime <jaime.hoyle@dhp.virginia.gov> Tue, Aug 2, 2022 at 11:24 PM
To: Charlotte Lenart <charlotte.lenart@dhp.virginia.gov>, Erin Barrett <erin.barrett@dhp.virginia.gov>

FYI

---------- Forwarded message ---------
From: **Chloe Billy** <chloeb22@vt.edu>
Date: Tue, Aug 2, 2022 at 3:13 PM
Subject: QMHP requirements
To: <jaime.hoyle@dhp.virginia.gov>
CC: Alexandra Krens <akrens@vt.edu>

Hello Jaime Hoyle,
We're Alexandra Krens and Chloe Billy, two graduate students in the Virginia Tech counselor education program. We're reaching out to you as part of a project focused on advocacy and legislation in the counseling profession.
We saw your petition to alter the educational requirements for Qualified Mental Health Professionals (QMHPs) and we have some concerns.
In preparation for this project, we spoke with a former QMHP-t, and she talked about often feeling unprepared to provide clients the care they needed, and that many QMHPs that she knew felt the same. Specifically, she talked about feeling ill-equipped to handle crisis situations. If a person like her, who has an undergraduate degree in psychology, feels she doesn't have the education or knowledge to provide adequate care to clients, we should be increasing educational requirements, not decreasing them.

There are already several ways a person can become a QMHP, including being an occupational therapist or a nurse, which doesn't require an educational background in mental health specifically, and provides a good way to allow people whose expertise comes mainly from experience, but still contains an educational component, to enter the field. We're open to the idea of similar professions which still contain a mental health education component coming into the field, but don't think that those without a background should be let in.

We are aware that part of the motivation for this is the labor shortage. To help with this, we suggest that the board consider starting a program or certification process specifically for QMHPs. This would allow more people to enter the field while ensuring they are properly equipped to help clients.

Thank you so much for listening to our concerns, we invite you to respond with your thoughts or feedback.

Sincerely,
Alexandra Krens and Chloe Billy

--
Jaime Hoyle, J.D. , Executive Director
Virginia Boards of Counseling, Psychology, and Social Work
Department of Health Professions
9960 Mayland Dr., Suite 300
Richmond, VA 23233

Virginia.gov Agencies | Governor

Agency **Department of Health Professions**

Board **Board of Counseling**

Chapter

Regulations Governing the Registration of Qualified Mental Health Professionals [18 VAC 115 - 80]

37 comments

All comments for this forum

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Commenter: Prof. Michael Moates, MA, LP, LBA, LMHC, LADAC 8/1/22 1:47 pm

Bad Idea

Hello,

Thank you for taking the time to read my comment. It is my opinion that this would be detrimental to the mental health community. Years of practice alone should not qualify anyone to be a supervisor. For example, someone who holds a doctorate in psychology but is not a licensed psychologist should not be supervised by someone with a bachelor's degree. This simply does not make sense.

I implore the board to reject this petition.

Thank you.

CommentID: **124374**

Commenter: Anonymous 8/2/22 6:45 pm

Opposed

Two years of experience as a QMHP is not equivalent to the education, training, and professional obligations/responsibility of a LMHP. I oppose this petition for rulemaking.

CommentID: **124649**

Commenter: Charlotte Markva 8/2/22 9:06 pm

Continually lowering the standard

My concern is that the standards, that are suppose to be for safety of the clients continually are being lowered. What is the purpose of licensure? To insure the safety of the public. Once again, you have the least experienced people being empowered to care for some of the most vulnerable people in our community. At least there should be a licensed professional to supervise the care that is given.

CommentID: **124668**

Commenter: Anonymous 8/3/22 8:18 am

Completely Inappropriate

The rationale for QMHPs to provide supervision to other QMHPs due to lack of LMHP types available is a ridiculous and watered down reason to encourage this change. QMHPs do not have the skill set or training that a licensed therapist has in order to guide the practice and service delivery for another QMHP. The purpose of supervision is to ensure that we are good stewards of services for the clients we serve. If we change that standard of service delivery we are doing a disservice and harm to our clients and our communities. I strongly oppose this change and continue to advocate for supervision by an LMHP type for all QMHPs.

CommentID: **124710**

Commenter: Virginia Association of Community Services Boards (VACSB) 8/4/22 4:04 pm

Support This Petition

Thank you for the opportunity to provide public comment. As petitioner, the Virginia Association of Community Services Boards (VACSB) is supportive of these proposed changes which fall into two categories, the second of which involves a guidance document change and therefore not listed on this petition. However, DHP will consider this guidance document change at its September 16, 2022 meeting, so please feel free to comment on the guidance document change as well.

1st A regulation change to allow a hybrid approach to supervision hours where the QMHP-Trainee would complete some supervision hours with a seasoned QMHP who is specifically trained for this supervision, and some supervision with an LMHP.

2nd Allow an undergraduate degree in criminal justice to be added to the Board of Counseling's guidance document titled 115-8 - Approved Degrees in Human Services and Related Fields for QMHP Registration and to reinstate sociology as an approved degree.

Substance of the Change:

1. **Supervision**

To allow a seasoned (2 years of experience and specifically trained for supervision) Qualified Mental Health Professional (QMHP) to provide supervision to a QMHP-Trainee. Currently regulations only allow an LMHP to provide that supervision. The request is to allow a hybrid approach to supervision hours, where the QMHP-Trainee would receive some supervision from a seasoned QMHP who is specifically trained for this supervision, and some supervision from an LMHP. The seasoned QMHP would provide supervision through-out since the seasoned QMHP is already there working closely with the QMHP-Trainee, and at least two hours a month of supervision would be provided by an LMHP.

Recommended Trainings: The Virginia Association of Community Services Board's (VACSB's) Mental Health Council recommends two trainings be developed in partnership with relevant state agencies and providers for approval by DHP. Those trainings would be for:

1. A QMHP-Trainee to take before becoming a registered QMHP.
2. A seasoned QMHP to take before providing supervision to a QMHP-Trainee.

Recommended Replacement Language for Section C in both 18VAC115-80-40 and 18VAC115-80-50. *A QMHP-Trainee's required work experience must be supervised by an LMHP or a QMHP who is trained for supervision. There must be documentation of at least weekly supervision to address training, provide feedback and address implementation of treatment plans. At least two hours a month of supervision must be provided by a LMHP while a QMHP-Trainee is completing work experience.*

2. **Allowable Degrees**

Add undergraduate degrees in sociology and criminal justice to the Board of Counseling's guidance document titled 115-8 - Approved Degrees in Human Services and Related Fields for QMHP Registration.

Rationale:

1. **Supervision**

LMHPs are in High Demand: In CSBs (and some private providers as well) there are not enough LMHPs on staff to provide supervision. Some rural CSBs only have 1-2 LMHPs on staff. Some programs have had to reduce services because they have to hire someone to provide the supervision, which is an inefficient use of resources given that there are most likely seasoned QMHPs on staff who could be trained to provide the supervision. Plus, from a business perspective, for the few LMHPs whom the CSBs do have on staff, their time is best being spent on billable therapy sessions.

QMHPs Can Provide More Specific Training: Seasoned and specially trained QMHPs can provide supervision that is more specific to what a QMHP-Trainee needs to learn and experience for the QMHP profession. The LMHP profession has different roles and responsibilities than a QMHP role. The LMHP may very well have never been trained or worked in the same job responsibilities of a QMHP.

The following are specific tasks or competencies that are unique to QMHPs. Though an LMHP can provide conceptual guidance of these areas, an experienced QMHP can provide position-specific guidance and oversight based on that QMHP's experience.

1. Coordinate care delivery
2. Engaging community resources
3. Knowledge and vetting of community resources
4. Levels of care and standards for care
5. Assess physical and psychological factors impacting the case in a variety of settings
6. Implementing recommendations from multidisciplinary care teams

Utilize QMHPs to Their Fullest Potential: The current trends in healthcare dictate that healthcare providers need to have the tools available to utilize their staff in the most efficient ways, so more people can be served and so that the provider is running a sustainable business model. One example is for staff to be able to practice to the outer edges of their scope of practice. Allowing seasoned QMHPs to provide supervision is an example of that. With this amendment to the current regulations, CSBs and other providers would be utilizing QMHPs to their fullest potential, which can motivate QMHPs to stay in that role longer and this would be maximizing providers' investment in staffing costs. As well, this allowance for QMHP supervision would make a large impact in incentivizing QMHP-Trainees to work at a CSB to become a QMHP, because supervision will be more readily available.

CSBs are experiencing serious problems with workforce recruitment and retention, which includes the professions of LMHPs and QMHPs. The goal of this request is to alleviate some of the barriers to registration for QMHP-Trainees and give more time back to the LMHPs to do the work they are licensed and trained to do without changes in adequate supervision to QMHP-Trainees.

2. **Allowable Degrees**

The pool of candidates from which CSBs and other providers could draw would be enhanced if a degree in sociology is added back to the Board of Counseling's guidance document. Removing a sociology degree has created a situation where fewer applicants are eligible for employment. As well, adding a degree in criminal justice to the list of approved degrees would be beneficial because CSBs serve legal-involved populations, provide substance use disorder services and mental health programs for mandated clients. CSBs estimate that only half of the applicants for QMHP/QMHP-Trainee positions meet the requirements because many applicants have qualifying experience, but don't meet the field of study requirement. Many of those candidates being turned away have a sociology or criminal justice degree. It takes the CSBs an average of 3-6 months to fill QMHP or QMHP-Trainee level positions.

CommentID: **127123**

Commenter: Sandra L Irby

8/4/22 6:24 pm

QMHP Reg Change

I am in support of the following:

As you are probably aware, the Mental Health Council has been working with VACSB on pursuing a regulation change through the Board of Counseling at the Department of Health Professionals to allow for:

1st A regulation change to allow a hybrid approach to supervision hours where the QMHP-Trainee would complete some supervision hours with a seasoned QMHP who is specifically trained for this supervision, and some supervision with an LMHP.

2nd Allow an undergraduate degree in criminal justice to be added to the Board of Counseling's guidance document titled 115-8 - Approved Degrees in Human Services and Related Fields for QMHP Registration and to reinstate sociology as an approved degree.

CommentID: **127125**

Commenter: Katherine Baker, Highlands Community Services

8/5/22 8:29 am

QMHP Regulation Change

In addition to considering a hybrid approach to supervision and for criminal justice to be an approved degree, I feel there are at least two other matters that should be taken into consideration.

1. **Sociology should once again be allowed to be considered as a Human Services related degree.**
2. **QMHP-C and QMHP-A candidates should have the same criteria for obtaining there designation. More specifically, those applying for a QMHP-C should be allowed to have an unrelated degree as long as they have 15 semester credit**

hours of human services classes and 3,000 hours of supervised experience. Currently a QMHP-C must have a human service related degree and the unrelated degree alternative that is afforded to QMHP-A candidates is not an option.

CommentID: **127126**

Commenter: Lauren Cressell 8/5/22 10:05 am

QMHP

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As you are probably aware, the Mental Health Council has been working with VACSB on pursuing a regulation change through the Board of Counseling at the Department of Health Professionals to allow for:

1st A regulation change to allow a hybrid approach to supervision hours where the QMHP-Trainee would complete some supervision hours with a seasoned QMHP who is specifically trained for this supervision, and some supervision with an LMHP.

2nd Allow an undergraduate degree in criminal justice to be added to the Board of Counseling's guidance document titled 115-8 - Approved Degrees in Human Services and Related Fields for QMHP Registration and to reinstate sociology as an approved degree.

CommentID: **127130**

Commenter: Stephanie Stewart, M.Ed, Norfolk Community Services Board 8/5/22 1:24 pm

Support for QMHP Changes

I am a Clinical Trainer and QMHP at Norfolk Community Services Board, and I am fully supportive of the proposed changes to the QMHP requirements. Sociology should have always remained an approved degree. Additionally, having trained QMHP's assist with QMHP-T's is a MUCH more feasible option than requiring LMHP's to provide supervision. There is a known shortage of LMHP's in Virginia at this time, and therefore it is extremely difficult to find LMHP's to supervise our trainees--it's hard enough finding supervision for licensure these days! Thank you so much for considering my comment.

Stephanie Stewart, M.Ed, Management Analyst I/Clinical Trainer

Norfolk Community Services Board

Norfolk, Virginia

CommentID: **127131**

Commenter: Melanie Tosh 8/5/22 2:11 pm

QMHP

QMHP

I am in support of the following:

1st A regulation change to allow a hybrid approach to supervision hours where the QMHP-Trainee would complete some supervision hours with a seasoned QMHP who is specifically trained for this supervision, and some supervision with an LMHP.

2nd Allow an undergraduate degree in criminal justice to be added to the Board of Counseling's guidance document titled 115-8 - Approved Degrees in Human Services and Related Fields for QMHP Registration and to reinstate sociology as an approved degree.
CommentID: **127132**

Commenter: Eric Greene, PD1 BHS/Frontier Health

8/5/22 2:53 pm

Support the VACSB petition

I support the changes listed in the VACSB petition. Specifically, the supervision of a QMHP trainee by a QMHP is consistent with the supervision process available with CSAC trainees. While supervision from an LMHP would be beneficial, many LMHP's are not familiar with the roles and tasks of a QMHP and have never worked as a QMHP directly. To obtain the CSAC credential, applicants must follow a prescriptive path of supervision, supervised experience and didactic learning. That process is not unlike the QMHP process until it diverges with the supervision requirements. The CSAC trainee is allowed to be supervised by a CSAC with 2 years experience. Allowing this change would promote consistency among certifications regulated by the board of counseling.

I support the allowance of both sociology and criminal justice as eligible degrees for the QMHP credential. Before the requirements changed, persons with these educational backgrounds provided services to CSB consumers. They brought diversity of thought and experience that was beneficial to the services rendered. These educational backgrounds should not have been excluded and allowing this petition will correct that.

CommentID: **127133**

Commenter: Prof. Michael Moates, MA, LP, LBA, LMHC, LADAC

8/5/22 6:59 pm

Response to Supporters Comments

There are many problems with the petition and the responses.

Petitioner requests "The petitioner requests that the Board of Counseling amend 18VAC115-80-40©(1) and 18VAC115-80-50©(1) to allow qualified QMHPs to provide supervision of QMHP-Trainees. QMHPs qualified to provide such supervision would have two or more years of experience and be specifically trained for supervision."

This is very ambiguous. In the first sentence they say "qualified QMHPs..." this is redundant and leads me to believe that they did not do adequate research. Specifically trained is not specific. Would this be a college course? a CEU? Would it require accreditation?

Second, the petition would have additional consequences beyond that of allowing supervision of a QMHP-Trainee by a QMHP with 2 years experience. As noted in 12VAC35-105-20, a QMHP may not engage in independent or autonomous practice. By allowing a QMHP to supervise independently you are removing the LMHP requirement for supervision.

In their comment, the Virginia Association of Community Services Boards stated that they want QMHP's to receive some supervision from a QMHP and some from a LMHP. This is a bad idea

that could cause conflicting information, uneducated responses, and discrimination of degree vs position.

I agree that both criminal justice and sociology should be added to the approved fields. I would also support adding the following: anthropology, medicine (non medical practice), speech and language pathology, addiction, drug and alcohol counseling, occupational therapy, chiropractic, naturopathic, communication disorders, and others related.

The Rationale offered by the Virginia Association of Community Services Boards is not acceptable. The rationale seems only to be concerned with the business and practitioner rather than the public safety which should always be first when considering changes. They do not address this even once.

I implore the board to grant and deny in part the petitioners request. Granting the additional specialites for qualification but rejecting the QMHP supervision. I personally believe that the QMHP-C and QMHP-A should be merged and that the requirements are the same. Virginia is the only state that I am aware of that does it like this.

Prof. Michael Moates, MA, LP, LBA, LMHC, LADAC

CommentID: **127137**

Commenter: QMHPT A&C

8/7/22 12:46 am

Agree

Adding a Criminal Justice degree to the credential will allow many law enforcement officers and personnel to transition into the mental health field to continue to help others after retirement or making a career change. Criminal Justice degree covers many classes that deals with the mental health population. QMHP A & C is very important when it come to working with the diversity of a population that is showing great deal of youth under the age of 18 and older adults entering into the system after being release from mental health institutions and prison . Reviewing the guideline is very important so adjustments can be made to allow staff to obtain their certification. When the grandfather clause was allowed many mental health employees was able to full filled their duties on a higher level.

CommentID: **127141**

Commenter: Anonymous

8/7/22 10:17 am

Proposed QMHP Supervisory Changes

1) How would we determine if a QMHP is qualified to provide training to QMHP-T? Is training enough? As someone who hires and works with QMHPs regularly, I see inconsistency in skill levels of QMHPs.

2) I am opposed to sharing LMHP and QMHP supervision. This places an additional burden on LMHP to know what QMHP trainer is doing and increases risk of sharing conflictual information, depending on knowledge, background, and skill set of QMHP.

3) I believe sociology should be added as an appropriate degree. My experience shows that they are just as qualified as someone who has a degree in psychology.

4) If we are going to allow QMHPs to supervise QMHP-T's, might we require QMHP-T's to go through basic training to acquire baseline universal skills like we do for peer counselors - active listening, reflection, non-judgmental stance, empathy, relationship building, crisis intervention skills, etc.?

CommentID: **127142**

Commenter: Jodie Burton 8/8/22 8:36 am

QMHP

I agree with the following:

1st A regulation change to allow a hybrid approach to supervision hours where the QMHP-Trainee would complete some supervision hours with a seasoned QMHP who is specifically trained for this supervision, and some supervision with an LMHP.

2nd Allow an undergraduate degree in criminal justice to be added to the Board of Counseling's guidance document titled 115-8 - Approved Degrees in Human Services and Related Fields for QMHP Registration and to reinstate sociology as an approved degree.
CommentID: **127147**

Commenter: Brandi Whitman, BA, QMHP- Norfolk CSB 8/8/22 10:56 am

QMHP training

The best training I have ever experienced is direct engagement with someone who knows what it takes and has done the job I am being trained to do. It is essential that we are taught the policies, procedures, and history of mental health professionals. It is also imperative that we learn alongside seasoned specific trainers so that real dialogue can occur about the specifics of the profession, particularly regarding areas that cannot be taught in textbooks or classrooms. I have met many individuals throughout my career who may not have had supervision from a licensed person, but had qualified direct experience that reflected positively in their work.

CommentID: **127149**

Commenter: Prof. Michael Moates, MA, LP, LBA, LMHC, LADAC 8/8/22 11:25 am

Comparison of CSAC

I just want to point out that the CASC is not a license to practice. It is a certification. It does not authorize mental health practice. I don't see how it compares to the QMHP.

CommentID: **127150**

Commenter: Anonymous 8/9/22 9:21 am

Concern

I do not believe the answer to a workforce shortage is to lower the requirements of those delivering or supervising services. The quality of services in Virginia appears to be continuously declining. More individuals seem to be failing to make sustainable progress in services despite being in services significantly longer. With a focus on improving the quality of services received and recovery focused mindset, individuals/families would be serviced more effectively, and in turn this will allow more individuals to be serviced. I do not see how this petition would improve or even maintain the quality and safety of services provided.

Two years of experience should not be the only qualifier considered to ensure an individual is "seasoned" enough to guide/supervise treatment. I would support the allowance of additional degrees to be considered as qualifying towards a QMHP, but would only do so if the level of expertise, education, and training of the supervisor is upheld. Regardless of degree or licensure status, any supervisor should be required to engage in training related to supervision for that particular scope of practice, whether they are supervising a QMHP or a resident working towards licensure.

CommentID: **127154**

Commenter: Anonymous

8/10/22 6:41 am

Support Sociology/Criminal Justice as approved QMHP degrees

Thank you for accepting this comment. I am in favor of adding Sociology and Criminal Justice as approved human service degrees for QMHP credentialing in Virginia. Sociology primarily focuses on understanding human interaction and social behavior which is relevant to MH and SUD. Undergrad/Graduate level Criminal Justice education includes rehabilitiative approaches to addressing criminal conduct which is strongly correlated to AOD and MH. The field of Criminal Justice is not simply punitive approaches to changing or deterring behavior, and includes enhanced focus on rehabilitation (especially in Juvenile Justive Systems where QMHPs provide support). The main issue, as Bachelor Level QMHPs are not considered "Therapists" or "Counselors" and can only provide psycho-education and skill building interventions, it is appropriate to approve Sociology and Criminal Justice as approved QMHP degrees as they are human services degrees (helping professionals) similar to Bachelor Level Social Work or Psychology.

CommentID: **127158**

Commenter: Michele Ebright

8/10/22 12:14 pm

Support for hybrid supervision of QMHP's and for allowing a criminal justice degree to be acceptable

Degree Requirements: Crossroads is a rural CSB, and the hiring of quality case management staff is frequently hindered by the degree requirements for for the QMHP registration. We have had to turn away good candidates because of this. It should not be forgotten that case management positions offer people who want to work in the mental health field and entry level work experience, where on the job training is much more significant than the degree. We believe that individuals with criminal justice and sociology degrees are qualified to learn the specific job functions of case management. In the event that we feel they don't have this potential, they will be selected out through the hiring process.

Hybrid Supervision: I support this regulation change as well. While I see the benefit of having some supervision provided by a licensed mental health professional, I see even more benefit to allowing a combination of supervision from two perspectives. Additionally, our clinicians are extremely taxed at present, and with the amount of turnover in case management positions, this just creates one more task for licensed clinicians that may not be essential.

CommentID: **127175**

Commenter: Jane Fetterman, LPC, CPRP

8/11/22 12:55 pm

In favor

I am in favor of VACSB's petition regarding QMHPs.

Supervision by a combination of QMHPs, with 2 years experience and trained in supervision, and LMHPs is a good way of getting broad look at client issues. While having different supervisors may give conflicting opinions/guidance, people having different opinions will continue throughout one's career.

I am in favor persons with degrees in criminal justice and sociology being eligible to pursue the QMHP.

Both of these will help to address the current mental health workforce shortage. Hopefully, it will also help to address the number of persons with mental illness who are incarcerated due to mental health issues.

CommentID: **127196**

Commenter: Adam S. Yoder, LPC

8/11/22 1:17 pm

Supervisor training is the key

I support this petition. When I was an Resident in Counseling I received supervision from another LPC, not a level above LPC. My LPC supervisor needed 2 years experience and the 20 hour supervision course. I believe the key to success with this petition will be the supervisor training provided to the QMHP's, not the number of years of experience.

CommentID: **127198**

Commenter: C. Scott-Tillerson

8/12/22 8:51 am

Support

I am in support of both of these proposed changes!

Adding sociology and criminal justice degrees to the accepted degree list will open the door for agencies to stop missing out on potentially good employees moving forward.

Having a QMHP, that is currently doing the work, supervise a QMHP-Trainee, makes sense. We will no longer be taking time away from other clinicians and their other assigned duties.

CommentID: **127204**

Commenter: Anonymous

8/13/22 11:56 am

Yes for the change

Having the education, knowledge and theory is very important, but having actual knowledge based on experience is essential for this job. Being trained by someone with more than 2 years experience is all we want when working on the field.

CommentID: **127209**

Commenter: Concerned LPC

8/15/22 8:32 pm

Bad idea

The proposed changes compromises public safety. 2 years experience as a QMHP is not sufficient to act in a supervisory capacity nor substitutes the clinical guidance and skillset of a LMHP for whom the clinical oversight is intended for.

Secondly, a criminal justice degree prepares an individual for a career path in law enforcement. The curriculum does not provide an adequate foundation in the etiology and treatment of behavioral disorders, which is needed given the SMI population that QMHPs are tasked to work with.

Perhaps the CSB needs to explore their staffing and retention concerns through other methods but this proposal is certainly not the ideal solution.

CommentID: **127249**

Commenter: Anonymous 8/16/22 8:20 am

In Support

I think allowing supervision of a QMHP trainee by a QMHP is a great idea, but I do think that it needs to be someone with more than 2 years experience. I think that the supervision should be by a QMHP with 5+ years of experience in the field and there should be training on providing supervision. LPC's and LCSW's are supervised by peers so why not QMHP's. There could be a mechanism for having an LMHP available to the supervising QMHP for consultation if needed.

As for sociology and criminal justice degrees, those should definitely be allowable degrees for QMHP's

CommentID: **127256**

Commenter: LPC 8/17/22 2:30 pm

Support

I support this petition. I think the supervision training is valuable for QMHP's in supervising QMHP-trainee's. QMHP's with experience and supervision training are capable of supervising trainee's. There is value in QMHP's providing the supervision as QMHP's are providing specific services in the mental health field that are very different than counseling services. LMHP's provide supervision to residents who are eligible for LMHP credential. I see this the same QMHP's providing supervision to trainee's eligible for OMHP credential. These are two very different credentials. Thank you for considering my comments.

CommentID: **127311**

Commenter: Anonymous 8/17/22 6:41 pm

Support CJ/SOC

The bottom line is QMHPs cannot provide Counseling, nor can they provide Therapy and should not be placed in the same supervision "bucket" as Residents in Counseling. In addition, Criminal Justice degrees are not simply "law enforcement" degrees as some have insinuated. Criminal Justice Curiculuum includes law, system management, detterence as well as rehabilitative programming, and offender interaction skills needed to facilitate changing behaivor.

CommentID: **127328**

Commenter: F. Valenine

8/17/22 7:20 pm

In Favor of VACBP petition

I am in favor of VACSB's petition regarding QMHPs providing supervision. I am also in favor of Criminal Justice and Sociology degrees as approved degrees for QMHP. Increasing Mental Health needs that are being experienced across the state are outpacing our workforce. Systems are needing to adapt to meet these ever increasing needs, and this may be that opportunity.

CommentID: **127330**

Commenter: Gabriella Caldwell-Miller

8/19/22 2:40 pm

Maximize the Dwindling BH Workforce

Thank you for the opportunity to provide public comment.

QMHPs are essential to the behavioral health workforce responsible for arranging, coordinating, monitoring, evaluating, and advocating across systems to address clients' complex needs. They are most directly involved with helping clients complete the action steps on the ISP. Allowing seasoned QMHPs to provide supervision hours for QMHP-Ts benefits the BH system in two ways. First, it will improve workforce retention by creating career advancement opportunities. Second, many LMHPs have never worked solely within the QMHP scope of practice. Rather, LMHPs scope of practice focuses more narrowly on clinical assessment and intervention. The presumption that LMHPs are uniquely able to impart competency and professional identity to QMHPs simply by virtue of clinical training is misguided. LMHPs provide supervision that highlights the broader clinical and ethical context of client care. However, seasoned QMHPs speak more directly to the application of theory into practice in real-time. Seasoned QMHPs can better assess the QMHP -T within the scope of practice and promote professional identity unique to the QMHP role.

Curricula in Criminal Justice and Sociology address human behavior, social psychology, societal issues, and the legal system - the major themes that human services agencies address in their mission. For many individuals graduating from undergraduate and graduate human service programs, there is a gap between theory and practice that on-the-job training fills. Quality assurance mechanisms are in place at the state level that defines professional development and training for QMHPs. The Board of Counseling outlines continuing education requirements, and the DBHDS Office of Licensure defines training standards to which all direct service employees at licensed facilities must adhere. With these factors in mind, individuals with degrees in Sociology and Criminal Justice are equipped and capable of holding the QMHP credential.
CommentID: **127367**

Commenter: Adrien Monti, Blue Ridge Behavioral Healthcare

8/22/22 2:59 pm

Agee with Proposed Changes

1. In favor of a regulation change to allow QMHP-trainees to be supervised by QMHPs with at least two years of experience who have been specifically trained to provide supervision. As a licensed clinician who currently supervises QMHP-trainees, I believe this supervision could be equally effective when completed by experienced QMHPs with relevant job experience and training.

IMPORTANT: **If some supervision must be done by LMHP, please include the language LMHP or LMHP-E. Regulations currently allow for a master's level clinician under supervision toward clinical licensure (LMHP-**

E) can provide supervision. We do not want to remove this ability and therefore make the requirements more strict.

2. In favor of allowing an undergraduate degree in criminal justice to be added to the Board of Counseling's guidance document titled 115-8 - Approved Degrees in Human Services and Related Fields for QMHP Registration and to reinstate sociology as an approved degree.

CommentID: **127385**

Commenter: Laura Fonner, LPC

8/23/22 8:05 am

Support

Thank you for considering the petition and providing an opportunity to comment. I am in support of this petition. It is appropriate and, in my experience, more effective to have someone with the same credentials supervising. It has become redundant and exhausting for agencies to provide two levels of supervision by two different staff. At our agency we have QMHP-A supervisors who have been doing this work effectively and efficiently for a very long time. They are capable and qualified to supervise those trying to achieve the same credentials. Licensed staff can be hard to come by and it is not practical to require them to supervise Residents in Counseling and QMHP-E's, in addition to regular supervision duties. Overtasking licensed staff places the goal of quality supervision at risk. Requiring supervisory CEU's is appropriate. Our industry does not need more regulations though. We need to set standards within our agencies to address supervisory training.

CommentID: **127393**

Commenter: Prof. Michael Moates, MA, LP, LBA, LMHC, LADAC

8/23/22 12:06 pm

Argument Based On Law

Pursuant to § 54.1-2400.1:

""Mental health professional" means a person who by education and experience is professionally qualified and licensed in Virginia to provide counseling interventions designed to facilitate an individual's achievement of human development goals and remediate mental, emotional, or behavioral disorders and associated distresses which interfere with mental health and development."

Someone with a bachelor's degree in criminal justice does not have the knowledge, experience, or education to train someone else regardless of experience. I do not object to the degree being a degree that qualifies for the QMHP.

I take issue when that same degree is used to train people on the foundations of "human development goals and remediate mental, emotional, or behavioral disorders and associated distresses which interfere with mental health and development." It is my opinion that that is not the proper foundation to teach or train on those issues.

I do not object to the creation of a QMHP-Supervisor certification to training someone if all of the following are met:

1. The QMHP has 3,000 hours of experience. 2 years is not a good criteria as someone could work 1 day a week for 2 years. 3,000 hours is specific.
2. The 3,000 hours were done under a medical doctor, counselor, psychologist, behavior analyst, addiction counselor, someone authorized by the state within the scope of practice, or QMHP-Supervisor.

3. The QMHP holds a bachelors degree or higher in psychology, counseling, sociology, anthropology, public health, social work, addiction counseling, special education, etc. or... holds a license by the Commonwealth of Virginia in an educational field that does not qualify as a Licensed Mental Health Professional.

CommentID: **127402**

Commenter: Bonnie Alford

8/29/22 2:59 pm

In Support

I am in support of QMHP -T supervisions completed by a QMHP-A with 5 years experience. As you are aware, many trainees have degrees and multiple years of training, just not the supervised number of hours required by the BOC. This can be due to difficulty with obtaining verfication from previous employers. Supervision training prior to a QMHP-A being certified to train could also be a requirement. Having the available support of a LPC or LPC-Resident, if needed, would also eliminate any concerns of not having input from licensed individuals. I also support having criminal justice and sociology as continued recognized degrees by the BOC.

CommentID: **127453**

Commenter: Colleen Kivley, Harrisonburg-Rockingham Community Services Board

8/30/22 12:31 pm

In Support

I support the proposal of experienced QMHPs supervising QMHP trainees as the proposal specifies that such QMHPs would be trained to provide supervision. I believe this is a responsible use of educated and experienced professionals and not a lowering of the standard.

CommentID: **127458**

Commenter: Carlinda Kleck, Loudoun County MHSADS

8/31/22 12:02 pm

Support

We are in support to allow QMHPs to supervise QMHP trainees along with LMHPs in a hybrid approach as outlined in the VACSB petition.

CommentID: **127470**

Commenter: Anonymous

8/31/22 12:44 pm

In support

I am in support of QMHP Trainees having supervision completed by experienced QMHPs who have access to a LMHP. QMHP supervisors could be required to complete additional training prior to supervising QMHP trainees and pass a competency test. I also support having criminal justice and sociology as continued recognized degrees.

CommentID: **127472**

Agenda Item: Consideration of petition for rulemaking to allow residents to use the title "LPC-R"

Included in your agenda package are:

- Petition for rulemaking received by the Board
- Comments received by the Board regarding the petition

Action items:

- Motion to initiate rulemaking in response to the petition; OR
- Motion to take no action, with specific reason(s) why.

Virginia Department of Health Professions
Board of Counseling

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Petition for Rule-making

The Code of Virginia (§ 2.2-4007) and the Public Participation Guidelines of this board require a person who wishes to petition the board to develop a new regulation or amend an existing regulation to provide certain information. Within 14 days of receiving a valid petition, the board will notify the petitioner and send a notice to the Register of Regulations identifying the petitioner, the nature of the request and the plan for responding to the petition. Following publication of the petition in the Register, a 21-day comment period will begin to allow written comment on the petition. Within 90 days after the comment period, the board will issue a written decision on the petition. If the board has not met within that 90-day period, the decision will be issued no later than 14 days after it next meets.

Please provide the information requested below. (Print or Type)

Petitioner's full name (Last, First, Middle initial, Suffix,)

Kaste, Ethan, A.

Street Address	Area Code and Telephone Number
4687 Forestdale Dr.	7013310162

City	State	Zip Code:
Fairfax	Virginia	22032

Email Address (optional)
ethankaste91@gmail.cm

Respond to the following questions:

1. What regulation are you petitioning the board to amend? Please state the title of the regulation and the section/sections you want the board to consider amending.

18VAC115-20-52.B.10

2. Please summarize the substance of the change you are requesting and state the rationale or purpose for the new or amended rule.

I would like to propose that we allow Resident in Counseling professionals to use the title Liscensed Professional Counselor - Resident (LPC-R). The Virginia Board of Counseling states that, "Resident" means an individual who has a supervisory contract and has been issued a temporary license by the board to provide clinical services in professional counseling under supervision (18VAC115-20-10.B). The regulation defines that resident's are able to provide professional counseling clinical services, affirming that the resident has the capacity to provide services in a professional capacity. However, 18VAC115-20-52.B.10 states that the board Residents may not call themselves professional counselors, which is not consistent with the understanding of the kind of services a resident provides, as defined in the former regulation. Allowing residents to use the title LPC-R would allow for consistancy for language in the document itself, but it would also provide other benefits. Besides the simple fact that utilizing utilizing an abbreviation for a title is easier than writting, "Resident in Counseling", it also allows for uniformity among the profession. Most states in the counseling profession are utilizing abbreviated terms for those working twoards a liscence, Maryland used LGPC for example.

3. State the legal authority of the board to take the action requested. In general, the legal authority for the adoption of regulations by the board is found in § 54.1-2400 of the Code of Virginia. If there is other legal authority for promulgation of a regulation, please provide that Code reference.

Signature: Ethan Kaste **Date:** 06/24/2022

Virginia.gov Agencies | Governor

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Agency **Department of Health Professions**

Board **Board of Counseling**

Chapter **Regulations Governing the Practice of Professional Counseling [18 VAC 115 - 20]**

23 comments

All good comments for this forum Show Only Flagged

Back to List of Comments

Commenter: Elizabeth Engelhorn 7/18/22 4:21 pm

Post Test

If an individual has passed their test and is in supervision with a licensed provider who is qualified as a supervisor, I am in agreement with this. However, I believe that they need to have passed their test.

CommentID: **122734**

Commenter: Ruth Ann Ott 7/18/22 5:28 pm

Petition for LPC-R

Wondering what the difference would make? They still would have the same stipulations placed on them, but with a shorter version for signatures. As long as they have passed their counseling board exams and are still being supervised for licensure, I am okay with the change.

CommentID: **122738**

Commenter: Prof. Michael Moates, MA, LP, LCMHC, LBA 7/18/22 9:46 pm

Comment Against Petition

Hello and thank you for taking the time to read my comment.

I have grave concerns about doing what the petitioner is asking. I believe that this will cause confusion to consumers and other entities by presuming that someone has a full license to practice.

The term resident in the medical field typically refers to a medical doctor who has reached a point of their career where they are refining their skills but have a full independent licensure to practice medicine.

The Board of Counseling currently has a good way of differentiating between when someone is in training and when someone has full licensure. There is no reason to change it especially in a way that can confuse consumers. Further, I do not agree with the other commenters that there should be a pre and post test title. Someone either has a full license to practice or they are in training. There should be no wiggle room.

The petitioner just graduate this year and it seems like he is trying to jump the gun. There is a requirement before getting the LPC title for a reason. Mr. Kaste is charging $185-230 well above the average for a therapist in training and the concern by me is that this would seek to add legitimacy (implying full credential) to a not yet fully licensed practitioner. See https://www.psychologytoday.com/us/therapists/ethan-kaste-arlington-va/983000.

Further under the authorizing statute § 54.1-3500. Definitions. it says that "**"Professional counselor" means a person trained** in the application of principles, standards, and methods of the counseling profession, including counseling interventions designed to facilitate an individual's achievement of human development goals and remediating mental, emotional, or behavioral disorders and associated distresses that interfere with mental health and development." You are not fully trained until you complete the educational, experiential, and examination requirements. Thus, it is my belief that this would not be in line with what the legislature intended.

Thank you.

Prof. Michael Moates, MA, LP, LBA, LCMHC

CommentID: **122753**

Commenter: Charlotte Markva, LPC, LMFT, CSAC, NCC

7/19/22 8:50 am

Potential for Public Confusion

I am concerned that if you use the title LPC-resident, you are sending the message to consumers of experience and qualifications met that are not the case. The current regulations are clear as to the experience level of the therapist. Already I perceive that consumers project onto residents having more experience that what many of them actually have. I don't think labels should be changed that could further confuse the general public.

CommentID: **122761**

Commenter: Cinda Caiella, LMFT

7/19/22 9:21 am

Against this unnecessary petition

The proposed change is unnecessary and would be a source of confusion. The title is a recognition of achieving full status as an LPC, with education, training, time under supervision, that is clearly defined and outlined in the relevant statutes. What would be gained, apart from a personal conceit? Counselors and the Board of Counseling have worked diligently to promote and defend this License and protect the public.

CommentID: **122762**

Commenter: Cynthia Miller, Ph.D., LPC

7/19/22 10:09 am

Purpose needs clarification

This petition, while perhaps well-intentioned, blurs the distinction between what it means to be a resident and what it means to be licensed. The title "Licensed Professional Counselor" is protected by law and is indicative of a counselor who has a credential to practice ***independently***. A resident is someone who has permission to practice, but only under the supervision of a Licensed Professional Counselor. In other words, the resident is not permitted to practice independently. Creating a designation of "Licensed Professional Counselor - Resident" blurs the

very important distinction between who can practice unsupervised and who cannot. The general public is unlikely to understand how an LPC differs from an LPC-R and that is a problem. Potential clients should clearly understand whether their counselor is independently licensed or not.

It does seem possible that a driving force behind this petition is the desire to bill insurance. Private insurance companies generally do not reimburse services provided by counselors who are not licensed. This is a problem and definitely creates additional barriers to treatment for people. If the end result of creating a designation like LPC-R is to open the path to insurance reimbursement I could get behind this, but it should come with clear requirements that anyone with an LPC-R designation must explain their residency status to every client.

CommentID: **122766**

Commenter: Joan Normandy-Dolberg, MA, MEd, LPC, Director, Family Counseling Springfiel

7/19/22 11:12 am

Against the change

This change is unnecessary and may (purposely?) mislead or confuse the public.

CommentID: **122770**

Commenter: Heather Honaker, LPC

7/20/22 9:47 pm

Against the petition

Strongly against this petition due to the possibility of public confusion.

CommentID: **122831**

Commenter: Holly Tracy LPC, LMFT, ACS, CTTS, RPT-S, CT, NCC

7/21/22 9:53 am

Strongly Against

The Board's mission is to protect the public. Part of that includes full awareness and transparency of a clinician's credentials. I believe LPC-R will further confuse the public and lead to a misunderstanding about credentials. Having spoken with clients and seeing how some Residents advertise, it is clear that clients are already confused. Let's not add to the potential for further misdirection.

CommentID: **122841**

Commenter: Anonymous

7/21/22 3:41 pm

For the Title Change

I'm for the change in title. The scope of practice, responsibilities and ethical mandates per VA Board of Counseling, and ACA, do not change. Simply the title changes. The current resident handbook still mandates that residents post their provisional license in a conspicuous location, inform clients that they can not practice independently or directly bill for services. Residents in Counseling would still have to complete the NMHCE, 3,500 hours of experience and be under the supervision of an independently licensed, board approved supervisor during that time frame.

I do understand the concerns of confusing the general public on the change. However, it does not change the board regulations on scope of practice for residents. Plus, I would argue that the general population finds the current title confusing already. As residents, it is their (and their supervisor's) ethical responsibility to provide psychoeducation on the limits of practice and trainee status in all of their public facing materials and all written communication.

Currently, in the state, a Certified Substance Abuse Counselor (CSAC) is a regulated bachelor's degree level profession. How does this title differ in terms of public confusion? How does this title resonate with the public's understanding? Of course, the CSAC is needed due to the substance use crisis, but let us look at the full picture in the state. Especially with the Counseling Compact gaining national traction. Clients want uniformity. Client's want clarity. This can be a step in that direction. If you are concerned, consider the following ACA Ethical Codes:

C.4.a. Accurate Representation

F.1.c. Informed Consent and Client Rights

F.5.c. Professional Disclosure

CommentID: **122853**

Commenter: Anonymous

7/22/22 4:15 pm

LPC-R

I am in agreement to allow Residence to sign their name as LPC-R. As someone who is in the hospital often seeing clients the term "Resident" sounds as if someone is in the medical field. It is very confusing for clients and I have had countless clients express this confusion. A Resident has been through a lengthy educational process, has obtained months of internship, and deserve the respect to have a title that all understand. Most of these Residence have been in the field for years. The title of "Resident" causes clients to assume that someone is uneducated in counseling. Many of the clients I see think that a Resident is either in a medical residency or is an undergrad student who have not yet obtained a BS or BA degree.

CommentID: **122872**

Commenter: Prof. Michael Moates, MA, LP, LCMHC, LBA, LMHP

7/22/22 6:43 pm

Concerns

I have concerns that all of those that are in favor are anonymous. I would ask the board to compare the IP addresses and behavior of those who are commenting.

CommentID: **122873**

Commenter: Anonymous

7/22/22 11:01 pm

For the Change

I believe that the credentials should read LPC-R. The R will be enough to show that the clinician is not fully licensed yet and is still in residency.

CommentID: **122874**

Commenter: William

7/23/22 7:46 pm

Wrong Answer for a Needed Change

I understand the desire for a change in designation for Counselors who are working on becoming licensed. I am graduating with my Master's in Counseling in a few weeks, so I am certainly invested in this issue.

I am inclined not to share some of the more extreme concerns here that this change is possibly intentionally designed to mislead the public, or that it would lead to mass confusion - at least not

any more mass confusion than our current system. This leads to my next point.

I do agree that the terminology should change. The term "Resident" in general is confusing, and not used by other mental health professions aside from Psychiatry, which of course is medical doctors. We are confusing some members of the public into thinking our background is more like that of a medical doctor than a therapist. Again, an unintentional issue I am sure, but I think we do need a new term. I do not like this term because I agree with concerns from others that it is easy to think that LPC-R means fully licensed. Perhaps we could simply come up with another term. Perhaps Supervisee in Professional Counseling (SPC or S-PC), Professional Counseling Supervisee, Professional Counselor in Training, or Pre-licensed Professional Counselor (Pre-LPC). I believe these terms are more clear. I do appreciate the idea of a shorter abbreviation.

CommentID: **122881**

Commenter: Meredith Adams, MS, NCC

7/24/22 2:52 pm

In Favor

As someone who currently serves as a Resident in Counseling, I am in favor of this motion. This motion does not change the scope of work that Residents in Counseling do nor does it change the supervision requirements, it simply allows Residents in Counseling to better market themselves to clients seeking care in a more transparent way to differentiate between LPCs and LPC-Rs. Residency is a rigorous process of growth and learning that differentiates itself from that of being a student which is worthy of further acknowledgement.

CommentID: **122897**

Commenter: Anonymous

7/24/22 7:44 pm

Strongly in Favor

I am strongly in favor of this motion and hope that the Board supports the petition.

CommentID: **122905**

Commenter: J. A. Elliott, LPC

7/24/22 9:28 pm

Strongly Against

I have serious concerns about this proposed change. I strongly believe that this will cause confusion to the general public and others by presuming that someone has a full license to practice. This confusion stems from the word Licensed being in the proposed title—which is misleading and could potentially break ethical codes to do no harm.

The Board of Counseling has a good way of differentiating between when someone is licensed and when someone is in their residency. There is not a good reason to change this distinction, especially in the way that the petitioner is asking. This proposed change can put people at risk of being exposed to harm due to the wording and the potential for misrepresentation by residents to clients. Further, this proposed change is confusing and potentially harmful to clients and the general public as well as the legitimacy of the profession and other entities/professions.

I agree with the concerns regarding the petitioner's motivations brought up by Prof. Michael Moates, MA, LP, LCMHC, LBA. He stated, "The petitioner just graduate this year and it seems like he is trying to jump the gun. There is a requirement before getting the LPC title for a reason. Mr. Kaste is charging $185-230 well above the average for a therapist in training and the concern by me is that this would seek to add legitimacy (implying full credential) to a not yet fully licensed practitioner. See https://www.psychologytoday.com/us/therapists/ethan-kaste-arlington-va/983000." Upon reviewing the provided link,, I second these concerns which further reinforces my aforementioned concern for the large potential for harm to clients and the misrepresentation of resident status by residents to clients.

Overall, I am strongly against this change and the potential harm it may cause to the profession, the field of mental health, and, most importantly, the general public—who are our potential clients/consumers.
CommentID: **122907**

Commenter: Fran Schaller LPC, CSAC

7/26/22 11:09 am

Petition to allow residents in counseling to use the title "LPC - Resident"

I disagree with this proposed change. It will lead to confusion in an already confusing system.

CommentID: **124032**

Commenter: Arlene Malone

7/29/22 1:41 pm

Strongly Against

To not repeat the sentiments of my colleagues who have argued against the approval of this petition, I am strongly against this petition and echo the concerns previously stated by my colleagues. It is already confusing for consumers, and approving a title of LPC-R will only add to that confusion, primarily because the word "licensed" is included in the title, which would be an incorrect and misleading characterization of the credential of a resident in counseling. I agree that another title would be clearer, such as Counselor-in-Training or Pre-Licensed Counselor, but that is not the petition at this point. LPC-R is not the answer.

CommentID: **124166**

Commenter: K

8/6/22 2:05 pm

Must be licensed

If you aren't officially trained and certified by State or university, then Licensed should not be used.

CommentID: **127140**

Commenter: ASHA GRAY LPC

8/11/22 7:52 am

In favor

I would be in favor of this switch. It's a reasonable simile of what is used now. It is also in line with what other states nearby use. Like DC's LGPC. It also makes it clear to clients what licensure this probationary licenced clinician is working towards.

CommentID: **127190**

Commenter: Anonymous

8/11/22 10:01 am

Response to ASHA GRAY LPC

ASHA GRAY LPC, your statement is false. Other states do not give the title LPC and add resident at the end. They have titles like associate counselor but that is not the same as being LPC - Resident. If the board elects to indulge this petition, I would request that the word "resident" must be spelt out. So it would be "LPC-Resident" rather than "LPC-R." I would also request that the

resident be required to get a signed consent form explaining the details of their title and supervision requirements.

CommentID: **127191**

Commenter: Ethan Kaste, Resident in Counseling

8/16/22 5:27 pm

Original Petition

I would like to propose that we allow Resident in Counseling professionals to use the title Licensed Professional Counselor - Resident (LPC-R), Licensed Resident Professional Counselor (LRPC), or another similar form for a few reasons:

1. Provides consistency and accuracy of terms in Virginia's regulations

The Virginia Board of Counseling defines "Resident" to mean, "An individual who has a supervisory contract and has been issued a temporary license by the board to provide clinical services in *professional counseling* [emphasis added] under supervision" (18VAC115-20-10.B). This regulation implies that residents are licensed individuals that are able to provide *professional* clinical services, affirming that the resident has the capacity to provide services in a professional capacity. However, 18VAC115-20-52.B.10 states that "Residents may *not* [emphasis added] call themselves professional counselors, directly bill for services rendered, or in any way represent themselves as independent, autonomous practitioners or professional counselors". The former regulation suggests that residents provide professional services but the latter seems to deny that. Further clarification on the definition of "professional counseling" may be needed, but instead of rewriting or redacting those regulations, the use of the title Licensed Professional Counselor - Resident (LPC-R) or Licensed Resident Professional Counselor (LRPC) be the designated title since it more accurately represents Residents in that they are supervised licensed individuals who provide professional services.

