Virginia Department of Health Professions
Board of Counseling

Agenda

Regulatory Committee Meeting
July 19, 2024
9960 Mayland Dr, Board Room 3
10:00 a.m.

Call to Order – Terry Tinsley, Ph.D, LPC, LMFT, CSOTP, Committee Chairperson

- Welcome and Introductions
- Mission of the Committee/Evacuation Instructions……Page 2

Approval of Agenda

Approval of Minutes

- Regulatory Committee Meeting – July 14, 2023*
  ……Page 4

Public Comment

The Committee 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.

New Business

- Petition for rulemaking to amend 18VAC115-20-52* -- Erin Barrett, JD, Department of Health Professions, Director of Legislative and Regulatory Affairs
  ……Page 50
- Review of draft exempt regulatory changes pursuant to Senate Bill 403* -- Ms. Barrett
  ……Page 85
- Discussion of potential board-approved trainings pursuant to Senate Bill 403 – Jaime Hoyle, Executive Director, Boards of Counseling, Psychology, and Social Work
  ……Page 109

Next Meeting

- Regulatory Committee Meeting – October 18, 2024

Meeting Adjournment

*Requires a Committee Vote.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 2.2-3707(F).

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.

EMERGENCY EGRESS

Please listen to the following instructions about exiting these premises in the event of an emergency.

In the event of a fire or other emergency requiring the evacuation of the building, alarms will sound. When the alarms sound, leave the room immediately. Follow any instructions given by the Security staff.

Board Room 1

Exit the room using one of the doors at the back of the room. (**Point**) Upon exiting the room, turn **RIGHT.** Follow the corridor to the emergency exit at the end of the hall.

Upon exiting the building, proceed straight ahead through the parking lot to the fence at the end of the lot. Wait there for further instructions.

Board Room 2

Exit the room using one of the doors at the back of the room. (Point) Upon exiting the room, turn **RIGHT.** Follow the corridor to the emergency exit at the end of the hall.

Upon exiting the building, proceed straight ahead through the parking lot to the fence at the end of the lot. Wait there for further instructions.

You may also exit the room using the side door (**Point**), turn **Right** out the door and make an immediate **Left**. Follow the corridor to the emergency exit at the end of the hall.

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Board Rooms 3 and 4

Exit the room using one of the doors at the back of the room. (**Point**) Upon exiting the room, turn **RIGHT.** Follow the corridor to the emergency exit at the end of the hall.

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Training Room 1

Exit the room using one of the doors at the back of the room. (**Point**) Upon exiting the room, turn **LEFT.** Follow the corridor to the emergency exit at the end of the hall.

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Training Room 2

Exit the room using one of the doors at the back of the room. (**Point**) Upon exiting the doors, turn **LEFT.** Follow the corridor to the emergency exit at the end of the hall.

Upon exiting the building, proceed straight ahead through the parking lot to the fence at the end of the lot. Wait there for further instructions.

Virginia Department of Health Professions
Board of Counseling

Virginia Board of Counseling
DRAFT Regulatory Committee Meeting Minutes
Friday, July 14, 2023, at 10:00 a.m.
9960 Mayland Drive, Henrico, VA 23233
Board Room 3

PRESIDING OFFICER:	Gerard Lawson, Ph.D., LPC, LSATP
COMMITTEE MEMBERS:	Terry Tinsley, Ph.D., LPC, LMFT, CSOTP
ABSENT MEMBERS:	Angela Charlton, Ph.D., LPC
BOARD STAFF PRESENT:	Jaime Hoyle, JD, Executive Director Jennifer Lang, Deputy Executive Director Charlotte Lenart, Deputy Executive Director
DHP STAFF PRESENT	Matt Novak, Policy Analyst, DHP
CALL TO ORDER:	Dr. Lawson called the Regulatory Committee meeting to order at 10:04 a.m.
ESTABLISHMENT OF A QUORUM:	Dr. Lawson requested Ms. Lenart confirm a quorum. Ms. Lenart then announced with two members present, a quorum was established.
MISSION STATEMENT:	Dr. Lawson read the mission statement of the Department of Health Professions, which is also the mission statement of the Committee and Board. He also reviewed the Emergency egress.
ADOPTION OF AGENDA:	The meeting agenda was adopted as presented.
APPROVAL OF MINUTES:	The draft meeting minutes from the Regulatory Committee Meeting held on May 4, 2022, were approved as written.
PUBLIC COMMENT:	There were no public comments.
PUBLIC ATTENDEES:	Lucas Baker, Longwood University student Tyler Cox, Lobbyist, Hancock, Daniel & Johnson, P.C. Denise Daly Konrad, Director of Strategic Initiatives, Virginia Health Care Foundation Jennifer Faison, Executive Director, Virginia Association of Community Services Boards Jennifer Fidura, Executive Director, Virginia Network of Private Providers
UNFINISHED BUSINESS:	Ms. Hoyle presented to the Committee members, staff, and the public a presentation that covered current Qualified Mental Health Professional

(QMHP) regulations, background information on the Department of Health Professions (DHP) role, survey question sent to the Regulatory Advisory Panel (RAP), identified concerns and potential solutions. (Attachment A)

Ms. Lang provided a summary of the disciplinary actions for all license types.