2. Uniformity in supervised licensure titles among other states.

Many states in the counseling profession are utilizing the terms "professional" and "licensed" for those who are graduated supervised individuals working towards. Alabama, California, Colorado, DC, Maryland, Georgia, and Hawaii are just some states that utilize various titles such as Associate Licensed Counselor (ALC), Licensed Associate Counselor (LAC), Licensed Associate Professional Counselor (LAPC), Licensed Graduate Professional Counselor (LGPC), Limited Licensed Professional Counselor (LLPC), Licensed Graduate Professional Counselor (LGPC), Provisional Licensed Professional Counselor (PLPC), and Licensed Professional Counselor Associate (LPCA).

https://www.counseling.org/knowledge-center/licensure-requirements/state-professional-counselor-licensure-boards

3. Ease of use

I personally do not consider it necessary to change the name, I just simply think it makes more sense to utilize Licensed Professional Counselor - Resident (LPC-R) or Licensed Resident Professional Counselor (LRPC) for the

aforementioned points. Lastly, and perhaps the least important point in this petition is the abbreviated use of a resident title such as LPC-R or LRPC is more simple to use than “Resident in Counseling”.

I want to thank everyone for their comments, I was looking forward to learning and hearing everyone’s different opinions! It is my first time operating in a regulatory capacity (however small it may be) so I was somewhat excited and honored to be a part of it. I am still a Resident in Counseling myself so I understood that there were going to be some perspectives that I had not considered. I also wished I had seen these comments earlier, I noticed that much of my reasoning for the petition was left out. So I would have posted this comment earlier in order to further clarify my reasons for suggesting the petition. I apologize for that.

CommentID: **127275**

Agenda Item: Consideration of final regulations following periodic review

Included in your agenda package are:

- Comments received via Town Hall on proposed stage changes
- Draft final regulations as recommended by the regulatory committee

Action needed:

- Discussion of recommended edits to final regulations; and
- Motion to adopt recommendation of regulatory committee for final regulations

Action: Periodic review [5230 / 8872]			
Commenter	**Title**	**Comment**	**Date/ID**
Larry Epp, Ed.D., a Past President, LCPCM	Differentiation of CACREP versus Non-CACREP Counselors Not Equitable or Evidence Based	At a time when the COVID-19 Pandemic has taught us that telehealth and license portability are critical to solving provider shortages, Virginia should be trying to create an easy to understand and streamlined licensure criteria to allow telehealth across state lines. When these conversations started, we did not have a national provider shortage, triggered by a secondary mental health pandemic, now that we do, our policies should be inclusive and allow the efficient portability of all counselors with three years of experience. The differentiation of CACREP versus non-CACREP counselors, and the punitive 10 year experience requirement for non-CACREP counselors, is not equitable and not justifiable based on the literature. This would exclude many of the graduates of Johns Hopkins from easily transferring their license to the Commonwealth, which has only had CACREP accreditation for 5 years, but is reputably one of the best programs in the US. Virginia should be modeling its regulations on the developing Counseling Compact and not diverging from this wise movement to eventually allow national telehealth portability.	3/23/22 8:42 am CommentID:120842
Peggy Brady-Amoon, PhD, LPC, Alliance for Professional Counselors	Opposition to inequitable licensure by endoresment proposal	The Alliance for Professional Counselors (APC), a national organization of counselors and counselor educators that supports interdisciplinary cooperation and licensure portability, remains strongly opposed to a specific provision in the Virginia Board of Counseling's proposal for licensure by endorsement that we objected to in 2019. We particularly object to the provision that would permit licensed counselors who graduated from programs accredited by CACREP to qualify for licensure in Virginia with 3 years post-licensure experience while licensed counselors who graduated from programs that are not affiliated with CAREP would need 10 years post-licensure experience to qualify for licensure in Virginia. There is NO evidence to support this proposed discrepancy. Furthermore, this proposal would harm the public by unnecessarily limiting the number of licensed counselors who would qualify for licensure (and therefore professional counseling work) in Virginia. This proposal would also harm the majority of licensed counselors who graduated from programs that are not affiliated with CACREP by making it seem, despite lack of evidence, that they are less qualified. We call your attention to the two successive Virginia Economic Impact Analyses (2016, 2017) for further information. Furthermore, as Virginia has historically been a leader in the profession, this proposal could set a negative precedent.	3/23/22 9:34 pm CommentID:120850

		We fully respect that these decisions are within the purview of the Commonwealth of Virginia. However, APC asks your consideration because these proposed regulations are determinantal to the citizens and economy of Virginia – and have national implications. In our view, the Counseling Compact is a significantly better option for portability than the current (or previous) proposals.	
Nick	Cacrep is nothing special	Only people ignorant of therapy practice would assume cacrep does anything influencing the quality of therapist to the degree Virginia is trying to infer with the difference of requirements. Try looking at additional certificates of practice with quality of requirements like 2-4 years of training and supervision in addition to a license. EMDR, Brainspotting, prolonged exposure, psychodrama all took me years to earn with high level PhDs and we all see terrific therapeutic outcomes. All clients pay high dollar for these specific services. I don't have a cacrep. Nobody who trains these certificates cares or even mentions cacrep. Anyone without those certificates have no clue what value they add to a practice. I can tell Virginia that if they did have a clue, they'd not make a cacrep the defining difference. I could easily outshine any recent graduate in skill level for years to come until they get the added value of advanced certification. This is the difference between a PA and a doctor with ten years surgery experience at a trauma center John Hopkins. Virginia is unaware enough to not know the difference or they'd even prefer a PA over the doctor because of their bachelors program. It's nothing short of pure ignorance to try to infer such meaning from cacrep. The most important work is field training and advanced certification	3/24/22 12:52 am CommentID:120852
Clayton Maguire, LPC LMFT	Urge "Counseling Compact" vs. CACREP	I have been licensed as a Professional Counselor in Virginia for 40 years, having graduated before CADREP existed. I urge the Board to not adopt regulations which require 3 years of experience for those graduating from a CACREP program vs. 10 from other colleges and Universities before licensed by endorsement. Only as I have been practicing for so long, and been a leader in the field (president of the state of Virginia affiliate of AMHCA), long term membership in ACA and AMHCA, do I know of the development of CACREP. Were I a recent college graduate, seeking graduate school admission, I might not even know of CACREP to use it as a screen for application. The current regulations screen effectively without adding a very biased 10 year requirement. Further, there is no evidence of which I am aware which would allow the equating of 3 years of experience of a CACREP graduate with 10 of one from a different credentialing graduate program. I would propose the Board instead adopt the Counseling	3/24/22 12:21 pm CommentID:120854

		Compact, which I know many of the Board members are following. For those not familiar, I urge you to review the writings on the Counseling Compact by Counseling's national representation associations (ACA and AMHCA). Now that all 50 states license counselors licensure by endorsement is in order and equitable measures from all 50 states is preferable. Thank you for considering my point of view.	
Jairo Fuertes, PHD	Another attempted grab by CACREP	There is zero (ZERO) evidence that training in CACREP programs is superior, leads to better trained professionals or better outcomes for patients and clients. However, there is plenty of evidence of CACREP'S consistent and nonrelenting pressure to mislead legislators and consumers into believing that their brand is superior. This is another market grab by CACREP that should be denied. They want to corner the market in training and mental health care. Please vote down this ridiculous proposal. Dr. Fuertes	3/24/22 1:24 pm CommentID:120855
Tom Dinzeo, Ph.D.	Unsupported distinction creating unnecessary inequity	The proposed move to require an additional 7 years of training for graduates of non-CACREP programs is based on a highly flawed and unsupported notion. If the Non-CACREP training programs meet the State educational requirements and the graduates of these programs demonstrate competence during the standard period of evaluation, then what is the sense of unnecessarily burdening these mental health providers with an additional time requirement. This seems like a shameless ploy to disenfranchise all non-CACREP training programs, many of which are not eligible for accreditation due to arbitrary reasons (e.g., too many clinical psychology affiliated faculty teaching courses and not enough with "counselor identity"). The Counseling Compact is a significantly better option than this proposal!	3/24/22 2:07 pm CommentID:120856
Anonymous	CACREP DISCRIMINATION	The erroneous misconception that CACREP is the only accreditation body capable of designing or judging a rigorous counseling program is discriminatory, shortsighted and without merit. There are many universities in the nation that are recognized by regional and national accreditation bodies that have programs that are far better or at least as good as the standards put out by CACREP. By discriminating against the students who attended those schools, you deprive the community of some of the best and most experienced therapists in the country. You also heavily lean into age discrimination. When I attended my Masters in Counseling Psychology program, my program far exceeded the number of classes and hours that were then required by CACREP, which was a fledgling organization trying to corner the market in counseling	3/24/22 2:18 pm CommentID:120857

education accreditation. They've largely succeeded in doing that by putting forth the notion that their programs produce "more ethical" and better educated counselors. That is simply untrue. The behavior of the ACA during a recent election where they shut down pre-election comments is indicative of a group who wants to silence the majority of all counselors who graduated before CACREP even existed. CACREP, ACA and NBCC seem to have worked together in a highly questionable way, by structuring tests and counselor demographic/opinion/practice questionnaires in such a way as to diminish well educated and highly skilled, respected and qualified therapists. It's my understanding that one of the NBCC licensing tests was recently pulled because it lacked the normative, rigorous research required for standardized tests. It's also my understanding that a recent head of NBCC was asked to step down because of highly unprofessional conduct and that the NBCC actually lost its ability to accredit continuing education programs for a time. The 3 aforementioned entities seem to have set up a "you scratch my back..." arrangement that enriches them all, reduces educational choice, deliberately controls outcomes on testing and that attempts to shut out the majority of counselors in the field today.

The ACA recently had an opportunity to break the glass ceiling of getting Masters level counselors approved by the VA, which we all know is serving combat veterans who are killing themselves at never before seen rates because they don't have adequate access to mental health care in a timely manner. For most of modern history the VA only used Social Workers, who practice counseling but are not trained as counselors. There is some overlap in skillset but the training, almost complete lack of psychological theory classes, and basic theoretical foundations are entirely different. Given this marvelous opportunity to improve the conditions for veterans everywhere, the ACA struck a deal with the VA that excluded all of the older, most experienced counselors in favor of CACREP trained counselors, who again, do not represent the majority or the best. I believe this was yet another self-serving move to corner the market in counseling education.

I believe the attempt to punish and exclude non-CAPREP counselors, constitutes violation of anti-trust laws. Discriminating against non-CACREP therapists violates anti-age discrimination laws and possibly violates the rights of faith-based colleges and their graduates since CACREP promotes positions that are not necessarily shared by faith-based counselors. Such colleges should feel free to pursue regional accreditation and opt out of CACREP without diminishing their students' ability to make a living.

Courtney Gasser, Ph.D., L.P., N.C.C.	Oppose current proposal--violation of licensure inclusivity	This proposal falsely suggests that licensed counselors who graduated from programs accredited by CACREP (who would need 3 years post-licensure experience) are more qualified than those who graduated from other programs (who would need 10 years post-licensure experience). There is no evidence that CACREP program graduates are better trained than the graduates of other programs. Also, licensed counselors who graduated from MPCAC accredited programs would be treated as second-class citizens as a result, which is inappropriate as both CACREP and MPCAC are accredited by CHEA and thus programs accredited by CACREP and MPCAC are meeting similar standards, and their graduates should be held to the same kinds of licensure rules. This proposal should be rescinded due to the above problem and, instead, the State of Virginia should pursue the Counseling Compact.	3/24/22 2:20 pm CommentID:120858
Anonymous	Urge Counseling Compact Vs. CACREP	There is zero (ZERO) evidence that training in CACREP programs is superior, leads to better-trained professionals or better outcomes for patients and clients. However, there is plenty of evidence of CACREP'S consistent and unrelenting pressure to mislead legislators and consumers into believing that their brand is superior. This is another market grab by CACREP that should be denied. They want to corner the market in training and mental health care. Please vote down this ridiculous proposal. I strongly urge the state of Virginia to push towards joining the counseling compact, a more inclusive route. If the pandemic, has taught us nothing, it has taught us that accessibility of mental health professionals is essential. Passing the proposal would be ignoring that.	3/24/22 2:50 pm CommentID:120859
Dr. Jody Kulstad	Inequitable Licensure Practices	This is a further attempt to push CACREP only onto Virginia counselor licensure. As others have noted, having CACREP accreditation only indicates that a program meets baseline requirements for training counselors. Programs who have CHOSEN to not pursue CACREP are often equally if not more rigorous and graduate excellent counseling professionals. This field needs more counselors, not less, and there is no evidence that those who graduate from CACREP programs are any more qualified than those who do not. To make a distinction and limit the licensing based on that is inequitable. To add to what another commentor mentioned - I graduate with my MA in Counseling in 1993 - long before CACREP had increased their requirements to 60 credits and before most programs even thought of anything but regional accreditation. This not only punishes those who graduate now, but those who	3/24/22 3:16 pm CommentID:120860

		graduated years ago. This field and our state needs to be more inclusive not exclusive.	
Debra Mollen	Stop the CACREP Monopoly	I add my strong opposition to the the current proposal that would unfairly and discriminatorily penalize professionals who graduate from non-CACREP-accredited programs. This proposal is not based on any scientific data that suggests licensed counselors educated in CACREP-accredited programs are in any way better prepared, trained, or equipped to serve in their roles than those from non-CACREP-accredited programs. Moreover, adding superfluous obstacles to those who graduate from other programs is unnecessary and ultimately penalizes both those who graduated from non-CACREP-accredited programs and the Virginians they serve.	3/24/22 4:51 pm CommentID:120861
Ashley Simon - University of Baltimore	CACREP Discriminatory Practices	I am disturbed beyond words that you feel that graduates of any university that are not accredited by CACREP are somehow not worthy of practicing in the state of Virginia. There are many fabulous schools that provide extensive education in counseling and clinical psychology. I am enrolled in University of Baltimore and they offer an extensive program for graduate students, consisting of three years of education and internship opportunities. There are many universities offering fantastic programs in psychology as well as accrediting bodies that support and demand excellence in the field. I am not sure I understand your reasoning behind this discriminatory judgement, especially during times when people in our country desperately need counselors to help them deal with their problems. The number of people suffering from mental health issues is far greater than we have witnessed in the past. Psychology has come a long way in its methods and understanding of the field as a whole. Without counselors, people are dying needlessly as they suffer in silence. Now is not the time to be assuming that one accrediting body is superior to the others. Ashley Simon	3/24/22 5:01 pm CommentID:120862
Bryan Kim, Ph.D., LMHC	Please do not support this legislation	To Whom It May Concern: I'm writing in strong opposition to the provision in this law that would permit other-state licensed counselors who graduated from programs accredited by CACREP to qualify for licensure in Virginia with 3 years post-licensure experience while other-state licensed counselors who graduated from programs that are not affiliated with CACREP would need 10 years of post-licensure experience. There is no scientific evidence to support this proposed discrepancy and it is discriminatory to those who are not CACREP graduates. Most importantly, the residents of Virginia will suffer because this proposed regulation will limit	3/24/22 5:22 pm CommentID:120863

		the number of qualified licensed counseling professionals to serve individuals with mental health difficulties, particularly during a time of COVID when the mental health service needs are so great. Please do not pass this regulation. sincerely, Bryan Kim, Ph.D., LMHC	
Mary Ammon, University of Baltimore	Inclusive Licensure Requirements are a Necessity	There is no scientific evidence stating that people who do not graduate from CACREP programs are any less qualified than those who do. This mandate would greatly restrict the amount of counselors who are in the mental health field at a time when practitioners are desperately needed. This is an elitist movement to discredit those who have graduated from programs that are perfectly qualified to educate counselors just because they don't have an arbitrary badge of accreditation next to their name. Licensure requirements should be based on critical individual requirements being fulfilled by a degree program, not because it has the endorsement of an organization. This mandate cannot go through and restrict access to licensure. There is a shortage of mental health practitioners in the field and to deliberately deny perfectly qualified graduates from obtaining licensure is to the great detriment of the public that needs these mental health resources. This is an unethical mandate and should not be passed.	3/24/22 5:44 pm CommentID:120864
Pamela Foley, Ph.D., Seton Hall University	No empirical evidence to support an additional 7 years of experience for non-CACREP graduates	I am writing to urge you to reject the proposed new rule for counselor licensure, requiring graduates of programs that are accredited by organizations other than CACREP to have an additional 7 years of experience. I would like to remind the Virginia Board of Counseling that their role is to protect the public. There is no evidence to support this requirement, and it will seriously limit the availability of mental health services to Virginia residents, at a time when the need for mental health support has greatly increased. As an educator in a program that has been training counselors for responsible professional practice for decades, I cannot see this proposal as anything other than an effort by a large guild to provide its own graduates with a privileged position, at the expense of graduates of equally rigorous training programs. Please reconsider this ill-advised and clearly self-serving proposal. Thank you.	3/25/22 9:44 am CommentID:120865
Janice C Lang, LCPC	Vote against this regulation!	There is no evidence that graduates from a CACREP accredited program are any more qualified than counselors who don't. There are many universities that produce exceedingly qualified counselors, thereby invalidating the need for such a counselor to have 7 more years of experience than one graduating from a	3/25/22 11:16 am CommentID:120867

		CACREP program. In addition, by enacting such legislation, you are artificially limiting the resources and possibilities that citizens of VA have when looking for mental health help. Not only are you limiting the options for your citizens, you are doing so during a time of greatly increased need. Vote no on this regulation and vote for inclusion of all counselors!	
Avi Pear - University of Baltimore	Of all times to restict license portability...	...now is NOT the time. Other commenters have raised valuable points against the merits of CACREP accreditation. To reiterate some, there is little research suggesting that CACREP accreditated counselors provide better care than non-accreditated counselors; CACREP's standards seem arbitrary and are hard to justify; CACREP does not recognize the value of counseling psychology. However, I'd like to emphasize a different aspect. During this difficult post-pandemic time, mental health practitioners are in high demand and many clinics have long waiting lists. The state of Virginia itself has a shortage of mental health providers (see here, here, here) According to NAMI, 22% of Virginians were unable to receive mental health care in February 2021. 56% of children 12-17 with depression were unable to receive treatment as well over the past year. By requiring CACREP accreditation, these numbers are sure to increase. Any additional protection to the public that CACREP accreditation purports is likely to be canceled out by the damage of restricting the number of therapists.	3/25/22 5:04 pm CommentID:120869
Azara Santiago Rivera, Ph.D.	In Opposition of the Differential Treatment Suggested in the Proposal	I am in full support of interdisciplinary cooperation and counselor license portability. Suggesting that licensed professional counselors who are graduates of CACREP accredited programs require only three years of post-licensure experience, whereas licensed professionals who are graduates of other counseling training program must have seven years of post-licensure experience is an example of unfounded differential treatment. This is clearly exclusionary. There is no evidence that licensed counselors from CACREP programs are better prepared than counselors who are graduates of other counseling programs. At a time of great need for mental health services in this country we should be working collaboratively across all counseling programs to train competent counselors, and facilitate licensure acquisition rather than engage in such divisiveness.	3/25/22 5:08 pm CommentID:120870
Autumn Boyle, University of Baltimore	You're Making the Mental Health Crisis Worse	As a graduate student on track for licensure in clinical professional counseling in the state of Maryland who will actively seek to get licensure in Virginia (so I can work in the DMV), this proposal seeks to make the current mental health crisis *much worse* in the state of Virginia. There is no empirical evidence to support that graduates of CACREP-accredited institutions are more qualified or prepared for licensure in the state of Virginia than graduates from, say, MPCAP-accredited	3/25/22 10:12 pm CommentID:120871

		institutions. With this proposal, the state of Virginia is severely restricting the number of counselors who may apply for licensure in the state of Virginia in the coming years. Why? There are only *three* CACREP-accredited clinical mental health counseling programs in the entire state of Maryland, none of which are in the DMV area. That means the graduates from Maryland clinical mental health counseling programs most likely to want to apply for licensure in the state of Virginia in the coming years would have to wait an *entire decade* to qualify. How on earth could this be considered a solution for the current mental health crisis in the state of Virginia? Make access to licensure equitable for *all* qualified mental health professionals, and put this decades-long feud between the American Counseling Association (who, without evidence, insists their accrediting body is superior) and the American Psychological Association to rest.	
Sr. Catherine Waters, OP, PhD, Professor Emerita, Caldwell University, Cald	Regulations Governing the Practice of Professional Counseling [18 VAC 115 ? 20]	Research has indicated that there is no identifiable difference in the preparation or competence between graduates of CACREP-accredited Counseling Programs and those from programs which did not choose to apply for this accreditation. There is no rationale therefore to create these stringent standards for graduates from the latter group. Please reconsider.	3/27/22 3:20 pm CommentID:120874
Jessica Martin, PhD; University at Albany-SUNY	IN OPPOSITION	*I'm writing to express my **opposition** to this endorsement proposal that would require licensed counselors from non-CACREP programs be required to show 7 more years of experience than their peers who graduated from CACREP programs. There is **no documented evidence** that licensed counselors who graduated from programs accredited by CACREP are better prepared than their peers who graduated from other programs. This proposal would **harm the public** by unnecessarily limiting the number of licensed counselors who would qualify for licensure (and therefore professional counseling work) in Virginia at a time when the people of Virginia need greater, not reduced, access to mental health care.*	3/28/22 9:49 am CommentID:120877
Anonymous	Opposition	I'm writing to express my **opposition** to this endorsement proposal that would require licensed counselors from non-CACREP programs be required to show 7 more years of experience than their peers who graduated from CACREP programs. There is **no documented evidence** that licensed counselors who	3/28/22 9:52 am CommentID:120878

		graduated from programs accredited by CACREP are better prepared than their peers who graduated from other programs. This proposal would **harm the public** by unnecessarily limiting the number of licensed counselors who would qualify for licensure (and therefore professional counseling work) in Virginia at a time when the people of Virginia need greater, not reduced, access to mental health care.	
Joseph Hammer, PhD, LP	Oppose this discriminatory regulatory action	This regulatory action would harm Virginians, who need greater access to qualified (i.e., already licensed) counselors, not lesser access. There is no documented evidence that licensed counselors from CACREP programs are better prepared than licensed counselors from programs accredited by other accrediting bodies such as MPCAC. So why give special treatment and create an arbitrary caste system to one group of professionals over another? And for anyone that cares about market access, fostering competition, and a healthy free market economy, this makes even less sense.	3/28/22 10:00 am CommentID:120880
Lynn Gilman	OPPOSE	*I'm writing to express my **opposition** to this endorsement proposal that would require licensed counselors from non-CACREP programs be required to show 7 more years of experience than their peers who graduated from CACREP programs. There is **no documented evidence** that licensed counselors who graduated from programs accredited by CACREP are better prepared than their peers who graduated from other programs. This proposal would **harm the public** by unnecessarily limiting the number of licensed counselors who would qualify for licensure (and therefore professional counseling work) in Virginia at a time when the people of Virginia need greater, not reduced, access to mental health care.*	3/28/22 10:07 am CommentID:120881
Alex Fietzer, PhD	Oppose proposed legislation requiring non-CACREP counselors to obtain 7 more years of experience	I'm writing to express my opposition to the Virginia Board of Counseling's current proposal that would require licensed counselors who graduated from CACREP-accredited programs to only require three years of post licensure experience whereas licensed counselors from non-CACREP-accredited programs would require ten years of post licensure experience. There is no current evidence that counselors graduating from CACREP-accredited programs are better prepared than their peers who graduated from other programs. Given the immense need for affordable mental health that licensed professional counselors can provide, this proposal risks harming the public good by limiting the number of licensed counselors who would qualify for licensure (and, therefore, professional counseling work) in the state of Virginia.	3/28/22 10:18 am CommentID:120882
Sally S	Oppose this baseless and prejudicial regulation	*I'm writing to express my **opposition** to this endorsement proposal that would require licensed counselors from non-CACREP programs be required*	3/28/22 10:20 am CommentID:120883

		*to show 7 more years of experience than their peers who graduated from CACREP programs. There is **no documented evidence** that licensed counselors who graduated from programs accredited by CACREP are better prepared than their peers who graduated from other programs. This proposal would **harm the public** by unnecessarily limiting the number of licensed counselors who would qualify for licensure (and therefore professional counseling work) in Virginia at a time when the people of Virginia need greater, not reduced, access to mental health care.* *Don't pander to CACREP guild interests - keep the well-being of the people of Virginia first!*	
Timothy Melchert	In Opposition	I am **strongly opposed** to this endorsement proposal that would require licensed counselors who graduated from non-CACREP programs to have 7 more years of professional experience than their peers from CACREP programs. There is no research evidence to support this requirement and the proposal is a highly unusual attempt to discriminate against programs not affiliated with CACREP. This proposal would **harm the public** by unnecessarily limiting the number of licensed counselors in Virginia at a time when there is a shortage of licensed behavioral health treatment professionals. It would also be embarrassing for the State of Virginia to impose such a discriminatory requirement.	3/28/22 10:28 am CommentID:120884
D ja Fitzgerald, M.Ed.	Opposition	I'm writing to convey my **opposition** to this endorsement proposal that would require licensed counselors from non-CACREP programs be required to show 7 more years of experience than their peers who graduated from CACREP programs. There is **no documented evidence** that licensed counselors who graduated from programs accredited by CACREP are better prepared than their peers who graduated from other programs. This proposal would **harm the public** by unnecessarily limiting the number of licensed counselors who would qualify for licensure (and therefore professional counseling work) in Virginia at a time when the people of Virginia need greater, not reduced, access to mental health care. I would hope that any policy change would stem from a data-informed position.	3/28/22 10:51 am CommentID:120886
Nathan Grant Smith, Ph.D.	Opposed to proposed requirements for licensed counselors	As a graduate of a Virginia university (Ph.D., Virginia Commonwealth University, 2002), I am writing to express my opposition to this endorsement proposal that would require licensed counselors from non-CACREP programs be required to show 7 more years of experience than their peers who graduated from CACREP programs. There is no documented evidence that licensed counselors who graduated from programs accredited by CACREP are better prepared than their peers who graduated from other programs. This proposal would harm the public by unnecessarily	3/28/22 11:02 am CommentID:120887

		limiting the number of licensed counselors who would qualify for licensure (and therefore professional counseling work) in Virginia at a time when the people of Virginia need greater, not reduced, access to mental health care.	
Robert A. Byrom Jr., PhD	Discriminatory CACREP Proposal	*I'm writing to express my **opposition** to this endorsement proposal that would require licensed counselors from non-CACREP programs be required to show 7 more years of experience than their peers who graduated from CACREP programs. There is **no documented evidence** that licensed counselors who graduated from programs accredited by CACREP are better prepared than their peers who graduated from other programs. This proposal would **harm the public** by unnecessarily limiting the number of licensed counselors who would qualify for licensure (and therefore professional counseling work) in Virginia at a time when the people of Virginia need greater, not reduced, access to mental health care.* There are a considerable number of alternatives (identified in other messages related to this very issue) that would add value to VA's mental health practitioner pool as contrasted with the loss of value that this proposal would create.	3/28/22 11:36 am CommentID:120888
Jennifer M. Taylor, Ph.D., Associate Professor and Training Director	In Opposition	I am writing to express my **opposition** to this endorsement proposal that would require licensed counselors from non-CACREP programs be required to show 7 more years of experience than their peers who graduated from CACREP programs. There is **no documented evidence** that licensed counselors who graduated from programs accredited by CACREP are better prepared than their peers who graduated from other programs, particularly as there are other national accrediting bodies (e.g., MPCAC, which is a CHEA-recognized accrediting organization) that prepare students with rigorous training standards. Many MPCAC programs (ours included) meet and exceed CACREP's training requirements, with the sole exception that the Ph.D. degrees of our faculty are in Counseling Psychology rather than Counselor Education. This proposal would **harm the public** by unnecessarily limiting the number of licensed counselors who would qualify for licensure (and therefore professional counseling work) in Virginia at a time when the people of Virginia need greater, not reduced, access to mental health care.	3/28/22 11:40 am CommentID:120889
Katharine Shaffer, PhD	OPPOSE proposed regulatory change regarding licensure by endorsement	This issue has been raised (and struck down) again and again in Virginia. No evidence exists that counselors trained in CACREP programs are superior *in any way* to counselors trained in programs accredited by MPCAC (recognized by CHEA as accrediting science-based counseling programs) or programs that remain unaccredited but have nonetheless been graduating license-eligible counselors for many decades. Many of	3/28/22 11:44 am CommentID:120890

		these programs actively choose *not* to pursue CACREP accreditation due to values differences or because of the discriminatory hiring practices for counselor educators only as core faculty in CACREP programs (yes, the 50% core faculty rule exists, but almost no program can afford to double its faculty to satisfy this inane requirement, which coincidentally works *against* a multidisciplinary approach to training and mental health care). None of CACREP's attempts to legitimize itself as the sole authority on counselor education are based in empirical fact and none are actually working on behalf of the *public*, which *is* the role of the regulatory board. At a time when mental health needs are at an all-time high, this attempt to prioritize CACREP graduates in practice (based on not a shred of evidence) is not only tone deaf, but dangerous for the mental health of Virginians who desperately need care from duly trained, licensed and experienced therapists, many of whom *did not and will not graduate from CACREP* programs.	
Anonymous	OPPOSE this legislation!		3/28/22 12:30 pm CommentID:120892
Rosie Phillips Davis	Regulations Governing the Practice of Professional Counseling [18 VAC 115 ? 20]	At a time of a crisis in mental health in our country the last thing we need is an act limiting the practice on a counselor for 7 years because they are not from a CACREP school. Where is the evidence for such a recommendation? It does not exist. I actually wish that even in the accredited programs individuals would have more training.	3/28/22 12:32 pm CommentID:120893
Mary O'Leary Wiley, PhD	Legislation is contrary to public need: Oppose	*I am writing to express my opposition to the proposal that would require non-CACREP programs be required to demonstrate seven more years of experience than those graduating from CACREP programs. There is no documented evidence that licensed counselors who graduated from programs accredited by exclusively one group (CACREP) are better trained or perform better than those who graduated from*	3/28/22 12:39 pm CommentID:120894

		other programs. Especially in this time of huge mental health distresss post-COVID-19 (health care providers, first responders, educators, students, etc. etc.), in Virginia and beyond, I believe this proposal would harm the public by needlessly limiting the number of counselors who would quality for licensure (and therefore professional counseling work) in Virginia.	
Brooke Rappaport	Oppose this legislation	I'm writing to express my opposition to this endorsement proposal that would require licensed counselors from non-CACREP programs be required to show 7 more years of experience than their peers who graduated from CACREP programs. There is no documented evidence that licensed counselors who graduated from programs accredited by CACREP are better prepared than their peers who graduated from other programs. This proposal would harm the public by unnecessarily limiting the number of licensed counselors who would qualify for licensure (and therefore professional counseling work) in Virginia at a time when the people of Virginia need greater, not reduced, access to mental health care.	3/28/22 1:17 pm CommentID:120896
Tamara Kintzer, NCC, LCPC	Oppose this legislation	Good afternoon, I graduated from an CACREP Accredited University and have been in practice for at least three years now at an OMHC in Salisbury Md. I have a Co-Worker who is equally as competent and educated as I am who has worked as a Mental Health therapist for the same amount of time but did not graduate from an Accredited program. To allow me to practice and not her hurts the people we are here to serve in a time where we are most needed. Please consider opposing this limiting legislation. Thank you, Tammy Kintzer, NCC, LCPC	3/28/22 1:59 pm CommentID:120897
A. Vareschi	Oppose	I'm writing to express my strong opposition to this proposal that would require licensed counselors from non-CACREP accredited programs to be required to earn 7 more years of experience than their colleagues graduating from CACREP accredited programs. There is no evidence that licensed counselors graduating from CACREP programs are better prepared than their colleagues who graduated from others. Two of my clinical supervisors graduated from non-CACREP accredited programs and their clinical acumen has been invaluable to my development as a	3/28/22 2:07 pm CommentID:120898

		clinician. This proposal would even further limit the number of licensed counselors available to serve Virginians in a climate where mental health services are more needed than ever.	
Simone	Oppose this legislation	I graduated from a non-CACREP program. I have been practicing since 2009 and prior to my graduation from graduate school I completed 60 credits. Individuals who attended non CACREP program are just as knowledgeable and have the clinical skills to support clients. This legislation will not be helpful during the current mental health crisis.	3/28/22 2:10 pm CommentID:120899
L.R.	Oppose Legislation		3/28/22 2:17 pm CommentID:120900
Meghan Powers, LGPC	Oppose legislation	Legislation that would put the credentials of CACREP-accredited practitioners over a broader portability of licensure ultimately hurts those vulnerable populations that need support the most. Unnecessarily limiting the ability to practice based on no evidence would only limit the accessibility of therapy. The state of Virginia can and should do better for its people.	3/28/22 2:25 pm CommentID:120901
Jeffrey Taulbee, LCPC, Wayfarer Counseling	Oppose this legislation, support the Counseling Compact instead	As a Licensed Clinical Professional Counselor in Maryland, I received my training from a clinical psychology program that emphasized evidence based practice, understanding and promoting scientific research, and ethical best practices. This program was not CACREP accredited, yet I received a comprehensive and thorough training. While I admire some the goals of CACREP, there is insufficient evidence to support the notion that CACREP is the sole arbiter of qualified counselors. In this mental health crisis, when the demand for qualified therapists is higher than ever and clients are struggling to find mental health providers who are able to accept new clients, this is a very ill-advised time to pass legislation that would exacerbate this problem even more.	3/28/22 2:34 pm CommentID:120902
Anonymous	Strongly oppose inclusive	CACREP only agendas are politically motivated, we need one based on data!	3/28/22 3:03 pm CommentID:120903

	policy is a necessity		
Christopher Hall, LCPC	Strongly Oppose	Any legislation that restricts rather than broadens access to services based upon insufficient data should not go into effect. There is no evidence that clinicians from CACREP schools are better prepared than those who did not. This proposal needlessly requires people to show 7 more years of experience if they did not go to a CACREP school, in effect limiting access to services. The Counseling Compact is a better option than this proposal.	3/28/22 3:16 pm CommentID:120905
Pamela Almandrez	Not a good idea	As a Mental Health Counselor in the state of Maryland who works with the College population; many of my clients are from DC, MD, VA, NJ and NY. When my clients have to withdrawal from school due to a medical reason or are returning to their home state for the summer, it is extremely difficult to find them a psychotherapist who is able to work with them long term. I want my clients to be able to establish a relationship with a therapist in their community where they can continue getting care even post-graduation. Outside of the DMV area, it is very difficult to find providers...you have no idea how helpful telemedicine has been during the past few years of the pandemic. Suddenly we were able to connect people with the perfect therapist for them, who specialized in their needs specifically, students that were restricted to their homes due to negative home lives, were still able to receive treatment. People who were inconsistent coming to therapy in person, suddenly had a 100% show rate. Moreover, there has been a great benefit to seeing the living spaces our clients are in, we are able to see just how bad their depression has become, we are able to see that they are unable to get out of bed, but still making the motivation to come to therapy because we are the only people who have not given up on them. Moreover, if individuals who were able to get help, no longer can receive services due to the state lines, where does that leave them? Who is going to help them? It is unethical to leave people without the care they need. Furthermore, the licensing restrictions in the VA make it really difficult for anyone with an out of state license to transfer their license over, so it sounds like VA will lose a lot of mental health care for their citizens and given the drastic increase in depression rates across America...this is not the time to pull back.	3/28/22 3:27 pm CommentID:120906
Kayla Watson, University of Baltimore	Strongly Oppose	I'm writing to express my strong **opposition** to this endorsement proposal that would require licensed counselors from non-CACREP programs to be required to show 7 more years of experience than their peers who graduated from CACREP programs. There is **no evidence** that licensed counselors who graduated from programs accredited by CACREP are better prepared than their peers who graduated from other	3/28/22 3:31 pm CommentID:120907

		programs. This proposal would **harm the public** by unnecessarily limiting the number of licensed counselors who would qualify for licensure in Virginia at a time when the people of Virginia need greater, not reduced, access to mental health care.	
Debra Ament, LCPC	counseling compact and reciprocity	Please allow reciprocity and equal licensing across the state line with Maryland. We all have many clients who work for the government and move back and forth across Maryland, DC and Virginia, and we need to offer these clients services without restrictions. All Masters level clinicians are trained and capable of working with clients in the region. Why would you put restirctions on any license from another state. At some point in time it would be nice to come together and have one national license for all Masters level counselors. And as of this date- more than half of my clients are still being seen through telehealth.	3/28/22 3:33 pm CommentID:120908
Gabrielle Shirdon, LCPC	Oppose Legislation	CACREP programs were just getting started when I was in graduate school, I started graduate school in 2009. The school I went to was CACREP aligned and I had to meet the same educational requirements that were required by CACREP, at that time. In order to get licensed you have to show proof that you took specific courses. That means if a counselor has all the required courses (60 credits) to get a license then they are qualified whether they went to a CACREP accredited school or not. Clinicians that have 60 credits and 3 years of experience have the same qualifications regardless of whether the program was accredited by CACREP. Clinicians with more experience shouldn't be excluded because they did graduate school before CACREP was a thing. It doesn't make us less qualified clinicians. We have also done more training since licensure.	3/28/22 3:34 pm CommentID:120909
Michael R. Marshall	I oppose this proposal	As a resident of Maryland--a state with close ties to and a border with Virginia--I and many I know will be affected as we seek mental health care close to where we work and when we must travel. As such, I strongly oppose this proposal. It would be unfair and discriminatory against non-CACREP program graduates. There is no evidence that licensed counselors from CACREP programs perform any better than those from other programs. This is a thinly veiled attempt by CACREP to create a cartel that would hurt the people who need qualified counselors the most. All licensed counselors should be accorded the same status and treatment. Regulators need to ensure that as many qualified professionals as possible	3/28/22 3:39 pm CommentID:120910

		are available to meet the growing demand for mental health therapy. This proposal will work against those goals and only cause confusion and suffering. Thank you.	
Boston College	Reg Amounts to Restraint of Trade, At Odds w/ FTC and DOD Recommendations, Unneceessary	The proposed regulation amounts to **restraint of trade**. Licensed counselors who'd bring knowledge and skill to VA in order to serve the public would be restricted from professional practice for 10 years post-license at a time when there are **public health and labor force crises**. Qualified applicants would be unable to practice, earn a living, and pay taxes in VA **based upon an unproven implication** that CACREP trained counselors are competent in 3 years, but others are not competent for 10 years. Most importantly, **the public would be harmed** by limited access to competent counselors at a time of crisis and by limited competition. The legislature in Florida recently passed legislation to eliminate a similarly restrictive law involving the educational requirements of counselors (see **FLA SB 566:** Mental Health Professional Licensure). The regulation is also **unnecessary**. There is a national legislative initiative underway (with the support of the ACA and AMHCA) to establish interstate compacts with the **reasonable universal license portability standard of 3-years post-license practice.** The **Dept of Defense** offered support for such interstate compacts to protect the spouses of active duty personnel who are harmed by restrictive trade practices. The FTC issued a 2018 report (which cited the DoD) that is also in favor of the interstate compact as the most efficient and effective way to resolve this issue. **In sum, the proposed regulation amounts to restraint of trade and is unnecessary.**	3/28/22 3:53 pm CommentID:120911
Wendy Meltzer, LPC	Oppose this regulation and support Counseling Compact	*I'm writing to express my **opposition** to this endorsement proposal that would require licensed counselors from non-CACREP programs be required to show 7 more years of experience than their peers who graduated from CACREP programs. This proposal would **harm the public** by unnecessarily limiting the number of licensed counselors who would qualify for licensure (and therefore professional counseling work) in Virginia at a time when the people of Virginia need greater, not reduced, access to mental health care. The Counseling Compact will increase access to necessary care.*	3/28/22 3:57 pm CommentID:120912
Rebecca M Schaffner	Strongly Opposed	As a therapist with over 7 years of experience I strongly oppose this! The mental health state of this nation is terrible and by implementing such discriminatory CACREP vs not and other issues we are severely limiting the mental health services for our	3/28/22 4:00 pm CommentID:120913

		people. Not to mention limiting services for the undeserved and rural populations. Let's Do No Harm and Serve the Public and allow us to do so!	
Michelle Schoonmaker, LCPC - private practice	Strongly oppose	I strongly oppose this action. There is no documented evidence that licensed counselors who graduated from programs accredited by CACREP are better prepared than their peers who graduated from other programs. There needs to be licensure portability, which the Counseling Compact addresses inclusively (https://counselingcompact.org/).	3/28/22 4:15 pm CommentID:120914
Anonymous	Opposed Legislation	This legislation works under the idea that CACREP is the only accrediting body that puts out competent counselors. There are many competent counselors that have gone to other programs including programs accredited by MPCAC. If one were to look at the standards for these programs you would see much overlap and the competencies of these counselors should not be lessened due to one accrediting body. This will hurt not only future counselors, but the public in general who needs more access to mental health professionals. It has been noted by multiple sources that mental health issues are the next area that needs to be tackled, this was true prior to COVID and have only worsened since. It's important to make sure counselors are competent, but saying that only CACREP counselors are competent in this amount of time is not accurate and could be harmful.	3/28/22 4:21 pm CommentID:120915
Anonymous	Oppose this legislation, support the counseling compact	The suggestion that counselors who attended non-cacrep schools are less qualified than those who did is false. My non-cacrep program integrated first hand clinical experience throughout the entire program which means I graduated with more experience and direct clinical hours than some who attended a CACREP school.	3/28/22 4:39 pm CommentID:120916
Anonymous	This is a barrier to mental health access	There is a shortage of mental health professionals and a surplus of mental health demand. The world is "on fire" and people need and are seeking help. **Enacting this legislation would reduce the number of eligible mental health professionals who can provide telehealth services in Virginia.** Non-CACREP accredited programs are valid and should not be weaponized in the form of restricted practice. Please, please reconsider. Respectfully, Shannon Graham LCPC	3/28/22 4:58 pm CommentID:120917
Catherine D NUGENT	Oppose this Legislation. Support the Counseling Compact Instead	I oppose the proposed legislation because it is precedented on an unproved claim--that graduates of CACREP-accredited programs are somehow more qualified than graduates of non-CACREP programs. There is no evidence to support this claim. Instead of this faulty framework, please support the Interstate	3/28/22 4:58 pm CommentID:120918

		Compact. This Compact would allow licensed counselors to practice across state lines, provinding services in a state in the Compact. During the pandemic, when licensure regulations were relaxed and waivers or temporary licenses easily availble, I began counseling with a client in DC. She sought my services particularly because of special expertise and training I have. When the waivers were ended, I had to refer this client to someone licensed in DC. (I am licensed in MD.) This was 6 months ago, and so far, she has not been able to find a therapist to meet her needs. This anecdote illustrates the fact that arbitrary licensure laws and regulations can run counter to a client's needs and preferences, denying a client the right to have continuity of care and choice of an expert provider who may not live in their state. Thank you for your consideration.	
Anonymous	Oppose this legislation	*I'm writing to express my **opposition** to this endorsement proposal that would require licensed counselors from non-CACREP programs be required to show 7 more years of experience than their peers who graduated from CACREP programs. There is **no documented evidence** that licensed counselors who graduated from programs accredited by CACREP are better prepared than their peers who graduated from other programs. This proposal would **harm the public** by unnecessarily limiting the number of licensed counselors who would qualify for licensure (and therefore professional counseling work) in Virginia at a time when the people of Virginia need greater, not reduced, access to mental health care.* Thank you. Licensed Clinical Psychologist	3/28/22 5:05 pm CommentID:120919
Shantisse Mason, LCPC, LCADC	Strongly Oppose	We need to ensure that everyone has opportunity for mental health services and those of us who have earned the degrees, certifications and trainings should not have restrictions to provide such service based the school/program we attended. This legislation is offensive and isolates those wanting to provide clinical services to the general public	3/28/22 5:12 pm CommentID:120920
Oppose the Legislation--Support the Counseling Compact	Oppose the Legislation & Support the Counseling Compact	There is no documented evidence to indicate that counselors who have graduated from CACREP accredited programs are better equipped to serve the public than counselors who have graduated from non-CACREP accredited programs. Despite this reality, these claims continue to be made, likely from organizations (like CACREP) who financially gain when legislation is changed to require CACREP accreditation. Over the past few years, I have witnessed the fear mongering of people and organizations that falsely claim that counselors who	3/28/22 5:20 pm CommentID:120921

		graduate from non-CACREP accredited schools pose a risk to the public as they are not as well trained. Stating that law makers must "protect the public" by ensuring that counselors have training from CACREP schools is to mislead lawmakers who have zero training in counseling for their own financial gain. At times, lawmakers make decisions with good intentions, but with zero understanding of the actual work of the professionals on the ground and/or of the implications of their decision-making. Changing legislation in support of CACREP means giving CACREP money and limiting access to much needed mental health counseling services. Rather than support CACREP, support the Counseling Compact. In doing so, you will increase access to counseling services while addressing the needs of people in modern and mobile times.	
Susan Morgan Stork, AASECT Certified Sex Therapist in MD, NM, DE	Oppose this Legislation + Support the Counseling Compact Instead - we are in crisis in Mental Health	There is no evidence to support this claim. Instead of this faulty framework, please support the Interstate Compact. This Compact would allow licensed counselors to practice across state lines, providing services in a state in the Compact. During the pandemic, when licensure regulations were relaxed + waivers or temporary licenses easily available, I began counseling a client in the DMV. She sought my services particularly because of the special expertise and training I have in Sex Therapy. When the waivers ended, I had to refer this client to someone licensed in Washington DC-- (I am licensed in MD, NM + DE.) This was 10+ months ago, and so far, this client has not been able to find a therapist to meet their specialty needs. This anecdote illustrates the fact that arbitrary licensure laws + regulations can be barriers to a client's needs and preferences, denying a client the right to have "continuity of care" and the choice of specialty provider *who may not live in their state of licensure.* Thank you for your deep consideration + attention to these mental health matters that impact EVERYONE in	3/28/22 5:20 pm CommentID:120922

		a time of a **Mental Health Crisis.**	
Suzette L Nozick	Opposition to inequitable licensure	Please allow practice across state lines. Or a movement towards that. Honestly, at this point it is the only thing that makes sense. And it is definitely best practices. Isn't that what we are supposed to be all about? Being stingy about who can and cannot care for Virginia residents is definitely NOT best practices	3/28/22 5:42 pm CommentID:120923
Anonymous	OPPOSE LEGISLATION	I strongly oppose this legislation that promotes inequitable licensure for counselors seeking licensure in VA. There is no evidence that suggests counselors who graduate from a CACREP accredited school are more prepared than counselors who attended non-CACREP schools. Creating an experience-needed disparity between counselors based on this accreditation is unethical and would create a clear barrier to access of mental health treatment in a time when mental health treatment is needed most. I recommend the Counseling Compact as a significantly better option than this proposal.	3/28/22 6:19 pm CommentID:120926
Carol Hallinan, LCPC	CACREP Measure	It's disappointing to find that so many counselors credentials are attempting to be diminished because some uneducated fools feel CACREP is the gold standard. I have been fully licensed for two years after completing a Masters in Counseling where I was well trained, offered and accepted many opportunities to hone my craft through internships, and tested for knowledge to be licensed in the SAME test taken by folks who went to a CACREP accredited school. I chose the school I went to because it matched my values, financial ability and scheduling needs at that time. Since graduating, I have become a certified trauma therapist, certified in EMDR and will be working towards my certification in psychedelic assisted therapy starting this summer. Do these mean less because I didn't attend the "right" school? I'm sorry for the people of Virginia that this is even being considered. They are no less in need of mental health assistance than others across the country but will be penalized if your board chooses to move forward with this terrible proposal. I strongly oppose this proposal and hope you are able to make good choices for the people of your state.	3/28/22 7:14 pm CommentID:120927
Anonymous	Oppose CACREP Provision	I am writing in opposition of the CACREP-exlusive provision with VA counseling license portability. In an effort to make psychotherapy more accessible during our nation's mental health crisis, this requirement would eliminate otherwise well qualified professionals to provide mental health care services to those in need. Thank you for your time and consideration.	3/28/22 8:11 pm CommentID:120928

Kevin N. Jenkins, LCPC	Strongly Oppose This Legislation	I strongly oppose this legislation. Consumers are seeking mental health services at a very high rate. Please allow licensed, competent, clinical therapists to work with these individuals.	3/28/22 8:12 pm CommentID:120929
Michael Gale, Ph.D.	Oppose	*I'm writing to express my **opposition** to this endorsement proposal that would require licensed counselors from non-CACREP programs be required to show 7 more years of experience than their peers who graduated from CACREP programs. There is **no documented evidence** that licensed counselors who graduated from programs accredited by CACREP are better prepared than their peers who graduated from other programs. This proposal would **harm the public** by unnecessarily limiting the number of licensed counselors who would qualify for licensure (and therefore professional counseling work) in Virginia at a time when the people of Virginia need greater, not reduced, access to mental health care.*	3/28/22 8:20 pm CommentID:120930
Stephanie G. Carrera, PhD, LP	Please Strongly Oppose this CACREP Proposal	*I **oppose** this endorsement proposal that would require licensed counselors from non-CACREP programs be required to show 7 more years of experience than their peers who graduated from CACREP programs. There is **no documented evidence** that licensed counselors who graduated from programs accredited by CACREP are better prepared than their peers who graduated from other programs. This proposal would **harm the public** by unnecessarily limiting the number of licensed counselors who would qualify for licensure (and therefore professional counseling work) in Virginia at a time when the people of Virginia need greater, not reduced, access to mental health care. Please strongly oppose this CACREP proposal.*	3/28/22 9:25 pm CommentID:120931
Stephanie Woodrow, LPC, Owner of the National Anxiety and OCD Treatment Cen	Opposed	With an increasing need from the public and demand on mental health clinicians, it's more important than ever that we do not add barriers to people accessing care. This will do just that. Please support the Counseling Compact and help not only Virginians, but clinicians treating patients in the state as well.	3/28/22 9:41 pm CommentID:120932
Andy suth , Adler University	Oppose Cacrep monopoly	*I'm writing to express my **opposition** to this endorsement proposal that would require licensed counselors from non-CACREP programs be required to show 7 more years of experience than their peers who graduated from CACREP programs. There is **no documented evidence** that licensed counselors who*	3/28/22 9:42 pm CommentID:120933

		*graduated from programs accredited by CACREP are better prepared than their peers who graduated from other programs. This proposal would **harm the public** by unnecessarily limiting the number of licensed counselors who would qualify for licensure (and therefore professional counseling work) in Virginia at a time when the people of Virginia need greater, not reduced, access to mental health care.*	
Simon Goldberg	Oppose legislation	I'm writing to express my **opposition** to this endorsement proposal that would require licensed counselors from non-CACREP programs be required to show 7 more years of experience than their peers who graduated from CACREP programs. There is **no documented evidence** that licensed counselors who graduated from programs accredited by CACREP are better prepared than their peers who graduated from other programs. This proposal would **harm the public** by unnecessarily limiting the number of licensed counselors who would qualify for licensure (and therefore professional counseling work) in Virginia at a time when the people of Virginia need greater, not reduced, access to mental health care. I believe this legislation represents an attempt to unfairly exclude qualified individuals from providing mental health treatment to the people of Virginia.	3/28/22 11:08 pm CommentID:120934
Melissa Ertl, PhD	Strong opposition	I strongly oppose this endorsement proposal. Not only is it unfair to require licensed counselors from non-CACREP programs to accrue 7 more years of clinical experience than their peers who graduated from CACREP programs in order to be licensed--but it is also an arbitrary and burdensome requirement that is not empirically-based and that would, without doubt, further the mental health disparities in the state of Virginia. There is no evidence that licensed counselors who graduated from programs accredited by CACREP are better prepared than their peers who graduated from other programs. At a time when licensed mental health counselors are in high need to support the mental health of the public, this proposal seeks to unnecessarily limit the number of licensed counselors who would qualify for licensure (and professional counseling work) in Virginia.	3/29/22 12:23 am CommentID:120935
Krissa Rouse, MA, LCPC	Strongly Opposed	There is **NO documented evidence that licensed counselors who graduated from programs accredited by CACREP are better prepared than their peers who graduated from other programs!** At a time when counseling services are in high demand, and those in need are struggling to find available providers, this bill will lead to greater shortages in care providers in Virginia.	3/29/22 7:38 am CommentID:120936
Noelle Benach, LCPC	I strongly oppose the proposed regulations - Put the	I strongly oppose the proposed regulations for licensure by endorsement as there is **no** documented evidence that licensed counselors who graduated from programs	3/29/22 7:59 am CommentID:120937

	needs of clients FIRST.	accredited by CACREP are better prepared than their peers who graduated from other programs. There is NO evidence that licensed counselors who graduated from programs accredited by CACREP are better prepared than their peers who graduated from other programs. This proposed legislation makes it difficult for clients to access specialized care that may not be available in their immediate vicinity, and therefor may cause significant harm to those seeking a continuation of care. Instead, I support the Counseling Compact, which accomplishes portability in an inclusive way. The Compact would allow licensed counselors to practice across state lines, providing services in a state in the Compact. I strongly urge you to consider these clients and skilled clinicians, especially during this global period of mental health crisis - and to vote **NO** to the proposed legislation. Thank you for your time and consideration.	
Cathryn Hay, PhD	Strongly opposed to this non-traditional and harmful means of accrediting unprepared individuals	This cockamany idea could only come from Virginia.	3/29/22 8:32 am CommentID:120938
mark Donovan	I oppose this legislation strongly	There is no evidence differentiating graduates of differently accredited programs from another. I own a large practice in Maryland. I was looking to open in Virginia. It this bill is passed I will cancel all plans to bring my practice to VA. There is no sense in this bill. It is purely political.	3/29/22 8:40 am CommentID:120939
Sharon S Rostosky	I oppose this regulation!!!		3/29/22 8:53 am CommentID:120940
Susan Roistacher LCPC,	CACREP requirements proposal	Strongly oppose. This proposal does not protect the public. It limits access to treatment unnecessarily,	3/29/22 9:00 am CommentID:120942

LCPCM President		without benefit to anyone.	
Ed Schultze	I strongly oppose this	I strongly oppose this	3/29/22 9:37 am CommentID:120945
Anonymous	I oppose this regulation	*I'm writing to express my **opposition** to this endorsement proposal that would require licensed counselors from non-CACREP programs be required to show 7 more years of experience than their peers who graduated from CACREP programs. There is **no documented evidence** that licensed counselors who graduated from programs accredited by CACREP are better prepared than their peers who graduated from other programs. This proposal would **harm the public** by unnecessarily limiting the number of licensed counselors who would qualify for licensure (and therefore professional counseling work) in Virginia at a time when the people of Virginia need greater, not reduced, access to mental health care.*	3/29/22 9:55 am CommentID:120947
FLERLAGE LCPC, LCADC	opposed	**I strongly oppose the proposed regulations - Put the needs of clients FIRST.** I strongly oppose the proposed regulations for licensure by endorsement as there is **no** documented evidence that licensed counselors who graduated from programs accredited by CACREP are better prepared than their peers who graduated from other programs. There is NO evidence that licensed counselors who graduated from programs accredited by CACREP are better prepared than their peers who graduated from other programs. This proposed legislation makes it difficult for clients to access specialized care that may not be available in their immediate vicinity, and therefor may cause significant harm to those seeking a continuation of care. Instead, I support the Counseling Compact, which accomplishes portability in an inclusive way. The Compact would allow licensed counselors to practice across state lines, providing services in a state in the Compact. I strongly urge you to consider these clients and skilled clinicians, especially during this global period of mental health crisis - and to vote **NO** to the proposed legislation. Thank you for your time and consideration. Debra Flerlage LCPC, LCADC	3/29/22 10:34 am CommentID:120948
Ruth Palmer, PhD, Eastern University	Strongly oppose		3/29/22 10:36 am CommentID:120949

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Christen Elizabeth Dressel	I oppose this regulation	Counselors who pursue their licensure go through rigorous steps regardless if they graduated from at CACREP program. Unless a counselor does not complete the steps for licensure or has disciplinary action there should not be any difference in steps for licensure based on where a counselor graduated from. If you meet the standards required and follow the licensing process that should be all that matters. Please do not limit the ability if people to help those in need with this regulation.	3/29/22 10:49 am CommentID:120951
Christen Elizabeth Dressel - LCPC, NCC, CCMHC	I oppose this regulation	Counselors who pursue their licensure go through rigorous steps regardless if they graduated from at CACREP program. Unless a counselor does not complete the steps for licensure or has disciplinary action there should not be any difference in steps for licensure based on where a counselor graduated from. If you meet the standards required and follow the licensing process that should be all that matters. Please do not limit the ability if people to help those in need with this regulation.	3/29/22 10:52 am CommentID:120952
Karla	Strongly Oppose	I strongly Oppose this legislation proposal.	3/29/22 11:19 am

Lawrence, LCPC, BC-TMH, CPC		There is no documented evidence that licensed counselors who graduated from programs accredited by CACREP are better prepared than their peers who graduated from other programs! In a time where there is a need for more not less qualified counselors to provide care to clients, this legislation would go against the needs of care for clients who desperately need it and I believe cause harm.	CommentID:120953
Anonymous	CACREP Rgulations	CACREP should not be required. There are so many other accredited university programs as well. I oppose this bill.	3/29/22 11:22 am CommentID:120954
Amy Price, MA, LCPC	Strongly Oppose	I join counseling professionals from across the country to urge you to stop the proposed regulations that would limit access to care for Virginia residents to only counselors who graduated from programs accredited by CACREP to qualify for licensure in Virginia with 3 years post-licensure experience, while imposing requirements of 10 years for licensed professionals who graduated from other accredited programs. CACREP is not the only accrediting body for counselor programs, and there is no documented evidence that their graduates are better prepared. Not only is this legislation discriminatory against qualified licensed counselors, it is proposed at a time when there are public health and labor force crises in behavioral health care impacting the residents of Virginia and beyond. The legislature in Florida recently passed legislation to eliminate a similarly restrictive law involving the educational requirements of counselors (see FLA SB 566: Mental Health Professional Licensure). Furthermore, there is a national legislative initiative underway (with the support of the ACA and AMHCA) to establish interstate compacts with the reasonable universal license portability standard of 3-years post-license practice. The Department of Defense offered support for such interstate compacts to protect the spouses of active duty personnel who are harmed by restrictive trade practices. The FTC issued a 2018 report which cited the DoD that is also in favor of the interstate compact as the most efficient and effective way to resolve this issue. In sum, the proposed regulation amounts to restraint of trade, is discriminatory against qualified healthcare professionals, and limits access to quality care for residents of Virginia thus making it more difficult for them to seek, obtain, and be treated for their mental health needs when they are most urgently needed.	3/29/22 11:27 am CommentID:120955
Anonymous	Oppose	Opposed to unnecessary barriers being put in place in the time of a mental health crisis in our country.	3/29/22 11:29 am CommentID:120956

Angela Keck	Oppose the proposed regulations	Oppose the proposed regulations.	3/29/22 11:36 am CommentID:120957
Kathleen Ferrara Lombardo MA, LCPC, Kathleen Ferrara Lombardo Counseling Se	oppose CACREP regulation	This is yet another attempt to make it more difficult to bring our Mental Health services when they are so needed. Instead of putting some stupid restriction in place that serves no beneficial purpose, put your focus on increased access to services.	3/29/22 11:49 am CommentID:120958
Catherine Martin-Davis, LCPC	Strongly Oppose	Strongly oppose.	3/29/22 11:54 am CommentID:120959
Katie Richard	Oppose	There is no documented evidence that licensed counselors who graduated from programs accredited by CACREP are better prepared than their peers who graduated from other programs. Requiring licensed counselors to show 7 more years of experience than their peers who graduated from programs accredited by CACREP will further limit the number of licensed professionals at a time of great need and when it is already challenging for most clients to find a therapist.	3/29/22 11:59 am CommentID:120960
Courtenay Culp, LCPC, LPC Prior ED and Past President of LCPCM	CACREP Legislation	Strongly oppose this legislation	3/29/22 12:08 pm CommentID:120961
Healing Songs Therapy	Strongly oppose	Strongly oppose this legislation!!	3/29/22 12:24 pm CommentID:120962
LaShandra C. Oliver-Moshier	During a mental health crisis we don't need arbitrary barriers put in place.	It's clear that we are in a mental health crisis. More people than ever are needing support after the last several years and choosing to create a rule that prevents therapists from practicing in the state of Virginia is the last thing we need. CACREP schools have not been shown to produce better clinicians, they just show they abide by new set of rules someone made up. tomorrow, some other accreditation board can make up another set of rules. Have a clinician apply and provide references if you want to gauge their qualifications. Basing that choice on their school is clearly just made up to put an arbitrary barrier in place that will prevent clients from getting much-needed care. You aren't guaranteeing folks good care, you're guaranteeing fewer options.	3/29/22 12:25 pm CommentID:120963
Yitzchak Feldman, University of Baltimore	Oppose	The Counseling Compact is a significantly better option than this proposal!	3/29/22 1:37 pm CommentID:120966
Jay Farris	CACREP requirement is ludicrous-strongly	The CACREP movement is another money making effort. It pushes already licensed professional counselors back to an academic environment to learn	3/29/22 2:03 pm CommentID:120967

	oppose	more theory, pay for more education, reduces the availability of mental health care providers; and for what? There is no research to indicate that the CACREP program produces better qualified, nor better professional counselors. What makes better counselors is quality supervision and experience, and further training with institutions such as the Beck Institute, Ellis Institute, Gottman Institute, etc. where counselors learn how to apply actual modalities, not just how to spell them! Put an end to this CACREP nonsense!	
Mega Gatewood	Strongly oppose - totally arbitrary distinction between CACREP and non CACREP		3/29/22 2:19 pm CommentID:120968
Nicole Johnson	I oppose this, this would further decrease access to the critical mental health care folks need	I oppose this amendment as this would further decrease access to the critical mental health care folks need. There are currently lengthy waitlists for folks to gain access to care and this not decreasing but increasing. This would create further the current mental health crisis. There is no documented evidence that licensed counselors who graduated from programs accredited by CACREP are better prepared than their peers who graduated from other programs! Why then, should the majority of licensed counselors who did not graduate from programs accredited by CACREP be required to show 7 more years of experience than their peers who graduated from programs accredited by CACREP? Why would the Commonwealth of Virginia want to unnecessarily reduce the number of licensed professionals at a time of great need? The Counseling Compact is a significantly better option than this proposal! The Alliance for Professional Counselors (APC) fully supports portability for all counselors and supports the Counseling Compact, which accomplishes portability in an inclusive way. https://counselingcompact.org.	3/29/22 2:29 pm CommentID:120969
Dr William Sharp	Opposition to monopolies and lack of evidence-based implications	I strongly oppose the distinction between CACREP and non-CACREP schools implied in this legislation. I have seen no evidence that the 2 years most masters students spend in a CACREP counseling program would be able to be licensed as a professional counselor more than three times faster than someone graduating from a regionally accredited non-CACREP program (the 3 years versus 10 years stated in the legislation). The distinction would create a monopoly for CACREP schools and the loss of a number of small colleges and university programs which have produced competent clinicians as no one would choose those schools if they had to work at diminished wages for 10 years versus 3. Inclusive and supportive alternatives are circulating nationwide now and would be a better option, i.e. interstate compacts to support license	3/29/22 2:50 pm CommentID:120970

		portability which would benefit both the public and the provider. These are supported by both professional counseling associations-- ACA and AMHCA. This legistation would amount to monopolies and has no basis in research or evidence which mental health should strive to be.	
Stephen Soldz, Boston Graduate School of Psychoanalysis	Object to CACREP Only	This proposed policy is deeply problematic and not in the interests of either the counseling profession or of Florida citizens. The counseling profession has a multiplicity of programs with varied accreditations. There is no empirical evidence that one is superior to another. Therefore, there is no rational argument for giving such extreme priority (3 years vs 10) to graduates of CACREP programs. This is simply a power grab by one segment of the profession, not a policy in the public interest.	3/29/22 3:05 pm CommentID:120971
Jessica Morrell	Opposing CACREP only!	I strongly oppose the amendment as this would further decrease access to the critical mental health care folks need. Mental health treatment is already hard to access for folks due to finances, a lack of counselors, and the public health crisis that has been ongoing. Not only is there a lack of evidence supporting the supposed superiority of CACREP-accredited graduates, but this amendment would significantly reduce the amount of clinicians that are able to provide quality care to clients that are in need of services. There are many potential clinicians from a wide range of qualified and esteemed programs that would positively impact clientele in the state of Virginia. Rather than this amendment, I strongly support the Counseling Compact. I strongly encourage the support of the Counseling Compact, which promotes accessibility and inclusive portability for potential and present clinicians. https://counselingcompact.org.	3/29/22 3:16 pm CommentID:120972
Stephen Soldz, Boston Graduate School of Psychoanalysis	Second submission, with correction	This proposed policy is deeply problematic and not in the interests of either the counseling profession or of Virginia citizens. The counseling profession has a multiplicity of programs with varied accreditations. There is no empirical evidence that one is superior to another. Therefore, there is no rational argument for giving such extreme priority (3 years vs 10) to graduates of CACREP programs. This is simply a power grab by one segment of the profession, not a policy in the public interest.	3/29/22 3:36 pm CommentID:120973
Patricia J. Simpson, LCPC, C-IAYT	trongly oppose. This proposal does not protect the public. It limits access to treatment unnecessari	As a Licensed Clinical Professional Counselor using my Maryland license for twenty years and now engaging in tele-therapy while living in Massachusetts for two years, I continue to see the range of treatment and portability needed to work with people in different states. I have been discouraged by the CACREP policies that shut out psychology from mental health. I consider the boundaries as discriminating to expertly train mental health practitioners and a negative impact on our communities across state barriers during these	3/29/22 3:54 pm CommentID:120974

		times of crisis. I support the Compact.	
Anonymous	Oppose	I strongly oppose	3/29/22 3:55 pm CommentID:120975
Anonymous	Oppose	I strongly oppose	3/29/22 3:55 pm CommentID:120976
Anonymous	Strongly Oppose	When states and organizations should be working together to facilitate mental health services to the population, why is Virginia working to limit it? That is a question that anyone who supports this bill must address.	3/29/22 4:01 pm CommentID:120977
Mollie Thorn	Strongly oppose CACREP only!	This regulation would not serve the public. It would limit the public's access to very much needed mental health services.	3/29/22 4:17 pm CommentID:120978
Aaron Brager	Opposed	There is no current evidence to support a non-CACREP accredited clinician is any less capable/competent than one with an accredited degree. That being said I have a CACREP degree and cannot say to any certainty I have had anything more in my education than others without this 'gold standard'.	3/29/22 4:23 pm CommentID:120979
Anonymous	cacrep is a company using regulatory capture to write itself into regulations for profit! Oppose!	I am an LPC in Virginia. This is a ridiculous proposal allowing private companies to influence policy for direct profit. I vehemenlty appose this process	3/29/22 4:37 pm CommentID:120980
Marli Corbett	Strongly Oppose	I strongly oppose this action as it would unfairly and unnecessarily limit access to quality mental health care in an already understaffed field. This is a time when regulatory boards should be moving **towards** portability rather than away from it. Furthermore, the inequitable treatment of licensed professionals who graduated from programs that were not CACREP-accredited is not evidence-based. Instead, please consider the the Counseling Compact, which accomplishes portability in an inclusive way. https://counselingcompact.org.	3/29/22 4:40 pm CommentID:120981
Mary Wilbanks	Oppose	This legislation does nothing but limit the public's access to what are very much needed mental health services. Also, I've been doing this work for 10yrs and have never seen how CACREP therapists are any better or better prepared than the rest of us. The research to support the legislation is based on faulty research. The conclusions are based on stated evidence that is not true. In fact given that the research results are not true, the whole research is biased and false.	3/29/22 4:41 pm CommentID:120982
Daniel Maurer	Opposed	I graduated from a master's program that was not CACREP six years ago. I obtained my LPC, LCADC, and ACS in the past six years. In working with fellow therapists and supervising therapists, I have never noticed any difference between clients from CACREP programs compared to those from other programs. In my first six years post graduation, I have had multiple people in the field comment how well trained I was in	3/29/22 6:00 pm CommentID:120984

		my education. To extend the amount of experience dramatically for non CARCEP schools is excessive and arbitrary.	
Margaret Fernan, LCPC	oppose	oppose	3/29/22 7:01 pm CommentID:120985
Eve Adams	Strongly Oppose	*I'm writing to express my **opposition** to this endorsement proposal that would require licensed counselors from non-CACREP programs be required to show 7 more years of experience than their peers who graduated from CACREP programs. There is **no documented evidence** that licensed counselors who graduated from programs accredited by CACREP are better prepared than their peers who graduated from other programs. This proposal would **harm the public** by unnecessarily limiting the number of licensed counselors who would qualify for licensure (and therefore professional counseling work) in Virginia at a time when the people of Virginia need greater, not reduced, access to mental health care.*	3/29/22 7:09 pm CommentID:120986
Meghan Maggitti	Oppose CACREP only	I support inclusion, this measure is discriminatory against counselors! NO to CACREP ONLY!	3/29/22 7:15 pm CommentID:120987
Giovanna D	Strongly Oppose	**"I'm writing to express my strong opposition to this endorsement proposal that would require licensed counselors from non-CACREP programs be required to show 7 more years of experience than their peers who graduated from CACREP programs. There is no documented evidence that licensed counselors who graduate from programs accredited by CACREP are better prepared than their peers who graduated from other programs. This proposal may cause harm to the people of Virginia by unnecessarily limiting the number of licensed counselors who qualify for licensure (and therefore professional counseling work) in Virginia at a time when the people of Virginia need greater, not reduced, access to mental health care."**	3/29/22 8:49 pm CommentID:120988
Sue Motulsky, EdD, Lesley University	Strongly oppose	*I'm writing to express my **opposition** to this endorsement proposal that would require licensed counselors from non-CACREP programs be required to show 7 more years of experience than their peers who graduated from CACREP programs. There is **no documented evidence** that licensed counselors who graduated from programs accredited by CACREP are better prepared than their peers who graduated from other programs. This proposal would **harm the public** by unnecessarily limiting the number of licensed counselors who would qualify for licensure (and therefore professional counseling work) in Virginia at a time when the people of Virginia need greater, not reduced, access to mental health care. CACREP wants to be the only game in town, but it is not and should not be. While it holds sway in some parts of the country, other parts such as New England, are able to train and graduate excellent mental health counselors*	3/29/22 11:41 pm CommentID:120989

		(some of the best in the US) in non-CACREP programs. There are other accrediting groups that also exist and no one player should be a monopoly--just like anti-trust movements. All qualified accredited programs and graduates should be treated the same under the law and by various states.	
Spring Oak Psychological Services	Strongly Oppose CACREP Exclusivity Legislation	Here we go again! CACREP trying to "sneak into" exclusivity status in Virginia. We are in a mental health pandemic! Now is not the time to be restricting access to qualified, competent mental health/professional counseling services. Additionally, we are in a desperately needed and long overdue time of inclusion, not exclusion of those who don't meet certain "standards" as CACREP is attempting to do. It is offensive to be viewed as inferior by these power hungry exclusivists. Regionally accredited graduate counseling programs (and thus their graduates) have been vetted by the regional accrediting bodies where their programs are located. Do we give higher status to certain doctors, nurses, social workers, lawyers, accountants, engineers, etc who graduate from graduate schools that have joined "trumped up" accrediting organizations? Not that I am aware of. The accrediting agencies that accredit these programs are the duly appointed agencies for their professional specialties in their regions. There are no competing accrediting agencies for these graduate schools. Why do we let the manipulative, power seeking CACREP attempt to "dupe" us! We're too smart for that, aren't we?	3/30/22 12:36 am CommentID:120991
Anonymous	OPPOSE	OPPOSE	3/30/22 9:40 am CommentID:120992
Emily Bullock Yowell, PhD University of Southern Mississippi	Strongly Oppose	The proposed regulations in Virginia to require 10 years of practice post-degree for individuals graduating from programs not affiliated with CACREP (such as programs accredited by MPCAC) while only requiring a more standard 3 years of those graduating from CACREP programs is overly restrictive, not based on evidence, and increases disparity in access to mental health assistance. In a period of mental health crisis in our country, placing additional restrictions on the practice of mental health practitioners in the wrong move. Let's focus on legislation that provides additional access to mental health care for Virginians rather than serving the agenda of well-funded lobbying groups.	3/30/22 11:33 am CommentID:120993
Anonymous	Strongly Oppose	*I'm writing to express my **opposition** to this endorsement proposal that would require licensed counselors from non-CACREP programs be required to show 7 more years of experience than their peers who graduated from CACREP programs. There is **no documented evidence** that licensed counselors who graduated from programs accredited by CACREP are*	3/30/22 11:36 am CommentID:120994

		*better prepared than their peers who graduated from other programs. This proposal would **harm the public** by unnecessarily limiting the number of licensed counselors who would qualify for licensure (and therefore professional counseling work) in Virginia at a time when the people of Virginia need greater, not reduced, access to mental health care.*	
Meg Connor	Strongly Oppose	*I strongly **oppose** this proposal because it requires licensed counselors from non-CACREP programs be required to show 7 more years of experience than their peers who graduated from CACREP programs. There is **no documented evidence** that licensed counselors who graduated from programs accredited by CACREP are better prepared than their peers who graduated from other programs. This is a marketing ploy by CACREP! At a time when mental health counseling services are needed more urgently than ever, this proposal would **harm the public** by unnecessarily limiting the number of licensed counselors who would qualify for licensure (and therefore professional counseling work) in Virginia.*	3/30/22 11:59 am CommentID:120997
Amy Moulton, LPC	Strongly Oppose: Please Do Not Restrict Mental Health Services	I wish to express my strong opposition to the endorsement proposal requiring graduates from non-CACREP programs to provide evidence of an additional seven years of training beyond what is required of their CACREP peers. This is an absolutely absurd regulation, there is no reason to require additional supervision that is **more than twice** the length of masters level graduate counseling programs. 1. There is no evidence that is not provided by CACREP which indicates that non-CACREP programs (and MPCAC or APA programs specifically) are inferior and do not appropriately train their graduates to work in the field. Evidence that is provided by CACREP has to be viewed through an appropriate lens of skepticism. 2. I cannot think of an elected public service official who has not acknowledged the increased need for mental health and substance use professionals within their community. This proposal disincentivizes and creates a barrier for those who would provide those services. There are limitations to the places that non-licensed mental healthcare professionals can work, limitations to the amount of money they can earn, and limitations to the populations they can work with. These limitations are appropriate as part of our training, however it is completely unreasonable to expect someone to spend **the better part of a decade** in that position. When the number of people in the mental healthcare field already have extremely high rates of burn out, why would we put in place regulations to	3/30/22 12:12 pm CommentID:120999

		make the job more inaccessible? There will be less people to provide the services that are needed, which leads to an overwhelmed system and higher rates of suicide, overdose, incarceration, and CPS involvement. 3. CACREP requires that the colleges and universities core faculty (all the professors) have a PhD from a CACREP-accredited program. I can understand reading this and going, "Yes, that's fine," however, if we consider that this endorsement would essentially require every counseling student to attend a CACREP institution or start out at a disadvantage to all their peers, this acts as a barrier for completely qualified educational counseling professionals. An APA accredited Counseling Psychology program likely has a number of experienced, talented, and qualified staff who also graduated from APA accredited programs. CACREP will freeze out faculty that may be very good educators and great clinicians with a lot of relevant expertise and they do so to advance CACREP as an organization NOT because someone with a PhD in Counseling Psych is unqualified to teach Masters Counseling students (they are absolutely are). I realize I have written a lot for you to read, however I sincerely hope you take the time to consider the information provided here. While this may seem a small matter to you, this would negatively impact potential future counselors, current counseling students who had the misfortune to pick a university that is fully accredited but does not have lobbyists, counseling professionals who provide education and supervision to the next generation, and, most importantly, the people who need the healthcare services that are provided by licensed counselors. Please, I urge you with all sincerity to reconsider this proposal. There are so many barriers to access of healthcare and none of these will be better addressed by what is being suggested. I thank you for your consideration of what I have written.	
Anonymous	Strongly Oppose	I strongly oppose this proposal as there is no evidence to suggest that licensed counselors who graduate from non-CACREP programs are less prepared than those who graduate from CACREP programs. Further, this will create harm to the general public by reducing the number of providers at a time when mental health counseling is much needed.	3/30/22 12:40 pm CommentID:121000
Susan Woodhouse, Ph.D.	Strongly Oppose	This is a harmful idea that would needlessly limit the mental health services available to the people of Virginia and would result in the groundless restraint of trade. Licensed counselors contribute in important ways	3/30/22 1:04 pm CommentID:121001

		to public health and mental health, and CACREP seeks to restrict duly trained professional counselors from being able to serve the people of Virginia for 10 years, under the mistaken notion that those trained in accredited programs outside of the CACREP system need additional practice post-training (10 years as compared to 3 years for CACREP). This is patently false. There are other accrediting bodies that legitimately provide OUTSTANDING training for licensed professional counselors. There is absolutely no evidence that counselors educated in CACREP-accredited programs are better prepared than professional counselors that are educated in MPCAC-accredited programs. It is time for the public and lawmakers to be aware of the fact that CACREP is attempting to create a CACREP monopoly by falsely implying that there is only one legitimate way to accredit professional counseling program. This is simply not true. The public would be harmed by this baseless restraint in trade that would limit access to needed treatment by the public in Virginia. This would harm the citizens of Virginia. Other states have recently passed legislation to get rid of restrictive laws much like this current proposal. For example, see FLA SB 566 (Mental Health Professional Licensure). There is a national legislative initiative, which is supported by the professional organizations for Professional Counselors, to develop interstate compacts with a reasonable universal license portability standard of 3-years post-license practice. The Department of Defense has supported the idea of such interstate compacts. Moreover, the FTC issued a report in 2018--citing the Department of Defense--saying that the FTC also supports interstate compacts as a way to efficiently and effectively resolve this issue and avoid unnecessary restraint of trade. There is nothing wrong with CACREP accreditation. However, CACREP is not the only strong accrediting body in our nation. Another important accrediting body is MPCAC--which stands for Master's in Psychology and Counseling Accreditation Council (http://mpcacaccreditation.org). Other professional organizations are likely to create strong accreditation standards as well. There is no reason to limit practice based on CACREP, because the public health is also well-served by these other accrediting bodies.	
Deparment of Counseling and Psychology, Lesley University	Strongly oppose		3/30/22 1:14 pm CommentID:121002

Julie V. Battle, Ph.D.	Strongly Oppose	The proposed regulations in Virginia to require 10 years of practice post degree for individuals graduating from programs not affiliated with CACREP (such as programs accredited by MPCAC) while only requiring 3 years of practice post-degree for individuals graduating from CACREP programs are overly restrictive and not based on any evidence. MPCAC requirements are comparable to CACREP requirements and add an emphasis on making sure services provided are empirically based. The mission of MPCAC is to "provide science-based education and training in the practice of counseling and psychological services at the master's degree level, using both counseling and psychological principles and theories as they apply to specific populations and settings" (http://mpcacaccreditation.org/). There are 59 programs across 23 states accredited by MPCAC, with 9 additional programs currently under review. Virginia is ranked 39th in access to mental health care (https://mhanational.org/issues/2021/ranking-states#four). The proposed regulations will deter students from MPCAC-accredited programs from moving to and practicing in Virginia. This is not good for the state, is not based in research, and is a restriction of trade that will likely result in legal challenges.	3/30/22 2:00 pm CommentID:121004
Anonymous	Strongly oppose	There is already a great deficit in the mental health world. There are not enough Therapists and we are in a true mental health crisis. To make it more difficult for Therapist to provide as many devices to as many clients as possible in a day would cause the crisis to increase further.	3/30/22 2:36 pm CommentID:121005
Anonymous LPC	Strongly Oppose CACREP Licensing Restrictions	This proposal places significant limitations on access to (and continuity of) care for individuals seeking mental health services. We are in the midst of a mental health crisis where providers are at max capacity and clients are needing to wait months in order to connect with necessary services. By placing limitations on licensure based off of arbitrary statements that CACREP status deems an individual more qualified to provide services, you are placing undue stress on an already maxed out system. I strongly oppose the proposed regulations for licensure by endorsement.	3/30/22 4:26 pm CommentID:121007
Anonymous	Strongly oppose	Strongly opposed. This is a superfluous measure, with no evidence to back the action.	3/30/22 4:58 pm CommentID:121009
Elizabeth Gil,	Opposed	There is **NO documented evidence that licensed**	3/30/22 5:01 pm

LCPC		**counselors who graduated from programs accredited by CACREP are better prepared than their peers who graduated from other programs!** At a time when counseling services are in high demand, and those in need are struggling to find available providers, this bill will lead to greater shortages in care providers in Virginia.	CommentID:121010
Anonymous	Strongly Oppose	I strongly oppose the proposed legislation, which supports CACREP-only licensure due to the false assumption that CACREP graduates are better off or more qualified than their peers who attended non-CACREP programs. These types of legislations perpetuate the national mental health provider shortage, which in turn will lead to an increase in clients in crisis (such as ER visits and psychiatric hospitalizations) and an increase in untreated mental health issues. Instead, I urge legislators to consider the Counseling Compact instead, which is more inclusive and streamlined for providers and offers clients more options.	3/30/22 5:33 pm CommentID:121012
Michael Saferin-Reed, M.S. NCC LCPC (Maryland)	Strongly Oppose	Given the need for more counselors and access to mental health services, this bill needs to be amended.	3/30/22 5:40 pm CommentID:121013
Elizabeth Barragato	Strongly oppose	*I'm writing to express my **opposition** to this endorsement proposal that would require licensed counselors from non-CACREP programs be required to show 7 more years of experience than their peers who graduated from CACREP programs. There is **no documented evidence** that licensed counselors who graduated from programs accredited by CACREP are better prepared than their peers who graduated from other programs. This proposal would **harm the public** by unnecessarily limiting the number of licensed counselors who would qualify for licensure (and therefore professional counseling work) in Virginia at a time when the people of Virginia need greater, not reduced, access to mental health care.*	3/30/22 5:54 pm CommentID:121014
Anonymous	Strongly oppose	Strongly oppose	3/30/22 6:33 pm CommentID:121015
Darryl Webster, LCPC	Oppose	Given that I graduated from a university that is now CACREP accredited, but was not CACREP accredited when I attended a few years ago, it makes no sense. What have I been doing for the last several years? This is what I call buffoonery.	3/30/22 6:36 pm CommentID:121016
Anonymous	Strongly Oppose	I strongly oppose this action. There is no documented evidence that licensed counselors who graduated from programs accredited by CACREP are better prepared than their peers who graduated from other programs. There needs to be licensure portability, which the Counseling Compact addresses inclusively (https://counselingcompact.org/).	3/30/22 6:42 pm CommentID:121017
Michael	Opposition from	The CACREP is not the first organization who has	3/30/22 8:08 pm

Moates, MA, QBA, LBA, QMHP-T/R	Global Institute for Behavior Practitioners and Examiners - Duplicate Discussion	tried to write itself into the law. A similar thing is happening right now in the Commonwealth Board of Medicine - Behavior Analysts where the BACB is trying to make itself required for licensure and the majority of comments oppose this. Just like with the CACREP, BACB similarly thinks that it is better than everyone else and want to block off providers during the COVID 19 crisis. See: https://townhall.virginia.gov/L/comments.cfm?stageid=8872 **Michael Moates, M.A., QBA, IBA, LBA, QMHP - T/R** Doctor of Education Candidate | Fielding Graduate University Executive Director, Global Institute for Behavior Practitioners and Examiners Adjunct College Professor of Psychology, University of the People Student Health Advisory Committee, Eagle Mountain Saginaw ISD Senior Member, Civil Air Patrol, United States Air Force Auxiliary Contributor, NewsBreak Licensed Behavior Analyst, Virginia Board of Medicine Qualified Behavior Analyst - Qualified Applied Behavior Analyst Credentialing Board International Behavior Analyst - International Behavior Analysis Organization Commissioned Notary Public, Texas Secretary of State Qualified Mental Health Professional - Trainee, State of Virginia Qualified Mental Health Professional - Registrant, State of Oregon Non-Violent Crisis Intervention Certified - Crisis Prevention Institute	CommentID:121021

		Certified Accreditation Evaluator, Distance Education Accreditation Commission Member, Christian Counselors of Texas Member, Alonso Center for Psycho?dynamic Studies Member, Carnegie Project on the Education Doctorate Member, American Nurses Association & Texas Nurses Association Member, International Society of Psychiatric Mental Health Nurses	
Shannon Reed, LCPC	This is not right!	I strongly oppose this legislation. The world is still in crisis and people need and want help. Please don't take away some individuals only way to receive help and support that they desperately need and deserve.	3/30/22 8:18 pm CommentID:121022
Michael Moates, MA, QBA, LBA, QMHP-T/R	THIS ALREADY FAILED AND THIS IS A SNEAK ATTEMPT TO CIRCUMVENT THE WILL OF THE PEOPLE BY A NEW BOARD	THIS ALREADY FAILED AND THIS IS A SNEAK ATTEMPT TO CIRCUMVENT THE WILL OF THE PEOPLE BY A NEW BOARD. SEE: https://townhall.virginia.gov/L/viewcomments.cfm?stageid=7071	3/30/22 8:44 pm CommentID:121023
Gregory Smith, LCPC	CACREP requirement-strongly oppose	Strongly opposed.	3/30/22 8:45 pm CommentID:121024
Montgomery County Counseling Center	Oppose- The shortage of providers is already too problematic to further limit ability to access care	There is already a severe shortage of mental health care providers and it's only going to get worse in the coming years. We need ALL hands on deck, not just "CACREP" hands on deck!	3/30/22 9:07 pm CommentID:121027
Michael Misterka, LCSW-C	Strongly Oppose	Strongly Oppose this bad idea esp. now when more providers are needed.	3/30/22 9:52 pm CommentID:121028
Beverly Smith, PhD, LPC (AMHCA President & Interim CEO)	Strongly Opposed		3/30/22 10:40 pm CommentID:121029

Anonymous	Opposed	Strongly opposed! This isn't right. Too much legislation, its a mental health crisis and people need help.	3/30/22 11:23 pm CommentID:121030
Jamey Leeanne Rislin, PhD, LCSW, MSW	Strongly Opposed	*I am writing to express my opposition to this endorsement proposal that would require licensed counselors from non-CACREP programs be required to show 7 more years of experience than their peers who graduated from CACREP programs. There is no documented evidence that licensed counselors who graduated from programs accredited by CACREP are better prepared than their peers who graduated from other programs. Furthermore, many licensed counselors who graduate from programs accredited by other accreditation bodies are required to engage in several years of study and hand-ons professional experience through practicums, internships and post-doctoral studies. This proposal would harm the public by unnecessarily limiting the number of licensed counselors who would qualify for licensure (and therefore professional counseling work) in Virginia at a time when the people of Virginia need greater, not reduced, access to mental health care. It would also limit the peoples ability to have and exercise choice in the type of professionals they can contract with for services to support the community.*	3/31/22 3:11 am CommentID:121032

Anonymous	Strongly Oppose	I strongly oppose the proposed regulations and legislation. People need help more than ever during this time.	3/31/22 8:40 am CommentID:121033
L Parker	Oppose this Legislation	*I currently live in Idaho, but have family in Virginia and plan to retire there with a small private practice* *I'm writing to express my **opposition** to this endorsement proposal that would require licensed counselors from non-CACREP programs be required to show 7 more years of experience than their peers who graduated from CACREP programs. There is **no documented evidence** that licensed counselors who graduated from programs accredited by CACREP are better prepared than their peers who graduated from other programs. This proposal would **harm the public** by unnecessarily limiting the number of licensed counselors who would qualify for licensure (and therefore professional counseling work) in Virginia at a time when the people of Virginia need greater, not reduced, access to mental health care.*	3/31/22 9:02 am CommentID:121034
Anonymous	Oppose the legislation - unequal and restriction of trade	The proposed regulations in Virginia to require 10 years of practice post degree for individuals graduating from programs not affiliated with CACREP (such as programs accredited by MPCAC) while only requiring 3 years of practice post-degree for individuals graduating from CACREP programs are overly restrictive and not based on any evidence. MPCAC requirements are comparable to CACREP requirements and add an emphasis on making sure services provided are empirically based. The mission of MPCAC is to "provide science-based education and training in the practice of counseling and psychological services at the master's degree level, using both counseling and psychological principles and theories as they apply to specific populations and settings" (http://mpcacaccreditation.org/). There are 59 programs across 23 states accredited by MPCAC, with 9 additional programs currently under review. Virginia is ranked 39th in access to mental health care (https://mhanational.org/issues/2021/ranking-states#four). The proposed regulations will deter students from MPCAC-accredited programs from moving to and practicing in Virginia. This is not good for the state, is not based in research, and is a restriction of trade that will likely result in legal challenges. As an educator of counselors in South Carolina who has had graduates move to VA this would deter competent providers from practicing in your state and reduces access to care. The goal should be competence and inclusivity, not decisions based solely on one accrediting body.	3/31/22 9:14 am CommentID:121035
Anonymous	Oppose	There is no difference in competency level between	3/31/22 9:21 am

		clinicians. I strongly oppose this bill. Allow us to help everyone in need because we are qualified to do so and the people are desperately asking for it.	CommentID:121036
Anonymous	Oppose	Oppose	3/31/22 9:31 am CommentID:121037
Crystal Hank, Psy.D., LCP, The Citadel	Strongly Oppose	I strongly oppose making individuals who have a non-CACREP master degrees have to have 10 (instead of 3) years of experience post-licensure in order to be eligible for licensure in VA. I am from VA originally, and in my move to South Carolina, began teaching in the Masters in Clinical-Counseling Psychology at The Citadel (which is accredited by MPCAC). I can honestly say that this program is as rigorous as even my doctorate program was (because the courses are taught by licensed clinical psychologists). There is no reason to require more years post-licensure, because our students even before graduation have been put through a comprehensive exam, a practicum placement, and an internship experience. By the time they seek the additional hours of supervised experience for licensure in SC, they are MORE THAN well prepared to work in this field. Even having a doctorate degree myself, I find that they become amazing colleagues due to their extensive training and rigorous education, and our field placements are always eager to hire our students post graduation. There is absolutely NO evidence to suggest that MPCAC accredited programs are less than CACREP accredited programs in any way. Aren't we an evidence based field? Where is the supporting research to make such a limiting decision? Please consider this, and oppose this legislation. Kind regards, Dr. Crystal Hank, Psy.D., LP Professor of Practice, Diversity and Inclusion Coordinator for the CCP, and Field Placement Coordinator, The Citadel P:540-969-8371 E: chank@citadel.edu	3/31/22 10:53 am CommentID:121038
Marie Aleman	Strongly Opposed--Do not severely reduce/limit the number of licensed professionals available!!	The Virginia Board of Counseling's current proposal offers several options for all licensed counselors who would seek a license in Virginia. However, this proposal, like several earlier proposals, **includes an option that falsely suggests that licensed counselors who graduated from programs accredited by CACREP (who would need 3 years post-licensure experience) are more qualified than those who graduated from Non-CACREP or Counseling Psychology programs (who would need 10 years post-licensure experience).**	3/31/22 12:21 pm CommentID:121039

		There is no documented evidence that licensed counselors who graduated from programs accredited by CACREP are better prepared than their peers who graduated from other programs! **Why then, should the majority of licensed counselors in Maryland who did not graduate from programs accredited by CACREP be required to show 7 more years of experience than their peers who graduated from programs accredited by CACREP to transfer their license to Virginia to offer telehealth services? Why would the Commonwealth of Virginia want to unnecessarily reduce the number of licensed professionals at a time of great need?** The Counseling Compact (see above) is a significantly better option than this proposal!	
Dr. Pamela Rice	Support for the Counseling Compact	I would like to express my support for the Counseling Compact because it accomplishes portability in an inclusive manner. Many counselors in Maryland who graduated from a program which is not CACREP accredited are as qualified as counselors who graduated from programs which are CACREP accredited. I am in support of the Counseling Compact because it will allow qualified counselors in Maryland to provide therapy for clients in Virginia who need their services.	3/31/22 12:25 pm CommentID:121040
Anonymous	Strongly Oppose	Strongly oppose any legislation that limits a humans ability to receive care from a provider	3/31/22 12:36 pm CommentID:121041
Amy Rottier, CCS	Strongly Oppose	There is no evidence differentiating graduates of differently accredited programs from another. By creating this artificial divide you are excluding opportunities for trained, effective counselors to help Virginians. This is incredibly irresponsible, especially in the current environment.	3/31/22 12:36 pm CommentID:121042
Samantha Klunk-Nduura, LCPC	Strongly Oppose	I am strongly opposed to this current proposal that would unfairly penalize professionals who graduate from non-CACREP-accredited programs. The proposal is not based on any scientific data that suggests licensed counselors educated in CACREP-accredited programs are in any way better prepared to serve in their roles as helping professionals than those from non-CACREP accredited programs. Additionally, this adds superfluous obstacles to individuals who are seeking care.	3/31/22 12:42 pm CommentID:121043
Caitlin Cordial, LGPC, B'Well Counseling Services	Increase Access to Mental Health Services.	I urge the state of Virginia to consider the adverse impact this legislation would have on it's residents. In the midst of an ongoing mental health crisis, severely limiting the workforce of counselors by favoring those from CACREP institutions would make life saving treatment inaccessible to many individuals seeking counseling. To date, there is absolutely no empirical evidence that shows counselors from CACREP institutions perform better than those from other	3/31/22 1:01 pm CommentID:121044

		programs. Please do not create a shortage of mental health providers on your state through this legislation. Please hold compassion for your residents, particularly those who need community mental health resources. They are often helped by providers from a wide range of competent training programs outside of CACREP accreditation.	
Julie Kraus, LCPC	Oppose	This recommends implementation of more barriers for those that need behavioral health services at a crucial time	3/31/22 1:13 pm CommentID:121045
Donna Carson	Opposed	I am registered as a Supervisor for RICs and recently received a survey asking how the state can assist in getting RICs licensed sooner as there is such a shortage of practitioners that people are suffering as they cannot find therapists.	3/31/22 2:06 pm CommentID:121047
Sandra Navarra	licensure in VA	I oppose the new ruling to show preference for counselors with a degree from a CACREP institution. Thank you for your time and thoughtful consideration.	3/31/22 2:58 pm CommentID:121048
NVLPC, the Virginia Chapter of AMHCA	Strongly Oppose	As the current President of Northern Virginia Licensed Professioal Counselors (NVLPC), the Virginia Chapter of the American Mental Health Counselors Association (AMHCA), I would like to represent two categories who may be impacted by this regulation change – the Licensed Professioal Counselor (LPC) and the military spouse. Being licensed as a professional counselor is very important to me. I am a military spouse and understand the trials of being military connected and trying to continue to work in this field. While I have not personally had to move to Virginia and get licensed afterwards, I have supervised military persons who wanted reciprocity in Virginia, and military connected families who have relocated here with a license from another jurisdiction, wanting to be licensed here in Virginia. It is my belief that any board-certified discipline be held to rigorous requirements for endorsement. I strongly oppose this regulation of a 10-year wait time for endorsement. I agree with the posts that have come before mine that highlight the need for providers not going away. If we impose unnecessary restrictions, I believe we hurt this profession. I have held my license for over 15-years and am a Clinical Supervisor for the LPC and the Licensed Marriage and Family Therapist (LMFT). If I were newly licensed, or a military spouse new to this area, and read these guidelines, I would be heart sick to discover that I may have to wait a max of 10-years before I could have endorsement in Virginia. In addition, I am strongly in favor of the counseling compact which would allow for reciprocity across state lines and support the rigor demanded for this credential. I believe if we are going to support the LPC and create an equitable platform for endorsement we need to support organizations such as	3/31/22 4:04 pm CommentID:121049