The Committee discussed the problems and possible solutions identified in the presentation. The Committee commented that the overhaul solution would need to be a legislative change but commented that some of the solutions presented seemed reasonable and necessary.

Committee took a break at 11:21am to 11:30am.

NEW BUSINESS: **Regulatory and Legislative Report**

Mr. Novak reviewed the current regulatory actions chart with the Committee.

Consideration of Petition for Rulemaking regarding supervision for QMHP-Ts and independent practice.

Motion:
Dr. Tinsley moved, which was properly seconded, to recommend to the Board to take no action. The motion passed unanimously.

Consideration of Petition for Rulemaking to License QMHPs

Motion:
Dr. Tinsley moved, which was properly seconded, to recommend to the Board to take no action as it is outside of the Boards authority. The motion passed unanimously.

NEXT MEETING: Dr. Lawson announced Regulatory Committee will meet on Friday, October 6, 2023, at the Department of Health Professions.

ADJOURNMENT: Mr. Lawson adjourned the July 14, 2023, Regulatory Meeting at 12:03 p.m.

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Gerard Lawson PhD, LPC, LSATP, Committee Chair

_____
Jaime Hoyle, JD, Executive Director

ATTACHMENT A

Board of Counseling
Regulatory Committee Meeting

"QMHP Discussion"

July 14, 2023

Agenda

- Current QMHP regulations
- Current QMHP Disciplinary Statistics
- Background on DHP's Role
- Survey questions sent to RAP and Stakeholders
- Identified Concerns and Potential Solutions
- Summary

Background

Current QMHP Regulatory Requirements

QMHP Definitions

- “Collaborative mental health services” means those rehabilitative supportive services that are provide by a QMHP, as set forth in a service plan under the direction of and in collaboration with either a mental health professional licensed in Virginia or a person under supervision that has been approved by the Board of Counseling, Board of Psychology, or Board of Social Work as a prerequisite or licensure.
- “Mental health professional” – person who by education and experience is professionally qualified and licensed in Virginia to provide counseling interventions designed to facilitate an individual’s achievement of human development goals and remediate mental, emotional, or behavioral disorders and associated distresses that interfere with mental health and development.
- “QMHP” includes qualified mental health professionals – adult and qualified mental health professionals –child
- “QMHP-A” – a QMHP who provides collaborative mental health services for adults. A QMHP-A shall provide such services as an employee or independent contractor of DBHDS or the DDOC, or as a provider licensed by DBHDS.
- “QMHP-C” – a person who by education and experience is professionally qualified and register y the board to provide collaborative mental health services for children and adolescents up to 22 years of age. A QMHP-C shall provide such services as an employee or independent contractor of the DBHDS or the DOC, or as a provider licensed by DBHDS.
- “QMHP-Trainee” means a person who is receiving supervised training to qualify as a QMHP registered with the Board.

QMHP-Trainee Requirements

- In order to register for a QMHP-trainee, prior to receiving supervised experience toward a QMHP-A, must provide verification of ONE of the following:

- Master's degree in psychology, social work, counseling, substance abuse, or marriage and family therapy from an accredited college or university;
- Minimum of bachelor's degree in a human services or related field from an accredited college or university;
- Current enrollment in a master's program in psychology, social work, counseling, substance abuse, marriage and family therapy , or human services with at least 30 semester or 45 quarter hours;
- Bachelors from an accredited college in an unrelated field that includes 15 semester credits or 22 quarter hours in a human services field;
- License as a registered nurse in Virginia.
- License as an occupational therapist.

QMHP-Trainee Requirements

- In order to register for a QMHP-trainee, prior to receiving supervised experience toward a QMHP-C, must provide verification of ONE of the following:

- Master's degree in psychology, social work, counseling, substance abuse, or marriage and family therapy from an accredited college or university;
- Minimum of bachelor's degree in a human services or special education from an accredited college or university;
- Current enrollment in a master's program in psychology, social work, counseling, substance abuse, marriage and family therapy , or human services with at least 30 semester or 45 quarter hours;
- License as a registered nurse in Virginia.
- License as an occupational therapist.