		AMHCA who advocate for the counseling compact.	
Linda Bacheller, PsyD, JD	Strongly Oppose	I strongly oppose the legistlation that would discriminate against those that come from non-CACREP-program. By putting a 10-year requirement, rather that 3-year which is required for CACREP you are putting individuals in an untenable position. You can not favor one side over the other, but you MUST give equal protection. As has been commented on before, there is no empirical evidence that CACREP programs are more rigorous, or put out students that are superior to students that come from a program housed in the psychology department of a university.	3/31/22 5:48 pm CommentID:121050
Spencer Niles	Strongly support.	The opposition offers comments that seem uninformed and lacking in professional counselor identity. Unfortunately, for them, identity matters. Identity is connected to training. Counselor training and psychologist training overlap but are also distinct. Professional affiliations, history, and professional orientation differ. I wonder if the same people who are so against this are advocating for a more inclusive APA? I wonder if they are upset because APA programs DO NOT hire CACREP PhD graduates? This is an attempt at turf grabbing by those against.	3/31/22 7:02 pm CommentID:121051
Pat Doane	Strongly opposed to this legislation and strongly support COMPACT. We need more available counselors	Strongly oppose this legislation. Strongly support COMPACT. We need more available counselors, not less.	3/31/22 9:21 pm CommentID:121056
Donna Gibson	Strongly support	As an LPC in VA and SC as well as a counselor educator, I can attest the majority of LPCs with the identity of counselor graduate from CACREP-accredited programs. CACREP has been the historical standard for quality training of counselors. In fact, the American Counseling Association who initiated the counseling compact movement endorses CACREP for counselor training. The many who oppose represent well-meaning individuals who are blaming this potential requirement for limiting the number of counselors who can serve individuals. In fact, that issue is not related to CACREP or the counseling profession at all. The psychology profession, many years ago, determined that their training would be limiting to doctoral-level practitioners. There are very few masters, practice-oriented psychology programs available to students in the country. Hence, when students seek these masters programs, they are uninformed that the only available license may be an LPC. Professional counselors should not have their training and licensure dictated by another discipline. That is a primary case for my support of this legislation.	4/1/22 11:50 am CommentID:121057

Anita Neuer Colburn	Strongly Support	If we don't stand up for who we are as a unique profession, we will ultimately not be recognizable as a separate discipline. The legislation on the table increases pathways to professional counselor licensure, rather than limiting them. Professional identity requires clear boundaries around who we are and who we're not, and CACREP accreditation is one boundary that helps protect and support professional counselor identity.	4/1/22 1:29 pm CommentID:121058
Lara Peter, Congruent Counseling	strongly oppose	*I'm writing to express my **opposition** to this endorsement proposal that would require licensed counselors from non-CACREP programs be required to show 7 more years of experience than their peers who graduated from CACREP programs. As a graduate of a counseling psychology program (non-CACREP), I am as prepared as my peers from other programs to provide effective and compassionate care to my clients.*	4/1/22 2:09 pm CommentID:121060
Society of Counseling Psychology, via Kimberly Howard	Strongly oppose	The Society of Counseling Psychology (SCP) is a national organization of counseling psychologists and counselor educators that supports interdisciplinary cooperation and licensure portability. As a professional group, we are writing to express our strong opposition to a specific provision in the Virginia Board of Counseling's proposal for licensure by endorsement that we objected to in 2019 – specifically that licensed counselors from non-CACREP programs would be required to show 7 more years of experience than their peers who graduated from CACREP programs. There is no documented evidence that counselors graduating from CACREP accredited programs are better prepared for practice or more effective in their practice than counselors who have graduated from other programs. Furthermore, we strongly believe that proposal would harm the public as it would unnecessarily limit the number of licensed counselors who would qualify for licensure in Virginia and therefore the depth and breadth of the counseling workforce in the state. (and therefore professional counseling work) in Virginia. This is particularly problematic as we have seen the need for mental health services on the rise. The people of Virginia need greater, not reduced, access to mental health care. We respectfully ask that you consider how the regulations would be detrimental to the well-being of the citizens Virginia as well as to the state's economy. In our view, the Counseling Compact is a significantly better option for portability than the current (or previous) proposals.	4/1/22 3:07 pm CommentID:121062
Lara Heflin, New Mexico Highlands	Strongly oppose	The proposed regulations in Virginia (to require 10 years of practice post degree for individuals graduating from programs not affiliated with CACREP while only	4/1/22 4:53 pm CommentID:121063

University		requiring 3 years of practice post-degree for individuals graduating from CACREP programs) constitute restraint of trade, are not based on evidence, and make it more difficult for citizens of Virginia to access quality mental health care. Virginia is ranked 39th in access to mental health care (https://mhanational.org/issues/2021/ranking-states#four), and the proposed legislation would worsen access to mental health care without providing any benefits to its citizens. While it is appropriate to regulate who provides mental health services, such regulations should be based on evidence. Many mental health programs (59 programs across 23 states) in Psychology or Counseling are accredited by MPCAC (which is itself CHEA-accredited), which has similar—**and in some ways more stringent**--educational requirements as CACREP's. MPCAC requirements emphasize ensuring services provided are empirically based, and emphasize thorough training in providing services to diverse populations. The mission of MPCAC is to "provide science-based education and training in the practice of counseling and psychological services at the master's degree level, using both counseling and psychological principles and theories as they apply to specific populations and settings" (http://mpcacaccreditation.org/). The proposed regulations will deter students from MPCAC-accredited programs from moving to and practicing in Virginia. Such regulations are not based in research, only on one group of individuals trying to restrict competitors from providing mental health services. Moreover, it likely constitutes restriction of trade that could result in legal challenges.	
Anthony Isacco, PhD Chatham University	Strongly oppose	The proposed regulations in Virginia to require 10 years of practice post degree for individuals graduating from programs not affiliated with CACREP (such as programs accredited by MPCAC) while only requiring 3 years of practice post-degree for individuals graduating from CACREP programs are overly restrictive and not based on any evidence. MPCAC requirements are comparable to CACREP requirements and add an emphasis on making sure services provided are empirically based. The mission of MPCAC is to "provide science-based education and training in the practice of counseling and psychological services at the master's degree level, using both counseling and psychological principles and theories as they apply to specific populations and settings" (http://mpcacaccreditation.org/). There are 59 programs across 23 states accredited by MPCAC, with 9 additional programs currently under review. Virginia is ranked 39th in access to mental health care (https://mhanational.org/issues/2021/ranking-	4/1/22 4:58 pm CommentID:121064

		states#four). The proposed regulations will deter students from MPCAC-accredited programs from moving to and practicing in Virginia. This is not good for the state, is not based in research, and is a restriction of trade that will likely result in legal challenges.	
Anonymous	Oppose CACREP Regulation	I am writing to strongly oppose the preferential treatment of counselors from CACREP programs in the proposed regulation for licensure by endorsement. There is not evidence that CACREP graduates are better prepared than those who come from programs with other types of accreditation. Further, as a faculty person in a program that WAS CACREP and is now MPCAC accredited, I can affirm that our program is not less rigorous and we made the change due to CACREP's exclusionary practices regarding faculty degrees (Counselor Education over Counseling/Clinical/School Psychology). Our graduates have no trouble passing the NCE and typically score higher than the average. There are many regulations that protect the public health in the licensure process including required curriculum, supervised field experiences, and examination at initial licensure. This proposed regulation is not in the service of protecting the public health, but will deter licensed professionals with degrees from non-CACREP accredited programs from seeking licensure in Virginia. This is a disservice to the mental health people in your communities. This regulation will yield fewer counselors seeking licensure in your state.	4/1/22 5:23 pm CommentID:121065
Anonymous	Strongly support	CACREP programs are specifically designed to train counselors in the skills they need to provide supportive services to clients.	4/1/22 7:42 pm CommentID:121066
Anonymous, LPC	Strongly Support	Professional identity is important and CACREP establishes those boundaries to ensure clear pathways for Professional Counselors to attain licensure.	4/1/22 7:43 pm CommentID:121067
Anonymous	Strongly support	Having standardized counselor training, which is regularly controlled by an external committee, is an important ingredient for effective professional counselors. CACREP sets clear standards for the necessary counselor identity and skills to attain licensure and ensure high quality services.	4/1/22 7:45 pm CommentID:121068
Anonymous	Strongly Oppose	Although professional identity is important, this will make it difficult for people from other states to gain licensure in VA.	4/1/22 8:44 pm CommentID:121069
Amber Pope, PhD, LPC, LMHC	Strongly oppose	At a time when there is an increased need for licensed MH professionals in VIrginia to serve our communities (I live in the Hampton Roads area and many of the LPCs here have wait lists, and it can take clients months to get in for outpatient treatment), the Board of Counseling should be working towards increased reciprocity for licensure with other states. Requiring a fully licensed counselor form another state without a CACREP degree to have 7 years more experience to	4/1/22 9:04 pm CommentID:121070

		get licensed by endorsement in VIrginia vs. a fully licensed counselor with a CACREP degree contradicts efforts in the state (such as those by the VIrginia Health Care Foundation described below) to increase the number of behavioral health providers within the next few years to meet the increased need for mental health services. The proposed legislation makes it exceedingly more difficult for fully licensed counselors from other states without CACREP degrees to get licensed, even though counselors getting licensed by endorsement have to demonstrate a 60 credit hour master's degree with coursework that mirrors CACREP standards. According to a white paper from the Virginia Healthcare Foundation (accessible here: https://www.vhcf.org/data/capacity-of-virginias-licensed-behavioral-health- workforce/), Virginia faced a shortage of licensed behavioral health providers including LPCs prior to the COVID-19 pandemic. Virginia ranks 39th in the number of behavioral health providers per 100,000 residents, and 41st in behavioral health accessibility. Approximately 41% of Virginians currently live in an area designated as a Mental Health Professional Shortage Area (MHPSA) by the Health Resources and Services Administration (HRSA) as compared to 30% of citizens residing in MHPSAs in other states. Further, the number of licensed behavioral health providers in Virginia is estimated to decrease in the next 5 years due to a) attrition from the profession which has been compounded by the COVID-19 pandemic, and b) because ~32% of LPCs in Virginia are within 10 years of retirement age. Hence, an additional 200 individuals need to be licensed per year to maintain the current number of LPCs in Virginia so increasing access and pathways to licensure is necessary to maintain the behavioral health workforce capacity and increase accessibility to mental health services for Virginian residents.	
Ashley Laws	In support	I am in support of the compact- it would further the field of counseling.	4/1/22 10:53 pm CommentID:121071
Kublai Duhart LCPC	Strongly Oppose	If individuals or groups are attempting to state that CACREP accredited programs are producing graduates who should receive privileges over non-CACREP	4/1/22 11:39 pm CommentID:121072

		accredited program graduates, they should present documentation to justify their statements. Has a study been conducted to show that CACREP graduates have scored significantly higher on the National Counseling Exam than graduates/students from non-CACREP accredited programs? As a graduate of an HBCU in Virginia for my undergraduate degree and then a graduate of an HBCU in Maryland for my Master's degree, I believe in providing quality services to all clients who are ready, willing, and able to work with me. There is a possibility that the Great State of Virginia will unfortunately negatively affect its citizens in ways that will be unrecognized by the uninformed and felt individually and deeply for generations to come by many if they are unable to receive mental and emotional services by providers who they believe can best meet their needs. I am vehemently against any and all separation of licensed professional counselors in any way due to the need for professional unity within the United States of America to combat the growing mental health disparities that are being seen on a growing basis.	
Jess Balk-Huffines, LCPC	Strongly oppose	Why would we alienate capable providers with long-term practice from serving Virginia residents? Mandating either the accreditation and/or multiple years of treatment above and beyond traditional supervision further prevents residents from accessing care. Additionally, why would current providers move to Virginia and/or seek licensure if they are unable to proceed? I do not understand why this is trying to moving forward again outside of further exclusionary gatekeeping.	4/2/22 11:26 am CommentID:121075

Project 5799 - Proposed

Board of Counseling

Result of Periodic Review

18VAC115-20-10. 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:

"Board"

"Counseling"

"Professional counselor"

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

"Ancillary counseling services" means activities such as case management, recordkeeping, referral, and coordination of services.

"Applicant" means any individual who has submitted an official application and paid the application fee for licensure as a professional counselor.

"CACREP" means the Council for Accreditation of Counseling and Related Educational Programs.

"Candidate for licensure" means a person who has satisfactorily completed all educational and experience requirements for licensure and has been deemed eligible by the board to sit for its examinations.

"Clinical counseling services" means activities such as assessment, diagnosis, treatment planning, and treatment implementation.

"Competency area" means an area in which a person possesses knowledge and skill and the ability to apply them in the clinical setting.

"Conversion therapy" means any practice or treatment as defined in § 54.1-2409.5 A of the Code of Virginia.

"CORE" means Council on Rehabilitation Education.

"Exempt setting" means an agency or institution in which licensure is not required to engage in the practice of counseling according to the conditions set forth in § 54.1-3501 of the Code of Virginia.

"Face-to-face" means the in-person delivery of clinical counseling services for a client or the use of visual, real-time, interactive, secured technology for delivery of such services.

"Group supervision" means the process of clinical supervision of no more than six persons in a group setting provided by a qualified supervisor.

"Internship" means a formal academic course from a regionally accredited college or university in which supervised, practical experience is obtained in a clinical setting in the application of counseling principles, methods, and techniques.

"Jurisdiction" means a state, territory, district, province, or country that has granted a professional certificate or license to practice a profession, use a professional title, or hold oneself out as a practitioner of that profession.

"Nonexempt setting" means a setting that does not meet the conditions of exemption from the requirements of licensure to engage in the practice of counseling as set forth in § 54.1-3501 of the Code of Virginia.

"Regional accrediting agency" means one of the regional accreditation agencies recognized by the U.S. Secretary of Education responsible for accrediting senior postsecondary institutions.

"Residency" means a postgraduate, supervised, clinical experience.

"Resident" means an individual who has a supervisory contract and has been issued a temporary license by the board to provide clinical services in professional counseling under supervision.

"Supervision" means the ongoing process performed by a supervisor who monitors the performance of the person supervised and provides regular, documented individual or group consultation, guidance, and instruction that is specific to the clinical counseling services being performed with respect to the clinical skills and competencies of the person supervised.

"Supervisory contract" means an agreement that outlines the expectations and responsibilities of the supervisor and resident in accordance with regulations of the board.

18VAC115-20-40. Prerequisites for licensure by examination.

Every applicant for licensure examination by the board shall:

1. Meet the degree program requirements prescribed in 18VAC115-20-49, the coursework requirements prescribed in 18VAC115-20-51, and the experience requirements prescribed in 18VAC115-20-52;

2. Pass the licensure examination specified by the board;

3. Submit the following to the board:

a. A completed application;

b. Official transcripts documenting the applicant's completion of the degree program and coursework requirements prescribed in 18VAC115-20-49 and 18VAC115-20-51. Transcripts previously submitted for board approval of a resident license do not have to be resubmitted unless additional coursework was subsequently obtained;

c. Verification of supervision forms documenting fulfillment of the residency requirements of 18VAC115-20-52 and copies of all required evaluation forms, including verification of current licensure of the supervisor if any portion of the residency occurred in another jurisdiction;

d. Verification of any other mental health or health professional license or certificate ever held in another jurisdiction;

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

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

4. Have no unresolved disciplinary action against a mental health or health professional license ~~or~~, certificate, or registration held in Virginia or in another jurisdiction. The board will consider history of disciplinary action on a case-by-case basis.

18VAC115-20-45. Prerequisites for licensure by endorsement.

A. Every applicant for licensure by endorsement shall hold or have held a professional counselor license for independent clinical practice in another jurisdiction of the United States and shall submit the following:

1. A completed application;

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

3. Verification of all mental health or health professional licenses ~~or~~, certificates, or registrations the applicant holds or has ever held in any other jurisdiction. In order to qualify

for endorsement the applicant shall have no unresolved action against a license or certificate. The board will consider history of disciplinary action on a case-by-case basis;

4. Documentation of having completed education and experience requirements as specified in subsection B of this section;

5. Verification of a passing score on an examination required for counseling licensure in the jurisdiction in which licensure was obtained;

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

7. An ~~affidavit~~ attestation of having read and understood the regulations and laws governing the practice of professional counseling in Virginia.

B. Every applicant for licensure by endorsement shall meet one of the following:

1. Educational requirements consistent with those specified in 18VAC115-20-49 and 18VAC115-20-51 and experience requirements consistent with those specified in 18VAC115-20-52; or

2. ~~If an applicant does not have~~ In lieu of documentation of educational and experience credentials consistent with those required by this chapter, ~~he shall~~ the applicant may provide:

~~a. Documentation of education and supervised experience that met the requirements of the jurisdiction in which he was initially licensed as verified by an official transcript and a certified copy of the original application materials; and~~

~~b.~~ a. Evidence of post-licensure clinical practice in counseling, as defined in § 54.1-3500 of the Code of Virginia, at the highest level for independent practice for 24 of the last 60 months immediately preceding his licensure application in Virginia. Clinical

practice shall mean the rendering of direct clinical counseling services ~~or,~~ clinical supervision of counseling services, or teaching graduate-level courses in counseling; ~~or~~

~~3. In lieu of transcripts verifying education and documentation verifying supervised experience, the board may accept verification from the credentials registry of the American Association of State Counseling Boards or any other board-recognized entity.~~

b. Verification of the Certified Clinical Mental Health Counselor credential from the National Board of Certified Counselors (NBCC) or any other board-recognized entity;

c. Evidence of an active license at the highest level of counselor licensure for independent practice for at least 10 years prior to the date of application; or

d. Evidence of an active license at the highest level of counselor licensure for independent practice for at least three years prior to the date of application and one of the following:

(1) The National Certified Counselor credential, in good standing, as issued by the NBCC; or

(2) A graduate-level degree from a program accredited in clinical mental health counseling by CACREP.

18VAC115-20-51. Coursework requirements.

A. The applicant shall have successfully completed ~~60~~:

1. The requirements for a degree in a program accredited by CACREP in clinical mental health counseling or any other specialty approved by the board; or

2. Sixty semester hours or 90 quarter hours of graduate study in the following core coursework with a minimum of three semester hours or 4.0 quarter hours in each of subdivisions ~~1 through 12~~ 2 a through 2 l of this subsection:

~~1.~~ a. Professional counseling identity, function, and ethics;

~~2.~~ b. Theories of counseling and psychotherapy;

~~3.~~ c. Counseling and psychotherapy techniques;

~~4.~~ d. Human growth and development;

~~5.~~ e. Group counseling and psychotherapy theories and techniques;

~~6.~~ f. Career counseling and development theories and techniques;

~~7.~~ g. Appraisal, evaluation, and diagnostic procedures;

~~8.~~ h. Abnormal behavior and psychopathology;

~~9.~~ i. Multicultural counseling theories and techniques;

~~10.~~ j. Research;

~~11.~~ k. Diagnosis and treatment of addictive disorders;

~~12.~~ l. Marriage and family systems theory; and

~~13.~~ 3. Supervised internship as a formal academic course of at least 600 hours to include 240 hours of face-to-face client contact. Only internship hours earned after completion of 30 graduate semester hours may be counted ~~towards~~ toward residency hours. If the academic course was less than 600 hours, the board may approve the completion of up to 100 of the 600 hours and up to 40 of the 240 hours of face-to-face client contact to be added to the hours required for residency.

B. If 60 graduate hours in counseling were completed prior to April 12, 2000, the board may accept those hours if they meet the regulations in effect at the time the 60 hours were completed.

18VAC115-20-52. Resident license and requirements for a residency.

A. Resident license. Applicants for temporary licensure as a resident in counseling shall:

1. Apply for licensure on a form provided by the board to include the following: (i) verification of a supervisory contract, (ii) the name and licensure number of the clinical supervisor and location for the supervised practice, and (iii) an attestation that the applicant will be providing clinical counseling services;

2. Have submitted an official transcript documenting a graduate degree that meets the requirements specified in 18VAC115-20-49 to include completion of the coursework and internship requirement specified in 18VAC115-20-51;

3. Pay the ~~registration~~ resident licensure fee;

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

5. Have no unresolved disciplinary action against a mental health or health professional license, certificate, or registration in Virginia or in another jurisdiction. The board will consider the history of disciplinary action on a case-by-case basis.

B. Residency requirements.

1. The applicant for licensure as a professional counselor shall have completed a 3,400-hour supervised residency in the role of a professional counselor working with various populations, clinical problems, and theoretical approaches in the following areas:

a. Assessment and diagnosis using psychotherapy techniques;

b. Appraisal, evaluation, and diagnostic procedures;

c. Treatment planning and implementation;

d. Case management and recordkeeping;

e. Professional counselor identity and function; and

f. Professional ethics and standards of practice.

2. The 3,400-hour residency shall include a minimum of 200 hours of in-person supervision between supervisor and resident in the consultation and review of clinical counseling services provided by the resident. Supervision shall occur at a minimum of one hour and a maximum of four hours per 40 hours of work experience during the period of the residency. For the purpose of meeting the 200-hour supervision requirement, in-person may include the use of secured technology that maintains client confidentiality and provides real-time, visual contact between the supervisor and the resident. Up to 20 hours of the supervision received during the supervised internship may be counted toward the 200 hours of in-person supervision if the supervision was provided by a licensed professional counselor.

3. No more than half of the 200 hours may be satisfied with group supervision. One hour of group supervision will be deemed equivalent to one hour of individual supervision.

4. Supervision that is not concurrent with a residency will not be accepted, nor will residency hours be accrued in the absence of approved supervision.

5. The residency shall include at least 2,000 hours of face-to-face client contact in providing clinical counseling services. The remaining hours may be spent in the performance of ancillary counseling services.

6. A graduate-level internship in excess of 600 hours, which was completed in a program that meets the requirements set forth in 18VAC115-20-49, may count for up to an additional 300 hours toward the requirements of a residency.

7. Supervised practicum and internship hours in a CACREP-accredited doctoral counseling program may be accepted for up to 900 hours of the residency requirement and up to 100 of the required hours of supervision provided the supervisor holds a current, unrestricted license as a professional counselor.

8. The residency shall be completed in not less than 21 months or more than ~~four~~ six years. Residents who began a residency before August 24, 2016, shall complete the residency by August 24, ~~2020~~ 2022. ~~An individual who does not complete the residency after four years shall submit evidence to the board showing why the supervised experience should be allowed to continue.~~ A resident shall meet the renewal requirements of subsection C of 18VAC115-20-100 in order to maintain a license in current, active status.

9. The board may consider special requests in the event that the regulations create an undue burden in regard to geography or disability that limits the resident's access to qualified supervision.

10. Residents may not call themselves professional counselors, directly bill for services rendered, or in any way represent themselves as independent, autonomous practitioners or professional counselors. During the residency, residents shall use their names and the initials of their degree, their resident license number, and the title "Resident in Counseling" in all written communications. Clients shall be informed in writing that the resident does not have authority for independent practice and is under supervision and shall provide the supervisor's name, professional address, and phone number.

11. Residents shall not engage in practice under supervision in any areas for which they have not had appropriate education.

12. Residency hours shall be accepted if they were approved by the licensing board in another United States jurisdiction ~~that meet~~ and completed in that jurisdiction, and if those hours are consistent with the requirements of this ~~section shall be accepted~~ subsection.

C. Supervisory qualifications. A person who provides supervision for a resident in professional counseling shall:

1. Document two years of post-licensure clinical experience;

2. Have received professional training in supervision, consisting of three credit hours or 4.0 quarter hours in graduate-level coursework in supervision or at least 20 hours of continuing education in supervision offered by a provider approved under 18VAC115-20-106; and

3. Hold an active, unrestricted license as a professional counselor or a marriage and family therapist in the jurisdiction where the supervision is being provided. At least 100 hours of the supervision shall be rendered by a licensed professional counselor. ~~Supervisors who are substance abuse treatment practitioners, school psychologists, clinical psychologists, clinical social workers, or psychiatrists and have been approved to provide supervision may continue to do so until August 24, 2017.~~

D. Supervisory responsibilities.

1. Supervision by any individual whose relationship to the resident compromises the objectivity of the supervisor is prohibited.

2. The supervisor of a resident shall assume full responsibility for the clinical activities of that resident specified within the supervisory contract for the duration of the residency, regardless of whether the supervisor is onsite or offsite at the location where services are provided by the resident.

3. The supervisor is accountable for the resident's compliance with residency requirements of this section.

4. The supervisor shall complete evaluation forms to be given to the resident at the end of each three-month period.

~~4.~~ 5. The supervisor shall report the total hours of residency and shall evaluate the applicant's competency in the six areas stated in subdivision B 1 of this section.

~~5.~~ 6. The supervisor shall provide supervision as defined in 18VAC115-20-10.

7. The supervisor shall maintain copies of supervisory contracts, quarterly reports, and the verification of supervision forms evaluating the applicant's competency for five years after termination or completion of supervision.

E. Applicants shall document successful completion of their residency on the Verification of Supervision Form at the time of application. Applicants must receive a satisfactory competency evaluation on each item on the evaluation sheet. Supervised experience obtained prior to April 12, 2000, may be accepted toward licensure if this supervised experience met the board's requirements that were in effect at the time the supervision was rendered.

18VAC115-20-106. Continuing competency activity criteria.

A. Continuing competency activities must focus on increasing knowledge or skills in one or more of the following areas:

1. Ethics, standards of practice, or laws governing behavioral science professions;

2. Counseling theory;

3. Human growth and development;

4. Social and cultural foundations;

5. The helping relationship;

6. Group dynamics, processing, and counseling;

7. Lifestyle and career development;

8. Appraisal of individuals;

9. Research and evaluation;

10. Professional orientation;

11. Clinical supervision;

12. Marriage and family therapy; or

13. Addictions.

B. Approved hours of continuing competency activity shall be one of the following types:

1. Formally organized learning activities or home study. Activities may be counted at their full hour value. Hours shall be obtained from one or a combination of the following board-approved, mental health-related activities:

a. Regionally accredited university or college level academic courses in a behavioral health discipline.

b. Continuing education programs offered by universities or colleges.

c. Workshops, seminars, conferences, or courses in the behavioral health field offered by federal, state, or local governmental agencies or licensed health facilities and licensed hospitals.

d. 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.

2. Individual professional activities.

a. ~~Publication/presentation/new~~ Publication, presentation, or new program development.

(1) Publication of articles. Activity will count for a maximum of eight hours. Publication activities are limited to articles in refereed journals or a chapter in an edited book.

(2) Publication of books. Activity will count for a maximum of 18 hours.

(3) Presentations. Activity will count for a maximum of eight hours. The same presentations may be used only once in a two-year period. Only actual presentation time may be counted.

(4) New program development. Activity will count for a maximum of eight hours. New program development includes a new course, seminar, or workshop. New courses shall be graduate or undergraduate level college or university courses.

(5) Attendance at board meetings or disciplinary proceedings. Activity shall count for actual time of meeting or proceeding for a maximum of two hours during one renewal period.

b. Dissertation. Activity will count for a maximum of 18 hours. Dissertation credit may only be counted once.

c. Clinical supervision/consultation. Activity will count for a maximum of ~~10~~ six hours. Continuing competency can only be granted for clinical supervision/consultation received on a regular basis with a set agenda. Continuing competency cannot be granted for supervision provided to others.

d. Leadership. Activity will count for a maximum of eight hours. The following leadership positions are acceptable for continuing competency credit: officer of state or national counseling organization; editor ~~and/or~~ or reviewer of professional counseling journals; member of state counseling ~~licensure/certification~~ licensure or certification board; member of a national counselor certification board; member of a national ethics disciplinary review committee rendering licenses; active member of a counseling committee producing a substantial written product; chair of a major counseling conference or convention; or other leadership positions with justifiable

professional learning experiences. The leadership positions must take place for a minimum of one year after the date of first licensure.

e. Practice related programs. Activity will count up to a maximum of eight hours. The board may allow up to eight contact hours of continuing competency as long as the regulant submits proof of attendance plus a written justification of how the activity assists ~~him~~ the regulant in ~~his~~ the direct service of ~~his~~ the regulant's clients. Examples include language courses, software training, and medical topics, etc.

18VAC115-20-107. 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.

2. Documentation of home study shall be made by identification of the source material studied, summary of content, and a signed affidavit attesting to completion of the home study.

3. Documentation of individual professional activities shall be by one of the following:

a. Certificates of participation;

b. Proof of presentations made;

c. Reprints of publications;

d. Letters from educational institutions or agencies approving continuing education programs;

e. Official notification from the association that sponsored the item writing workshop or continuing education program; or

f. Documentation of attendance at formal staffing or participation in clinical supervision/consultation by a signed ~~affidavit~~ attestation on a form provided by the board.

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

18VAC115-20-110. Late renewal; 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 18VAC115-20-20 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 professional counselor license after one year or more and wishes to resume practice shall (i) apply for reinstatement~~,~~; (ii) pay the reinstatement fee for a lapsed license~~,~~; (iii) submit verification of any mental health license ~~he~~ the person holds or has held in another jurisdiction, if applicable~~,~~; (iv) provide a current report from the U.S. Department of Health and Human Services National Practitioner Data Bank; and (v) 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 professional counselor 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.

D. A person who fails to renew a resident license after one year or more and wishes to resume his residency within the six-year limitation from the date of initial issuance of a resident license shall (i) apply for reinstatement; (ii) pay the initial licensure fee for a resident in counseling; and (iii) provide evidence of having met continuing competency requirements not to exceed a maximum of 12 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 resident license.

18VAC115-20-130. 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 counseling.

B. Persons licensed or registered by the board shall:

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

2. Practice only within the 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 that 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~~ professional, 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~~ document efforts to coordinate care;

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;

13. Advertise professional services fairly and accurately in a manner that is not false, misleading, or deceptive, including compliance with 18VAC115-20-52 regarding the requirements for representation to the public by residents in counseling; ~~and~~

14. Not engage in conversion therapy with any person younger than 18 years of age;

15. Make appropriate referrals based on the interests of the client; and

16. Not willfully or negligently breach the confidentiality between a practitioner and a client. A breach of confidentiality that is required or permitted by applicable law or is beyond the control of the practitioner shall not be considered negligent or willful.

C. In regard to patient records, persons licensed or registered 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;

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

3. Disclose or release records to others only with the client's 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 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 10 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 or multiple relationships, persons licensed or registered by the board shall:

1. Avoid dual or multiple relationships with clients that could impair professional judgment or increase the risk of harm to clients. Examples of such relationships include familial, social, financial, business, bartering, or close personal relationships with clients. Counselors 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 or neglect 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 counsel persons with whom they have had a romantic relationship or sexual intimacy. Counselors shall not engage in romantic relationships or sexual intimacies with former clients within a minimum of five years after terminating the counseling relationship. Counselors 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~~ person under supervision or student. Counselors shall avoid any nonsexual dual relationship with a ~~supervisee~~ person under supervision or student in which there is a risk of exploitation or potential harm to the ~~supervisee~~ person under supervision 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 or registered by this board shall report to the board known or suspected violations of the laws and regulations governing the practice of professional counseling.

F. Persons licensed or registered 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.

18VAC115-20-140. Grounds for revocation, suspension, probation, reprimand, censure, or denial of renewal of license or registration.

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. ~~Procurement of~~ Procuring, attempting to procure, or maintaining a license~~, including submission of an application or supervisory forms,~~ or registration 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. Demonstrating an inability to practice counseling with reasonable skill and safety to clients by reason of illness or substance misuse or as a result of any mental, emotional, or physical condition;

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

~~5.~~ 6. Performance of functions outside the demonstrable areas of competency;

~~6.~~ 7. Failure to comply with the continued competency requirements set forth in this chapter;

~~7.~~ 8. 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.~~ 9. Performance of an act likely to deceive, defraud, or harm the public~~.~~;

10. Knowingly allowing persons under supervision to jeopardize client safety or provide care to clients outside of such person's scope of practice or area of responsibility;

11. Having an action taken against a health or mental health license, certification, registration, or application in Virginia or other jurisdiction;

12. Failing to cooperate with an employee of the Department of Health Professions in the conduct of an investigation; or

13. Failing to report evidence of child abuse or neglect as required in § 63.2-1509 of the Code of Virginia or abuse of aged or incapacitated adults as required in § 63.2-1606 of the Code of Virginia.

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.

18VAC115-50-10. 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: (i) "board," (ii) "marriage and family therapy," (iii) "marriage and family therapist," and (iv) "practice of marriage and family therapy."

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

"Ancillary counseling services" means activities such as case management, recordkeeping, referral, and coordination of services.

"CACREP" means the Council for Accreditation of Counseling and Related Educational Programs.

"COAMFTE" means the Commission on Accreditation for Marriage and Family Therapy Education.

"Clinical marriage and family services" means activities such as assessment, diagnosis, and treatment planning and treatment implementation for couples and families.

"Conversion therapy" means any practice or treatment as defined in § 54.1-2409.5 A of the Code of Virginia.

"Face-to-face" means the in-person delivery of clinical marriage and family services for a client or the use of visual, real-time, interactive, secured technology for delivery of such services.

"Internship" means a formal academic course from a regionally accredited university in which supervised practical experience is obtained in a clinical setting in the application of counseling principles, methods, and techniques.

"Regional accrediting agency" means one of the regional accreditation agencies recognized by the U.S. Secretary of Education as responsible for accrediting senior post-secondary institutions and training programs.

"Residency" means a postgraduate, supervised clinical experience.

"Resident" means an individual who has a supervisory contract and has been issued a temporary license by the board approval to provide clinical services in marriage and family therapy under supervision.

"Supervision" means an ongoing process performed by a supervisor who monitors the performance of the person supervised and provides regular, documented, individual or group consultation, guidance, and instruction with respect to the clinical skills and competencies of the person or persons being supervised.

"Supervisory contract" means an agreement that outlines the expectations and responsibilities of the supervisor and resident in accordance with regulations of the board.

18VAC115-50-20. Fees.

A. The board has established fees for the following:

Application and initial licensure as a resident	$65
Pre-review of education only	$75
Initial licensure by examination: Processing and initial licensure as a marriage and family therapist	$175
Initial licensure by endorsement: Processing and initial licensure as a marriage and family therapist	$175
Active annual license renewal for a marriage and family therapist	$130
Inactive annual license renewal for a marriage and family therapist	$65
Annual renewal for a resident in marriage and family therapy	$30
~~Penalty for late~~ Late renewal for a marriage and family therapist	$45
Late renewal for resident in marriage and family therapy	$10

Reinstatement of a lapsed license for a marriage and family therapist	$200
Reinstatement of lapsed resident license	$75
Verification of license to another jurisdiction	$30
Additional or replacement licenses	$10
Additional or replacement wall certificates	$25
Returned check or dishonored credit or debit card	$50
Reinstatement following revocation or suspension	$600

B. All fees are nonrefundable.

C. Examination fees shall be determined and made payable as determined by the board.

18VAC115-50-40. Application for licensure by endorsement.

A. Every applicant for licensure by endorsement shall hold or have held a license for the independent clinical practice of marriage and family ~~license~~ therapy in another jurisdiction in the United States and shall submit:

1. A completed application;

2. The application processing and initial licensure fee prescribed in 18VAC115-50-20;

3. Documentation of licensure as follows:

a. Verification of all mental health or health professional licenses ~~or~~, certificates, or registrations the applicant holds or has ever held in any other jurisdiction. In order to qualify for endorsement, the applicant shall have no unresolved action against a license or certificate. The board will consider history of disciplinary action on a case-by-case basis; and

b. Documentation of a marriage and family therapy license obtained by standards specified in subsection B of this section;

4. Verification of a passing score on a marriage and family therapy licensure examination in the jurisdiction in which licensure was obtained;

5. An ~~affidavit~~ attestation of having read and understood the regulations and laws governing the practice of marriage and family therapy in Virginia; and

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

B. Every applicant for licensure by endorsement shall meet one of the following:

1. Educational requirements consistent with those specified in 18VAC115-50-50 and 18VAC115-50-55 and experience requirements consistent with those specified in 18VAC115-50-60;

2. ~~If an applicant does not have~~ In lieu of documentation of educational and experience credentials consistent with those required by this chapter, ~~he shall~~ the applicant may provide:

~~a. Documentation of education and supervised experience that met the requirements of the jurisdiction in which he was initially licensed as verified by an official transcript and a certified copy of the original application materials; and~~

~~b.~~ a. Evidence of post-licensure clinical practice as a marriage and family therapist for 24 of the last 60 months immediately preceding his licensure application in Virginia. Clinical practice shall mean the rendering of direct clinical services in marriage and family therapy ~~or~~, clinical supervision of marriage and family services, or teaching graduate level courses in marriage and family therapy; ~~or~~

~~3. In lieu of transcripts verifying education and documentation verifying supervised experience, the board may accept verification from the credentials registry of the American Association of State Counseling Boards or any other board-recognized entity.~~

b. Evidence of an active license at the highest level of licensure for independent practice of marriage and family therapy for at least 10 years prior to the date of application; or

c. Evidence of an active license at the highest level of licensure for independent practice of marriage and family therapy for at least three years prior to the date of application and a graduate-level degree from a program accredited in marriage and family therapy by COAMFTE or CACREP.

18VAC115-50-55. Coursework requirements.

A. The applicant shall have successfully completed:

1. The requirements for a marriage and family therapy program accredited by CACREP; or

2. The applicant shall have successfully completed 60 semester hours or 90 quarter hours of graduate coursework with ~~a minimum of six semester hours or nine quarter hours completed in each of the core areas identified in subdivisions 1 and 2 of this subsection, and three semester hours or 4.0 quarter hours in each of the core areas identified in subdivisions 3 through 9 of this subsection~~:

~~1. Marriage and family studies (marital and family development; family systems theory);~~

~~2. Marriage and family therapy (systemic therapeutic interventions and application of major theoretical approaches);~~

~~3.~~ a. A minimum of 12 semester hours or 18 quarter hours completed in marriage and family studies (marital and family development, family systems, systemic therapeutic interventions, and application of major theoretical approaches).

b. Three semester hours or four quarter hours in each of the following core areas:

(1) Human growth and development across the lifespan;

~~4.~~ (2) Abnormal behaviors;

~~5.~~ (3) Diagnosis and treatment of addictive behaviors;

~~6.~~ (4) Multicultural counseling;

~~7.~~ (5) Professional identity and ethics;

~~8.~~ (6) Research (research methods; quantitative methods; statistics); or

~~9.~~ (7) Assessment and treatment (appraisal, assessment and diagnostic procedures); and

~~10. Supervised~~ c. A supervised internship as a formal academic course of at least 600 hours to include 240 hours of direct client contact, of which 200 hours shall be with couples and families. Only internship hours earned after completion of 30 graduate semester hours may be counted towards residency hours. If the academic course was less than 600 hours, the board may approve the completion of up to 100 of the 600 hours and up to 40 of the 240 hours of direct client contact to be added to the hours required for residency.

B. If the applicant holds a current, unrestricted license as a professional counselor, clinical psychologist, or clinical social worker, the board may accept evidence of successful completion of 60 semester hours or 90 quarter hours of graduate study~~, including~~. However, the applicant must provide evidence of a minimum of ~~six~~ 12 semester hours or ~~nine~~ 18 quarter hours completed in marriage and family ~~studies (marital and family development; family systems theory) and six semester hours or nine quarter hours completed in marriage and family therapy (systemic therapeutic interventions and application of major theoretical approaches)~~ therapy (marital and

family development, family systems, systemic therapeutic interventions, and application of major theoretical approaches).

18VAC115-50-60. Resident license and requirements for a residency.

A. Resident license. Applicants for temporary licensure as a resident in marriage and family therapy shall:

1. Apply for licensure on a form provided by the board to include the following: (i) verification of a supervisory contract, (ii) the name and licensure number of the supervisor and location for the supervised practice, and (iii) an attestation that the applicant will be providing marriage and family services.

2. Have submitted an official transcript documenting a graduate degree as that meets the requirements specified in 18VAC115-50-50 to include completion of the coursework and internship requirement specified in 18VAC115-50-55;

3. Pay the ~~registration~~ resident license fee;

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

5. Have no unresolved disciplinary action against a mental health or health professional license, certificate, or registration in Virginia or in another jurisdiction. The board will consider the history of disciplinary action on a case-by-case basis.

B. Residency requirements.

1. The applicant for licensure as a marriage and family therapist shall have completed no fewer than 3,400 hours of supervised residency in the role of a marriage and family therapist, to include 200 hours of in-person supervision with the supervisor in the consultation and review of marriage and family services provided by the resident. For the

purpose of meeting the 200 hours of supervision required for a residency, in-person may also include the use of technology that maintains client confidentiality and provides real-time, visual contact between the supervisor and the resident. At least one-half of the 200 hours of supervision shall be rendered by a licensed marriage and family therapist.

a. Residents shall receive a minimum of one hour and a maximum of four hours of supervision for every 40 hours of supervised work experience.

b. No more than 100 hours of the supervision may be acquired through group supervision, with the group consisting of no more than six residents. One hour of group supervision will be deemed equivalent to one hour of individual supervision.

c. Up to 20 hours of the supervision received during the supervised internship may be counted towards the 200 hours of in-person supervision if the supervision was provided by a licensed marriage and family therapist or a licensed professional counselor.

2. The 3,400-hour residency shall include documentation of at least 2,000 hours in face-to-face clinical marriage and family services of which 1,000 hours shall be face-to-face client contact with couples or families or both. The remaining hours of the 3,400-hour residency may be spent in the performance of ancillary counseling services. For applicants who hold current, unrestricted licensure as a professional counselor, clinical psychologist, or clinical social worker, the remaining hours may be waived.

3. The ~~residency shall consist of practice in the core areas set forth in 18VAC115-50-55.~~ applicant for licensure shall have completed a 3,400-hour supervised residency in the role of a marriage and family therapist working with various populations, clinical problems, and theoretical approaches in the following areas:

a. Assessment and diagnosis using psychotherapy techniques;

b. Appraisal, evaluation, and diagnostic procedures;

c. Treatment planning and implementation;

d. Case management and recordkeeping;

e. Marriage and family therapy identity and function; and

f. Professional ethics and standards of practice.

4. The residency shall begin after the completion of a master's degree in marriage and family therapy or a related discipline as set forth in 18VAC115-50-50.

5. A graduate-level internship in excess of 600 hours, which was completed in a program that meets the requirements set forth in 18VAC115-50-50, may count for up to an additional 300 hours towards the requirements of a residency.

6. Supervised practicum and internship hours in a COAMFTE-accredited or a CACREP-accredited doctoral program in marriage and family therapy or counseling may be accepted for up to 900 hours of the residency requirement and up to 100 of the required hours of supervision provided the supervisor holds a current, unrestricted license as a marriage and family therapist or professional counselor.

7. The board may consider special requests in the event that the regulations create an undue burden in regard to geography or disability that limits the resident's access to qualified supervision.

8. Residents shall not call themselves marriage and family therapists, directly bill for services rendered, or in any way represent themselves as marriage and family therapists. During the residency, residents may use their names, the initials of their degree, their resident license number, and the title "Resident in Marriage and Family Therapy." Clients shall be informed in writing that the resident does not have authority for independent

practice and is under supervision, along with the name, address, and telephone number of the resident's board-approved supervisor.

9. Residents shall not engage in practice under supervision in any areas for which they do not have appropriate education.

10. The residency shall be completed in not less than 21 months or more than ~~four~~ six years from the start of residency. Residents who began a residency before August 24, 2016, shall complete the residency by August 24, ~~2020~~ 2022. ~~An individual who does not complete the residency after four years shall submit evidence to the board showing why the supervised experience should be allowed to continue.~~ A resident shall meet the renewal requirements of subsection C of 18VAC115-50-90 in order to maintain a resident license in current, active status.

11. Residency hours ~~that are~~ shall be accepted if they were approved by the licensing board in another United States jurisdiction and ~~that meet~~ completed in that jurisdiction and if those hours are consistent with the requirements of subsection B of this section ~~shall be accepted~~.

12. Supervision that is not concurrent with a residency will not be accepted, nor can residency hours be accrued in the absence of approved supervision.

C. Supervisory qualifications. A person who provides supervision for a resident in marriage and family therapy shall:

1. Hold an active, unrestricted license as a marriage and family therapist or professional counselor in the jurisdiction where the supervision is being provided;

2. Document two years post-licensure marriage and family therapy experience; and

3. Have received professional training in supervision, consisting of three credit hours or 4.0 quarter hours in graduate-level coursework in supervision or at least 20 hours of

continuing education in supervision offered by a provider approved under 18VAC115-50-96. At least one-half of the 200 hours of supervision shall be rendered by a licensed marriage and family therapist. ~~Supervisors who are clinical psychologists, clinical social workers, or psychiatrists and have been approved to provide supervision may continue to do so until August 24, 2017.~~

D. Supervisory responsibilities.

1. The supervisor shall complete evaluation forms to be given to the resident at the end of each three-month period. The supervisor shall report the total hours of residency and evaluate the applicant's competency to the board. The supervisor shall maintain copies of supervisory contracts, quarterly reports, and verification of supervision forms evaluating an applicant's competency for five years after termination or completion of supervision.

2. Supervision by an individual whose relationship to the resident is deemed by the board to compromise the objectivity of the supervisor is prohibited.

3. The supervisor shall provide supervision as defined in 18VAC115-50-10 and shall assume full responsibility for the clinical activities of residents as specified within the supervisory contract ~~for the duration~~ until completion or termination of the residency, regardless of whether the supervisor is onsite or offsite at the location where services are provided by the resident.

4. The supervisor is accountable for the resident's compliance with residency requirements of this section.

18VAC115-50-70. General examination requirements.

A. All applicants for initial licensure shall pass an examination, as prescribed by the board, with a passing score as determined by the board. ~~The examination is waived for an applicant who holds a current and unrestricted license as a professional counselor issued by the board.~~

B. An applicant is required to pass the prescribed examination within six years from the date of initial issuance of a resident license by the board.

C. A resident shall remain in a residency practicing under supervision until the resident has passed the licensure examination and been granted a license as a marriage and family therapist.

18VAC115-50-96. Continuing competency activity criteria.

A. Continuing competency activities must focus on increasing knowledge or skills in one or more of the following areas:

1. Ethics, standards of practice or laws governing behavioral science professions;

2. Counseling theory;

3. Human growth and development;

4. Social and cultural foundations;

5. The helping relationship;

6. Group dynamics, processing and counseling;

7. Lifestyle and career development;

8. Appraisal of individuals;

9. Research and evaluation;

10. Professional orientation;

11. Clinical supervision;

12. Marriage and family therapy; or

13. Addictions.

B. Approved hours of continuing competency activity shall be one of the following types:

1. Formally organized learning activities or home study. Activities may be counted at their full hour value. Hours shall be obtained from one or a combination of the following board-approved, mental health-related activities:

a. Regionally accredited university or college level academic courses in a behavioral health discipline.

b. Continuing education programs offered by universities or colleges.

c. Workshops, seminars, conferences, or courses in the behavioral health field offered by federal, state, or local governmental agencies or licensed health facilities and licensed hospitals.

d. 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.

2. Individual professional activities.

a. ~~Publication/presentation/new~~ Publication, presentation, or new program development.

(1) Publication of articles. Activity will count for a maximum of eight hours. Publication activities are limited to articles in refereed journals or a chapter in an edited book.

(2) Publication of books. Activity will count for a maximum of 18 hours.

(3) Presentations. Activity will count for a maximum of eight hours. The same presentations may be used only once in a two-year period. Only actual presentation time may be counted.

(4) New program development activity will count for a maximum of eight hours. New program development includes a new course, seminar, or workshop. New courses shall be graduate or undergraduate level college or university courses.

(5) Attendance at board meetings or disciplinary proceedings. Activity shall count for actual time of meeting or proceeding for a maximum of two hours during one renewal period.

b. Dissertation. Activity will count for a maximum of 18 hours. Dissertation credit may only be counted once.

c. Clinical supervision/consultation. Activity will count for a maximum of ~~10~~ six hours. Continuing competency can only be granted for clinical supervision/consultation received on a regular basis with a set agenda. Continuing competency cannot be granted for supervision that you provide to others.

d. Leadership. Activity will count for a maximum of eight hours. The following leadership positions are acceptable for continuing competency credit: officers of state or national counseling organization; editor or reviewer of professional counseling journals; member of state counseling ~~licensure/certification~~ licensure or certification board; member of a national counselor certification board; member of a national ethics disciplinary review committee rendering licenses; active member of a counseling committee producing a substantial written product; chair of a major counseling conference or convention; other leadership positions with justifiable professional learning experiences. The leadership positions must take place for a minimum of one year after the date of first licensure.

e. Practice related programs. Activity will count up to a maximum of eight hours. The board may allow up to eight contact hours of continuing competency as long as the regulant submits proof of attendance plus a written justification of how the activity assists ~~him~~ the regulant in ~~his~~ the direct service of ~~his~~ the regulant's clients. Examples include language courses, software training, medical topics, etc.

18VAC115-50-97. 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, licensee shall provide:

a. Official transcripts showing credit hours earned; or

b. Certificates of participation.

2. Documentation of home study shall be made by identification of the source material studied, summary of content, and a signed affidavit attesting to completion of the home study.

3. Documentation of individual professional activities shall be by one of the following:

a. Certificates of participation;

b. Proof of presentations made;

c. Reprints of publications;

d. Letters from educational institutions or agencies approving continuing education programs;

e. Official notification from the association that sponsored the item writing workshop or continuing education program; or

f. Documentation of attendance at formal staffing ~~shall be~~ or participation in clinical supervision/consultation by signed ~~affidavit~~ attestation on a form provided by the board.

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

18VAC115-50-100. Late renewal, 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 18VAC115-50-20 as well as the license fee prescribed for the period the license was not renewed and providing evidence of having met all applicable continuing competency requirements.

B. A person seeking reinstatement of a marriage and family therapy license one year or more after its expiration date must:

1. Apply for reinstatement and pay the reinstatement fee;

2. Submit ~~documentation~~ verification of any mental health license he holds or has held in another jurisdiction, if applicable;

3. Submit evidence regarding the continued ability to perform the functions within the scope of practice of the license if required by the board to demonstrate competency; ~~and~~

4. Provide evidence of having met all applicable continuing competency requirements not to exceed a maximum of 80 hours obtained within the four years immediately preceding application for reinstatement; and

5. Provide a current report from the U.S. Department of Health and Human Services National Practitioner Data Bank.

C. A person wishing to reactivate an inactive marriage and family license shall submit (i) the renewal fee for active licensure minus any fee already paid for inactive licensure renewal and (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, obtained within the four years immediately preceding application for reinstatement. The board may require additional evidence regarding the person's continued ability to perform the functions within the scope of practice of the license.

D. A person who fails to renew a resident license after one year or more and wishes to resume his residency within the six-year limitation from the date of initial issuance of a resident license shall (i) apply for reinstatement; (ii) pay the initial licensure fee for a resident in counseling; and (iii) provide evidence of having met continuing competency requirements not to exceed a maximum of 12 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 resident license.

18VAC115-50-110. Standards of practice.

A. The protection of the public's 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 marriage and family therapy.

B. Persons licensed or registered by the board shall:

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

2. Practice only within the 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 marriage and family therapy information, concepts, applications, and practices that 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 client of the risks and benefits of any such treatment. Ensure that the welfare of the client is not 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~~ professional, 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~~ document efforts to coordinate care;

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;

13. Advertise professional services fairly and accurately in a manner that is not false, misleading or deceptive, including compliance with 18VAC115-50-60 regarding requirements for representation to the public by residents in marriage and family therapy; ~~and~~

14. Not engage in conversion therapy with any person younger than 18 years of age;

15. Make appropriate referrals based on the interests of the client; and

16. Not willfully or negligently breach the confidentiality between a practitioner and a client. A breach of confidentiality that is required or permitted by applicable law or is beyond the control of the practitioner shall not be considered negligent or willful.

C. In regard to patient records, persons licensed or registered by the board shall:

1. Maintain timely, accurate, legible, and complete 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;

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

3. Disclose or release client records to others only with clients' expressed written consent or that of their 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 by obtaining informed consent from clients or their 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 10 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 transferred to another mental health service provider or given to the client or his legally authorized representative.

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

1. Avoid dual or multiple relationships with clients that could impair professional judgment or increase the risk of harm to clients. Examples of such relationships include familial, social, financial, business, bartering, or close personal relationships with clients. Marriage and family therapists shall take appropriate professional precautions when a dual or multiple 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 also not counsel persons with whom they have had a sexual intimacy or romantic relationship. Marriage and family

therapists shall not engage in romantic relationships or sexual intimacies with former clients within a minimum of five years after terminating the counseling relationship. Marriage and family 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 marriage and family therapist does not change the nature of the conduct nor lift the regulatory prohibition;

3. Not engage in any romantic relationships or sexual relationship or establish a counseling or psychotherapeutic relationship with a ~~supervisee~~ person under supervision or student. Marriage and family therapists shall avoid any nonsexual dual relationship with a ~~supervisee~~ person under supervision or student in which there is a risk of exploitation or potential harm to the ~~supervisee~~ person under supervision 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 or registered by this board shall report to the board known or suspected violations of the laws and regulations governing the practice of marriage and family therapy.

F. Persons licensed or registered 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.

18VAC115-50-120. Disciplinary action.

A. Action by the board to revoke, suspend, deny issuance or removal of a license~~,~~ or registration or take other 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 marriage and family therapy, or any provision of this chapter;

2. ~~Procurement of~~ Procuring, attempting to procure, or maintaining a license~~, including submission of an application or supervisory forms,~~ or registration 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 the general public ~~or if one is unable to practice marriage and family therapy 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. Demonstrating an inability to practice marriage and family therapy with reasonable skill and safety to clients by reason of illness or substance misuse or as a result of any mental, emotional, or physical condition;

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

~~5.~~ 6. Performance of functions outside the demonstrable areas of competency;

~~6.~~ 7. Violating or abetting another person in the violation of any provision of any statute applicable to the practice of marriage and family therapy, or any part or portion of this chapter;

~~7.~~ 8. Failure to comply with the continued competency requirements set forth in this chapter; ~~or~~

~~8.~~ 9. Performance of an act likely to deceive, defraud, or harm the public;

10. Knowingly allowing persons under supervision to jeopardize client safety or provide care to clients outside of such person's scope of practice or area of responsibility;

11. Having an action taken against a health or mental health license, certification, registration, or application in Virginia or other jurisdiction;

12. Failing to cooperate with an employee of the Department of Health Professions in the conduct of an investigation; or

13. Failing to report evidence of child abuse or neglect as required in § 63.2-1509 of the Code of Virginia, or abuse of aged or incapacitated adults as required in § 63.2-1606 of the Code of Virginia.

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.

18VAC115-60-10. 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:

"Board"

"Licensed substance abuse treatment practitioner"

"Substance abuse"

"Substance abuse treatment"

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

"Ancillary services" means activities such as case management, recordkeeping, referral, and coordination of services.

"Applicant" means any individual who has submitted an official application and paid the application fee for licensure as a substance abuse treatment practitioner.

"CACREP" means the Council for Accreditation of Counseling and Related Educational Programs.

"Candidate for licensure" means a person who has satisfactorily completed all educational and experience requirements for licensure and has been deemed eligible by the board to sit for its examinations.

"Clinical substance abuse treatment services" means activities such as assessment, diagnosis, treatment planning, and treatment implementation.

"COAMFTE" means the Commission on Accreditation for Marriage and Family Therapy Education.

"Competency area" means an area in which a person possesses knowledge and skill and the ability to apply them in the clinical setting.

"Conversion therapy" means any practice or treatment as defined in § 54.1-2409.5 A of the Code of Virginia.

"Exempt setting" means an agency or institution in which licensure is not required to engage in the practice of substance abuse treatment according to the conditions set forth in § 54.1-3501 of the Code of Virginia.

"Face-to-face" means the in-person delivery of clinical substance abuse treatment services for a client or the use of visual, real-time, interactive, secured technology for delivery of such services.

"Group supervision" means the process of clinical supervision of no more than six persons in a group setting provided by a qualified supervisor.

"Internship" means a formal academic course from a regionally accredited university in which supervised, practical experience is obtained in a clinical setting in the application of counseling principles, methods and techniques.

"Jurisdiction" means a state, territory, district, province, or country that has granted a professional certificate or license to practice a profession, use a professional title, or hold oneself out as a practitioner of that profession.

"Nonexempt setting" means a setting that does not meet the conditions of exemption from the requirements of licensure to engage in the practice of substance abuse treatment as set forth in § 54.1-3501 of the Code of Virginia.

"Regional accrediting agency" means one of the regional accreditation agencies recognized by the U.S. Secretary of Education responsible for accrediting senior postsecondary institutions.

"Residency" means a postgraduate, supervised, clinical experience.

"Resident" means an individual who has a supervisory contract and has been issued a temporary license by the board to provide clinical services in substance abuse treatment under supervision.

"Supervision" means the ongoing process performed by a supervisor who monitors the performance of the person supervised and provides regular, documented individual or group consultation, guidance, and instruction with respect to the clinical skills and competencies of the person supervised.

"Supervisory contract" means an agreement that outlines the expectations and responsibilities of the supervisor and resident in accordance with regulations of the board.

18VAC115-60-20. Fees required by the board.

A. The board has established the following fees applicable to licensure as a substance abuse treatment practitioner or resident in substance abuse treatment:

Application and initial licensure as a resident in substance abuse treatment	$65
Pre-review of education only	$75
Initial licensure by examination: Processing and initial licensure as a substance abuse treatment practitioner	$175
Initial licensure by endorsement: Processing and initial licensure as a substance abuse treatment practitioner	$175
Active annual license renewal for a substance abuse treatment practitioner	$130
Inactive annual license renewal for a substance abuse treatment practitioner	$65
Annual renewal for a resident in substance abuse treatment	$30
Duplicate license	$10
Verification of license to another jurisdiction	$30
Late renewal for a substance abuse treatment practitioner	$45
Late renewal for a resident in substance abuse treatment	$10
Reinstatement of a lapsed license of a substance abuse treatment practitioner	$200
Reinstatement of a lapsed resident license	$75
Replacement of or additional wall certificate	$25
Returned check or dishonored credit or debit card	$50
Reinstatement following revocation or suspension	$600

B. All fees are nonrefundable.

C. Examination fees shall be determined and made payable as determined by the board.

18VAC115-60-40. Application for licensure by examination.

Every applicant for licensure by examination by the board shall:

1. Meet the degree program, coursework, and experience requirements prescribed in 18VAC115-60-60, 18VAC115-60-70, and 18VAC115-60-80;

2. Pass the examination required for initial licensure as prescribed in 18VAC115-60-90;

3. Submit the following items to the board:

a. A completed application;

b. Official transcripts documenting the applicant's completion of the degree program and coursework requirements prescribed in 18VAC115-60-60 and 18VAC115-60-70. Transcripts previously submitted for board approval of a resident license do not have to be resubmitted unless additional coursework was subsequently obtained;

c. Verification of supervision forms documenting fulfillment of the residency requirements of 18VAC115-60-80 and copies of all required evaluation forms, including verification of current licensure of the supervisor of any portion of the residency occurred in another jurisdiction;

d. ~~Documentation~~ Verification of any other mental health or health professional license or certificate ever held in another jurisdiction;

e. The application processing and initial licensure fee as prescribed in 18VAC115-60-20; and

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

4. Have no unresolved disciplinary action against a mental health or health professional license ~~or~~, certificate, or registration held in Virginia or in another jurisdiction. The board will consider history of disciplinary action on a case-by-case basis.

18VAC115-60-50. Prerequisites for licensure by endorsement.

Every applicant for licensure by endorsement shall submit:

1. A completed application;

2. The application processing and initial licensure fee as prescribed in 18VAC115-60-20;

3. Verification of all mental health or health professional licenses ~~or~~, certificates, or registrations ever held in any other jurisdiction. In order to qualify for endorsement, the applicant shall have no unresolved disciplinary action against a license ~~or~~, certificate, or registration. The board will consider history of disciplinary action on a case-by-case basis;

4. Further documentation of one of the following:

a. A current license for the independent practice of substance abuse treatment ~~license~~ or addiction counseling in good standing in another jurisdiction ~~obtained by meeting requirements substantially equivalent to those set forth in this chapter~~; or

b. A mental health license in good standing from Virginia or another United States jurisdiction in a category acceptable to the board that required completion of a master's degree in mental health to include 60 graduate semester hours in mental health as documented by an official transcript; and

(1) Board-recognized national certification in substance abuse treatment or addiction counseling;

(2) If the master's degree was in substance abuse treatment, ~~two years of~~ the applicant shall have post-licensure experience in providing substance abuse treatment or

addiction counseling in 24 out of the past 60 months immediately preceding the submission of the application to the board;

(3) If the master's degree was not in substance abuse treatment or addiction counseling, ~~five~~ two years of post-licensure experience in substance abuse treatment or addiction counseling plus 12 credit hours of didactic training in the substance abuse treatment competencies set forth in 18VAC115-60-70 C as documented by an official transcript; or

(4) Current substance abuse counselor certification in Virginia in good standing ~~or a Virginia substance abuse treatment specialty licensure designation~~ with two years of post-licensure or certification substance abuse treatment or addiction counseling experience; ~~or~~

~~c. Documentation of education and supervised experience that met the requirements of the jurisdiction in which he was initially licensed as verified by an official transcript and a certified copy of the original application materials and evidence of post-licensure clinical practice for 24 of the last 60 months immediately preceding his licensure application in Virginia. Clinical practice shall mean the rendering of direct clinical substance abuse treatment services or clinical supervision of such services;~~

5. Verification of a passing score on ~~a substance abuse~~ the licensure examination ~~as established by the jurisdiction in which licensure was obtained. The examination is waived for an applicant who holds a current and unrestricted license as a professional counselor within the Commonwealth of Virginia~~ prescribed in 18VAC115-60-90, or if the applicant is licensed in another jurisdiction, a licensing examination deemed to be substantially equivalent by the board;

6. An ~~affidavit~~ attestation of having read and understood the regulations and laws governing the practice of substance abuse treatment in Virginia; and

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

18VAC115-60-60. Degree program requirements.

A. The applicant shall have completed a graduate degree from a program that prepares individuals to practice substance abuse treatment, addiction counseling, or a related counseling discipline as defined in § 54.1-3500 of the Code of Virginia from a college or university accredited by a regional accrediting agency that meets the following criteria:

1. There must be a sequence of academic study with the expressed intent to prepare counselors as documented by the institution;

2. There must be an identifiable counselor training faculty and an identifiable body of students who complete that sequence of academic study; and

3. The academic unit must have clear authority and primary responsibility for the core and specialty areas.

B. Programs that are approved by CACREP as programs in addictions counseling are recognized as meeting the requirements of subsection A of this section.

C. Graduates of programs that are not within the United States or Canada shall provide documentation from an acceptable credential evaluation service that provides information that allows the board to determine if the program meets the requirements set forth in this chapter.

18VAC115-60-70. Coursework requirements.

A. The applicant shall have successfully completed ~~60 semester hours or 90 quarter hours of graduate study.~~

~~B. The applicant shall have completed~~:

1. The requirements for a degree in a program accredited by CACREP in addiction counseling or any other specialty approved by the board; or

2. The applicant shall have successfully completed 60 semester hours or 90 quarter hours of graduate study in a general core curriculum containing a minimum of three semester hours or 4.0 quarter hours in each of the areas identified in this section:

~~1.~~ a. Professional identity, function and ethics;

~~2.~~ b. Theories of counseling and psychotherapy;

~~3.~~ c. Counseling and psychotherapy techniques;

~~4.~~ d. Group counseling and psychotherapy, theories and techniques;

~~5.~~ e. Appraisal, evaluation and diagnostic procedures;

~~6.~~ f. Abnormal behavior and psychopathology;

~~7.~~ g. Multicultural counseling, theories and techniques;

~~8.~~ h. Research; and

~~9.~~ i. Marriage and family systems theory.

~~C.~~ B. The applicant shall also have completed 12 graduate semester credit hours or 18 graduate quarter hours in the following substance abuse treatment competencies. Evidence of current certification as a master addictions counselor may be used to verify completion of the required graduate hours specified in this subsection.

1. Assessment, appraisal, evaluation and diagnosis specific to substance ~~abuse~~ use disorder;

2. Treatment planning models, client case management, interventions and treatments to include relapse prevention, referral process, step models and documentation process;

3. Understanding addictions: The biochemical, sociocultural, and psychological factors of substance use and abuse;

4. Addictions and special populations including~~, but not limited to,~~ adolescents, women, ethnic groups and the elderly; and

5. Client and community education.

~~D.~~ C. The applicant shall have completed a supervised internship of 600 hours as a formal academic course to include 240 hours of ~~direct~~ face-to-face client contact, of which 200 hours shall be in addiction counseling or treating substance ~~abuse-specific treatment problems~~ use disorder. Only internship hours earned after completion of 30 graduate semester hours may be counted towards residency hours. If the academic course was less than 600 hours, the board may approve completion of up to 100 of the 600 hours and up to 40 of the 240 hours of face-to-face client contact to be added to the hours required for residency.

~~E. One course may satisfy study in more than one content area set forth in subsections B and C of this section.~~

~~F. If the applicant holds a current, unrestricted license as a professional counselor, clinical psychologist, or clinical social worker, the board may accept evidence of successful completion of 60 semester hours or 90 quarter hours of graduate study, including the hours specified in subsection C of this section.~~

18VAC115-60-80. Resident license and requirements for a residency.

A. Licensure. Applicants for a temporary resident license in substance abuse treatment shall:

1. Apply for licensure on a form provided by the board to include the following: (i) verification of a supervisory contract, (ii) the name and licensure number of the supervisor and location for the supervised practice, and (iii) an attestation that the applicant will be providing substance abuse treatment services;

2. Have submitted an official transcript documenting a graduate degree that meets the requirements specified in 18VAC115-60-60 to include completion of the coursework and internship requirement specified in 18VAC115-60-70;

3. Pay the registration fee;

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

5. Have no unresolved disciplinary action against a mental health or health professional license, certificate, or registration in Virginia or in another jurisdiction. The board will consider the history of disciplinary action on a case-by-case basis.

B. Applicants who are beginning their residencies in exempt settings shall register supervision with the board to assure acceptability at the time of application.

C. Residency requirements.

1. The applicant for licensure as a substance abuse treatment practitioner shall have completed no fewer than 3,400 hours in a supervised residency in substance abuse treatment with various populations, clinical problems and theoretical approaches in the following areas:

a. Clinical evaluation;

b. Treatment planning, documentation, and implementation;

c. Referral and service coordination;

d. Individual and group counseling and case management;

e. Client family and community education; and

f. Professional and ethical responsibility.

2. The residency shall include a minimum of 200 hours of in-person supervision between supervisor and resident occurring at a minimum of one hour and a maximum of four hours per 40 hours of work experience during the period of the residency.

a. No more than half of these hours may be satisfied with group supervision.

b. One hour of group supervision will be deemed equivalent to one hour of individual supervision.

c. Supervision that is not concurrent with a residency will not be accepted, nor will residency hours be accrued in the absence of approved supervision.

d. For the purpose of meeting the 200-hour supervision requirement, in-person supervision may include the use of technology that maintains client confidentiality and provides real-time, visual contact between the supervisor and the resident.

e. Up to 20 hours of the supervision received during the supervised internship may be counted towards the 200 hours of in-person supervision if the supervision was provided by a licensed professional counselor.

3. The residency shall include at least 2,000 hours of face-to-face client contact in providing clinical services with at least 1,000 of those hours providing substance abuse treatment ~~services~~ or addiction counseling with individuals, families, or groups of ~~individuals suffering from the effects of substance abuse or dependence~~ people with substance use disorder. The remaining hours (1,400 of the 3,400) may be spent in the performance of ancillary services.

4. A graduate level degree internship in excess of 600 hours, which is completed in a program that meets the requirements set forth in 18VAC115-60-70, may count for up to an additional 300 hours towards the requirements of a residency.

5. The residency shall be completed in not less than 21 months or more than ~~four~~ six years from the start of the residency. Residents who began a residency before August 24, 2016, shall complete the residency by August 24, ~~2020~~ 2022. ~~An individual who does not complete the residency after four years shall submit evidence to the board showing why the supervised experience should be allowed to continue.~~ A resident shall meet the renewal requirements of subsection C of 18VAC115-60-110 in order to maintain a license in current, active status.

6. The board may consider special requests in the event that the regulations create an undue burden in regard to geography or disability that limits the resident's access to qualified supervision.

7. Residents may not call themselves substance abuse treatment practitioners, directly bill for services rendered, or in any way represent themselves as independent, autonomous practitioners or substance abuse treatment practitioners. During the residency, residents shall use their names and the initials of their degree, their resident license number, and the title "Resident in Substance Abuse Treatment" in all written communications. Clients shall be informed in writing that the resident does not have authority for independent practice and is under supervision and shall provide the board-approved supervisor's name, professional address, and telephone number.

8. Residents shall not engage in practice under supervision in any areas for which they have not had appropriate education.

9. Residency hours that are approved by the licensing board in another United States jurisdiction and ~~that meet~~ are completed in that jurisdiction shall be accepted if those hours are consistent with the requirements of this ~~section shall be accepted~~ subsection.

D. Supervisory qualifications.

1. A person who provides supervision for a resident in substance abuse treatment shall hold an active, unrestricted license as a professional counselor or substance abuse treatment practitioner in the jurisdiction where the supervision is being provided. ~~Supervisors who are marriage and family therapists, school psychologists, clinical psychologists, clinical social workers, clinical nurse specialists, or psychiatrists and have been approved to provide supervision may continue to do so until August 24, 2017.~~

2. All supervisors shall document two years post-licensure substance abuse treatment experience and at least 100 hours of didactic instruction in substance abuse treatment. Supervisors must document a three-credit-hour course in supervision, a 4.0-quarter-hour course in supervision, or at least 20 hours of continuing education in supervision offered by a provider approved under 18VAC115-60-116.

E. Supervisory responsibilities.

1. Supervision by any individual whose relationship to the resident compromises the objectivity of the supervisor is prohibited.

2. The supervisor of a resident shall assume full responsibility for the clinical activities of that resident specified within the supervisory contract ~~for the duration~~ until completion or termination of the residency, regardless of whether the supervisor is onsite or offsite at the location where services are provided by the resident.

3. The supervisor is accountable for the resident's compliance with residency requirements of this section.

4. The supervisor shall complete evaluation forms to be given to the resident at the end of each three-month period. The supervisor shall maintain copies of supervisory contracts, quarterly reports, and the verification of supervision forms evaluating an applicant's competency for five years after termination or completion of supervision.

~~4.~~ 5. The supervisor shall report the total hours of residency to the board and shall evaluate the applicant's competency in the six areas stated in subdivision C 1 of this section.

~~F. Documentation of supervision. Applicants shall document successful completion of their residency on the Verification of Supervision form at the time of application. Applicants must receive a satisfactory competency evaluation on each item on the evaluation sheet.~~

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

A. Every applicant for licensure as a substance abuse treatment practitioner by examination shall pass a written examination as prescribed by the board. Such applicant is required to pass the prescribed examination within six years from the date of initial issuance of a resident license by the board.

B. Every applicant for licensure as a substance abuse treatment practitioner by endorsement shall have passed a substance abuse examination deemed by the board to be substantially equivalent to the Virginia examination.

C. ~~The examination is waived for an applicant who holds a current and unrestricted license as a professional counselor issued by the board.~~

~~D.~~ The board shall establish a passing score on the written examination.

~~E.~~ D. A resident shall remain in a residency practicing under supervision until the resident has passed the licensure examination and been granted a license as a substance abuse treatment practitioner.

18VAC115-60-116. Continuing competency activity criteria.

A. Continuing competency activities must focus on increasing knowledge or skills in one or more of the following areas:

1. Ethics, standards of practice or laws governing behavioral science professions;

2. Counseling theory;

3. Human growth and development;

4. Social and cultural foundations;

5. The helping relationship;

6. Group dynamics, processing and counseling;

7. Lifestyle and career development;

8. Appraisal of individuals;

9. Research and evaluation;

10. Professional orientation;

11. Clinical supervision;

12. Marriage and family therapy; or

13. Addictions.

B. Approved hours of continuing competency activity shall be one of the following types:

1. Formally organized learning activities or home study. Activities may be counted at their full hour value. Hours shall be obtained from one or a combination of the following board-approved, mental health-related activities:

a. Regionally accredited university-or college-level academic courses in a behavioral health discipline.

b. Continuing education programs offered by universities or colleges.

c. Workshops, seminars, conferences, or courses in the behavioral health field offered by federal, state, or local governmental agencies or licensed health facilities and licensed hospitals.

d. 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) The 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.

2. Individual professional activities.

a. ~~Publication/presentation/new~~ Publication, presentation, or new program development.

(1) Publication of articles. Activity will count for a maximum of eight hours. Publication activities are limited to articles in refereed journals or a chapter in an edited book.

(2) Publication of books. Activity will count for a maximum of 18 hours.

(3) Presentations. Activity will count for a maximum of eight hours. The same presentations may be used only once in a two-year period. Only actual presentation time may be counted.

(4) New program development. Activity will count for a maximum of eight hours. New program development includes a new course, seminar, or workshop. New courses shall be graduate or undergraduate level college or university courses.

(5) Attendance at board meetings or disciplinary proceedings. Activity shall count for actual time of meeting or proceeding for a maximum of two hours during one renewal period.

b. Dissertation. Activity will count for a maximum of 18 hours. Dissertation credit may only be counted once.

c. Clinical supervision/consultation. Activity will count for a maximum of ~~10~~ six hours. Continuing competency can only be granted for clinical supervision/consultation received on a regular basis with a set agenda. Continuing competency cannot be granted for supervision that you provide to others.

d. Leadership. Activity will count for a maximum of eight hours. The following leadership positions are acceptable for continuing competency credit: officers of state

or national counseling organization; editor or reviewer of professional counseling journals; member of state counseling ~~licensure/certification~~ licensure or certification board; member of a national counselor certification board; member of a national ethics disciplinary review committee rendering licenses; active member of a counseling committee producing a substantial written product; chair of a major counseling conference or convention; other leadership positions with justifiable professional learning experiences. The leadership positions must take place for a minimum of one year after the date of first licensure.

e. Practice related programs. Activity will count up to a maximum of eight hours. The board may allow up to eight contact hours of continuing competency as long as the regulant submits proof of attendance plus a written justification of how the activity assists ~~him~~ the regulant in ~~his~~ the direct service of ~~his~~ the regulant's clients. Examples include language courses, software training, medical topics, etc.

18VAC115-60-117. 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, licensee shall provide:

a. Official transcripts showing credit hours earned; or

b. Certificates of participation.

2. Documentation of home study shall be made by identification of the source material studied, summary of content, and a signed affidavit attesting to completion of the home study.

3. Documentation of individual professional activities shall be by one of the following:

a. Certificates of participation;

b. Proof of presentations made;

c. Reprints of publications;

d. Letters from educational institutions or agencies approving continuing education programs;

e. Official notification from the association that sponsored the item writing workshop or continuing education program; or

f. Documentation of attendance at formal staffing or participation in clinical supervision/consultation shall be by signed ~~affidavit~~ attestation on a form provided by the board.

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

18VAC115-60-120. Late renewal; reinstatement.

A. A person whose license has expired may renew it within one year after its expiration date by paying the late renewal fee prescribed in 18VAC115-60-20, as well as the license 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 substance abuse treatment practitioner license after one year or more and wishes to resume practice shall (i) apply for reinstatement~~,~~; (ii) pay the

reinstatement fee for a lapsed license~~,~~; (iii) submit verification of any mental health license ~~he~~ the person holds or has held in another jurisdiction, if applicable~~,~~; (iv) provide a current report from the U.S. Department of Health and Human Services National Practitioner Data Bank; and (v) provide evidence of having met all applicable continuing competency requirements not to exceed a maximum of 80 hours obtained within the four years immediately preceding application for reinstatement. 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 substance abuse treatment practitioner 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 obtained within the four years immediately preceding application for reactivation; 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.

D. A person who fails to renew a resident license after one year or more and wishes to resume his residency within the six-year limitation from the date of initial issuance of a resident license shall (i) apply for reinstatement; (ii) pay the initial licensure fee for a resident in substance abuse treatment; and (iii) provide evidence of having met continuing competency requirements not to exceed a maximum of 12 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 resident license.

18VAC115-60-130. 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 substance abuse treatment.

B. Persons licensed or registered by the board shall:

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

2. Practice only within the 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 substance abuse treatment information, concepts, application, and practices that 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~~ professional, 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~~ document efforts to coordinate care;

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;

13. Advertise professional services fairly and accurately in a manner that is not false, misleading or deceptive, including compliance with 18VAC115-60-80 regarding requirements for representation to the public by residents in counseling; ~~and~~

14. Not engage in conversion therapy with any person younger than 18 years of age;

15. Make appropriate referrals based on the interests of the client; and

16. Not willfully or negligently breach the confidentiality between a practitioner and a client. A breach of confidentiality that is required or permitted by applicable law or is beyond the control of the practitioner shall not be considered negligent or willful.

C. In regard to patient records, persons licensed or registered by the board shall:

1. Maintain timely, accurate, legible, and complete 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;

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

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

4. Maintain client records for a minimum of five years or as otherwise required by law from the date of termination of the substance abuse treatment 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 10 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; and

5. Ensure confidentiality in the usage of client records and clinical materials by obtaining informed consent from clients or their 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.

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

1. Avoid dual or multiple relationships with clients that could impair professional judgment or increase the risk of harm to clients. Examples of such relationships include familial, social, financial, business, bartering, or close personal relationships with clients. Counselors 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 or neglect 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 counsel persons with whom they have had a romantic relationship or sexual intimacy. Licensed substance abuse treatment practitioners shall not engage in romantic relationships or sexual intimacies with former clients within a minimum of five years after terminating the counseling relationship. Licensed substance abuse treatment practitioners 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 licensed substance abuse treatment practitioner does not change the nature of the conduct nor lift the regulatory prohibition;

3. Not engage in any sexual intimacy or romantic relationship or establish a counseling or psychotherapeutic relationship with a ~~supervisee~~ person under supervision or student. Licensed substance abuse treatment practitioners shall avoid any nonsexual dual relationship with a ~~supervisee~~ person under supervision or student in which there is a risk of exploitation or potential harm to the ~~supervisee~~ person under supervision 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 or registered by this board shall report to the board known or suspected violations of the laws and regulations governing the practice of substance abuse treatment.

F. Persons licensed or registered 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.

18VAC115-60-140. Grounds for revocation, suspension, probation, reprimand, censure, or denial of renewal of license or registration.

A. Action by the board to revoke, suspend, deny issuance or renewal of a license, or take other disciplinary action may be taken in accord 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 substance abuse treatment, or any provision of this chapter;

2. ~~Procurement of~~ Procuring, attempting to procure, or maintaining a license~~, including submission of an application or supervisory forms,~~ or registration 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 substance abuse treatment 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. Demonstrating an inability to practice substance abuse treatment with reasonable skill and safety to clients by reason of illness or substance misuse or as a result of any mental, emotional, or physical condition;

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

~~5.~~ 6. Performance of functions outside the demonstrable areas of competency;

~~6.~~ 7. Failure to comply with the continued competency requirements set forth in this chapter;

~~7.~~ 8. Violating or abetting another person in the violation of any provision of any statute applicable to the practice of licensed substance abuse ~~therapy~~ treatment, or any part or portion of this chapter; ~~or~~

~~8.~~ 9. Performance of an act likely to deceive, defraud, or harm the public;

10. Knowingly allowing persons under supervision to jeopardize client safety or provide care to clients outside of such person's scope of practice or area of responsibility;

11. Having an action taken against a health or mental health license, certification, registration, or application in Virginia or other jurisdiction;

12. Failing to cooperate with an employee of the Department of Health Professions in the conduct of an investigation; or

13. Failing to report evidence of child abuse or neglect as required in § 63.2-1509 of the Code of Virginia, or abuse of aged or incapacitated adults as required in § 63.2-1606 of the Code of Virginia.

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.

Agenda Item: Consideration of fast-track regulatory action to reduce regulatory burden

Included in your agenda package are:

- Suggested staff fast-track revisions to reduce burdens to licensure

Staff note: This will likely be the first of two or three such actions over the next several years. This issue will be revisited once changes from the periodic review are effective and more regulations are available for the Board to amend.

Action items:

- Motion to adopt fast-track action to amend Chapters 20, 30, 50, and 60 to reduce burdens on licensure

Project 7358 - Fast-Track

Board of Counseling

Regulatory reduction for Chapters 20, 30, 50, and 60

18VAC115-20-45. Prerequisites for licensure by endorsement.

A. Every applicant for licensure by endorsement shall hold or have held a professional counselor license in another jurisdiction of the United States and shall submit the following:

1. A completed application;

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

3. Verification of all mental health or health professional licenses or certificates ever held in any other jurisdiction. In order to qualify for endorsement the applicant shall have no unresolved action against a license or certificate. The board will consider history of disciplinary action on a case-by-case basis;

4. Documentation of having completed education and experience requirements as specified in subsection B of this section;

5. ~~Verification of a passing score on an examination required for counseling licensure in the jurisdiction in which licensure was obtained;~~

~~6.~~ A current report from the U.S. Department of Health and Human Services National Practitioner Data Bank (NPDB); and

~~7.~~6. An affidavit of having read and understood the regulations and laws governing the practice of professional counseling in Virginia.

B. Every applicant for licensure by endorsement shall meet one of the following:

1. Educational requirements consistent with those specified in 18VAC115-20-49 and 18VAC115-20-51 and experience requirements consistent with those specified in 18VAC115-20-52;

2. If an applicant does not have educational and experience credentials consistent with those required by this chapter, he shall provide:

a. Documentation of education and supervised experience that met the requirements of the jurisdiction in which he was initially licensed as verified by an official transcript and a certified copy of the original application materials; and

b. Evidence of post-licensure clinical practice in counseling, 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 counseling services or clinical supervision of counseling services; or

3. In lieu of transcripts verifying education and documentation verifying supervised experience, the board may accept verification from the credentials registry of the American Association of State Counseling Boards or any other board-recognized entity.

18VAC115-20-52. Resident license and requirements for a residency.

A. Resident license. Applicants for temporary licensure as a resident in counseling shall:

1. ~~Apply for licensure on a form provided by the board to include the following: (i) verification of a supervisory contract, (ii) the name and licensure number of the clinical supervisor and location for the supervised practice, and (iii) an attestation that the applicant will be providing clinical counseling services;~~

~~2.~~ Have submitted an official transcript documenting a graduate degree that meets the requirements specified in 18VAC115-20-49 to include completion of the coursework and internship requirement specified in 18VAC115-20-51;

~~3.~~2. Pay the registration fee;

~~4.~~3. Submit a current report from the U.S. Department of Health and Human Services National Practitioner Data Bank (NPDB); and

~~5.~~4. Have no unresolved disciplinary action against a mental health or health professional license, certificate, or registration in Virginia or in another jurisdiction. The board will consider the history of disciplinary action on a case-by-case basis.

B. Residency requirements.

1. The applicant for licensure as a professional counselor shall have completed a 3,400-hour supervised residency in the role of a professional counselor working with various populations, clinical problems, and theoretical approaches in the following areas:

a. Assessment and diagnosis using psychotherapy techniques;

b. Appraisal, evaluation, and diagnostic procedures;

c. Treatment planning and implementation;

d. Case management and recordkeeping;

e. Professional counselor identity and function; and

f. Professional ethics and standards of practice.

2. The residency shall include a minimum of 200 hours of in-person supervision between supervisor and resident in the consultation and review of clinical counseling services provided by the resident. Supervision shall occur at a minimum of one hour and a maximum of four hours per 40 hours of work experience during the period of the residency. For the purpose of meeting the 200-hour supervision requirement, in-person may include the use of secured technology that maintains client confidentiality and provides real-time, visual contact between the supervisor and the resident. Up to 20 hours of the supervision

received during the supervised internship may be counted toward the 200 hours of in-person supervision if the supervision was provided by a licensed professional counselor.

3. No more than half of the 200 hours may be satisfied with group supervision. One hour of group supervision will be deemed equivalent to one hour of individual supervision.

4. Supervision that is not concurrent with a residency will not be accepted, nor will residency hours be accrued in the absence of approved supervision.

5. The residency shall include at least 2,000 hours of face-to-face client contact in providing clinical counseling services. The remaining hours may be spent in the performance of ancillary counseling services.

6. A graduate-level internship in excess of 600 hours, which was completed in a program that meets the requirements set forth in 18VAC115-20-49, may count for up to an additional 300 hours toward the requirements of a residency.

7. Supervised practicum and internship hours in a CACREP-accredited doctoral counseling program may be accepted for up to 900 hours of the residency requirement and up to 100 of the required hours of supervision provided the supervisor holds a current, unrestricted license as a professional counselor.

8. The residency shall be completed in not less than 21 months or more than four years. Residents who began a residency before August 24, 2016, shall complete the residency by August 24, 2020. An individual who does not complete the residency after four years shall submit evidence to the board showing why the supervised experience should be allowed to continue. A resident shall meet the renewal requirements of subsection C of 18VAC115-20-100 in order to maintain a license in current, active status.

9. The board may consider special requests in the event that the regulations create an undue burden in regard to geography or disability that limits the resident's access to qualified supervision.

10. Residents may not call themselves professional counselors, directly bill for services rendered, or in any way represent themselves as independent, autonomous practitioners or professional counselors. During the residency, residents shall use their names and the initials of their degree, and the title "Resident in Counseling" in all written communications. Clients shall be informed in writing that the resident does not have authority for independent practice and is under supervision and shall provide the supervisor's name, professional address, and phone number.

11. Residents shall not engage in practice under supervision in any areas for which they have not had appropriate education.

12. Residency hours approved by the licensing board in another United States jurisdiction that meet the requirements of this section shall be accepted.

C. Supervisory qualifications. A person who provides supervision for a resident in professional counseling shall:

1. Document two years of post-licensure clinical experience;

2. Have received professional training in supervision, consisting of three credit hours or 4.0 quarter hours in graduate-level coursework in supervision or at least 20 hours of continuing education in supervision offered by a provider approved under 18VAC115-20-106; and

3. Hold an active, unrestricted license as a professional counselor or a marriage and family therapist in the jurisdiction where the supervision is being provided. At least 100 hours of the supervision shall be rendered by a licensed professional counselor. Supervisors who

are substance abuse treatment practitioners, school psychologists, clinical psychologists, clinical social workers, or psychiatrists and have been approved to provide supervision may continue to do so until August 24, 2017.

D. Supervisory responsibilities.

1. Supervision by any individual whose relationship to the resident compromises the objectivity of the supervisor is prohibited.

2. The supervisor of a resident shall assume full responsibility for the clinical activities of that resident specified within the supervisory contract for the duration of the residency.

3. The supervisor shall complete evaluation forms to be given to the resident at the end of each three-month period.

4. The supervisor shall report the total hours of residency and shall evaluate the applicant's competency in the six areas stated in subdivision B 1 of this section.

5. The supervisor shall provide supervision as defined in 18VAC115-20-10.

E. Applicants shall document successful completion of their residency on the Verification of Supervision Form at the time of application. Applicants must receive a satisfactory competency evaluation on each item on the evaluation sheet. Supervised experience obtained prior to April 12, 2000, may be accepted toward licensure if this supervised experience met the board's requirements that were in effect at the time the supervision was rendered.

18VAC115-30-61. Prerequisites for certification by examination for substance abuse counseling assistants.

A. Every applicant for certification as a substance abuse counseling assistant shall pass a written examination approved by the board. The board shall determine the passing score on the examination.

1. If an applicant fails to achieve a passing score within two years of board approval to sit for the examination, the applicant shall reapply according to regulations in effect at that time.

2. An applicant who has applied twice and has not passed the examination shall not be approved to retake the examination, unless the applicant can provide evidence of extenuating circumstances for failure to pass the examination within the four-year period.

B. Every applicant for examination for certification by the board shall:

1. Meet the educational and experience requirements prescribed in 18VAC115-30-62 and 18VAC115-30-63; and

2. Submit the following to the board within the timeframe established by the board:

a. A completed application form;

b. Official transcript documenting attainment of a high school diploma, a general education development (GED) certificate, or a post-secondary degree;

c. The application processing and initial certification fee;

d. Verification of all health or mental health licenses or certificates ever held in Virginia or in any other jurisdiction. In order to qualify for certification, the applicant shall have no unresolved action against a license or certificate. The board will consider the history of disciplinary action on a case-by-case basis; and

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

18VAC115-50-60. Resident license and requirements for a residency.

A. Resident license. Applicants for temporary licensure as a resident in marriage and family therapy shall:

1. ~~Apply for licensure on a form provided by the board to include the following: (i) verification of a supervisory contract, (ii) the name and licensure number of the supervisor and location for the supervised practice, and (iii) an attestation that the applicant will be providing marriage and family services.~~

~~2.~~ Have submitted an official transcript documenting a graduate degree as that meets the requirements specified in 18VAC115-50-50 to include completion of the coursework and internship requirement specified in 18VAC115-50-55;

~~3.~~2. Pay the registration fee;

~~4.~~3. Submit a current report from the U.S. Department of Health and Human Services National Practitioner Data Bank (NPDB); and

~~5.~~4. Have no unresolved disciplinary action against a mental health or health professional license, certificate, or registration in Virginia or in another jurisdiction. The board will consider the history of disciplinary action on a case-by-case basis.

B. Residency requirements.

1. The applicant for licensure as a marriage and family therapist shall have completed no fewer than 3,400 hours of supervised residency in the role of a marriage and family therapist, to include 200 hours of in-person supervision with the supervisor in the consultation and review of marriage and family services provided by the resident. For the purpose of meeting the 200 hours of supervision required for a residency, in-person may also include the use of technology that maintains client confidentiality and provides real-time, visual contact between the supervisor and the resident. At least one-half of the 200 hours of supervision shall be rendered by a licensed marriage and family therapist.

a. Residents shall receive a minimum of one hour and a maximum of four hours of supervision for every 40 hours of supervised work experience.

b. No more than 100 hours of the supervision may be acquired through group supervision, with the group consisting of no more than six residents. One hour of group supervision will be deemed equivalent to one hour of individual supervision.

c. Up to 20 hours of the supervision received during the supervised internship may be counted towards the 200 hours of in-person supervision if the supervision was provided by a licensed marriage and family therapist or a licensed professional counselor.

2. The residency shall include documentation of at least 2,000 hours in clinical marriage and family services of which 1,000 hours shall be face-to-face client contact with couples or families or both. The remaining hours may be spent in the performance of ancillary counseling services. For applicants who hold current, unrestricted licensure as a professional counselor, clinical psychologist, or clinical social worker, the remaining hours may be waived.

3. The residency shall consist of practice in the core areas set forth in 18VAC115-50-55.

4. The residency shall begin after the completion of a master's degree in marriage and family therapy or a related discipline as set forth in 18VAC115-50-50.

5. A graduate-level internship in excess of 600 hours, which was completed in a program that meets the requirements set forth in 18VAC115-50-50, may count for up to an additional 300 hours towards the requirements of a residency.

6. Supervised practicum and internship hours in a COAMFTE-accredited or a CACREP-accredited doctoral program in marriage and family therapy or counseling may be accepted for up to 900 hours of the residency requirement and up to 100 of the required hours of supervision provided the supervisor holds a current, unrestricted license as a marriage and family therapist or professional counselor.

7. The board may consider special requests in the event that the regulations create an undue burden in regard to geography or disability that limits the resident's access to qualified supervision.

8. Residents shall not call themselves marriage and family therapists, directly bill for services rendered, or in any way represent themselves as marriage and family therapists. During the residency, residents may use their names, the initials of their degree, and the title "Resident in Marriage and Family Therapy." Clients shall be informed in writing that the resident does not have authority for independent practice and is under supervision, along with the name, address, and telephone number of the resident's supervisor.

9. Residents shall not engage in practice under supervision in any areas for which they do not have appropriate education.

10. The residency shall be completed in not less than 21 months or more than four years. Residents who began a residency before August 24, 2016, shall complete the residency by August 24, 2020. An individual who does not complete the residency after four years shall submit evidence to the board showing why the supervised experience should be allowed to continue. A resident shall meet the renewal requirements of subsection C of 18VAC115-50-90 in order to maintain a resident license in current, active status.

11. Residency hours that are approved by the licensing board in another United States jurisdiction and that meet the requirements of this section shall be accepted.

C. Supervisory qualifications. A person who provides supervision for a resident in marriage and family therapy shall:

1. Hold an active, unrestricted license as a marriage and family therapist or professional counselor in the jurisdiction where the supervision is being provided;

2. Document two years post-licensure marriage and family therapy experience; and

3. Have received professional training in supervision, consisting of three credit hours or 4.0 quarter hours in graduate-level coursework in supervision or at least 20 hours of continuing education in supervision offered by a provider approved under 18VAC115-50-96. At least one-half of the 200 hours of supervision shall be rendered by a licensed marriage and family therapist. Supervisors who are clinical psychologists, clinical social workers, or psychiatrists and have been approved to provide supervision may continue to do so until August 24, 2017.

D. Supervisory responsibilities.

1. The supervisor shall complete evaluation forms to be given to the resident at the end of each three-month period. The supervisor shall report the total hours of residency and evaluate the applicant's competency to the board.

2. Supervision by an individual whose relationship to the resident is deemed by the board to compromise the objectivity of the supervisor is prohibited.

3. The supervisor shall provide supervision as defined in 18VAC115-50-10 and shall assume full responsibility for the clinical activities of residents as specified within the supervisory contract for the duration of the residency.

18VAC115-60-80. Resident license and requirements for a residency.

A. Licensure. Applicants for a temporary resident license in substance abuse treatment shall:

1. ~~Apply for licensure on a form provided by the board to include the following: (i) verification of a supervisory contract, (ii) the name and licensure number of the supervisor and location for the supervised practice, and (iii) an attestation that the applicant will be providing substance abuse treatment services;~~

~~2.~~ Have submitted an official transcript documenting a graduate degree that meets the requirements specified in 18VAC115-60-60 to include completion of the coursework and internship requirement specified in 18VAC115-60-70;

~~3.~~2. Pay the registration fee;

~~4.~~3. Submit a current report from the U.S. Department of Health and Human Services National Practitioner Data Bank (NPDB); and

~~5.~~4. Have no unresolved disciplinary action against a mental health or health professional license, certificate, or registration in Virginia or in another jurisdiction. The board will consider the history of disciplinary action on a case-by-case basis.

B. Applicants who are beginning their residencies in exempt settings shall register supervision with the board to assure acceptability at the time of application.

C. Residency requirements.

1. The applicant for licensure as a substance abuse treatment practitioner shall have completed no fewer than 3,400 hours in a supervised residency in substance abuse treatment with various populations, clinical problems and theoretical approaches in the following areas:

a. Clinical evaluation;

b. Treatment planning, documentation, and implementation;

c. Referral and service coordination;

d. Individual and group counseling and case management;

e. Client family and community education; and

f. Professional and ethical responsibility.

2. The residency shall include a minimum of 200 hours of in-person supervision between supervisor and resident occurring at a minimum of one hour and a maximum of four hours per 40 hours of work experience during the period of the residency.

a. No more than half of these hours may be satisfied with group supervision.

b. One hour of group supervision will be deemed equivalent to one hour of individual supervision.

c. Supervision that is not concurrent with a residency will not be accepted, nor will residency hours be accrued in the absence of approved supervision.

d. For the purpose of meeting the 200-hour supervision requirement, in-person supervision may include the use of technology that maintains client confidentiality and provides real-time, visual contact between the supervisor and the resident.

e. Up to 20 hours of the supervision received during the supervised internship may be counted towards the 200 hours of in-person supervision if the supervision was provided by a licensed professional counselor.