Virginia Department of Health Professions

Guidance Document on Approved QMHP Degrees

- Art Therapy
- Behavioral Sciences
- Child Development
- Child and Family Studies/Services
- Cognitive Sciences
- Community Mental Health
- Counseling (Mental health, Vocational, Pastoral, etc.)
- Counselor Education
- Early Childhood Development
- Education (with a focus in psychology and/or special education)
- Educational Psychology
- Family Development/Relations
- Gerontology
- Health and Human Services
- Human Development
- Human Services
- Marriage and Family Therapy
- Music Therapy
- Nursing
- Psychiatric Rehabilitation
- Psychology
- Rehabilitation Counseling
- School Counseling
- Social Work
- Special Education
- Therapeutic Recreation
- Vocational Rehabilitation
- Sociology – (accepted until May 31, 2021)

Pathways to QMHP-A Registration

In order to qualify, you must provide evidence of ONE of the following:

- Master's degree in psychology, social work, counseling, substance abuse, or marriage and family therapy from an accredited college or university, you need:
    - Evidence you have had an intern or practicum of at least 500 hours of experience with persons who have a mental illness.
- Minimum of bachelor's degree in a human services or related field from an accredited college, you need:
    - Evidence of 1,500 hours of supervised experience (verification of supervised experience form)
- Bachelor's from an accredited college in an unrelated field, you need:
    - 15 semester credits or 22 quarter hours in a human services field
    - 3,000 hours of supervised experience
- License as a registered nurse in Virginia, you need:
    - 1,500 hours of supervised experience
- License as an occupational therapist in Virginia, you need:
    - With an internship or practicum of at least 500 hours or,
    - 1,500 hours of supervised experience

All supervised experience must be obtained within a 5-year period immediately preceding the application for registration

Supervised Experience Requirements for QMHP-A

- An applicant without an approved master's degree, shall provide documentation of providing direct services to individuals as part of a population of adults with mental illness in a setting where mental health treatment, practice, observation or diagnosis occurs.
- Services provided shall be appropriate to the practice of a QMHP-A.
- Services must be provided under the supervision of a licensed mental health professional or a person under supervision approved by a board as a pre-requisite for licensure under the Boards of Counseling, Psychology, or Social Work.
- Supervision obtained in another US jurisdiction shall be provided by a mental health professional licensed in Virginia or licensed in that jurisdiction.
- Consist of face-to-face training until supervisor determines competency in the provision of QMHP-A services, then supervision may be indirect (the supervisor is either on-site or immediately available for consultation with the person being trained).
- Hours obtained in a bachelor's or master's level internship or practicum in a human services field may be counted toward completion of the required hours.
- Supervised experience obtained prior to meeting the education requirements shall not be accepted.

Pathways to QMHP-C Registration

In order to qualify, you must provide evidence of ONE of the following:

- Master's degree in psychology, social work, counseling, substance abuse, or marriage and family therapy from an accredited college or university, you need:
    - Evidence you have had an internship or practicum of at least 500 hours of experience with children or adolescents who have a mental illness.
- Minimum of bachelor's degree in a human services or in special education from an accredited college, you need:
    - Evidence of 1,500 hours of supervised experience
- License as a registered nurse in Virginia, you need:
    - 1,500 hours of supervised experience
- License as an occupational therapist in Virginia, you need:
    - 1,500 hours of supervised experience

All supervised experience must be obtained within a 5-year period immediately preceding the application for registration

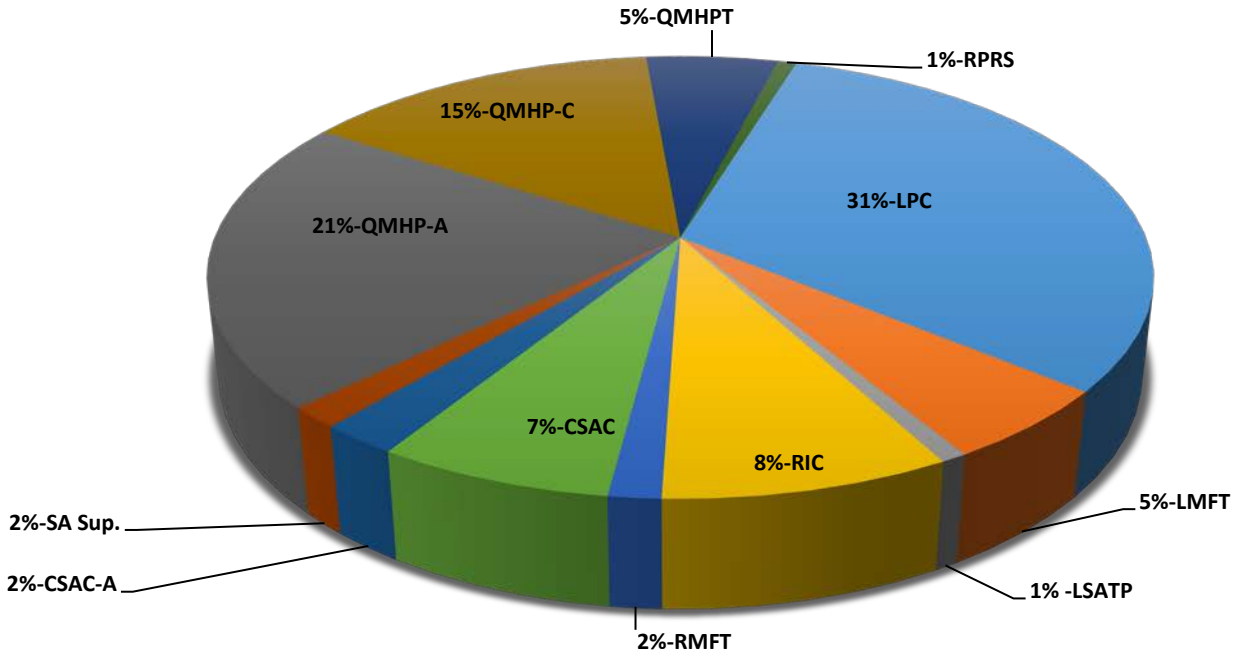
Supervised Experience Requirements for QMHP-C

- An applicant without an approved master's degree shall provide documentation of direct services to individuals as part of a population of children or adolescents with mental illness in a setting where mental health treatment, practice, observation or diagnosis occurs.
- Services provided shall be appropriate to the practice of a QMHP-C.
- Services must be under the supervision of a licensed mental health professional or a person under supervision approved by a board as a pre-requisite for licensure under the Boards of Counseling, Psychology, or Social Work.
- Supervision obtained in another US jurisdiction shall be provided by a mental health professional licensed in Virginia or licensed in that jurisdiction.
- Supervision must consist of face-to-face training until supervisor determines competency in the provision of QMHP-C services, then supervision may be indirect (the supervisor is either on-site or immediately available for consultation with the person being trained).
- Hours obtained in a bachelor's or master's level internship or practicum in a human services field may be counted toward completion of the required hours of experience.
- Supervised experience obtained prior to meeting the education requirements shall not be accepted.

QMHP Disciplinary Statistics

Counseling Violations * Jan 1, 2018 - Jul 13, 2023

LPC (41) LMFT (7) LSATP (1) Resident in Coun (11) Resident in MFT (2) CSAC (9) CSAC-A (3) SA Supervisee (2) QMHP-A (28) QMHP-C (19) QMHP-T (7) RPRS (1)



Credential Type	Total Active Credentials (as of 7/13/2023)	Total Violations (1/1/2018 – 7/13/2023)	% of Credentials with Violations
Licensed Professional Counselor (LPC)	8,793	41	0.47%
Resident in Counseling (RIC)	3,106	11	0.35%
Licensed Marriage & Family Therapists (LMFT)	1,035	7	0.67%
Resident in Marriage & Family Therapy (RMFT)	163	2	1.23%
Licensed Substance Abuse Treatment Practitioner (LSATP)	441	1	0.22%
Resident in SA	14	0	n/a
Certified Substance Abuse Counselor (CSAC)	1,655	9	0.54%
Substance Abuse Supervisee (SA Supervisee)	2,370	2	0.08%
Certified Substance Abuse Counseling Assistant (CSAC-A)	244	3	1.23%
Qualified Mental Health Professional-Adult (QMHP-A)	6,034	28	0.46%
Qualified Mental Health Professional-Child (QMHP-C)	3,978	19	0.48%
Qualified Mental Health Professional-Trainee (QMHP-T)	9,091	7	0.08%
Registered Peer Recovery Specialist (RPRS)	557	1	0.18%

Total Licensees	10,269	49	0.48%
Total Residents	3,283	13	0.40%
Total QMHPs/Trainees	19,103	54	0.28%

Background for BOC's Role

- Ensure QMHP's meet the minimum requirements for the role to ensure public safety and alleviate this requirement from employers.
- Provide accountability and ensure public safety.
- Ensure that DMAS funds programs and people who are not a threat to public safety or committing fraud.
- With minimum requirements, DBHDS and DMAS have the flexibility to require more supervision, more education, or more years of experience for certain roles within their programs.

Questions sent to the QMHP Regulatory Advisory Panel, Stakeholders, and Board Members (1/2)

1. What types of services are QMHP'As, QMHP-Cs, QMHP-Trainees, and QMHPs not regulated by the Board of Counseling, providing in agencies?
2. Should the Board of Counseling regulate all QMHPs, not just those in DBHDS or DOC settings?
3. Please define the scope of practice for each type if you can.
4. Would defining in the regulations or Code, scopes of practice for the QMHPs be beneficial?
5. Do you feel that a bachelor's level degree is beneficial, or if a formal degree could be replaced with more supervision and/or specialized training? If so, what level of education and which specific courses/trainings are necessary.
6. Would in-depth required training provide a better foundation than a specific degree and or coursework? What information should be included in this training, how long, training by whom and when should the training take place? Or should there be multiple required trainings?
7. Do you think there should be additional or different levels of QMHPs with defined scopes of practice, education and experience?
8. Are the QMHP-A and QMHP-C designations necessary? How could they be changed or improved?

Questions sent to the QMHP Regulatory Advisory Panel, Stakeholders, and Board Members (2/2)

9. What education do you feel is the minimum amount necessary for each registration?
10. What are the barriers to practice?
11. Should the Board be more specific in the supervision requirements?
12. Why should the Board allow a QMHP to supervise?
13. What should be the minimum requirements to be a supervisor, and should the supervision be different if it was from someone other than a LMHP or resident (supervisee)?
14. If there are levels of QMHPs, should there be levels of supervisors and supervisor requirements, and what would that look like?
15. It seems like there is a lot of misinformation out in the public about the requirements and the expectations of QMHPs, how could the Board best address this?