3. The residency shall include at least 2,000 hours of face-to-face client contact in providing clinical substance abuse treatment services with individuals, families, or groups of individuals suffering from the effects of substance abuse or dependence. The remaining hours may be spent in the performance of ancillary services.

4. A graduate level degree internship in excess of 600 hours, which is completed in a program that meets the requirements set forth in 18VAC115-60-70, may count for up to an additional 300 hours towards the requirements of a residency.

5. The residency shall be completed in not less than 21 months or more than four years. Residents who began a residency before August 24, 2016, shall complete the residency by August 24, 2020. An individual who does not complete the residency after four years

shall submit evidence to the board showing why the supervised experience should be allowed to continue. A resident shall meet the renewal requirements of subsection C of 18VAC115-60-110 in order to maintain a license in current, active status.

6. The board may consider special requests in the event that the regulations create an undue burden in regard to geography or disability that limits the resident's access to qualified supervision.

7. Residents may not call themselves substance abuse treatment practitioners, directly bill for services rendered, or in any way represent themselves as independent, autonomous practitioners or substance abuse treatment practitioners. During the residency, residents shall use their names and the initials of their degree, and the title "Resident in Substance Abuse Treatment" in all written communications. Clients shall be informed in writing that the resident does not have authority for independent practice and is under supervision and shall provide the supervisor's name, professional address, and telephone number.

8. Residents shall not engage in practice under supervision in any areas for which they have not had appropriate education.

9. Residency hours that are approved by the licensing board in another United States jurisdiction and that meet the requirements of this section shall be accepted.

D. Supervisory qualifications.

1. A person who provides supervision for a resident in substance abuse treatment shall hold an active, unrestricted license as a professional counselor or substance abuse treatment practitioner in the jurisdiction where the supervision is being provided. Supervisors who are marriage and family therapists, school psychologists, clinical psychologists, clinical social workers, clinical nurse specialists, or psychiatrists and have been approved to provide supervision may continue to do so until August 24, 2017.

2. All supervisors shall document two years post-licensure substance abuse treatment experience and at least 100 hours of didactic instruction in substance abuse treatment. Supervisors must document a three-credit-hour course in supervision, a 4.0-quarter-hour course in supervision, or at least 20 hours of continuing education in supervision offered by a provider approved under 18VAC115-60-116.

E. Supervisory responsibilities.

1. Supervision by any individual whose relationship to the resident compromises the objectivity of the supervisor is prohibited.

2. The supervisor of a resident shall assume full responsibility for the clinical activities of that resident specified within the supervisory contract for the duration of the residency.

3. The supervisor shall complete evaluation forms to be given to the resident at the end of each three-month period.

4. The supervisor shall report the total hours of residency and shall evaluate the applicant's competency in the six areas stated in subdivision C 1 of this section.

F. Documentation of supervision. Applicants shall document successful completion of their residency on the Verification of Supervision form at the time of application. Applicants must receive a satisfactory competency evaluation on each item on the evaluation sheet.

Agenda Item: Consideration of amendments to Guidance Document 115-1.1

Included in your agenda package are:

- Recommended changes to Guidance Document 115-1.1 based on discussion from regulatory committee

Action needed:

- Motion to adopt amendments to Guidance Document 115-1.1

Board of Counseling

Possible Actions for Non-Compliance with Continuing Education Requirements; Recommendations for Continuing Education Requirements

Disciplinary or Alternative Actions for Non-Compliance with Continuing Education Requirements.

The Board has adopted the following guidelines for resolution of cases of non-compliance with continuing education requirements:

Cause	Possible Action
Short due to unacceptable hours	Confidential Consent Agreement ("CCA"); 30 day make up
Short 1-10 hours	CCA; 30 day make up
Short 11-15 hours	Consent Order; monetary penalty of $300; 30 day make up
Short 16-20 hours	Informal fact-finding conference scheduled
Did not respond to audit request	Informal fact-finding conference scheduled

NOTE: In all cases the licensee will be audited the following renewal cycle.

Recommendations for Continuing Education.

The Board recommends that practitioners complete continuing education credits which focus on working with diverse populations annually to ensure the needs of all Virginians are met.

Agenda Item: Consideration of NOIRA to remove regulations duplicative of Code with regard to conversion therapy of minors

Included in your agenda package are:

- Virginia Code § 54.1-2409.5 – prohibition of conversion therapy on minors
- 18VAC115-20-10
- 18VAC115-20-130

Action items:

- Discussion of notice of intended regulatory action to remove duplicative conversion therapy regulations from Chapters 20, 30, 50, and 60
- Motion to adopt notice of intended regulatory action to remove duplicative conversion therapy regulations from Chapters 20, 30, 50, and 60.

9/1/2022

Code of Virginia
Title 54.1. Professions and Occupations
Chapter 24. General Provisions

§ 54.1-2409.5. Conversion therapy prohibited.

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

B. No person licensed pursuant to this subtitle or who performs counseling as part of his training for any profession licensed pursuant to this subtitle shall engage in conversion therapy with a person under 18 years of age. Any conversion therapy efforts with a person under 18 years of age engaged in by a provider licensed in accordance with the provisions of this subtitle or who performs counseling as part of his training for any profession licensed pursuant to this subtitle shall constitute unprofessional conduct and shall be grounds for disciplinary action by the appropriate health regulatory board within the Department of Health Professions.

2020, cc. 41, 721.

9/1/2022

Virginia Administrative Code
Title 18. Professional And Occupational Licensing
Agency 115. Board of Counseling
Chapter 20. Regulations Governing the Practice of Professional Counseling

18VAC115-20-10. 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:

"Board"

"Counseling"

"Professional counselor"

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

"Ancillary counseling services" means activities such as case management, recordkeeping, referral, and coordination of services.

"Applicant" means any individual who has submitted an official application and paid the application fee for licensure as a professional counselor.

"CACREP" means the Council for Accreditation of Counseling and Related Educational Programs.

"Candidate for licensure" means a person who has satisfactorily completed all educational and experience requirements for licensure and has been deemed eligible by the board to sit for its examinations.

"Clinical counseling services" means activities such as assessment, diagnosis, treatment planning, and treatment implementation.

"Competency area" means an area in which a person possesses knowledge and skill and the ability to apply them in the clinical setting.

"Conversion therapy" means any practice or treatment as defined in § 54.1-2409.5 A of the Code of Virginia.

"CORE" means Council on Rehabilitation Education.

"Exempt setting" means an agency or institution in which licensure is not required to engage in the practice of counseling according to the conditions set forth in § 54.1-3501 of the Code of Virginia.

"Face-to-face" means the in-person delivery of clinical counseling services for a client.

"Group supervision" means the process of clinical supervision of no more than six persons in a group setting provided by a qualified supervisor.

"Internship" means a formal academic course from a regionally accredited college or university in which supervised, practical experience is obtained in a clinical setting in the application of counseling principles, methods, and techniques.

"Jurisdiction" means a state, territory, district, province, or country that has granted a professional certificate or license to practice a profession, use a professional title, or hold oneself out as a practitioner of that profession.

"Nonexempt setting" means a setting that does not meet the conditions of exemption from the requirements of licensure to engage in the practice of counseling as set forth in § 54.1-3501 of the Code of Virginia.

"Regional accrediting agency" means one of the regional accreditation agencies recognized by the U.S. Secretary of Education responsible for accrediting senior postsecondary institutions.

"Residency" means a postgraduate, supervised, clinical experience.

"Resident" means an individual who has a supervisory contract and has been issued a temporary license by the board to provide clinical services in professional counseling under supervision.

"Supervision" means the ongoing process performed by a supervisor who monitors the performance of the person supervised and provides regular, documented individual or group consultation, guidance, and instruction that is specific to the clinical counseling services being performed with respect to the clinical skills and competencies of the person supervised.

"Supervisory contract" means an agreement that outlines the expectations and responsibilities of the supervisor and resident in accordance with regulations of the board.

Statutory Authority

§ 54.1-2400 of the Code of Virginia.

Historical Notes

Derived from VR560-01-02 § 1.1, eff. July 6, 1988; amended, Virginia Register Volume 5, Issue 24, eff. September 27, 1989; Volume 7, Issue 14, eff. May 8, 1991; Volume 9, Issue 25, eff. October 6, 1993; Volume 16, Issue 13, eff. April 12, 2000; Volume 24, Issue 24, eff. September 3, 2008; Volume 30, Issue 19, eff. July 3, 2014; Volume 32, Issue 24, eff. August 24, 2016; Volume 37, Issue 20, eff. June 23, 2021; Volume 37, Issue 24, eff. August 18, 2021.

9/1/2022

Virginia Administrative Code
Title 18. Professional And Occupational Licensing
Agency 115. Board of Counseling
Chapter 20. Regulations Governing the Practice of Professional Counseling

18VAC115-20-130. 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 counseling.

B. Persons licensed or registered by the board shall:

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

2. Practice only within the 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 that 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;

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

14. Not engage in conversion therapy with any person younger than 18 years of age.

C. In regard to patient 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;

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

3. Disclose or release records to others only with the client's 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 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 10 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 familial, social, financial, business, bartering, or close personal relationships with clients. Counselors 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 counsel persons with whom they have had a romantic relationship or sexual intimacy. Counselors shall not engage in romantic relationships or sexual intimacies with former clients within a minimum of five years after terminating the counseling relationship. Counselors 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. Counselors 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 professional counseling.

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.

Statutory Authority

§ 54.1-2400 of the Code of Virginia.

Historical Notes

Derived from VR560-01-02 § 6.1, eff. July 6, 1988; amended, Virginia Register Volume 5, Issue 24, eff. September 27, 1989; Volume 7, Issue 14, eff. May 8, 1991; Volume 9, Issue 25, eff. October 6, 1993; Volume 16, Issue 13, eff. April 12, 2000; Volume 22, Issue 7, eff. January 11, 2006; Volume 23, Issue 21, eff. July 25, 2007; Volume 25, Issue 20, eff. July 23, 2009; Volume 30, Issue 19, eff. July 3, 2014; Volume 32, Issue 24, eff. August 24, 2016; Volume 37, Issue 24, eff. August 18, 2021.

Workforce Shortage and the Opioid Epidemic

DAVID CASSISE

VAMARP PRESIDENT

Opioid Treatment Programs

- Provide comprehensive treatment, including medication and counseling, to people with opioid use disorder
- Evidence-based outpatient care with daily monitoring
- Gold Standard for opioid treatment (CDC, SAMHSA, WHO)
- 50 years of research shows:
  - Reduces relapse rates
  - Reduces mortality rates
  - Reduces criminality
  - Reduces transmission of STIs
  - Improves local economy
  - Improves quality of life
  - Improves employment rates

The Opioid Epidemic

- 2021 was the highest year on record for overdose deaths
  - About a 30% increase from the previous year
  - 75% of all overdoses were due to opioids
- In Virginia, one person dies every 4 hours from an overdose
- 30% increase in patient census year over year
- Yet, only 20% of people with opioid use disorder receive any treatment

- THE DEMAND IS HIGH!

Counselor Shortage

- Not enough people entering the human services field to meet the demand
- In the next 5 – 10 years more people will be retiring
- Many people have either just stopped working or have switched fields
- With the increased amount of people seeking treatment it continues to be difficult to maintain an appropriate ratio of patients to staff

The Impact of High Demand and Short Supply

- Caseload sizes are high
- Burnout and turnover increasing more than ever
- Quality of treatment is beginning to suffer
- Almost impossible to meet all the regulatory requirements
  - All state and DMAS regulations submit to DHP credentialing
- IN SUMMARY:
  - The epidemic has significantly increased while the needed workforce is decreasing. Furthermore, there continues to be more demands, regulations, and requirements that cannot be fulfilled adequately.
  - People are dying because they cannot get into treatment!

How You Can Help

- Ease some of the CSAC credentialing requirements
  - In trying to improve the quality of the counselor that is providing a service the irony is that the quality is reduced because there are too many requirements and hoops to jump through
- Ease reciprocity requirements
  - Honor national certifications (e.g. CADC) if they have the appropriate degree
- Become part of the compact license
- Reduce the number of required supervision hours
- Add resources to improve turn around time for approvals
- Use the date submitted rather than approval date as the start date

Thank You!

Questions?

DRAFT

Virginia's Licensed Professional Counselor Workforce: 2022

Healthcare Workforce Data Center

July 2022

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 7,000 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 their ongoing cooperation.*

Thank You!

Virginia Department of Health Professions

David E. Brown, DC
Director

Healthcare Workforce Data Center Staff:

Yetty Shobo, PhD	Rajana Siva, MBA	Christopher Coyle	Jacquelyne Assi Abe
Director	*Data Analyst*	*Research Assistant*	*Intern*

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Executive Director

Jaime H. Hoyle, JD

Contents

The Licensed Professional Counselor Workforce At a Glance:

The Workforce

Licensees:	8,168
Virginia's Workforce:	6,799
FTEs:	5,621

Survey Response Rate

All Licensees:	86%
Renewing Practitioners:	97%

Demographics

Female:	82%
Diversity Index:	43%
Median Age:	46

Background

Rural Childhood:	30%
HS Degree in VA:	50%
Prof. Degree in VA:	64%

Education

Masters:	88%
Doctorate:	12%

Finances

Median Income:	$70k-$80k
Health Insurance:	60%
Under 40 w/ Ed. Debt:	69%

Current Employment

Employed in Prof.:	94%
Hold 1 Full-Time Job:	55%
Satisfied?:	96%

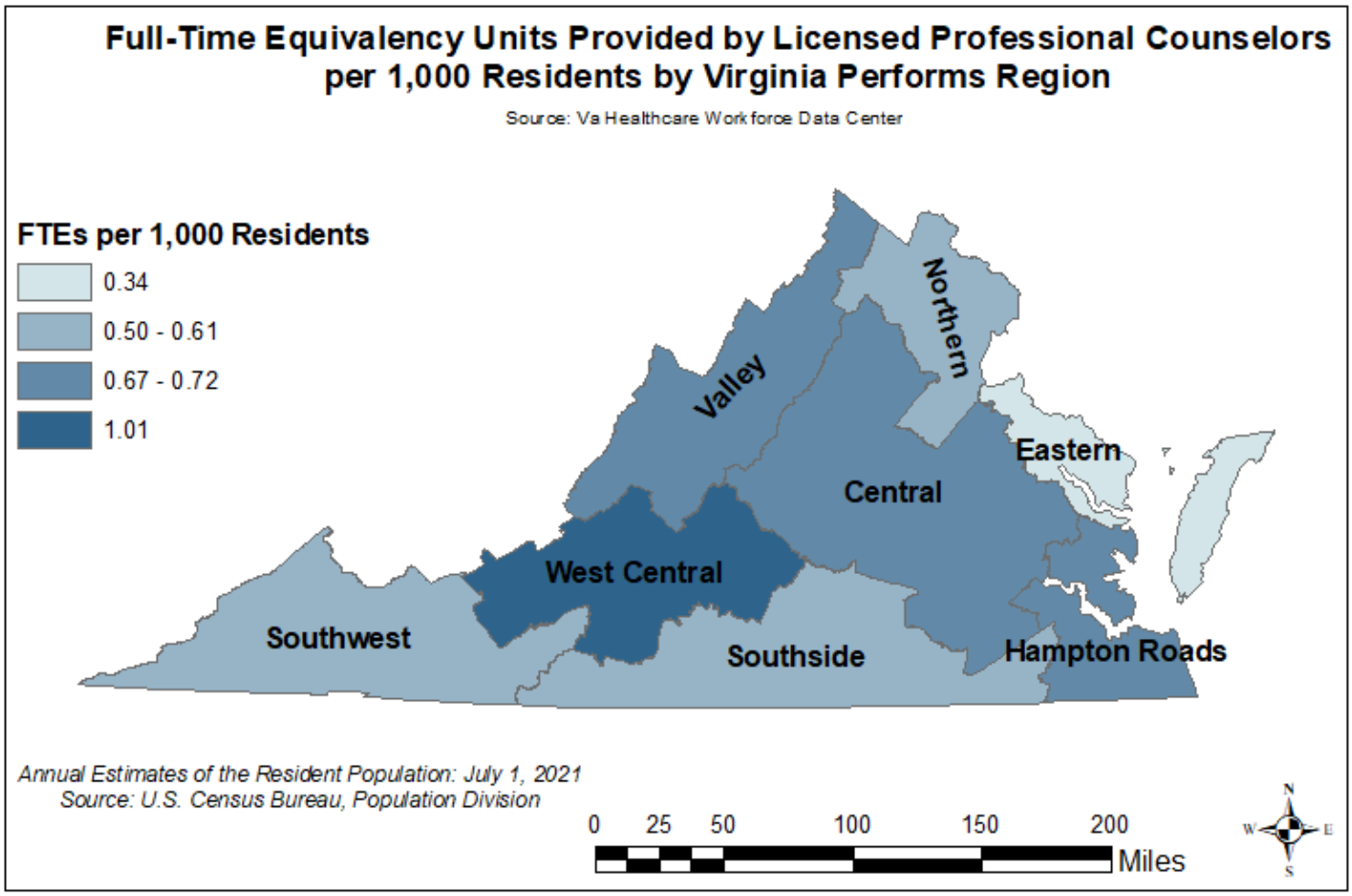
Job Turnover

Switched Jobs:	7%
Employed Over 2 Yrs.:	63%

Time Allocation

Patient Care:	70%-79%
Administration:	10%-19%
Patient Care Role:	62%

Source: Va. Healthcare Workforce Data Center



Results in Brief

This report contains the results of the 2022 Licensed Professional Counselor (LPC) Workforce Survey. More than 7,000 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 86% of the 8,168 LPCs who are licensed in the state and 97% of renewing practitioners.

The HWDC estimates that 6,799 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 5,621 "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 86% of those LPCs who are under the age of 40. In a random encounter between two LPCs, there is a 43% 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 47%. However, both of these values are below the comparable diversity index of 58% for Virginia's population as a whole. Three out of every ten LPCs grew up in a rural area, and more than one-fifth of those LPCs who grew up in a rural area currently work in a non-metro area of Virginia. In total, 9% of all LPCs work in a non-metro area of the state.

Among all LPCs, 94% are currently employed in the profession, 55% hold one full-time job, and 41% work between 40 and 49 hours per week. Nearly two-thirds of all LPCs have been employed at their primary work location for more than two years, while 2% have experienced underemployment at some point in the past year. Four out of every five LPCs are employed in the private sector, including 64% who work in the for-profit sector. The median annual income of Virginia's LPC workforce is between $70,000 and $80,000. Among all LPCs, 96% indicated that they are satisfied with their current work situation, including 70% 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 2017 LPC workforce. The number of licensed LPCs in Virginia has increased by 66% (8,168 vs. 4,933). In addition, the size of Virginia's LPC workforce has increased by 59% (6,799 vs. 4,287), and the number of FTEs provided by this workforce has increased by 56% (5,621 vs. 3,606). Virginia's renewing LPCs are more likely to respond to this survey (97% vs. 95%).

The percentage of all LPCs who are female has increased (82% vs. 79%), while the median age of the LPC workforce has fallen (46 vs. 50). In addition, the diversity index of Virginia's LPC workforce has increased (43% vs. 32%). This increase in the diversity index has also occurred among LPCs who are under the age of 40 (47% vs. 36%). There has been no change in either the percentage of LPCs who grew up in a rural area (30%) or the percentage of all LPCs who currently work in a non-metro area of the state (9%).

LPCs are more likely to carry education debt (52% vs. 42%), and the median debt amount among those LPCs with education debt has increased ($90k-$100k vs. $50k-$60k). Virginia's LPCs are also more likely to be employed in the profession (94% vs. 92%) and hold one full-time job (55% vs. 53%). In addition, the one-year rate of involuntary unemployment has fallen (< 1% vs. 1%). LPCs in Virginia are more likely to work in the for-profit sector (64% vs. 55%) instead of the non-profit sector (16% vs. 20%) or a state/local government (17% vs. 22%).

The median annual income of Virginia's LPCs has increased ($70k-$80k vs. $50k-$60k). Although most LPCs continue to receive this income in the form of a salary or commission, this percentage has fallen (55% vs. 58%). Meanwhile, wage and salaried LPCs are slightly less likely to receive at least one employer-sponsored benefit (73% vs. 74%). Virginia's LPCs are slightly more likely to indicate that they are satisfied with their current work situation (96% vs. 95%), although there has been no change among those LPCs who indicated that they are very satisfied (70%).

A Closer Look:

Licensees		
License Status	**#**	**%**
Renewing Practitioners	6,791	83%
New Licensees	986	12%
Non-Renewals	391	5%
All Licensees	**8,168**	**100%**

Source: Va. Healthcare Workforce Data Center

HWDC surveys tend to achieve very high response rates. Among all renewing LPCs, 97% submitted a survey. These represent 86% of the 8,168 LPCs who held a license at some point during the survey period.

Definitions

1. **The Survey Period:** The survey was conducted in June 2022.
2. **Target Population:** All LPCs who held a Virginia license at some point between July 2021 and June 2022.
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 2022.

Response Rates			
Statistic	**Non Respondents**	**Respondents**	**Response Rate**
By Age			
Under 35	238	875	79%
35 to 39	184	1,144	86%
40 to 44	147	1,077	88%
45 to 49	114	844	88%
50 to 54	107	815	88%
55 to 59	81	636	89%
60 to 64	72	576	89%
65 and Over	179	1,079	86%
Total	**1,122**	**7,046**	**86%**
New Licenses			
Issued in Past Year	563	423	43%
Metro Status			
Non-Metro	61	542	90%
Metro	735	5,382	88%
Not in Virginia	326	1,121	77%

Source: Va. Healthcare Workforce Data Center

Response Rates	
Completed Surveys	**7,046**
Response Rate, All Licensees	**86%**
Response Rate, Renewals	**97%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Licensed LPCs

Number:	8,168
New:	12%
Not Renewed:	5%

Response Rates

All Licensees:	86%
Renewing Practitioners:	97%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Workforce

Virginia's LPC Workforce:	6,799
FTEs:	5,621

Utilization Ratios

Licensees in VA Workforce:	83%
Licensees per FTE:	1.45
Workers per FTE:	1.21

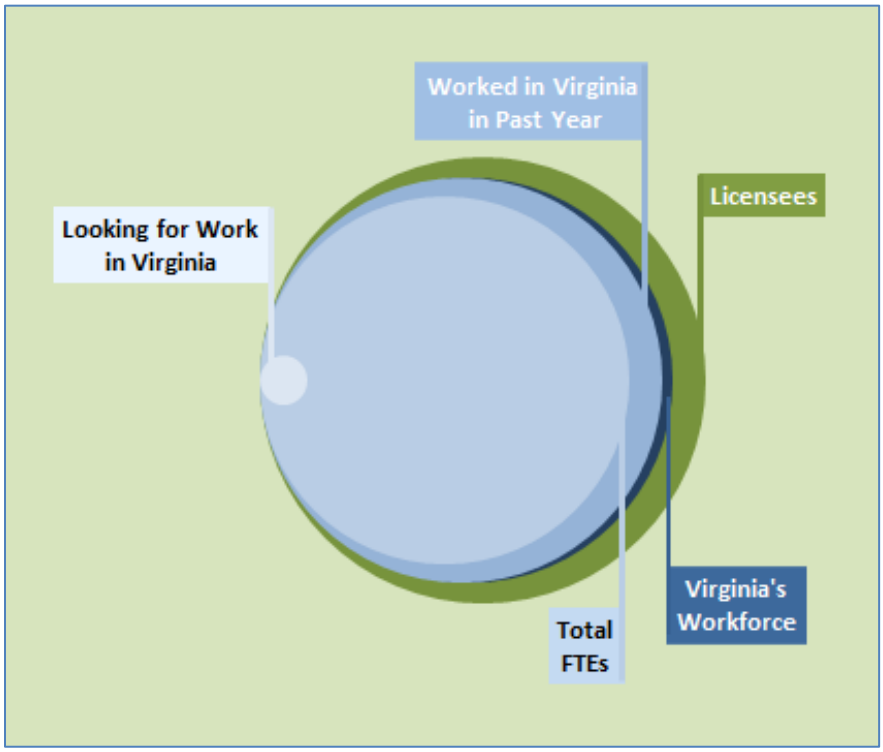
Source: Va. Healthcare Workforce Data Center

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	6,703	99%
Looking for Work in Virginia	96	1%
Virginia's Workforce	**6,799**	**100%**
Total FTEs	**5,621**	
Licensees	**8,168**	

Source: Va. Healthcare Workforce Data Center



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/

A Closer Look:

Age & Gender						
Age	Male		Female		Total	
	#	% Male	#	% Female	#	% in Age Group
Under 35	108	12%	798	88%	906	16%
35 to 39	149	16%	808	84%	957	17%
40 to 44	122	14%	760	86%	882	15%
45 to 49	112	17%	540	83%	653	11%
50 to 54	110	17%	529	83%	639	11%
55 to 59	74	15%	403	85%	477	8%
60 to 64	111	26%	314	74%	425	7%
65 and Over	240	30%	570	70%	810	14%
Total	**1,025**	**18%**	**4,723**	**82%**	**5,749**	**100%**

Source: Va. Healthcare Workforce Data Center

Race & Ethnicity					
Race/ Ethnicity	Virginia*	LPCs		LPCs Under 40	
	%	#	%	#	%
White	60%	4,230	73%	1,294	70%
Black	19%	1,021	18%	350	19%
Asian	7%	88	2%	30	2%
Other Race	0%	42	1%	8	0%
Two or More Races	3%	136	2%	58	3%
Hispanic	10%	261	5%	117	6%
Total	**100%**	**5,778**	**100%**	**1,857**	**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, 2021.

Source: Va. Healthcare Workforce Data Center

At a Glance:

Gender

% Female:	82%
% Under 40 Female:	86%

Age

Median Age:	46
% Under 40:	32%
% 55 and Over:	30%

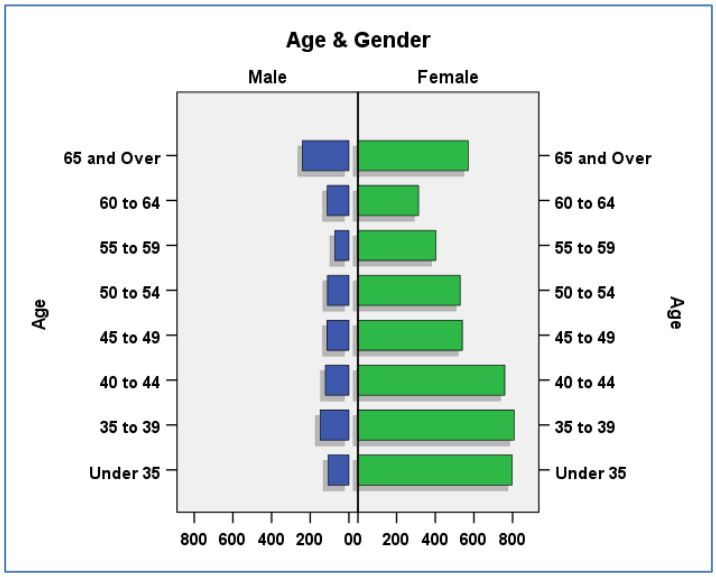
Diversity

Diversity Index:	43%
Under 40 Div. Index:	47%

Source: Va. Healthcare Workforce Data Center

In a chance encounter between two LPCs, there is a 43% chance that they would be of different races or ethnicities, a measure known as the diversity index. For Virginia's population as a whole, the comparable diversity index is 58%.

Nearly one-third of all LPCs are under the age of 40, and 86% 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 47%.



Source: Va. Healthcare Workforce Data Center

At a Glance:

Childhood

Urban Childhood:	15%
Rural Childhood:	30%

Virginia Background

HS in Virginia:	50%
Prof. Edu. in VA:	64%
HS or Prof. Edu. in VA:	74%

Location Choice

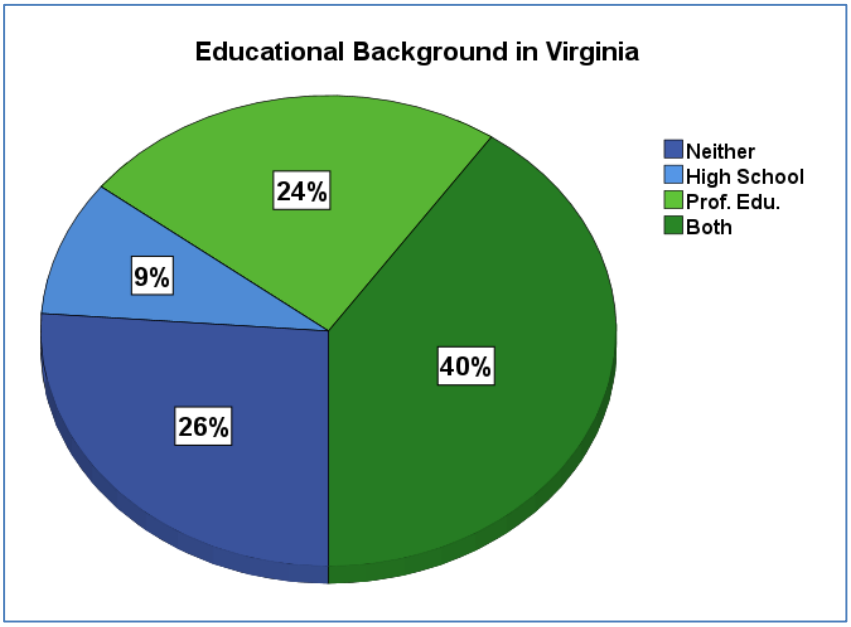
% Rural to Non-Metro:	21%
% Urban/Suburban to Non-Metro:	4%

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%	61%	18%
2	Metro, 250,000 to 1 Million	40%	50%	11%
3	Metro, 250,000 or Less	42%	48%	10%
	Non-Metro Counties			
4	Urban, Pop. 20,000+, Metro Adjacent	68%	19%	13%
6	Urban, Pop. 2,500-19,999, Metro Adjacent	63%	30%	7%
7	Urban, Pop. 2,500-19,999, Non-Adjacent	88%	8%	4%
8	Rural, Metro Adjacent	63%	31%	6%
9	Rural, Non-Adjacent	67%	23%	9%
	Overall	**30%**	**55%**	**15%**

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

Three out of every ten LPCs grew up in a self-described rural area, and 21% of LPCs who grew up in a rural area currently work in a non-metro county. In total, 9% of all LPCs in the state currently work in a non-metro county.

Top Ten States for Licensed Professional Counselor Recruitment

Rank	All LPCs			
	High School	#	Init. Prof. Degree	#
1	Virginia	2,834	Virginia	3,660
2	Pennsylvania	306	Washington, D.C.	189
3	New York	303	Maryland	173
4	Maryland	242	Minnesota	167
5	Outside U.S./Canada	196	Pennsylvania	137
6	North Carolina	191	North Carolina	122
7	Florida	152	Florida	112
8	Ohio	141	New York	106
9	New Jersey	135	Kentucky	91
10	California	90	Texas	74

Source: Va. Healthcare Workforce Data Center

One-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, one-half received their high school degree in Virginia, while 62% received their initial professional degree in the state.

Rank	Licensed in the Past Five Years			
	High School	#	Init. Prof. Degree	#
1	Virginia	1,344	Virginia	1,653
2	Pennsylvania	131	Minnesota	129
3	New York	127	Washington, D.C.	93
4	Maryland	112	Pennsylvania	78
5	North Carolina	102	Maryland	77
6	Outside U.S./Canada	93	New York	62
7	Florida	81	North Carolina	58
8	Ohio	66	Kentucky	58
9	New Jersey	55	Florida	54
10	Texas	48	Massachusetts	33

Source: Va. Healthcare Workforce Data Center

Among all licensees in Virginia, 17% 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, 89% 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:	1,368
% 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	3	0%
Master's Degree	4,939	88%
Doctor of Psychology	115	2%
Other Doctorate	536	10%
Total	**5,594**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

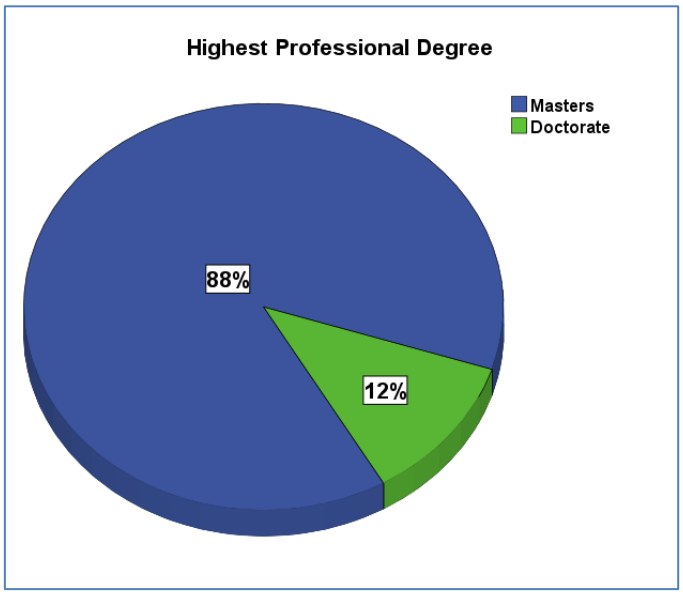
Education

Masters: 88%
Doctorate/PhD: 12%

Education Debt

Carry Debt: 52%
Under Age 40 w/ Debt: 69%
Median Debt: $90k-$100k

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

Education Debt				
Amount Carried	**All LPCs**		**LPCs Under 40**	
	#	**%**	**#**	**%**
None	2,356	48%	478	31%
Less than $10,000	180	4%	56	4%
$10,000-$29,999	302	6%	115	7%
$30,000-$49,999	250	5%	87	6%
$50,000-$69,999	262	5%	113	7%
$70,000-$89,999	263	5%	143	9%
$90,000-$109,999	342	7%	165	11%
$110,000-$129,999	246	5%	124	8%
$130,000-$149,999	187	4%	84	5%
$150,000 or More	515	11%	188	12%
Total	**4,903**	**100%**	**1,553**	**100%**

Source: Va. Healthcare Workforce Data Center

More than half of all LPCs carry education debt, including 69% of those LPCs who are under the age of 40. For those LPCs with education debt, the median debt amount is between $90,000 and $100,000.

At a Glance:

Primary Specialty

Mental Health:	65%
Child:	7%
Substance Abuse:	5%

Secondary Specialty

Substance Abuse:	14%
Mental Health:	14%
Behavioral Disorders:	14%

Source: Va. Healthcare Workforce Data Center

Nearly two-thirds of all 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	3,595	65%	679	14%
Child	367	7%	418	9%
Substance Abuse	270	5%	701	14%
Behavioral Disorders	267	5%	656	14%
Family	127	2%	356	7%
Marriage	100	2%	307	6%
School/Educational	85	2%	192	4%
Sex Offender Treatment	40	1%	60	1%
Forensic	27	0%	47	1%
Rehabilitation	22	0%	28	1%
Vocational/Work Environment	18	0%	43	1%
Health/Medical	17	0%	41	1%
Gerontologic	6	0%	5	0%
Public Health	5	0%	15	0%
Industrial-Organizational	3	0%	10	0%
Neurology/Neuropsychology	2	0%	19	0%
Social	1	0%	23	0%
Experimental or Research	0	0%	4	0%
General Practice (Non-Specialty)	385	7%	812	17%
Other Specialty Area	219	4%	423	9%
Total	**5,556**	**100%**	**4,836**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Employment

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

Positions Held

1 Full-Time: 55%
2 or More Positions: 28%

Weekly Hours:

40 to 49: 41%
60 or More: 6%
Less than 30: 20%

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	5,330	94%
Employed, NOT in a Behavioral Sciences-Related Capacity	152	3%
Not Working, Reason Unknown	0	0%
Involuntarily Unemployed	5	< 1%
Voluntarily Unemployed	84	2%
Retired	72	1%
Total	**5,647**	**100%**

Source: Va. Healthcare Workforce Data Center

Among all LPCs, 94% are currently employed in the profession, 55% hold one full-time job, and 41% work between 40 and 49 hours per week.

Current Weekly Hours		
Hours	**#**	**%**
0 Hours	161	3%
1 to 9 Hours	150	3%
10 to 19 Hours	358	6%
20 to 29 Hours	615	11%
30 to 39 Hours	1,010	18%
40 to 49 Hours	2,249	41%
50 to 59 Hours	686	12%
60 to 69 Hours	239	4%
70 to 79 Hours	56	1%
80 or More Hours	24	0%
Total	**5,548**	**100%**

Source: Va. Healthcare Workforce Data Center

Current Positions		
Positions	**#**	**%**
No Positions	161	3%
One Part-Time Position	828	15%
Two Part-Time Positions	257	5%
One Full-Time Position	3,033	55%
One Full-Time Position & One Part-Time Position	1,085	20%
Two Full-Time Positions	53	1%
More than Two Positions	146	3%
Total	**5,563**	**100%**

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Annual Income		
Income Level	**#**	**%**
Volunteer Work Only	53	1%
Less than $20,000	228	5%
$20,000-$29,999	186	4%
$30,000-$39,999	200	5%
$40,000-$49,999	354	8%
$50,000-$59,999	490	11%
$60,000-$69,999	647	15%
$70,000-$79,999	635	14%
$80,000-$89,999	519	12%
$90,000-$99,999	333	8%
$100,000 or More	781	18%
Total	**4,423**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Earnings
Median Income: $70k-$80k

Benefits
(Salary/Wage Employees Only)
Health Insurance: 60%
Retirement: 56%

Satisfaction
Satisfied: 96%
Very Satisfied: 70%

Source: Va. Healthcare Workforce Data Center

Job Satisfaction		
Level	**#**	**%**
Very Satisfied	3,815	70%
Somewhat Satisfied	1,414	26%
Somewhat Dissatisfied	177	3%
Very Dissatisfied	51	1%
Total	**5,455**	**100%**

Source: Va. Healthcare Workforce Data Center

The typical LPC earns between $70,000 and $80,000 per year. Among LPCs who receive either an hourly wage or a salary as compensation at their primary work location, 73% receive at least one employer-sponsored benefit, including 60% who have access to health insurance.

Employer-Sponsored Benefits			
Benefit	**#**	**%**	**% of Wage/Salary Employees**
Paid Vacation	2,392	45%	65%
Health Insurance	2,269	43%	60%
Dental Insurance	2,132	40%	57%
Retirement	2,120	40%	56%
Paid Sick Leave	2,098	39%	57%
Group Life Insurance	1,553	29%	42%
Signing/Retention Bonus	367	7%	10%
At Least One Benefit	**2,828**	**53%**	**73%**

*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 . . .?	**#**	**%**
Experienced Involuntary Unemployment?	29	0%
Experience Voluntary Unemployment?	233	3%
Work Part-Time or Temporary Positions, but Would Have Preferred a Full-Time/Permanent Position?	145	2%
Work Two or More Positions at the Same Time?	1,771	26%
Switch Employers or Practices?	495	7%
Experience at Least One?	**2,295**	**34%**

Source: Va. Healthcare Workforce Data Center

Less than 1% of Virginia's LPCs experienced involuntary unemployment at some point during the past year. By comparison, Virginia's average monthly unemployment rate was 3.1% during the same time period.[1]

Location Tenure				
Tenure	**Primary**		**Secondary**	
	#	**%**	**#**	**%**
Not Currently Working at This Location	87	2%	60	4%
Less than 6 Months	258	5%	149	10%
6 Months to 1 Year	533	10%	194	13%
1 to 2 Years	1,127	21%	370	25%
3 to 5 Years	1,446	27%	360	24%
6 to 10 Years	900	17%	203	14%
More than 10 Years	1,048	19%	162	11%
Subtotal	**5,399**	**100%**	**1,498**	**100%**
Did Not Have Location	104		5,207	
Item Missing	1,296		94	
Total	**6,799**		**6,799**	

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: < 1%
Underemployed: 2%

Turnover & Tenure

Switched Jobs: 7%
New Location: 21%
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	2,176	55%
Hourly Wage	543	14%
By Contract	324	8%
Business/Practice Income	890	22%
Unpaid	32	1%
Subtotal	**3,966**	**100%**
Did Not Have Location	104	
Item Missing	2,729	

Source: Va. Healthcare Workforce Data Center

[1] 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 2.5% and a high of 4.2%. At the time of publication, the unemployment rate for June 2022 was still preliminary.

At a Glance:

Concentration

Top Region:	28%
Top 3 Regions:	70%
Lowest Region:	1%

Locations

2 or More (Past Year):	29%
2 or More (Now*):	26%

Source: Va. Healthcare Workforce Data Center

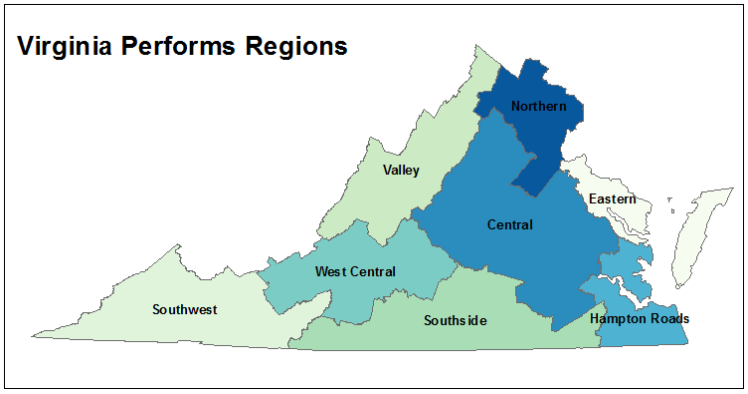
Seven out of every ten LPCs in the state work in Northern Virginia, Central Virginia, and Hampton Roads.

A Closer Look:

Regional Distribution of Work Locations

Virginia Performs Region	Primary Location		Secondary Location	
	#	%	#	%
Central	1,149	21%	316	20%
Eastern	55	1%	21	1%
Hampton Roads	1,118	21%	336	22%
Northern	1,516	28%	408	26%
Southside	190	4%	58	4%
Southwest	230	4%	50	3%
Valley	367	7%	79	5%
West Central	717	13%	178	11%
Virginia Border State/D.C.	23	0%	40	3%
Other U.S. State	41	1%	68	4%
Outside of the U.S.	0	0%	2	0%
Total	**5,406**	**100%**	**1,556**	**100%**
Item Missing	1,289		35	

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	95	2%	153	3%
1	3,808	69%	3,890	71%
2	854	16%	823	15%
3	679	12%	598	11%
4	29	1%	16	0%
5	12	0%	6	0%
6 or More	11	0%	2	0%
Total	**5,488**	**100%**	**5,488**	**100%**

*At the time of survey completion, June 2022.

Source: Va. Healthcare Workforce Data Center

Among all LPCs, 26% currently have multiple work locations, while 29% have had multiple work locations over the past year.

A Closer Look:

Location Sector				
Sector	Primary Location		Secondary Location	
	#	%	#	%
For-Profit	3,242	64%	1,102	79%
Non-Profit	818	16%	174	12%
State/Local Government	890	17%	101	7%
Veterans Administration	23	0%	2	0%
U.S. Military	76	1%	6	0%
Other Federal Government	42	1%	11	1%
Total	**5,091**	**100%**	**1,396**	**100%**
Did Not Have Location	104		5,207	
Item Missing	1,604		196	

Source: Va. Healthcare Workforce Data Center

At a Glance:
(Primary Locations)

Sector

For-Profit: 64%
Federal: 3%

Top Establishments

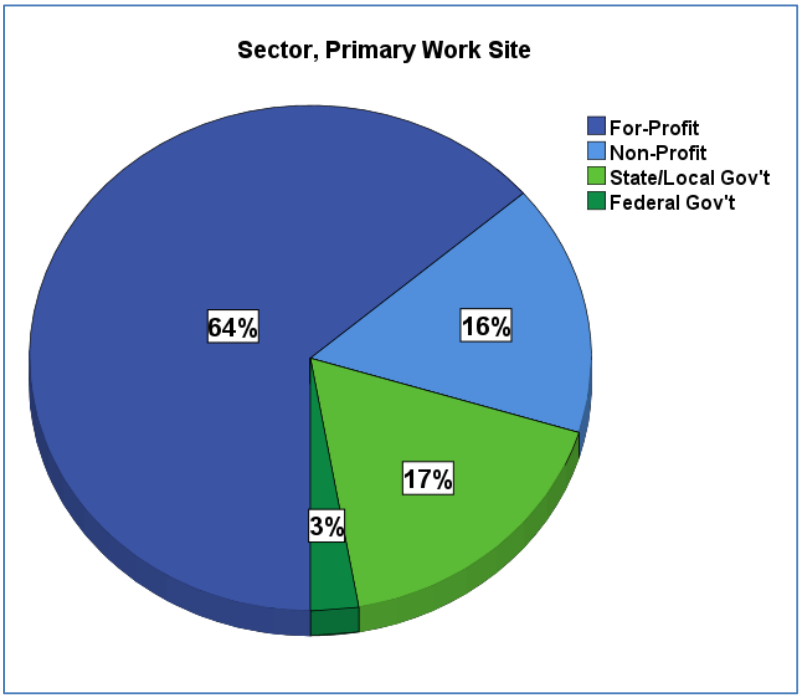
Private Practice, Group: 22%
Private Practice, Solo: 20%
Mental Health Facility: 13%

Payment Method

Cash/Self-Pay: 65%
Private Insurance: 56%

Source: Va. Healthcare Workforce Data Center

Four out of every five LPCs work in the private sector, including 64% who work in the for-profit sector. Another 17% 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	1,086	22%	348	26%
Private Practice, Solo	989	20%	311	23%
Mental Health Facility, Outpatient	645	13%	186	14%
Community Services Board	619	12%	75	6%
Community-Based Clinic or Health Center	419	8%	120	9%
School (Providing Care to Clients)	263	5%	18	1%
Academic Institution (Teaching Health Professions Students)	144	3%	60	4%
Residential Mental Health/Substance Abuse Facility	91	2%	24	2%
Hospital, Psychiatric	83	2%	18	1%
Corrections/Jail	79	2%	16	1%
Hospital, General	65	1%	15	1%
Administrative or Regulatory	47	1%	8	1%
Physician Office	20	0%	0	0%
Rehabilitation Facility	14	0%	1	0%
Residential Intellectual/Development Disability Facility	9	0%	1	0%
Long-Term Care Facility, Nursing Home	6	0%	2	0%
Home Health Care	4	0%	1	0%
Other Practice Setting	370	7%	141	10%
Total	**4,953**	**100%**	**1,345**	**100%**

Source: Va. Healthcare Workforce Data Center

Group and solo private practices employ more than 40% of all LPCs in Virginia. Another 13% of LPCs work at outpatient mental health facilities.

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	4,431	65%
Private Insurance	3,788	56%
Medicaid	2,532	37%
Medicare	584	9%

Source: Va. Healthcare Workforce Data Center

At a Glance:
(Primary Locations)

Languages Offered

Spanish:	15%
French:	4%
Chinese:	4%

Means of Communication

Other Staff Members:	44%
Virtual Translation:	41%
Respondent:	26%

Source: Va. Healthcare Workforce Data Center

Among all LPCs, 15% are employed at a primary work location that offers Spanish language services for patients.

A Closer Look:

Languages Offered		
Language	**#**	**% of Workforce**
Spanish	1,002	15%
French	275	4%
Chinese	263	4%
Arabic	261	4%
Korean	252	4%
Vietnamese	222	3%
Hindi	212	3%
Persian	210	3%
Urdu	201	3%
Tagalog/Filipino	200	3%
Amharic, Somali, or Other Afro-Asiatic Languages	187	3%
Pashto	180	3%
Other Language	205	3%
At Least One Language	**1,160**	**17%**

Source: Va. Healthcare Workforce Data Center

Means of Language Communication		
Provision	**#**	**% of Workforce with Language Services**
Other Staff Member is Proficient	514	44%
Virtual Translation Services	477	41%
Respondent is Proficient	302	26%
Onsite Translation Service	260	22%
Other	57	5%

Source: Va. Healthcare Workforce Data Center

More than two out of every five LPCs who are employed at a primary work location that offers language services for patients provide it by means of a staff member who is proficient.