Identified Concerns and Possible Solutions

- The following slides attempt to provide solutions that reflect the suggestions from the RAP and stakeholders.

Identified Concerns and Possible Solutions

Education Requirements and Specialized Training

Education Requirements and Specialized Training

- Problem: **The pathways to become a QMHP-A or a QMHP-C are numerous, varied, complicated, and subjective which ironically result in many individuals not having an affordable or appropriate pathway to becoming a QMHP.**
- The regulations outline different combinations of education and experience over a long period of time and without detailed supervision requirements or prior training that would prepare QMHPs for the jobs they would work.
- The Board of Counseling (BOC) denies many applicants because they fail to meet the education requirements for this entry level position.
- The current pathways construct barriers to entry to practice as a QMHP, limit job flexibility, and fail to build or sustain a pipeline for the behavioral health care workforce.
- Community Services Boards (CSBs) report that the degree requirements have prevented people who have experience and willingness to take on the role. Specifically, they estimate that only half of the applicants for QMHP/QMHP-Trainee positions meet the requirements because many applicants have qualifying experience, but do not meet the field of study requirements. Many of those candidates have a sociology or criminal justice degree. It takes CSBs an average of 3-6 months to fill QMHP or QMHP -Trainee level positions.

Education Requirements and Specialized Training

- Potential Overhaul Solution: **The BOC should streamline the regulatory process, eliminate the specific degree requirements, and instead require specialized training focused on the QMHP supportive role in the behavioral health care workforce.**
  - Amend the regulations to allow someone with minimum of an associate's degree to become a QMHP.
  - Amend the regulations to require a specialized QMHP training.
  - Amend the regulations to require a jurisprudence exam.
  - Persons with an associate's, bachelor's, or master's degree must take the specialized QMHP training and the jurisprudence exam. No matter the education degree level, specialized QMHP training, one year of experience and passage of the jurisprudence exam would be necessary to be eligible for the QMHP.

Education Requirements and Specialized Training

Potential Overhaul Solution Cont…

- The BOC, DBHDS, VACSB, and DMAS should collaborate to develop the curriculum.
- The training could be offered through the community college system. There is already a framework for this type of training. If this is required, maybe consider changing the QMHP to a certification.
- Or, the training could be constructed in modules on a web-based platform. With this approach, the trainings should be competency-based with quizzes/tests for each module. With this approach it should probably remain a registration.
    - The trainings could be made available on the platform where case management training modules are currently accessed.
    - The QMHP training could pull information with revisions from already available training modules, such as the case management trainings, certified peer specialists, and direct support competencies. Suggested modules include Scope of work, Ethics, Fraud and Abuse reporting to DBHDS, Children's Protective Services (CPS)/Adult Protective Services (APS), DMAS, and BOC, Human Rights training, Addiction signs and symptoms, Crisis de-escalation, Person-Centered services, Accessing Emergency Services, Housing 101, Recognizing and Celebrating Diversity, HIPAA, working as a member of a treatment team, and Crisis Support Plans, and Documentation/record keeping. Again, there is already a framework to develop either type of training, so we do not start from scratch.
- To really expand the pipeline, the BOC, DBHDS, the Virginia Counselor Association (VCA), the CSBs, and DMAS could work with the Department of Education (DOE) or the Community Colleges to develop a Career and Technical Education (CTE) program for QMHPs. Upon completion of the program, the student would graduate high school with an associate's degree and completion of the QMHP specialized training and be eligible to register with the Board as a QMHP-trainee.
- The BOC would develop the jurisprudence examination focused on ethics, the standards of practice, and issues where the Board receives complaints. Focusing on these issues would ensure that QMHPs understand the regulations and their scope of practice, and hopefully prevent the current complaints and disciplinary actions the QMHPs currently face.

Education Requirements and Specialized Training

Justification for an overhaul:

- Elimination of the specific degree requirements would open the field and allow job flexibility.
- As a profession currently regulated only as a registration, there technically should be no entry standard.
- Experience and tailored training matters more for this para-profession. Most survey responders noted degree should not matter because degree programs do not focus on therapeutic/helping skills.
- The CSBs noted that the 72-hour training course for certification of peer recovery specialists is similar to what should be taught to QMHPs.
- The QMHP is also similar to the Community Health Worker role and that training is 40 hours.
- Everyone with any degree could register as a QMHP-Trainee and then after completion of the specialized training, completion of one year of supervised experience, and passing the jurisprudence exam, could become registered as a QMHP.
- The CSBs noted that the diversity of degrees has been beneficial to helping clients.

Education Requirements and Specialized Training

- Potential Minimal Change Solution:
  - Amend the guidance document to allow sociology and criminal justice degrees.
- Take no action.

Identified Concerns and Possible Solutions

QMHP Designations

QMHP Designations

- Problem: **The code and regulations provide three QMHP designations: QMHP-A, QMHP-C, and QMHP-Trainee. The QMHP-A and QMHP-C designations limit entry into the workforce and inhibit job flexibility.**
- There is no reason for the separation. Licensed providers are not required to designate whether they work with children or adults. They just must have taken the requisite continuing education to ensure that they have the requisite knowledge and training to provide the appropriate services. The same should be true for QMHPs.
- If the BOC opts to have a required specialized training, then it would include the training necessary to work with all populations.
- Having separate designations is a barrier to providing services and recruiting staff. The scope of work is the same.

QMHP Designations

- Potential Overhaul Solution: **The QMHP-A and QMHP-C should be collapsed into one designation and the BOC would continue to register QMHP-Trainees.**
  - Continuing to register QMHPs would coincide with stronger supervision requirements.
- **Take no action**

Identified Concerns and Possible Solutions

QMHP Supervision Requirements

QMHP Supervision Requirements

- Problem: **The regulations only allow an LMHP to supervise all categories of QMHPs. There is already a limited supply of LMHPs available to provide much-needed clinical services to the Commonwealth and supervision demands prevent LMHPs from devoting time to the clinical services.**
- There remains a shortage of LMHPs in the public sector to supervise QMHPs, which leads to reductions in needed services. Additionally, LMHPs are also supervise residents for licensure. As such requiring only LMHPs to supervise QMHPs adds more strain to the system.
- Many LMHPs have never worked as QMHPs. To assume they can appropriately supervise a QMHP by virtue of having more education is a faulty assumption. The day-to-day challenges and their power differential within systems are different. An experienced QMHP can problem-solve from lived experience. QMHPs know QMHP work, which is mostly targeted case management. LMHPs do not necessarily make good case managers. Seasoned and specially trained QMHPs can provide supervision that is more specific to the profession.

QMHP Supervision Requirements

Potential Overhaul Solution: <u>The BOC should add a QMHP-Supervisor designation and develop a supervision structure that relieves the supervision burden on LMHPs, reduced the amount and time LMHP must supervise QMHPs by allowing certain QMHPs to provide some supervision of other QMHPs.</u>

- A QMHP could obtain the QMHP-Supervisor designation with 5 years of experience, no founded complaints or disciplinary action, and completion of a QMHP Supervisor training. This designation would allow a QMHP, in collaboration with an LMHP, to supervise less-experienced QMHPs.
- Because the QMHPs are already a large number and continue to grow, it seems that the LMHP time would be better utilized focusing on the supervision of the smaller number of QMHP-trainees who need the most intense supervision in the beginning of their careers. Then, we could utilize experienced QMHPs to provide ongoing supervision to newer, less-experienced QMHPs. The supervision requirements would be more intensive for the trainees and would be spelled out in the regulations. Ongoing supervision of QMHPs would also be spelled out in the regulations.

QMHP Supervision Requirements

Potential Overhaul Solution: <u>The BOC should add a QMHP-Supervisor designation and develop a supervision structure that relieves the supervision burden on LMHPs, reduced the amount and time LMHP must supervise QMHPs by allowing certain QMHPs to provide some supervision of other QMHPs. (Cont)</u>

- The LMHP would also have to complete the QMHP supervisor training and would be required to meet regularly with the QMHP-trainees. But with less QMHP-trainees, the LMHPs could better utilize their skills, experience and knowledge providing clinical care to the public. And because the QMHP-Supervisors have met the certification requirements, have 5 years of experience, and have taken the supervision course they are in an appropriate position to take on more of the supervisory responsibilities and relieve the burden on the LMHPs. Of course, QMHPs cannot act independently so there will always be an LMHP ultimately responsible. The specifics of the ongoing supervision would be left to DMAS and the providers.
- The QMHP supervision training itself could also be in modules and mirror the supervision requirements for LMHPs. At a minimum any training should include information about ways to document supervision, topics to be covered, addressing concerns, and when to escalate to a LMHP.

QMHP Supervision Requirements

- Tiered Supervision Solution:
- We could create two levels of QMHP Supervisor. A QMHP Supervisor-1 with 5 years experience, no founded complaints or disciplinary action, and completion of a QMHP Supervisor training. A QMHP Supervisor – 2 with 10 or more years of experience, no founded complaints or disciplinary action, and completion of QMHP Supervisor training.
- A QMHP Supervisor-2 could supervise the QMHP-trainees because they are most familiar with the role. The QMHP Supervisor-Level-1 could supervise lesser experienced QMHPs. The LMHP remains ultimately responsible and could supervise the QMHP supervisors. The regulations would define the amount of time for supervision and it would be the same for each level. Additionally, DMAS and the providers could dictate the specifics of the supervision.