At a Glance:
(Primary Locations)

Typical Time Allocation

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

Roles

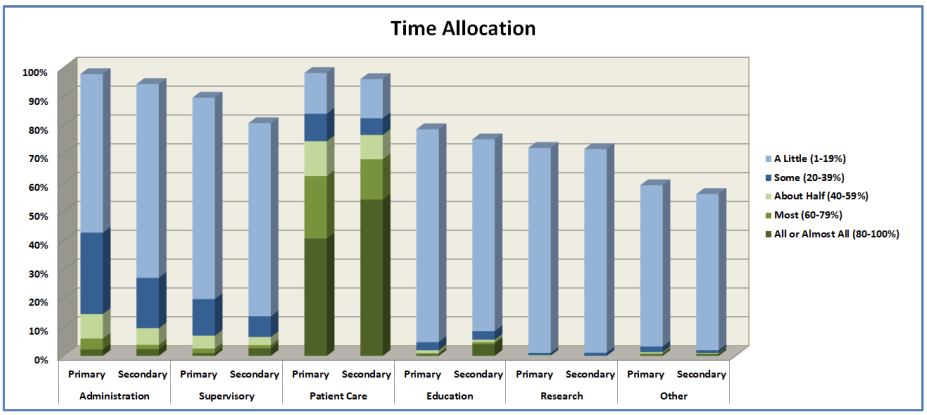
Patient Care:	62%
Administration:	6%
Supervisory:	3%

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, 62% 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%)	2%	2%	1%	3%	41%	54%	1%	4%	0%	0%	0%	1%
Most (60-79%)	4%	1%	2%	1%	22%	14%	0%	1%	0%	0%	0%	0%
About Half (40-59%)	8%	6%	4%	3%	12%	8%	1%	1%	0%	0%	0%	0%
Some (20-39%)	28%	17%	13%	7%	10%	6%	3%	3%	1%	1%	2%	1%
A Little (1-19%)	55%	67%	70%	67%	14%	14%	74%	66%	71%	71%	56%	54%
None (0%)	2%	6%	10%	19%	2%	4%	21%	25%	28%	28%	41%	44%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Patients Per Week				
# of Patients	Primary Location		Secondary Location	
	#	%	#	%
None	422	8%	153	11%
1 to 24	3,054	61%	1,063	79%
25 to 49	1,444	29%	106	8%
50 to 74	69	1%	11	1%
75 or More	49	1%	13	1%
Total	**5,038**	**100%**	**1,346**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

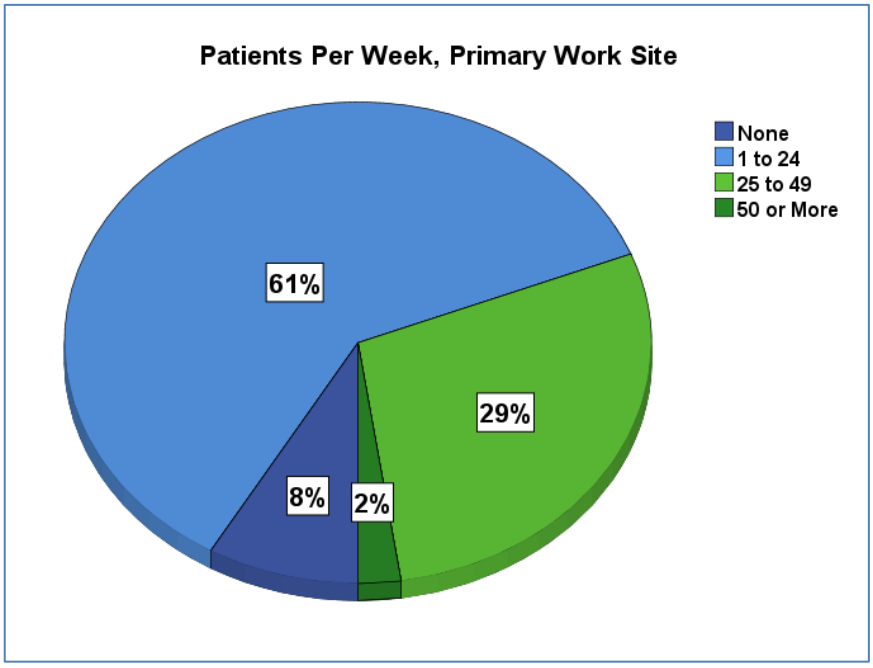
Patients Per Week

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, nearly 80% treat between 1 and 24 patients per week.



Source: Va. Healthcare Workforce Data Center

At a Glance:
(Primary Locations)

Typical Patient Allocation

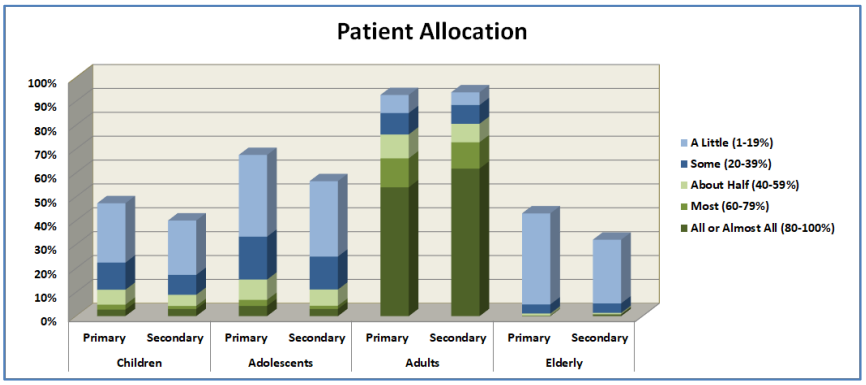
Children:	None
Adolescents:	1%-9%
Adults:	80%-89%
Elderly:	None

Roles

Children:	5%
Adolescents:	7%
Adults:	66%
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, 66% 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%	3%	4%	3%	54%	62%	0%	1%
Most (60-79%)	2%	1%	3%	1%	12%	11%	0%	0%
About Half (40-59%)	6%	5%	8%	7%	10%	8%	1%	1%
Some (20-39%)	11%	8%	18%	14%	9%	8%	4%	4%
A Little (1-19%)	25%	23%	34%	32%	8%	5%	38%	27%
None (0%)	53%	60%	32%	43%	7%	6%	57%	68%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Retirement Expectations				
Expected Retirement Age	All LPCs		LPCs 50 and Over	
	#	%	#	%
Under Age 50	69	1%	-	-
50 to 54	140	3%	12	1%
55 to 59	310	7%	56	3%
60 to 64	812	17%	206	10%
65 to 69	1,418	30%	548	28%
70 to 74	930	20%	543	27%
75 to 79	349	7%	222	11%
80 or Over	180	4%	115	6%
I Do Not Intend to Retire	537	11%	281	14%
Total	**4,744**	**100%**	**1,983**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Retirement Expectations

All LPCs

Under 65: 28%

Under 60: 11%

LPCs 50 and Over

Under 65: 14%

Under 60: 3%

Time Until Retirement

Within 2 Years: 5%

Within 10 Years: 20%

Half the Workforce: By 2047

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.

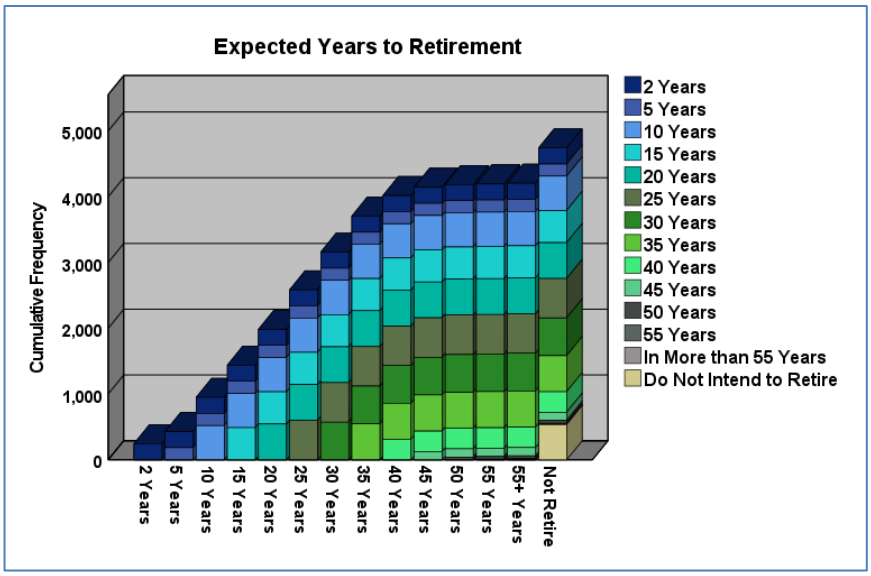
Future Plans		
Two-Year Plans:	#	%
Decrease Participation		
Leave Profession	71	1%
Leave Virginia	166	2%
Decrease Patient Care Hours	657	10%
Decrease Teaching Hours	52	1%
Increase Participation		
Increase Patient Care Hours	982	14%
Increase Teaching Hours	503	7%
Pursue Additional Education	776	11%
Return to the Workforce	37	1%

Source: Va. Healthcare Workforce Data Center

By comparing retirement expectation to age, we can estimate the maximum years to retirement for LPCs. While 5% 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 2047.

Time to Retirement			
Expect to Retire Within. . .	**#**	**%**	**Cumulative %**
2 Years	245	5%	5%
5 Years	184	4%	9%
10 Years	522	11%	20%
15 Years	490	10%	30%
20 Years	545	11%	42%
25 Years	600	13%	55%
30 Years	573	12%	67%
35 Years	549	12%	78%
40 Years	312	7%	85%
45 Years	126	3%	87%
50 Years	42	1%	88%
55 Years	9	0%	88%
In More than 55 Years	11	0%	89%
Do Not Intend to Retire	537	11%	100%
Total	**4,744**	**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 2032. Retirement will peak at 13% of the current workforce around 2047 before declining to under 10% of the current workforce again around 2062.

At a Glance:

FTEs

Total:	5,621
FTEs/1,000 Residents[2]:	0.650
Average:	0.84

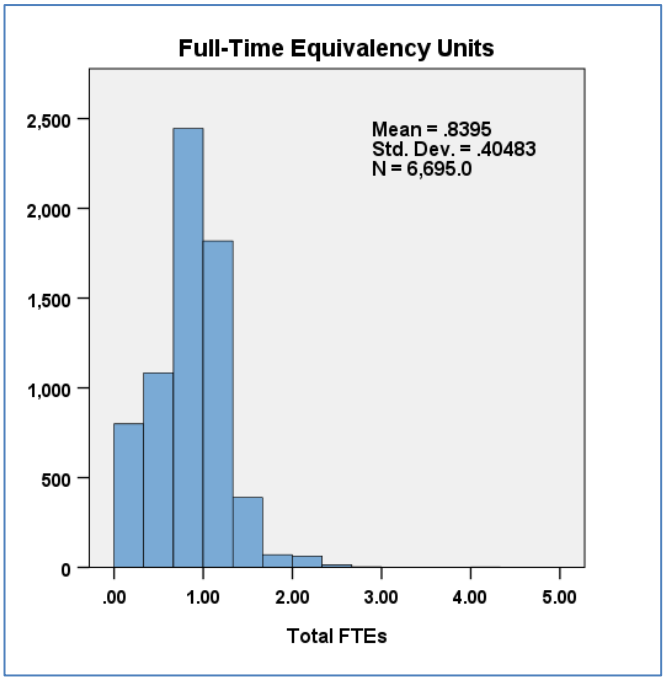
Age & Gender Effect

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:

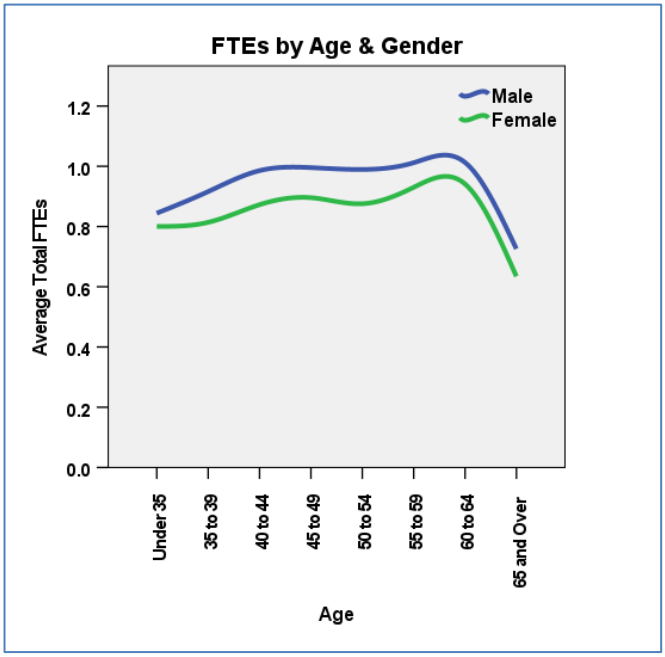


Source: Va. Healthcare Workforce Data Center

The typical (median) LPC provided 0.82 FTEs over the past year, or approximately 33 hours per week for 50 weeks. Although FTEs appear to vary by age and gender, statistical tests did not verify that a difference exists.[3]

Full-Time Equivalency Units		
Age	**Average Age**	**Median Age**
Under 35	0.80	0.80
35 to 39	0.81	0.80
40 to 44	0.88	0.84
45 to 49	0.89	0.82
50 to 54	0.85	0.83
55 to 59	0.92	0.84
60 to 64	1.00	1.09
65 and Over	0.68	0.74
Gender		
Male	0.91	0.96
Female	0.84	0.85

Source: Va. Healthcare Workforce Data Center

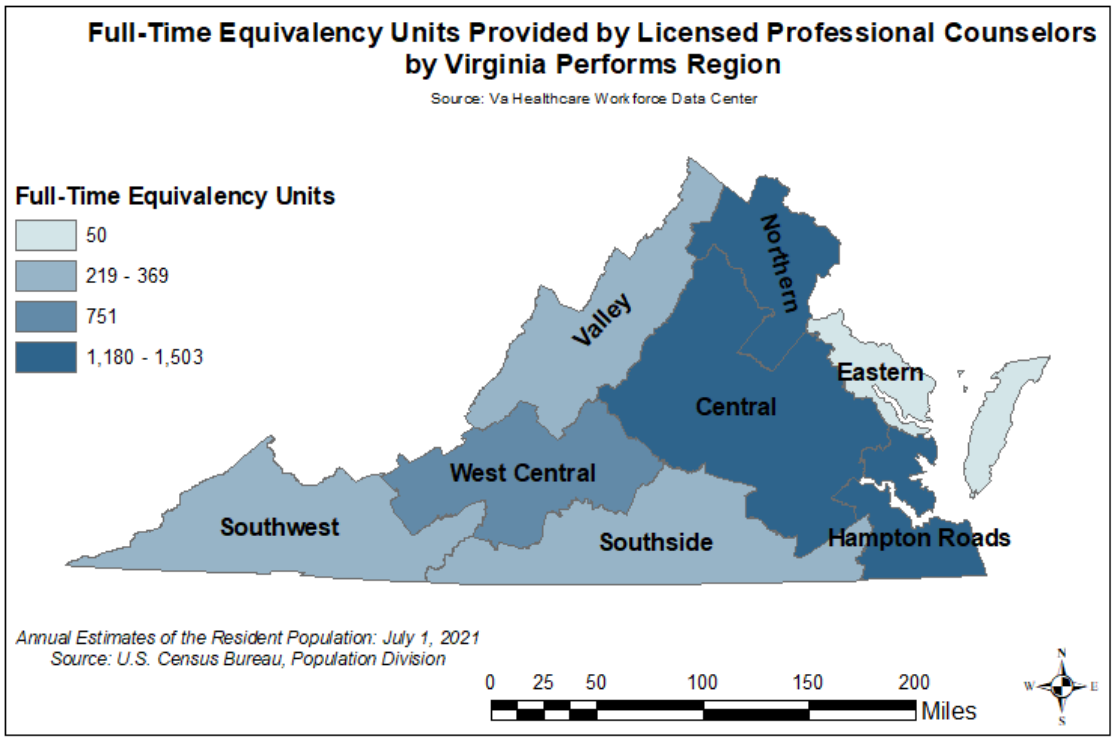


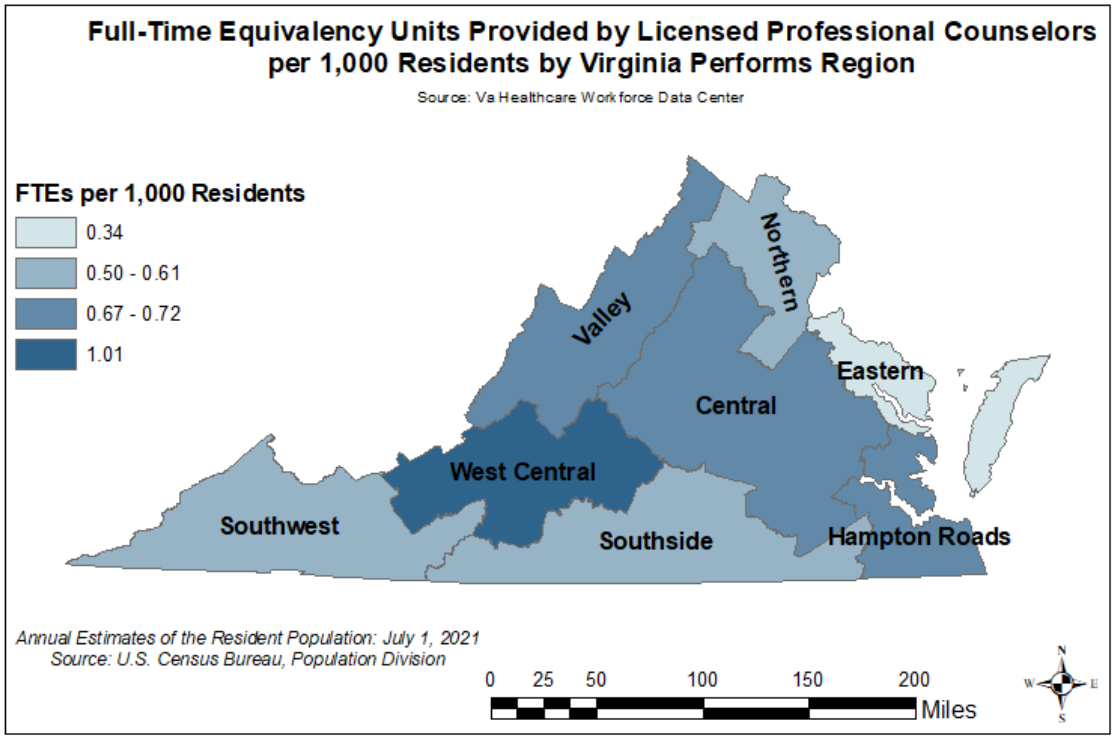
Source: Va. Healthcare Workforce Data Center

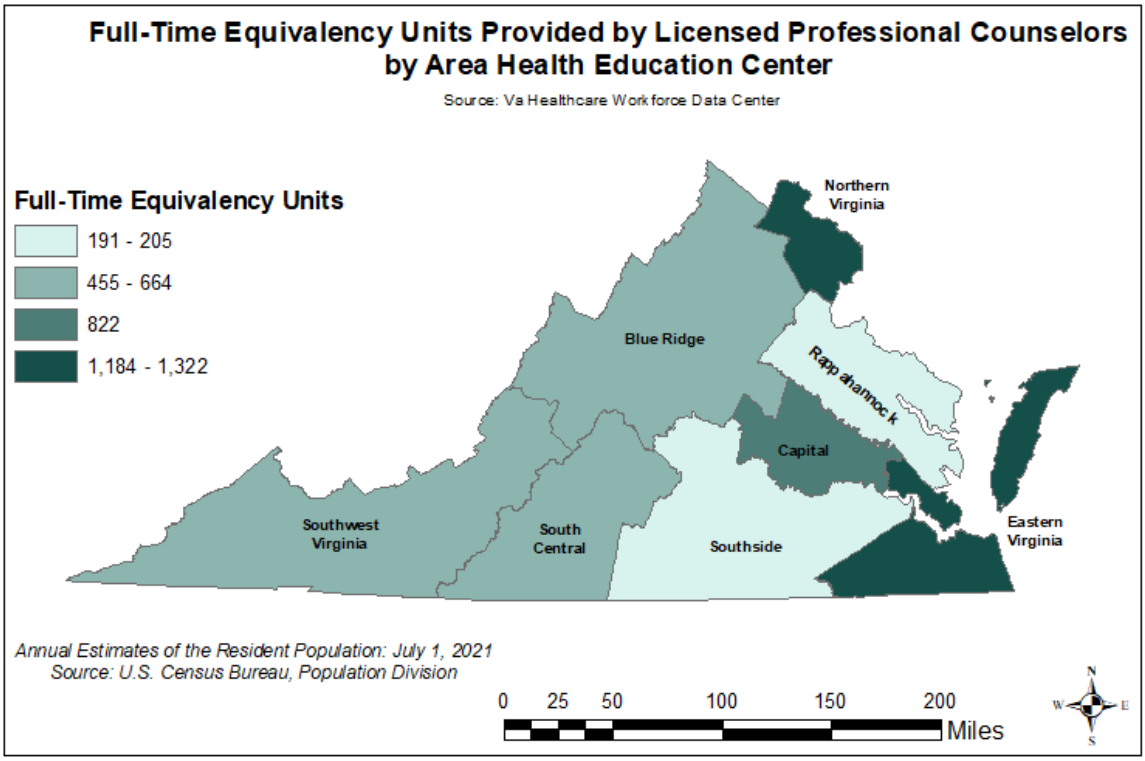
[2] Number of residents in 2021 was used as the denominator.
[3] Due to assumption violations in Mixed between-within ANOVA (Levene's Test was significant).

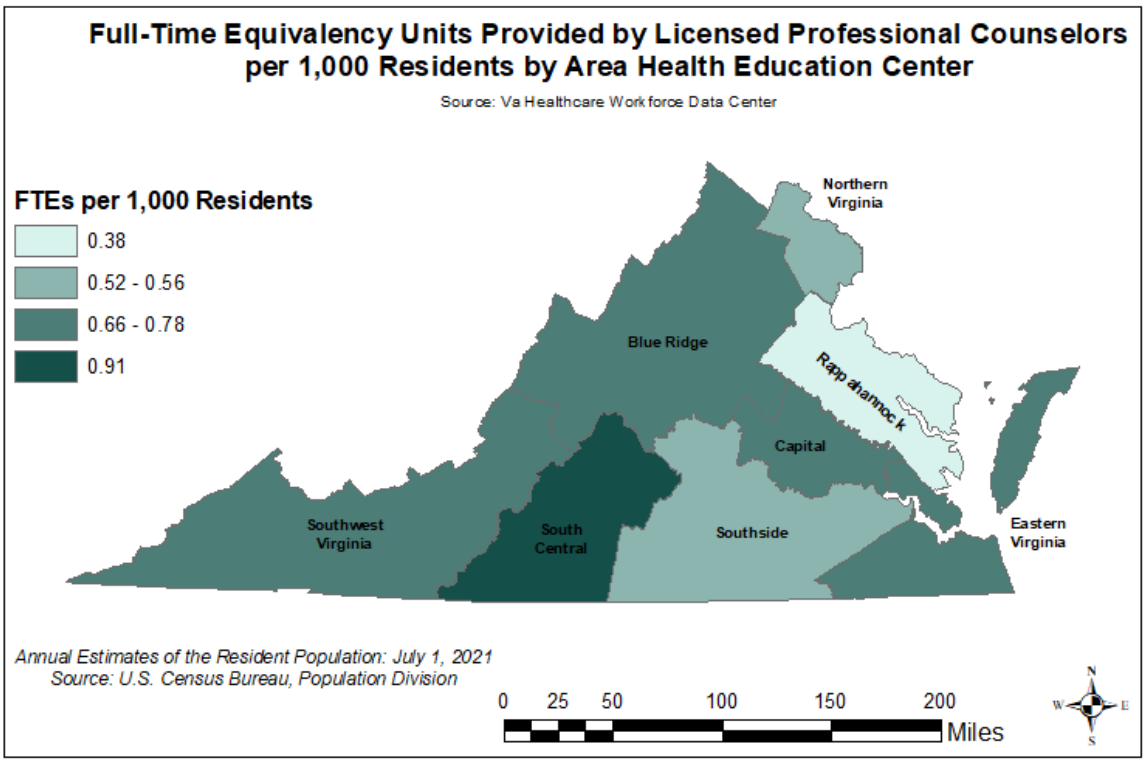
Maps

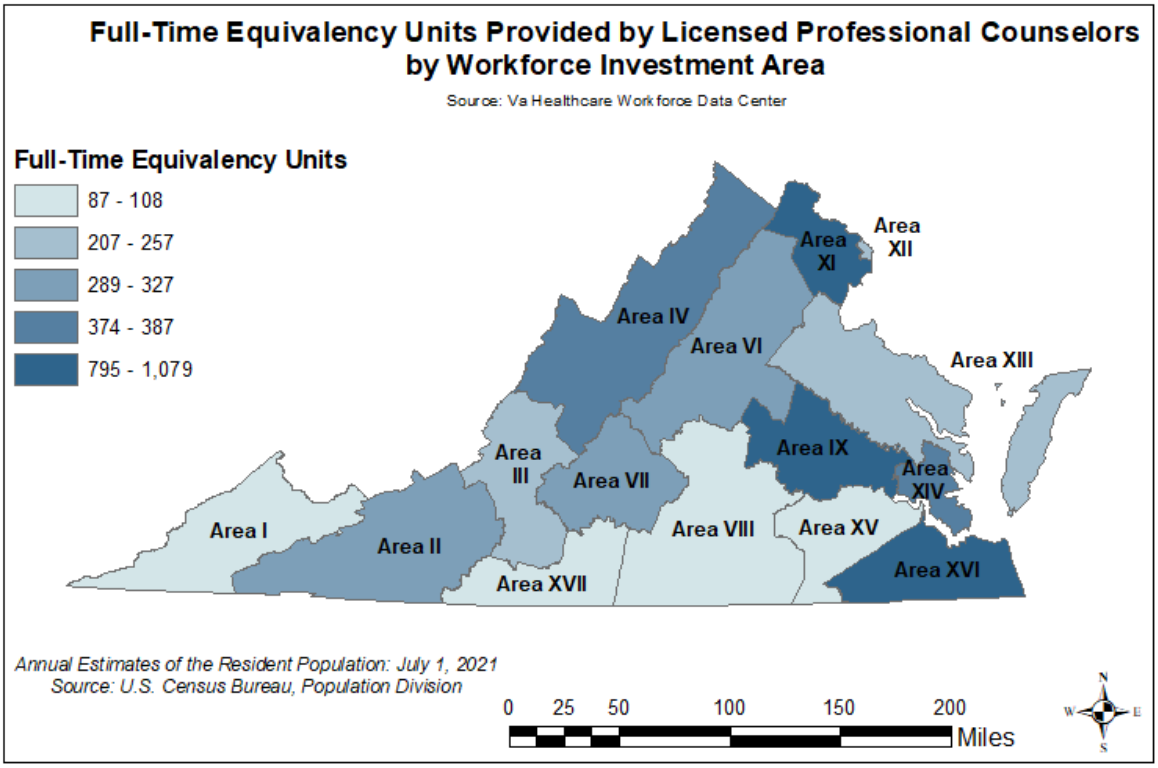
Virginia Performs Regions

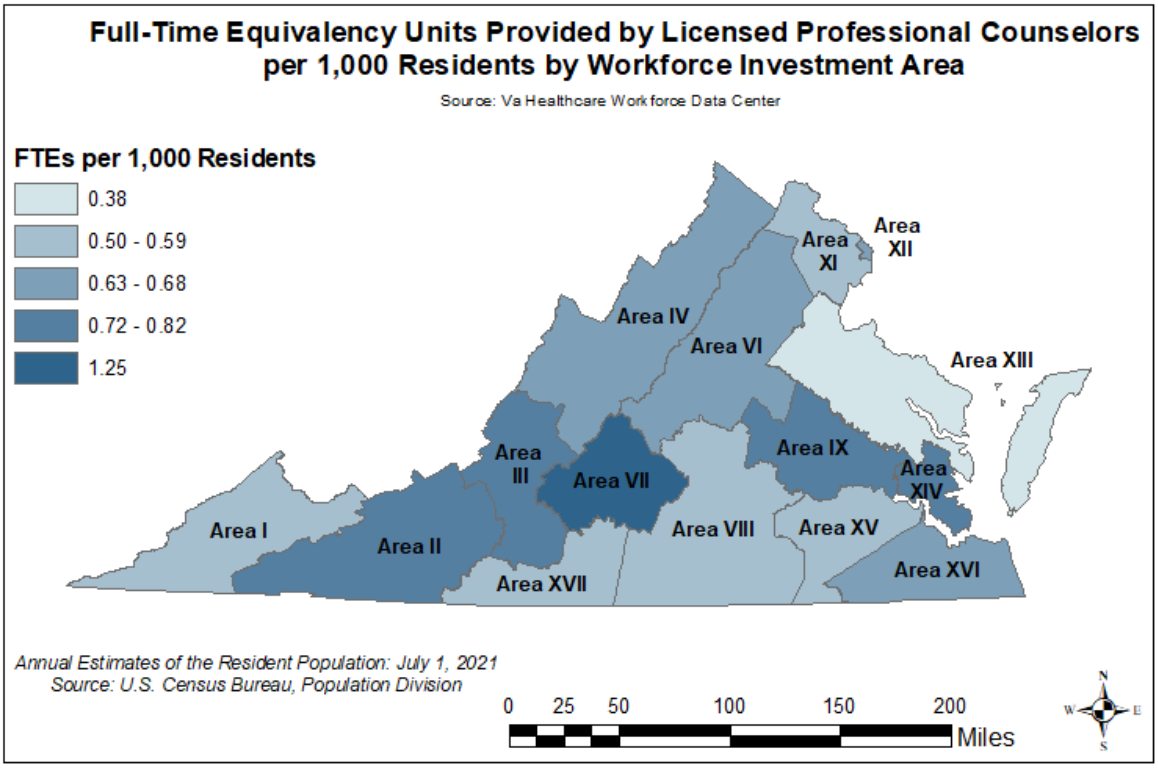


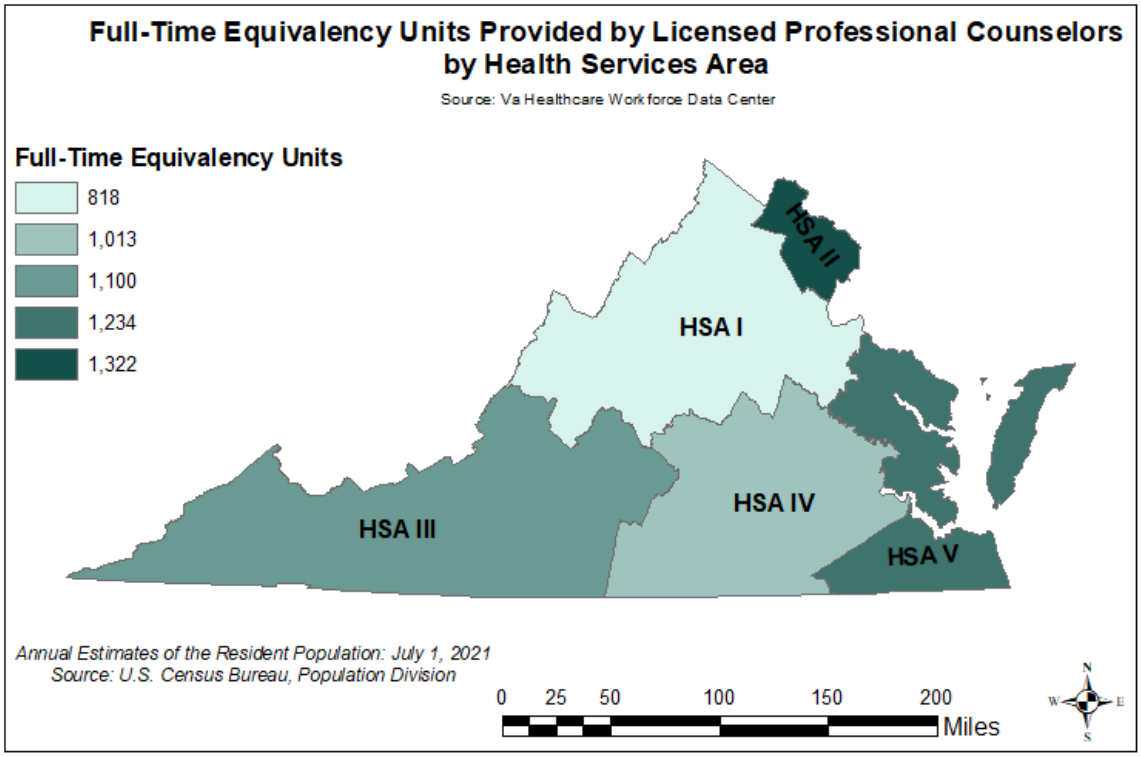


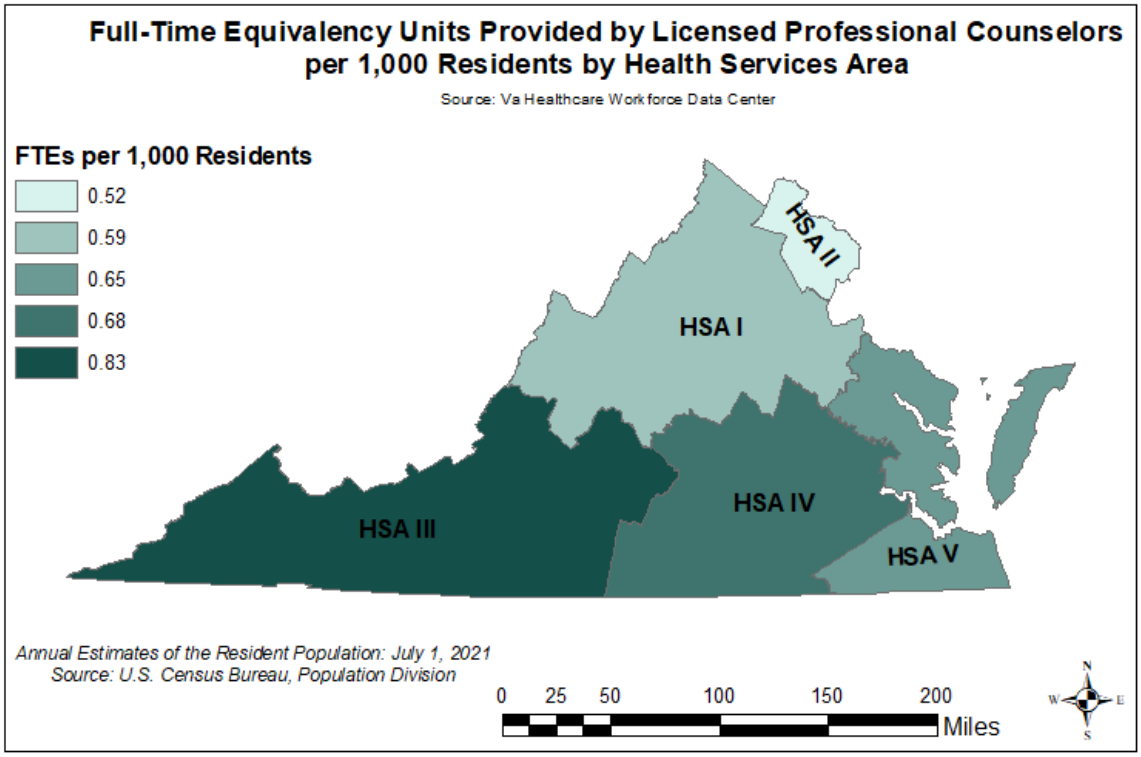

Full-Time Equivalency Units Provided by Licensed Professional Counselors by Area Health Education Center
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
191 - 205
455 - 664
822
1,184 - 1,322
Northern Virginia
Blue Ridge
Rappahannock
Capital
Eastern Virginia
Southwest Virginia
South Central
Southside
Annual Estimates of the Resident Population: July 1, 2021
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S

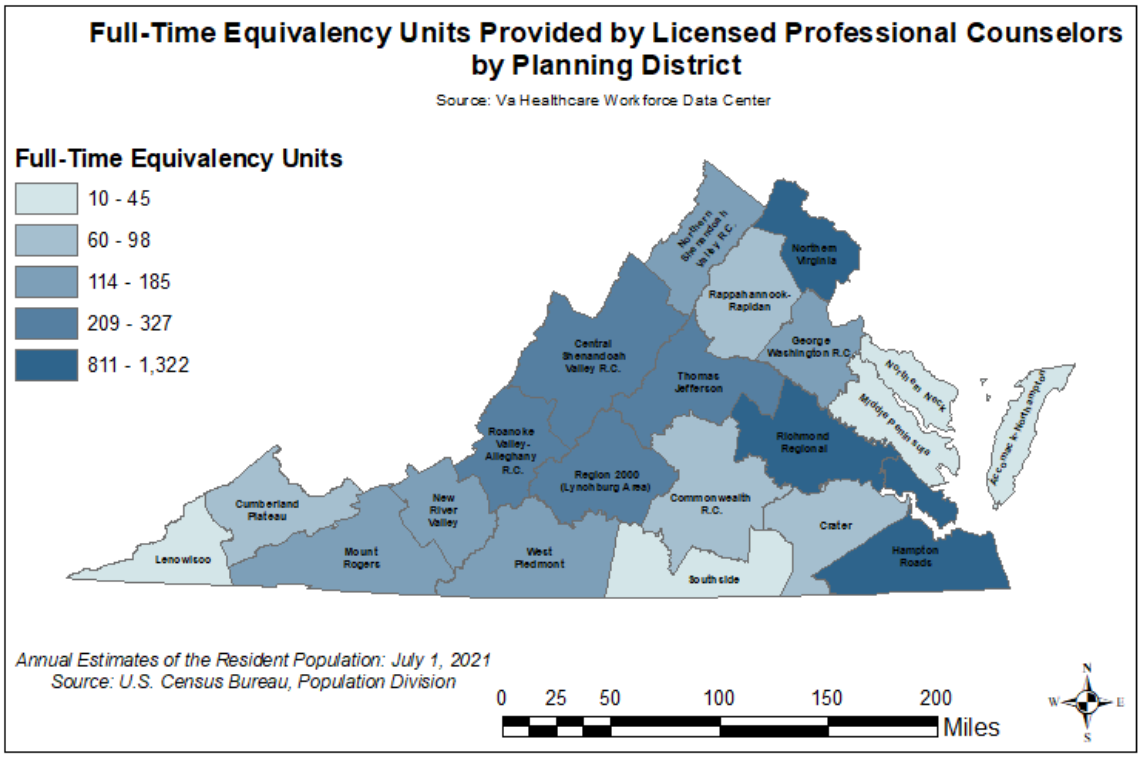

Full-Time Equivalency Units Provided by Licensed Professional Counselors per 1,000 Residents by Area Health Education Center
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.38
0.52 - 0.56
0.66 - 0.78
0.91
Northern Virginia
Blue Ridge
Rappahannock
Capital
Eastern Virginia
Southwest Virginia
South Central
Southside
Annual Estimates of the Resident Population: July 1, 2021
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S

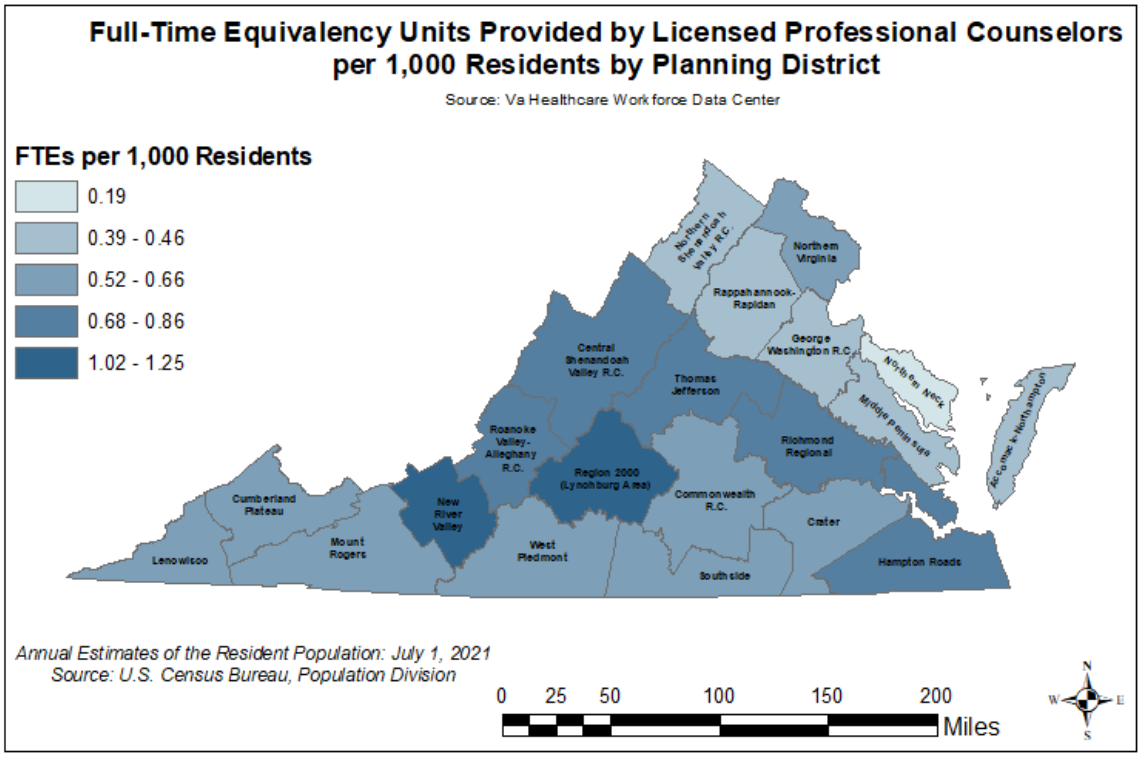

Full-Time Equivalency Units Provided by Licensed Professional Counselors by Workforce Investment Area
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
87 - 108
207 - 257
289 - 327
374 - 387
795 - 1,079
Area I
Area II
Area III
Area IV
Area VI
Area VII
Area VIII
Area IX
Area XI
Area XII
Area XIII
Area XIV
Area XV
Area XVI
Area XVII
Annual Estimates of the Resident Population: July 1, 2021
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full-Time Equivalency Units Provided by Licensed Professional Counselors per 1,000 Residents by Workforce Investment Area
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.38
0.50 - 0.59
0.63 - 0.68
0.72 - 0.82
1.25
Area I
Area II
Area III
Area IV
Area VI
Area VII
Area VIII
Area IX
Area XI
Area XII
Area XIII
Area XIV
Area XV
Area XVI
Area XVII
Annual Estimates of the Resident Population: July 1, 2021
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full-Time Equivalency Units Provided by Licensed Professional Counselors by Health Services Area
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
818
1,013
1,100
1,234
1,322
HSA I
HSA II
HSA III
HSA IV
HSA V
Annual Estimates of the Resident Population: July 1, 2021
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full-Time Equivalency Units Provided by Licensed Professional Counselors per 1,000 Residents by Health Services Area
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.52
0.59
0.65
0.68
0.83
HSA I
HSA II
HSA III
HSA IV
HSA V
Annual Estimates of the Resident Population: July 1, 2021
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full-Time Equivalency Units Provided by Licensed Professional Counselors by Planning District
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
10 - 45
60 - 98
114 - 185
209 - 327
811 - 1,322
Northern Shenandoah Valley R.C.
Northern Virginia
Rappahannock-Rapidan
George Washington R.C.
Central Shenandoah Valley R.C.
Thomas Jefferson
Northern Neck
Middle Peninsula
Accomack-Northampton
Roanoke Valley-Alleghany R.C.
Richmond Regional
Region 2000 (Lynchburg Area)
Commonwealth R.C.
Crater
Cumberland Plateau
New River Valley
Mount Rogers
West Piedmont
Lenowisco
South side
Hampton Roads
Annual Estimates of the Resident Population: July 1, 2021
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full-Time Equivalency Units Provided by Licensed Professional Counselors per 1,000 Residents by Planning District
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.19
0.39 - 0.46
0.52 - 0.66
0.68 - 0.86
1.02 - 1.25
Northern Shenandoah Valley R.C.
Northern Virginia
Rappahannock-Rapidan
George Washington R.C.
Central Shenandoah Valley R.C.
Thomas Jefferson
Northern Neck
Middle Peninsula
Accomack-Northampton
Roanoke Valley-Alleghany R.C.
Richmond Regional
Region 2000 (Lynchburg Area)
Commonwealth R.C.
Crater
Cumberland Plateau
New River Valley
Mount Rogers
West Piedmont
Lenowisco
South side
Hampton Roads
Annual Estimates of the Resident Population: July 1, 2021
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S

Appendices

Appendix A: Weights

Rural Status	Location Weight			Total Weight	
	#	Rate	Weight	Min.	Max.
Metro, 1 Million+	4,436	87.85%	1.138	1.105	1.249
Metro, 250,000 to 1 Million	787	89.07%	1.123	1.090	1.232
Metro, 250,000 or Less	894	87.70%	1.140	1.107	1.251
Urban, Pop. 20,000+, Metro Adj.	92	89.13%	1.122	1.089	1.231
Urban, Pop. 20,000+, Non-Adj.	0	NA	NA	NA	NA
Urban, Pop. 2,500-19,999, Metro Adj.	226	88.94%	1.124	1.091	1.234
Urban, Pop. 2,500-19,999, Non-Adj.	146	91.10%	1.098	1.065	1.205
Rural, Metro Adj.	100	92.00%	1.087	1.055	1.193
Rural, Non-Adj.	39	87.18%	1.147	1.113	1.259
Virginia Border State/D.C.	781	79.77%	1.254	1.217	1.376
Other U.S. State	666	74.77%	1.337	1.298	1.467

Source: Va. Healthcare Workforce Data Center

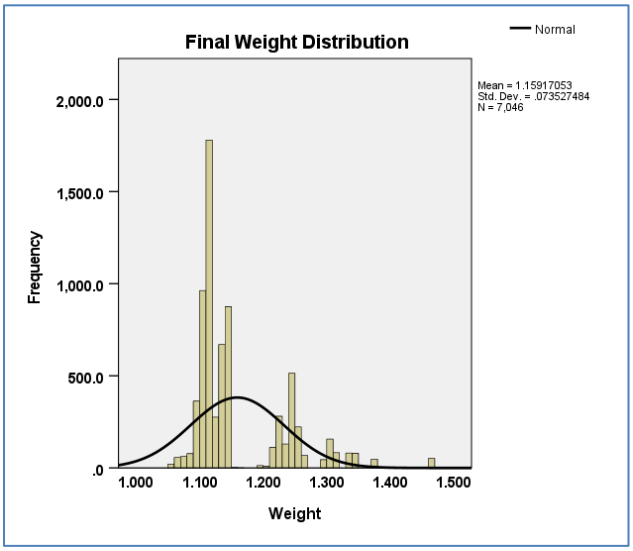
Age	Age Weight			Total Weight	
	#	Rate	Weight	Min.	Max.
Under 35	1,113	78.62%	1.272	1.193	1.467
35 to 39	1,328	86.14%	1.161	1.088	1.339
40 to 44	1,224	87.99%	1.136	1.066	1.311
45 to 49	958	88.10%	1.135	1.064	1.309
50 to 54	922	88.39%	1.131	1.061	1.305
55 to 59	717	88.70%	1.127	1.057	1.301
60 to 64	648	88.89%	1.125	1.055	1.298
65 and Over	1,258	85.77%	1.166	1.093	1.345

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: **0.862635**



Source: Va. Healthcare Workforce Data Center

Virginia Department of Health Professions
Cash Balance
As of june 30, 2021

	109 Counseling
Board Cash Balance as June 30, 2020	$ 2,083,660
YTD FY21 Revenue	2,010,340
Less: YTD FY21 Direct and Allocated Expenditures	1,565,247
Board Cash Balance as June 30, 2021	$ 2,528,753

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 10900 - Counseling

For the Period Beginning July 1, 2020 and Ending June 30, 2021

Account Number	Account Description	Amount	Budget	Amount Under/(Over) Budget	% of Budget
4002400	Fee Revenue				
4002401	Application Fee	465,396.00	294,600.00	(170,796.00)	157.98%
4002406	License & Renewal Fee	1,525,535.00	1,533,075.00	7,540.00	99.51%
4002407	Dup. License Certificate Fee	5,970.00	825.00	(5,145.00)	723.64%
4002409	Board Endorsement - Out	9,705.00	1,740.00	(7,965.00)	557.76%
4002421	Monetary Penalty & Late Fees	320.00	13,960.00	13,640.00	2.29%
4002430	Board Changes Fee	2,340.00	-	(2,340.00)	0.00%
4002432	Misc. Fee (Bad Check Fee)	380.00	140.00	(240.00)	271.43%
	Total Fee Revenue	2,009,646.00	1,844,340.00	(165,306.00)	108.96%
4003000	Sales of Prop. & Commodities				
4003020	Misc. Sales-Dishonored Payments	694.00	-	(694.00)	0.00%
	Total Sales of Prop. & Commodities	694.00	-	(694.00)	0.00%
	Total Revenue	2,010,340.00	1,844,340.00	(166,000.00)	109.00%
5011110	Employer Retirement Contrib.	19,819.78	22,136.52	2,316.74	89.53%
5011120	Fed Old-Age Ins- Sal St Emp	14,356.16	13,241.23	(1,114.93)	108.42%
5011140	Group Insurance	2,117.85	2,051.38	(66.47)	103.24%
5011150	Medical/Hospitalization Ins.	22,327.50	38,112.00	15,784.50	58.58%
5011160	Retiree Medical/Hospitalizatn	1,774.05	1,714.59	(59.46)	103.47%
5011170	Long term Disability Ins	965.53	933.84	(31.69)	103.39%
	Total Employee Benefits	61,360.87	78,189.56	16,828.69	78.48%
5011200	Salaries				
5011230	Salaries, Classified	158,307.23	153,088.00	(5,219.23)	103.41%
5011250	Salaries, Overtime	28,330.89	-	(28,330.89)	0.00%
	Total Salaries	186,638.12	153,088.00	(33,550.12)	121.92%
5011300	Special Payments				
5011310	Bonuses and Incentives	66.00	-	(66.00)	0.00%
5011340	Specified Per Diem Payment	2,500.00	-	(2,500.00)	0.00%
5011380	Deferred Compnstn Match Pmts	288.00	1,728.00	1,440.00	16.67%
	Total Special Payments	2,854.00	1,728.00	(1,126.00)	165.16%
5011400	Wages				
5011410	Wages, General	4,893.90	20,000.00	15,106.10	24.47%
	Total Wages	4,893.90	20,000.00	15,106.10	24.47%
5011600	Terminatn Personal Svce Costs				
5011660	Defined Contribution Match - Hy	3,004.23	-	(3,004.23)	0.00%
	Total Terminatn Personal Svce Costs	3,004.23	-	(3,004.23)	0.00%
5011930	Turnover/Vacancy Benefits		-	-	0.00%
	Total Personal Services	258,751.12	253,005.56	(5,745.56)	102.27%
5012000	Contractual Svs				
5012100	Communication Services				
5012110	Express Services	-	295.00	295.00	0.00%
5012120	Outbound Freight Services	5.19	-	(5.19)	0.00%

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 10900 - Counseling

For the Period Beginning July 1, 2020 and Ending June 30, 2021

Account Number	Account Description	Amount	Budget	Amount Under/(Over) Budget	% of Budget
5012140	Postal Services	10,237.87	8,232.00	(2,005.87)	124.37%
5012150	Printing Services	6.00	120.00	114.00	5.00%
5012160	Telecommunications Svcs (VITA)	698.06	900.00	201.94	77.56%
5012190	Inbound Freight Services	20.99	-	(20.99)	0.00%
	Total Communication Services	10,968.11	9,547.00	(1,421.11)	114.89%
5012200	Employee Development Services				
5012210	Organization Memberships	1,400.00	1,400.00	-	100.00%
5012240	Employee Trainng/Workshop/Conf	1,175.00	-	(1,175.00)	0.00%
	Total Employee Development Services	2,575.00	1,400.00	(1,175.00)	183.93%
5012300	Health Services				
5012360	X-ray and Laboratory Services	-	140.00	140.00	0.00%
	Total Health Services	-	140.00	140.00	0.00%
5012400	Mgmnt and Informational Svcs	-			
5012420	Fiscal Services	26,987.70	9,280.00	(17,707.70)	290.82%
5012440	Management Services	390.40	134.00	(256.40)	291.34%
5012460	Public Infrmtnl & Relatn Svcs	92.00	5.00	(87.00)	1840.00%
5012470	Legal Services	126.25	475.00	348.75	26.58%
	Total Mgmnt and Informational Svcs	27,596.35	9,894.00	(17,702.35)	278.92%
5012500	Repair and Maintenance Svcs				
5012510	Custodial Services	756.84	-	(756.84)	0.00%
5012530	Equipment Repair & Maint Srvc	2,186.53	-	(2,186.53)	0.00%
5012560	Mechanical Repair & Maint Srvc	-	34.00	34.00	0.00%
	Total Repair and Maintenance Svcs	2,943.37	34.00	(2,909.37)	8656.97%
5012600	Support Services				
5012630	Clerical Services	14,095.52	110,551.00	96,455.48	12.75%
5012640	Food & Dietary Services	285.03	1,075.00	789.97	26.51%
5012660	Manual Labor Services	829.93	1,170.00	340.07	70.93%
5012670	Production Services	1,397.36	5,380.00	3,982.64	25.97%
5012680	Skilled Services	31,284.12	16,764.00	(14,520.12)	186.61%
	Total Support Services	47,891.96	134,940.00	87,048.04	35.49%
5012800	Transportation Services				
5012820	Travel, Personal Vehicle	218.88	4,979.00	4,760.12	4.40%
5012850	Travel, Subsistence & Lodging	-	1,950.00	1,950.00	0.00%
5012880	Trvl, Meal Reimb- Not Rprtble	-	988.00	988.00	0.00%
	Total Transportation Services	218.88	7,917.00	7,698.12	2.76%
	Total Contractual Svs	92,193.67	163,872.00	71,678.33	56.26%
5013000	Supplies And Materials				
5013100	Administrative Supplies				
5013110	Apparel Supplies	28.58	-	(28.58)	0.00%
5013120	Office Supplies	2,678.53	597.00	(2,081.53)	448.66%
	Total Administrative Supplies	2,707.11	597.00	(2,110.11)	453.45%
5013400	Medical and Laboratory Supp.				