- TAKE NO ACTION

Identified Concerns and Possible Solutions

QMHP Scope of Practice

QMHP Scope of Practice

- Problem: **Neither the Code nor the Regulations define the scope of practice for QMHPs.**
- Lack of a defined scope of practice causes confusion and uncertainty for QMHPs, LMHP supervisors, and the public.
- A QMHP cannot know what they cannot do if they are unclear as to what they can do and vice versa.

QMHP Scope of Practice

Potential Overhaul Solution: The BOC should define the scope of practice in code or regulation and produce a guidance document and chart like the one created for Substance Use Disorders

- The BOC should collaborate with DBHDS and DMAS to define the scope. Collaboration will help to ensure continuity and clarity for providers.

TAKE NO ACTION

Identified Concerns and Possible Solutions

Regulating All QMHPs

Regulating all QMHPs

Problem: **The BOC only regulates QMHPs employed with the DBHDS and the Department of Corrections (DOC)**

- The CSBs expressed frustration that the needed regulations hold them to a higher and more burdensome standard in comparison to some of the private providers who allegedly utilize QMHPs to do most of their work (unlicensed practice), and just utilize LMHPs for signatures.

Regulating All QMHPs

- Potential Overhaul Solution: **The Board should amend the definition of a QMHP and regulate all QMHPs regardless of setting.**
- The BOC should regulate all QMHPs just as they do all LMHPs, regardless of setting. The need for accountability does not depend on the setting.
- Regulating all QMHPs would ensure consistency with experience, would define minimum qualifications, and allow a QMHP to change employers with the reassurance that the BOC has vetted and verified the education, experience, and disciplinary concerns.
- Once the definitions are changed, the BOC must ensure that the legislation carries an emergency clause so that the regulations can be adopted quickly. The BOC would have to coordinate the timing of these definition changes with DBHDS and DMAS to ensure consistency and clarity for providers and the public.

TAKE NO ACTION

Identified Concerns and Possible Solutions

Name Change

Regulating all QMHPs

Problem: **The name Qualified Mental Health Professional is misleading.**

- The BOC has never liked the name "Qualified Mental Health Professional" because they feel it is misleading. The definition of a "mental health professional" is stated right above the definition of a QMHP and it is misleading.

Name Change

- Potential Overhaul Solution: **The Board should change the name of the QMHP**
- If the BOC amends the Code to change the definition or to collapse the QMHP-A and QMHP-C into one designation, they should change the name.
- Suggestions have included Behavioral Health Support Specialist (BHSS) or Behavioral Health Wellness Coach (BHWC).

TAKE NO ACTION

Identified Concerns and Possible Solutions

Creation of Advisory Board

Creating an Advisory Board

Problem: **The QMHPs are the largest profession regulated under the BOC and yet they have no voice on the BOC.**

- The workforce and settings are very different for LMHPs and QMHPs.
- Any profession being regulated should have a voice.
  - CSACs, Registered Peer Recovery Specialists (RPRS), and Certified Rehabilitation Providers (CRPs) do not have a voice on the Board.

TAKE NO ACTION

Creating an Advisory Board

- Potential Overhaul Solution: <u>Create a BOC Allied Health Advisory Board</u>

- The Advisory Board could consist of 5 members: two QMHPs, one CSAC, one citizen member, and one other that would prioritize being filled by a RPRS or CRP, but if the numbers are low, it could be filled by a QMHP or CSAC as well.

Summary

- The above Recommendations provide solutions that reflect the responses from the RAP and stakeholders.
- The Overhaul recommendations aim to reduce barriers for a registered profession and provide targeted training, more specificity with respect to scope and supervision, as well as more structured supervision that allows LMHPs to provide the services they need and the QMHPs to remain supportive of the LMHPs.
- All but one of the survey respondents objected to a tiered system, or more levels of QMHPs.

Agenda Item: Petition for rulemaking

Included in your agenda package:

- Petition for rulemaking received by the Board to amend 18VAC115-20-52 to

    - Reduce the total required residency hours from 3,400 to 3,000;
    - Reduce residency client contact hours from 2,000 to 1,500; and
    - Change supervision requirements from a minimum of 200 hours to a requirement for weekly supervision with no minimum;

- Public comments received through the Regulatory Town Hall regarding the petition; and

- 18VAC115-20-52.

Staff Note: 76 public comments were received regarding the petition. 45 were clearly in support, or in support of two of the three requests. 19 were in opposition. Six contained complex responses that were not easily categorized. Three did not address the petition at all but suggested other requirements or commented on other aspects of the practice of counseling. Several comments were not counted in these numbers because the comments were duplicates or extensions of a previous commenter's earlier reply that was already counted.

Action needed:

- Motion to recommend that the full Board either:
    - Accept the petition and initiate rulemaking; or
    - Take no action on the petition, including reasons why.