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 10900 - Counseling

For the Period Beginning July 1, 2020 and Ending June 30, 2021

Account Number	Account Description	Amount	Budget	Amount Under/(Over) Budget	% of Budget
5013420	Medical and Dental Supplies	3.75	-	(3.75)	0.00%
	Total Medical and Laboratory Supp.	3.75	-	(3.75)	0.00%
5013500	Repair and Maint. Supplies				
5013510	Building Repair & Maint Materl	9.88	-	(9.88)	0.00%
5013520	Custodial Repair & Maint Matrl	1.36	-	(1.36)	0.00%
	Total Repair and Maint. Supplies	11.24	-	(11.24)	0.00%
5013600	Residential Supplies				
5013630	Food Service Supplies	-	183.00	183.00	0.00%
	Total Residential Supplies	-	183.00	183.00	0.00%
	Total Supplies And Materials	2,722.10	780.00	(1,942.10)	348.99%
5015000	Continuous Charges				
5015100	Insurance-Fixed Assets				
5015160	Property Insurance	-	46.00	46.00	0.00%
	Total Insurance-Fixed Assets	-	46.00	46.00	0.00%
5015300	Operating Lease Payments				
5015340	Equipment Rentals	609.26	540.00	(69.26)	112.83%
5015350	Building Rentals	96.00	-	(96.00)	0.00%
5015360	Land Rentals	-	60.00	60.00	0.00%
5015390	Building Rentals - Non State	11,918.97	11,275.00	(643.97)	105.71%
	Total Operating Lease Payments	12,624.23	11,875.00	(749.23)	106.31%
5015400	Service Charges				
5015470	Private Vendor Service Charges:	32.52	-	(32.52)	0.00%
	Total Service Charges	32.52	-	(32.52)	0.00%
5015500	Insurance-Operations				
5015510	General Liability Insurance	-	170.00	170.00	0.00%
5015540	Surety Bonds	-	11.00	11.00	0.00%
	Total Insurance-Operations	-	181.00	181.00	0.00%
	Total Continuous Charges	12,656.75	12,102.00	(554.75)	104.58%
5022000	Equipment				
5022100	Computer Hrdware & Sftware				
5022170	Other Computer Equipment	2,095.51	-	(2,095.51)	0.00%
	Total Computer Hrdware & Sftware	2,095.51	-	(2,095.51)	0.00%
5022200	Educational & Cultural Equip				
5022240	Reference Equipment	-	77.00	77.00	0.00%
	Total Educational & Cultural Equip	-	77.00	77.00	0.00%
5022600	Office Equipment				
5022610	Office Appurtenances	-	42.00	42.00	0.00%
	Total Office Equipment	-	42.00	42.00	0.00%
5022700	Specific Use Equipment				
5022710	Household Equipment	30.11	-	(30.11)	0.00%
5022740	Non Power Rep & Maint- Equip	2.22	-	(2.22)	0.00%

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 10900 - Counseling

For the Period Beginning July 1, 2020 and Ending June 30, 2021

Account Number	Account Description	Amount	Budget	Amount Under/(Over) Budget	% of Budget
	Total Specific Use Equipment	32.33	-	(32.33)	0.00%
	Total Equipment	2,127.84	119.00	(2,008.84)	1788.10%
	Total Expenditures	368,451.48	429,878.56	61,427.08	85.71%
	Allocated Expenditures				
20100	**Behavioral Science Exec**	228,685.33	230,164.99	1,479.67	99.36%
30100	**Data Center**	186,641.21	289,189.12	102,547.91	64.54%
30200	**Human Resources**	19,770.35	18,464.91	(1,305.44)	107.07%
30300	**Finance**	153,479.65	159,731.01	6,251.36	96.09%
30400	**Director's Office**	51,799.97	57,392.70	5,592.73	90.26%
30500	**Enforcement**	429,756.56	413,776.77	(15,979.79)	103.86%
30600	**Administrative Proceedings**	59,360.24	69,905.67	10,545.43	84.91%
30700	**Impaired Practitioners**	589.55	246.30	(343.26)	239.37%
30800	**Attorney General**	2,974.55	1,522.95	(1,451.60)	195.31%
30900	**Board of Health Professions**	41,402.71	43,200.63	1,797.91	95.84%
31100	**Maintenance and Repairs**	394.47	2,464.19	2,069.72	16.01%
31300	**Emp. Recognition Program**	307.10	1,240.91	933.81	24.75%
31400	**Conference Center**	1,729.18	357.03	(1,372.15)	484.32%
31500	**Pgm Devlpmnt & Implmentn**	19,905.11	25,731.66	5,826.55	77.36%
	Total Allocated Expenditures	1,196,795.98	1,313,388.85	116,592.87	91.12%
	Net Revenue in Excess (Shortfall) of Expenditures	$ 445,092.54	$ 101,072.59	$ (344,019.95)	440.37%

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 10900 - Counseling

For the Period Beginning July 1, 2020 and Ending June 30, 2021

Account Number	Account Description	July	August	September	October	November	December	January	February	March	April
4002400	Fee Revenue										
4002401	Application Fee	41,775.00	42,620.00	33,680.00	33,460.00	32,940.00	31,741.00	37,120.00	35,315.00	44,895.00	43,030.00
4002406	License & Renewal Fee	31,655.00	6,635.00	3,605.00	3,350.00	2,330.00	21,490.00	41,845.00	8,965.00	5,960.00	4,165.00
4002407	Dup. License Certificate Fee	500.00	310.00	270.00	200.00	160.00	445.00	585.00	270.00	350.00	370.00
4002409	Board Endorsement - Out	655.00	540.00	710.00	655.00	425.00	675.00	655.00	1,050.00	930.00	1,140.00
4002421	Monetary Penalty & Late Fees	70.00	135.00	20.00	-	50.00	-	25.00	-	-	-
4002430	Board Changes Fee	30.00	180.00	150.00	270.00	240.00	150.00	360.00	300.00	210.00	30.00
4002432	Misc. Fee (Bad Check Fee)	-	-	35.00	70.00	-	-	140.00	50.00	35.00	50.00
	Total Fee Revenue	74,685.00	50,420.00	38,470.00	38,005.00	36,145.00	54,501.00	80,730.00	45,950.00	52,380.00	48,785.00
4003000	Sales of Prop. & Commodities										
4003020	Misc. Sales-Dishonored Payments	-	-	30.00	100.00	-	-	100.00	174.00	175.00	115.00
	Total Sales of Prop. & Commodities	-	-	30.00	100.00	-	-	100.00	174.00	175.00	115.00
	Total Revenue	74,685.00	50,420.00	38,500.00	38,105.00	36,145.00	54,501.00	80,830.00	46,124.00	52,555.00	48,900.00
5011000	Personal Services										
5011100	Employee Benefits										
5011110	Employer Retirement Contrib.	2,249.15	1,663.86	1,663.86	1,663.86	1,663.86	1,663.86	1,663.86	1,663.86	1,692.46	1,692.46
5011120	Fed Old-Age Ins- Sal St Emp	1,527.66	1,212.20	1,189.95	1,162.33	1,124.41	1,173.62	1,163.07	1,199.68	1,191.41	1,347.18
5011140	Group Insurance	244.58	177.24	177.24	177.24	177.24	177.24	177.24	177.24	180.74	180.74
5011150	Medical/Hospitalization Ins.	2,748.00	2,061.00	2,061.00	2,061.00	2,061.00	-	2,061.00	2,061.00	2,061.00	2,061.00
5011160	Retiree Medical/Hospitalizatn	208.29	148.14	148.14	148.14	148.14	148.14	148.14	148.14	151.08	151.08
5011170	Long term Disability Ins	112.58	80.70	80.70	80.70	80.70	80.70	80.70	80.70	82.30	82.30
	Total Employee Benefits	7,090.26	5,343.14	5,320.89	5,293.27	5,255.35	3,243.56	5,294.01	5,330.62	5,358.99	5,514.76
5011200	Salaries										
5011230	Salaries, Classified	18,368.79	13,228.08	13,228.08	13,228.08	13,228.08	13,228.08	13,228.08	13,358.53	13,488.98	13,488.98
5011250	Salaries, Overtime	2,118.12	2,999.27	2,708.62	2,347.80	1,851.64	2,061.80	2,336.45	2,683.39	2,444.59	3,332.44
	Total Salaries	20,486.91	16,227.35	15,936.70	15,575.88	15,079.72	15,289.88	15,564.53	16,041.92	15,933.57	16,821.42
5011310	Bonuses and Incentives	-	-	-	-	-	-	-	-	-	-

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 10900 - Counseling

For the Period Beginning July 1, 2020 and Ending June 30, 2021

Account Number	Account Description	July	August	September	October	November	December	January	February	March	April
5011340	Specified Per Diem Payment	-	-	500.00	50.00	500.00	100.00	50.00	200.00	350.00	50.00
5011380	Deferred Compnstn Match Pmts	36.00	24.00	24.00	24.00	24.00	24.00	24.00	24.00	24.00	24.00
	Total Special Payments	36.00	24.00	524.00	74.00	524.00	124.00	74.00	224.00	374.00	74.00
5011400	Wages										
5011410	Wages, General	-	-	-	-	-	-	-	-	-	1,148.40
	Total Wages	-	-	-	-	-	-	-	-	-	1,148.40
5011600	Terminatn Personal Svce Costs										
5011660	Defined Contribution Match - Hy	358.65	248.92	248.92	248.92	248.92	248.92	248.92	248.92	258.04	258.04
	Total Terminatn Personal Svce Costs	358.65	248.92	248.92	248.92	248.92	248.92	248.92	248.92	258.04	258.04
	Total Personal Services	27,971.82	21,843.41	22,030.51	21,192.07	21,107.99	18,906.36	21,181.46	21,845.46	21,924.60	23,816.62
5012000	Contractual Svs										
5012100	Communication Services										
5012120	Outbound Freight Services	-	-	-	-	-	-	5.19	-	-	-
5012140	Postal Services	1,313.22	790.82	361.67	1,217.34	408.91	952.98	740.56	862.31	622.11	930.66
5012150	Printing Services	-	-	-	-	-	6.00	-	-	-	-
5012160	Telecommunications Svcs (VITA)	62.41	64.08	63.27	58.48	43.03	60.49	54.86	59.12	53.21	54.74
5012190	Inbound Freight Services	0.52	-	0.79	-	3.20	0.42	0.53	-	-	-
	Total Communication Services	1,376.15	854.90	425.73	1,275.82	455.14	1,019.89	801.14	921.43	675.32	985.40
5012200	Employee Development Services										
5012210	Organization Memberships	-	-	900.00	-	-	-	500.00	-	-	-
5012240	Employee Trainng/Workshop/Conf	-	-	-	-	100.00	-	-	475.00	600.00	-
	Total Employee Development Services	-	-	900.00	-	100.00	-	500.00	475.00	600.00	-
5012400	Mgmnt and Informational Svcs										
5012420	Fiscal Services	13,897.45	598.97	144.46	168.92	-	46.27	422.35	-	1,080.25	213.39
5012440	Management Services	156.60	-	76.44	-	36.46	-	41.09	-	21.66	-
5012460	Public Infrmtnl & Relatn Svcs	92.00	-	-	-	-	-	-	-	-	-
5012470	Legal Services	-	-	-	-	-	-	-	-	-	-
	Total Mgmnt and Informational Svcs	14,146.05	598.97	220.90	168.92	36.46	46.27	463.44	-	1,101.91	213.39

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 10900 - Counseling

For the Period Beginning July 1, 2020 and Ending June 30, 2021

Account Number	Account Description	July	August	September	October	November	December	January	February	March	April
5012500	Repair and Maintenance Svcs										
5012510	Custodial Services	-	63.07	63.07	-	189.21	-	126.14	63.07	63.07	63.07
5012530	Equipment Repair & Maint Srvc	-	4.72	-	2,167.65	4.72	-	-	4.72	-	-
	Total Repair and Maintenance Svcs	-	67.79	63.07	2,167.65	193.93	-	126.14	67.79	63.07	63.07
5012600	Support Services										
5012630	Clerical Services	11,032.48	1,463.04	-	-	1,600.00	-	-	-	-	-
5012640	Food & Dietary Services	85.05	55.12	78.92	-	-	-	-	65.94	-	-
5012660	Manual Labor Services	10.00	144.17	-	16.86	23.46	148.14	-	-	487.30	-
5012670	Production Services	90.09	151.97	60.40	74.34	131.80	6.00	194.60	75.10	340.86	28.50
5012680	Skilled Services	2,122.65	1,903.35	1,913.82	1,853.52	1,908.46	2,045.70	1,573.23	1,880.84	6,388.07	1,706.82
	Total Support Services	13,340.27	3,717.65	2,053.14	1,944.72	3,663.72	2,199.84	1,767.83	2,021.88	7,216.23	1,735.32
5012800	Transportation Services										
5012820	Travel, Personal Vehicle	-	-	73.60	-	73.60	-	-	71.68	-	-
	Total Transportation Services	-	-	73.60	-	73.60	-	-	71.68	-	-
	Total Contractual Svs	28,862.47	5,239.31	3,736.44	5,557.11	4,522.85	3,266.00	3,658.55	3,557.78	9,656.53	2,997.18
5013000	Supplies And Materials										
5013100	Administrative Supplies										
5013110	Apparel Supplies	9.94	-	9.13	-	-	-	9.51	-	-	-
5013120	Office Supplies	228.28	217.54	216.83	-	405.74	157.74	314.25	126.29	74.61	454.93
	Total Administrative Supplies	238.22	217.54	225.96	-	405.74	157.74	323.76	126.29	74.61	454.93
5013400	Medical and Laboratory Supp.										
5013420	Medical and Dental Supplies	-	-	-	-	-	3.75	-	-	-	-
	Total Medical and Laboratory Supp.	-	-	-	-	-	3.75	-	-	-	-
5013500	Repair and Maint. Supplies										
5013510	Building Repair & Maint Materl	-	9.88	-	-	-	-	-	-	-	-
5013520	Custodial Repair & Maint Matrl	-	1.36	-	-	-	-	-	-	-	-
	Total Repair and Maint. Supplies	-	11.24	-	-	-	-	-	-	-	-

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 10900 - Counseling

For the Period Beginning July 1, 2020 and Ending June 30, 2021

Account Number	Account Description	July	August	September	October	November	December	January	February	March	April
	Total Supplies And Materials	238.22	228.78	225.96	-	405.74	161.49	323.76	126.29	74.61	454.93
5015000	Continuous Charges										
5015300	Operating Lease Payments										
5015340	Equipment Rentals	55.74	48.70	48.70	5.39	97.40	48.70	55.74	-	97.40	54.09
5015350	Building Rentals	-	-	-	24.00	-	24.00	-	-	24.00	24.00
5015390	Building Rentals - Non State	1,017.55	1,035.69	993.79	944.67	1,002.28	943.87	936.64	984.15	938.11	995.34
	Total Operating Lease Payments	1,073.29	1,084.39	1,042.49	974.06	1,099.68	1,016.57	992.38	984.15	1,059.51	1,073.43
5015400	Service Charges										
5015470	Private Vendor Service Charges:	9.48	-	-	-	-	-	-	23.04	22.30	-
	Total Service Charges	9.48	-	-	-	-	-	-	23.04	22.30	-
	Total Continuous Charges	1,082.77	1,084.39	1,042.49	974.06	1,099.68	1,016.57	992.38	1,007.19	1,081.81	1,073.43
5022000	Equipment										
5022170	Other Computer Equipment	-	-	2,085.29	(37.66)	47.88	-	-	-	-	-
	Total Computer Hrdware & Sftware	-	-	2,085.29	(37.66)	47.88	-	-	-	-	-
5022710	Household Equipment	-	-	-	-	-	-	-	-	-	-
5022740	Non Power Rep & Maint- Equip	-	-	-	-	-	-	2.22	-	-	-
	Total Specific Use Equipment	-	-	-	-	-	-	2.22	-	-	-
	Total Equipment	-	-	2,085.29	(37.66)	47.88	-	2.22	-	-	-
	Total Expenditures	58,155.28	28,395.89	29,120.69	27,685.58	27,184.14	23,350.42	26,158.37	26,536.72	32,737.55	28,342.16
	Allocated Expenditures										
20100	Behavioral Science Executive Director	26,920.61	18,119.38	18,231.79	18,978.75	19,116.55	17,400.62	19,673.35	19,906.30	19,355.42	19,621.82
20200	Opt\Vet-Med\ASLP Executive Director	-	-	-	-	-	-	-	-	-	-

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 10900 - Counseling

For the Period Beginning July 1, 2020 and Ending June 30, 2021

Account Number	Account Description	July	August	September	October	November	December	January	February	March	April
20400	Nursing / Nurse Aide	-	-	-	-	-	-	-	-	-	-
20600	Funeral\LTCA\PT Executive Director	-	-	-	-	-	-	-	-	-	-
30100	Technology and Business Services	22,025.55	15,899.77	17,409.86	15,924.23	11,911.16	22,998.82	25,540.26	10,980.64	11,022.97	8,355.25
30200	Human Resources	95.06	98.59	119.34	17,248.66	166.47	308.69	325.81	260.39	257.79	293.86
30300	Finance	15,997.14	11,749.75	12,482.00	19,420.14	6,159.16	12,045.49	13,231.33	13,465.05	13,313.04	12,702.89
30400	Director's Office	5,859.39	4,163.95	4,206.24	4,145.45	4,740.85	3,984.87	4,687.94	4,227.71	4,176.94	4,433.56
30500	Enforcement	45,714.92	32,052.29	33,366.91	34,223.15	38,373.02	35,291.96	42,109.60	37,338.47	39,460.18	39,532.67
30600	Administrative Proceedings	11,614.02	7,892.78	1,817.53	9,061.40	6,668.88	4,700.53	2,020.77	6,590.60	322.49	3,184.75
30700	Health Practitioners' Monitoring Program	71.77	480.06	3.81	4.99	4.27	4.01	3.20	3.23	4.08	4.30
30800	Attorney General	1,258.57	-	-	358.08	-	-	999.82	-	-	358.08
30900	Board of Health Professions	4,710.69	2,811.61	5,116.44	2,586.44	5,581.23	2,336.34	2,975.95	4,455.13	2,828.30	3,586.03
31000	SRTA	-	-	-	-	-	-	-	-	-	-
31100	Maintenance and Repairs	-	-	394.47	-	-	-	-	-	-	-
31300	Employee Recognition Program	-	6.34	-	-	2.07	1.32	-	90.33	15.45	58.75
31400	Conference Center	3.47	16.60	124.92	(3.38)	(12.38)	(249.94)	4.16	351.34	1,013.83	240.91
31500	Program Development and Implementation	2,270.42	1,447.50	1,780.37	1,367.16	1,968.53	2,031.47	1,992.44	1,568.60	1,480.04	1,520.52
31600	Healthcare Workforce	-	-	-	-	-	-	-	-	-	-
31800	CBC (Criminal Background Check Unit)	-	-	-	-	-	-	-	-	-	-
	Total Allocated Expenditures	136,541.61	94,738.61	95,053.68	123,315.06	94,679.82	100,854.17	113,564.63	99,237.79	93,250.54	93,893.38
	Net Revenue in Excess (Shortfall) of Expenditures	$ (120,011.89)	$ (72,714.50)	$ (85,674.37)	$ (112,895.64)	$ (85,718.96)	$ (69,703.59)	$ (58,893.00)	$ (79,650.51)	$ (73,433.09)	$ (73,335.54)

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 10900 - Counseling

For the Period Beginning July 1, 2020 and Ending June 30, 2021

Account Number	Account Description	May	June	Total
4002400	Fee Revenue			
4002401	Application Fee	40,050.00	48,770.00	465,396.00
4002406	License & Renewal Fee	496,855.00	898,680.00	1,525,535.00
4002407	Dup. License Certificate Fee	880.00	1,630.00	5,970.00
4002409	Board Endorsement - Out	1,010.00	1,260.00	9,705.00
4002421	Monetary Penalty & Late Fees	-	20.00	320.00
4002430	Board Changes Fee	240.00	180.00	2,340.00
4002432	Misc. Fee (Bad Check Fee)	-	-	380.00
	Total Fee Revenue	539,035.00	950,540.00	2,009,646.00
4003000	Sales of Prop. & Commodities			
4003020	Misc. Sales-Dishonored Payments	-	-	694.00
	Total Sales of Prop. & Commodities	-	-	694.00
	Total Revenue	539,035.00	950,540.00	2,010,340.00
5011000	Personal Services			
5011100	Employee Benefits			
5011110	Employer Retirement Contrib.	1,692.46	846.23	19,819.78
5011120	Fed Old-Age Ins- Sal St Emp	1,307.31	757.34	14,356.16
5011140	Group Insurance	180.74	90.37	2,117.85
5011150	Medical/Hospitalization Ins.	2,061.00	1,030.50	22,327.50
5011160	Retiree Medical/Hospitalizatn	151.08	75.54	1,774.05
5011170	Long term Disability Ins	82.30	41.15	965.53
	Total Employee Benefits	5,474.89	2,841.13	61,360.87
5011200	Salaries			
5011230	Salaries, Classified	13,488.98	6,744.49	158,307.23
5011250	Salaries, Overtime	2,045.79	1,400.98	28,330.89
	Total Salaries	15,534.77	8,145.47	186,638.12
5011310	Bonuses and Incentives	-	66.00	66.00

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 10900 - Counseling

For the Period Beginning July 1, 2020 and Ending June 30, 2021

Account Number	Account Description	May	June	Total
5011340	Specified Per Diem Payment	300.00	400.00	2,500.00
5011380	Deferred Compnstn Match Pmts	24.00	12.00	288.00
	Total Special Payments	324.00	478.00	2,854.00
5011400	Wages			-
5011410	Wages, General	1,914.00	1,831.50	4,893.90
	Total Wages	1,914.00	1,831.50	4,893.90
5011600	Terminatn Personal Svce Costs			
5011660	Defined Contribution Match - Hy	258.04	129.02	3,004.23
	Total Terminatn Personal Svce Costs	258.04	129.02	3,004.23
	Total Personal Services	23,505.70	13,425.12	258,751.12
5012000	Contractual Svs			-
5012100	Communication Services			-
5012120	Outbound Freight Services	-	-	5.19
5012140	Postal Services	871.84	1,165.45	10,237.87
5012150	Printing Services	-	-	6.00
5012160	Telecommunications Svcs (VITA)	58.66	65.71	698.06
5012190	Inbound Freight Services	0.53	15.00	20.99
	Total Communication Services	931.03	1,246.16	10,968.11
5012200	Employee Development Services			
5012210	Organization Memberships	-	-	1,400.00
5012240	Employee Trainng/Workshop/Conf	-	-	1,175.00
	Total Employee Development Services	-	-	2,575.00
5012400	Mgmnt and Informational Svcs			
5012420	Fiscal Services	76.77	10,338.87	26,987.70
5012440	Management Services	58.15	-	390.40
5012460	Public Infrmtnl & Relatn Svcs	-	-	92.00
5012470	Legal Services	126.25	-	126.25
	Total Mgmnt and Informational Svcs	261.17	10,338.87	27,596.35

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 10900 - Counseling

For the Period Beginning July 1, 2020 and Ending June 30, 2021

Account Number	Account Description	May	June	Total
5012500	Repair and Maintenance Svcs			
5012510	Custodial Services	63.07	63.07	756.84
5012530	Equipment Repair & Maint Srvc	4.72	-	2,186.53
	Total Repair and Maintenance Svcs	67.79	63.07	2,943.37
5012600	Support Services			
5012630	Clerical Services	-	-	14,095.52
5012640	Food & Dietary Services	-	-	285.03
5012660	Manual Labor Services	-	-	829.93
5012670	Production Services	122.30	121.40	1,397.36
5012680	Skilled Services	4,394.32	3,593.34	31,284.12
	Total Support Services	4,516.62	3,714.74	47,891.96
5012800	Transportation Services			
5012820	Travel, Personal Vehicle	-	-	218.88
	Total Transportation Services	-	-	218.88
	Total Contractual Svs	5,776.61	15,362.84	92,193.67
5013000	Supplies And Materials			
5013100	Administrative Supplies			-
5013110	Apparel Supplies	-	-	28.58
5013120	Office Supplies	164.97	317.35	2,678.53
	Total Administrative Supplies	164.97	317.35	2,707.11
5013400	Medical and Laboratory Supp.			
5013420	Medical and Dental Supplies	-	-	3.75
	Total Medical and Laboratory Supp.	-	-	3.75
5013500	Repair and Maint. Supplies			
5013510	Building Repair & Maint Materl	-	-	9.88
5013520	Custodial Repair & Maint Matrl	-	-	1.36
	Total Repair and Maint. Supplies	-	-	11.24

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 10900 - Counseling

For the Period Beginning July 1, 2020 and Ending June 30, 2021

Account Number	Account Description	May	June	Total
	Total Supplies And Materials	164.97	317.35	2,722.10
5015000	Continuous Charges			
5015300	Operating Lease Payments			
5015340	Equipment Rentals	48.70	48.70	609.26
5015350	Building Rentals	-	-	96.00
5015390	Building Rentals - Non State	1,073.67	1,053.21	11,918.97
	Total Operating Lease Payments	1,122.37	1,101.91	12,624.23
5015400	Service Charges			
5015470	Private Vendor Service Charges:	(22.30)	-	32.52
	Total Service Charges	(22.30)	-	32.52
	Total Continuous Charges	1,100.07	1,101.91	12,656.75
5022000	Equipment			
5022170	Other Computer Equipment	-	-	2,095.51
	Total Computer Hrdware & Sftware	-	-	2,095.51
5022710	Household Equipment	30.11	-	30.11
5022740	Non Power Rep & Maint- Equip	-	-	2.22
	Total Specific Use Equipment	30.11	-	32.33
	Total Equipment	30.11	-	2,127.84
	Total Expenditures	30,577.46	30,207.22	368,451.48
	Allocated Expenditures			
20100	Behavioral Science Executive Director	18,981.55	12,379.22	228,685.33
20200	Opt\Vet-Med\ASLP Executive Director	-	-	-

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 10900 - Counseling

For the Period Beginning July 1, 2020 and Ending June 30, 2021

Account Number	Account Description	May	June	Total
20400	Nursing / Nurse Aide	-	-	-
20600	Funeral\LTCA\PT Executive Director	-	-	-
30100	Technology and Business Services	6,701.13	17,871.55	186,641.21
30200	Human Resources	279.77	315.94	19,770.35
30300	Finance	13,869.91	9,043.75	153,479.65
30400	Director's Office	4,447.28	2,725.79	51,799.97
30500	Enforcement	33,590.36	18,703.03	429,756.56
30600	Administrative Proceedings	2,786.33	2,700.17	59,360.24
30700	Health Practitioners' Monitoring Program	3.28	2.56	589.55
30800	Attorney General	-	-	2,974.55
30900	Board of Health Professions	2,772.39	1,642.15	41,402.71
31000	SRTA	-	-	-
31100	Maintenance and Repairs	-	-	394.47
31300	Employee Recognition Program	127.66	5.17	307.10
31400	Conference Center	141.89	97.75	1,729.18
31500	Program Development and Implementation	1,519.04	959.01	19,905.11
31600	Healthcare Workforce	-	-	-
31800	CBC (Criminal Background Check Unit)	-	-	-
	Total Allocated Expenditures	85,220.60	66,446.09	1,196,795.98
	Net Revenue in Excess (Shortfall) of Expenditures	$ 423,236.94	$ 853,886.69	$ 445,092.54

Virginia Department of
Health Professions
Board of Counseling

Discipline Reports

MAY 1, 2022 - AUGUST 31, 2022

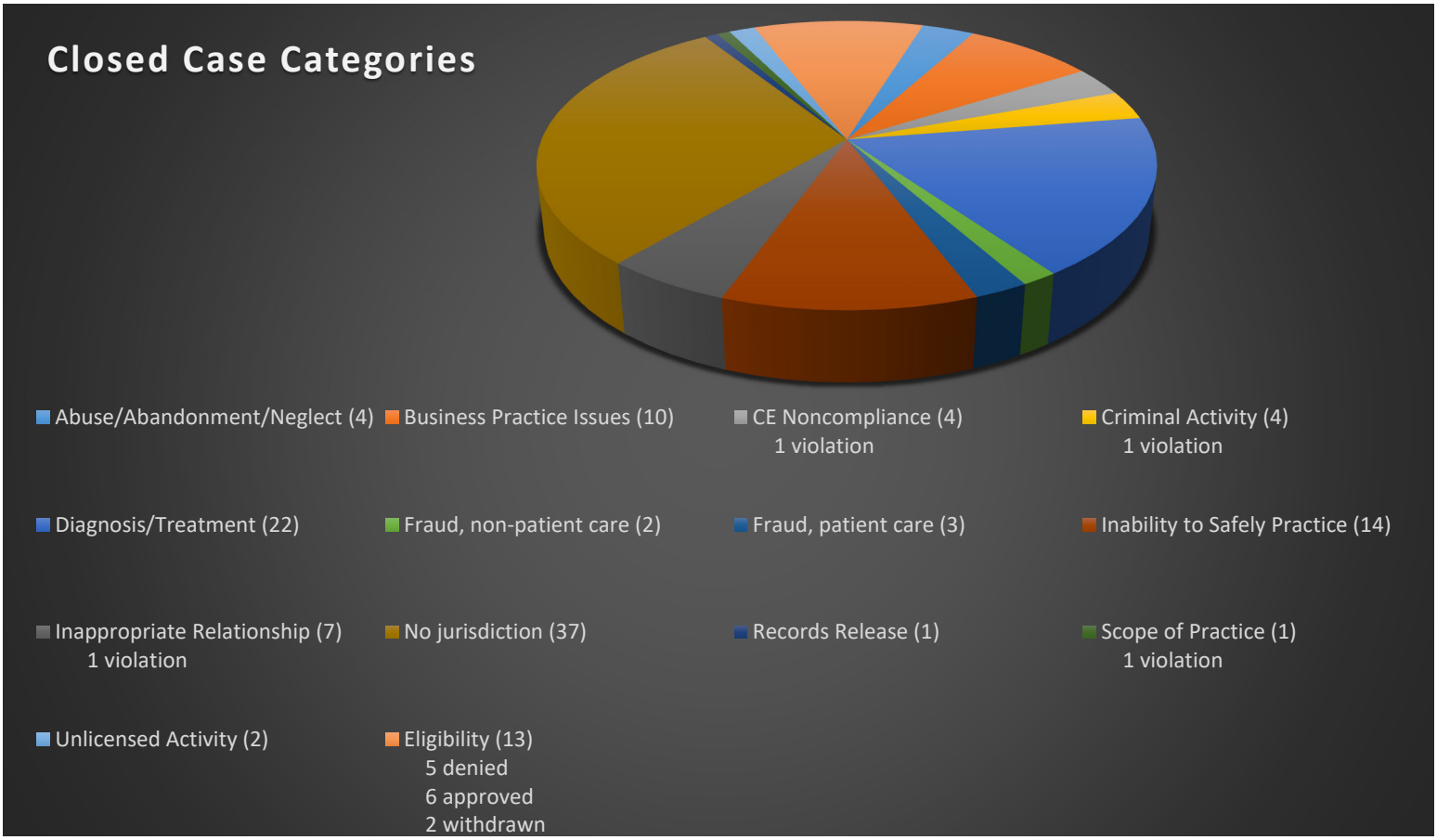
NEW CASES RECEIVED IN BOARD MAY 1, 2022 - AUGUST 31, 2022				
	Counseling	**Psychology**	**Social Work**	**BSU Total**
Cases **Received** for Board review	132	43	40	***215***

OPEN CASES (as of 08/31/2022)				
Open Case Stage	**Counseling**	**Psychology**	**Social Work**	**BSU Total**
Probable Cause Review	69	119	44	
Scheduled for Informal Conferences	31	2	14	
Scheduled for Formal Hearings	4	4	0	
Other (pending CCA, PHCO, hold, etc.)	15	11	6	
Cases with APD for processing (IFC, FH, Consent Order)	8	3	1	
TOTAL CASES AT BOARD LEVEL	**127**	**139**	**65**	***331***
OPEN INVESTIGATIONS	**102**	**26**	**24**	***152***
TOTAL OPEN CASES	**229**	**165**	**89**	***483***

UPCOMING CONFERENCES AND HEARINGS		
Informal Conferences	Conferences Held:	July 8, 2022 (Special Conference Committee)
	Scheduled Conferences:	October 24, 2022 (Agency Subordinate) November 18, 2022 (Special Conference Committee) December 1, 2022 (Agency Subordinate) January 27, 2023 (Special Conference Committee) February 28, 2023 (Agency Subordinate) March 31, 2023 (Special Conference Committee) May 19, 2023 (Special Conference Committee)
Formal Hearings	Hearings Held:	May 13, 2022
	Scheduled Hearings:	November 4, 2022

Virginia Department of
Health Professions
Board of Counseling

CASES CLOSED (MAY 1, 2022 - AUGUST 31, 2022)	
Closed – **no violation**	93
Closed – **undetermined**	16
Closed – **violation**	4
Credentials/Reinstatement – **Denied**	5
Credentials/Reinstatement – **Approved**	6
TOTAL CASES CLOSED	**124**



AVERAGE CASE PROCESSING TIMES (counted on closed cases)	
Average time for case closures	**174**
Avg. time in Enforcement (investigations)	117
Avg. time in APD (IFC/FH preparation)	54
Avg. time in Board (includes hearings, reviews, etc).	66
Avg. time with board member (probable cause review)	6

Virginia Department of
Health Professions
Board of Counseling

LICENSING REPORT

Satisfaction Survey Results	
4rd Quarter (April 1 – June 30)	**96.6%**

Totals as of September 6, 2022*

Current Licenses	
Certified Substance Abuse Counselor	1,701
Substance Abuse Trainee	2,182
Substance Abuse Counseling Assistant	241
Licensed Marriage and Family Therapist	1,008
Marriage & Family Therapist Resident	142
Licensed Professional Counselor	8,106
Resident in Counseling	2,831
Substance Abuse Treatment Practitioner	392
Substance Abuse Treatment Residents	11
Rehabilitation Provider	161
Qualified Mental Health Prof-Adult	6,288
Qualified Mental Health Prof-Child	4,308
Trainee for Qualified Mental Health Prof	7,817
Registered Peer Recovery Specialist	420
Total	**35,608***

*Unofficial numbers (for informational purposes only)

Virginia Department of
Health Professions
Board of Counseling

Licenses, Certifications and Registrations Issued

License Type	April 2022	May 2022	June 2022	July 2022*	August 2022*
Certified Substance Abuse Counselor	16	3	14	12	11
Substance Abuse Trainee	11	27	22	30	43
Certified Substance Abuse Counseling Assistant	4	4	2	6	5
Licensed Marriage and Family Therapist	8	7	7	8	15
Marriage & Family Therapist Resident	2	2	2	8	4
Pre-Education Review for LMFT	2	0	1	0	0
Licensed Professional Counselor	91	71	73	76	113
Resident in Counseling	62	38	96	121	123
Pre-Education Review for LPC	11	7	3	4	9
Substance Abuse Treatment Practitioner	7	3	2	3	11
Substance Abuse Treatment Residents	0	0	0	0	0
Pre-Education Review for LSATP	0	0	0	0	0
Rehabilitation Provider	0	1	0	1	1
Qualified Mental Health Prof-Adult	43	23	58	90	66
Qualified Mental Health Prof-Child	36	25	45	42	41
Trainee for Qualified Mental Health Prof	183	118	189	223	182
Registered Peer Recovery Specialist	16	11	17	15	22
Total	**492**	**340**	**531**	**639**	**646**

*Unofficial numbers (for informational purposes only)

Virginia Department of
Health Professions
Board of Counseling

Licenses, Certifications and Registration Applications Received

Applications Received	April 2022*	May 2022*	June 2022*	July 2022*	August 2022*
Certified Substance Abuse Counselor	19	5	12	14	8
Substance Abuse Trainee	25	19	35	22	39
Certified Substance Abuse Counseling Assistant	5	4	3	3	4
Licensed Marriage and Family Therapist	12	9	13	8	10
Marriage & Family Therapist Resident	4	6	9	7	4
Pre-Education Review for LMFT	0	0	0	0	0
Licensed Professional Counselor	94	100	94	100	131
Resident in Counseling	54	129	119	93	129
Pre-Education Review for LPC	11	3	8	3	6
Substance Abuse Treatment Practitioner	4	5	7	9	4
Substance Abuse Treatment Residents	2	1	1	1	1
Pre-Education Review for LSATP	0	0	0	0	0
Rehabilitation Provider	0	2	0	0	0
Qualified Mental Health Prof-Adult	80	96	131	92	111
Qualified Mental Health Prof-Child	57	73	78	70	70
Trainee for Qualified Mental Health Prof	217	241	223	220	223
Registered Peer Recovery Specialist	28	15	24	19	28
Total	**612**	**708**	**757**	**661**	**768**

*Unofficial numbers (for informational purposes only)

Virginia Department of
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Board of Counseling

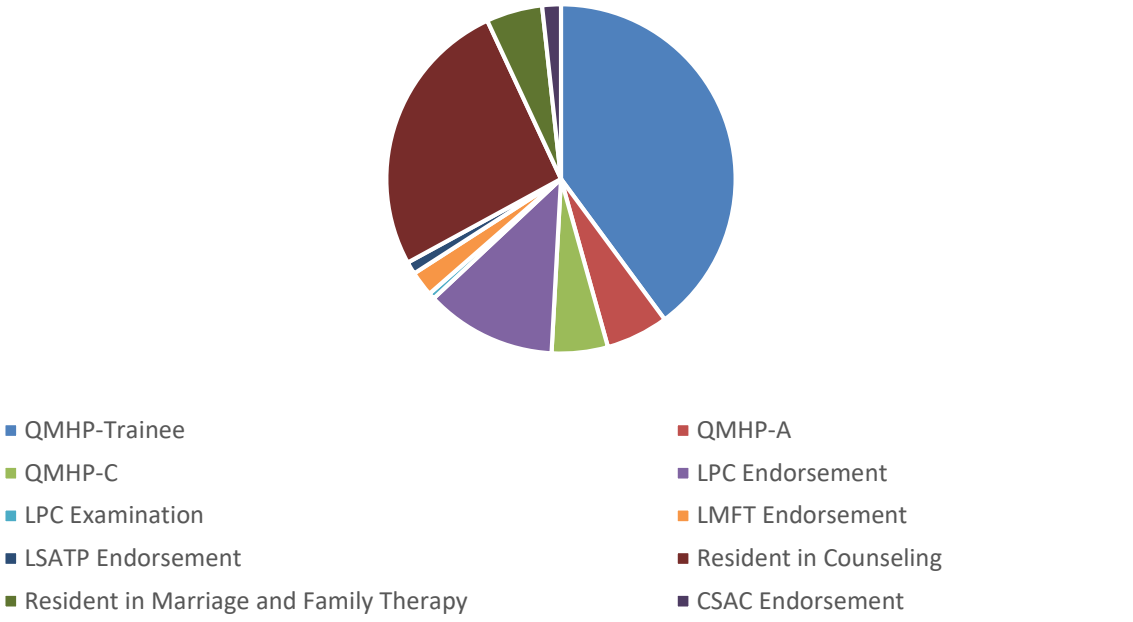
2022 Deferred Applications (1/1/2022 - 8/31/2022)

Total - 173

Appealed: 11

Approved After Providing Additional Information: 15

*Unofficial numbers (for informational purposes only)



QMHP-Trainee – (2 appealed, 7 approved)	
Coursework	69
QMHP-A – (1 appealed , 3 approved)	
Coursework	8
Coursework and supervision	1
Supervision	1
QMHP-C	
Degree	5
Degree and supervision	4

LMFT Endorsement	
Internship hours	1
Coursework	1
Degree, coursework and supervision	1
Coursework and supervision	1
Resident in Marriage and Family Therapy	
Coursework	7
Internship	1
Coursework and Internship	1

LPC Endorsement – (1 appealed , 1 approved)	
Equivalent license	7
Coursework	2
Coursework and supervision	4
Supervision/Supervisor	7
Degree, coursework and supervision	1
Resident in Counseling – (6 appealed, 4 approved)	
Coursework	34
Degree	10
Ethics	1
LPC Examination	
Supervision	1

LSATP Endorsement	
Equivalent license	2

CSAC Endorsement (1 appealed)	
Equivalent license	3

Additional Information:

- **Board of Counseling Staffing Information:**

  - The Board currently has three full-time and two part-time staff members to answer phone calls, emails and to process applications across all license, certification and registration types. The Board is currently interviewing for the vacant positions.
    - Licensing Staff:
      - Brenda Maida – Licensing Program Manager (Full-Time)
      - Victoria Cunningham – Licensing Specialist (Full-Time)
      - Dalyce Logan – Licensing Specialist (Full-Time-effective 8/10/22)
      - Vacant – Licensing Specialist
      - Marcia Santelli – Licensing Administration Assistant (Part-Time)
    - QMHP Staff:
      - Sandie Cotman – Licensing Program Manager (Full-Time)
      - Shannon Brogan – Licensing Specialists (Full-Time effective 8/10/22)
      - Sarah Bryant - Licensing Administration Assistant (Part-Time)