Secretariat **Health and Human Resources**

Agency **Department of Health Professions**

Board **Board of Counseling**

Edit Petition

Petition 406

Petition Information	
Petition Title	Petition to change residency and supervision requirements for licensed professional counselors
Date Filed	3/11/2024 [Transmittal Sheet]
Petitioner	Brandy Rucker
Petitioner's Request	The petitioner requests that the Board of Counseling amend 18VAC115-20-52 to: 1. Reduce the total required residence hours from 3,400 to 3,000; 2. Reduce residency client contact hours from 2,000 to 1,500; and 3. Change supervision requirements from a minimum of 200 hours to a requirement for weekly supervision with no minimum.
Agency's Plan	The petition for rulemaking will be published in the Virginia Register of Regulations on March 20, 2024. The petition will also be published on the Virginia Regulatory Town Hall at www.townhall.virginia.gov to receive public comment, which will open on March 20, 2024 and will close on May 8, 2024. The Board will consider the petition and all comments in support or opposition at the next meeting after the close of public comment, currently scheduled for August 2, 2024. The petitioner will be notified of the Board's decision after that meeting.
Comment Period	Began 4/8/2024 Ended 5/8/2024 76 comments
Virginia Register Announcement	Submitted on 3/11/2024 The Virginia Register of Regulations Published on: 4/8/2024 Volume: 40 Issue: 17
Agency Decision	Pending

Contact Information	
Name / Title:	Jaime Hoyle / *Executive Director*
Address:	9960 Mayland Drive Suite 300 Henrico, 23233

Email Address:	**jaime.hoyle@dhp.virginia.gov**
Telephone:	(804)367-4406 FAX: (804)527-4435 TDD: ()-

This petition was created by Erin Barrett on 03/11/2024 at 1:09pm

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,)
Rucker, Brandy M

Street Address	Area Code and Telephone Number	
6218 Strongbow Dr	8508907753	
City: Moseley	State: Virginia	Zip Code: 23120

Email Address (optional)
bmrucker@yahoo.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.

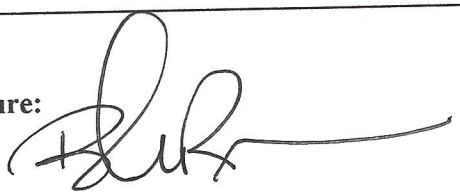
Virginia Department of Health Professions Board of Counseling (2023), requires that LPC residents complete "a 3,400-hour supervised residency in counseling practice with 2,000 hours of face-to-face client contact."

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

I propose the following change to the LPC face-to-face requirements in the state of Virginia: "A resident must document 3,000 hour supervised residency in counseling practice with various populations, clinical problems, and theoretical approaches with 1500 hours of face-to-face client contact within this 3,000 hour supervised residency." Residency hours in excess of 1500+ may increase the likelihood of burnout, unnecessary supervision costs, low pay, the need for multiple work sites to increase hours, and future counselors who abandon the field altogether. Mental health is a need, and the demand is growing. Why do LCSWs and LPCs both require a master's level education, nationally recognized exams, and accredited programs yet have to meet substantially different supervision hours to perform commensurate work. LPCs serve amongst a wide range of other mental health professions to include LCSW's performing in similar work settings to include hospitals, private practices, community health and schools.

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.

None

Signature: 

Date: 29 Feb 2024

Virginia Department of
Health Professions
Board of Counseling

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www.dhp.virginia.gov/counseling

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

Street Address	Area Code and Telephone Number	
6218 Strongbow Dr	8508907753	
City: Moseley	State: Virginia	Zip Code: 23120

Email Address (optional)
bmrucker@yahoo.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.

Virginia Department of Health Professions Board of Counseling (2023), requires that LPC residents complete "A minimum of 200 hours of supervisory sessions, occurring at a minimum of 1 hour and a maximum of 4 hours."

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

I propose the following change to the LPC supervision requirements in the state of Virginia: "A minimum of 1 hour and a maximum of 4 hours (as needed) of weekly supervision must be documented as completed by the approved supervisor. The approved supervisor does not need to provide a specific number of hours per quarter. They will only annotate if the weekly minimum requirements were met for that quarter, continuing until all direct and indirect supervision hours have been reached. This change will mitigate the cost of additional supervision, reallocating funds to further training and development for residents. This change will hopefully facilitate an increase in licensed counselors to contribute to our deficits within the mental health community. The state of Virginia projects a shortage of licensed mental health providers. However, many professionals cannot stay in the field and continue their licensure process due to the constraints of low pay, unfavorable work conditions, and supervision costs.

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.

None

Signature: 

Date: 29 Feb 2024

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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]**

76 comments

All good comments for this forum Show Only Flagged

Back to List of Comments

Commenter: Anonymous 4/9/24 8:16 am

LPC Residency and Supervision Hours Amendment

I am in support of these changes. I feel it will help those individuals transferring from other states whom are not independently licensed as an LPC since every state board has different requirements to obtain licensure. Being we are a military heavy community, I feel this could also benefit military spouses whom may be currently working in the field and pursuing licensure as LPC or are looking into beginning a career as a helping professional since the length of their spouse's tour is limited.

CommentID: **222501**

Commenter: Anonymous 4/10/24 6:53 am

Please review these proposed changes

According to a qualitative study called "*United We Stand: Narrative Study to Aid the Counseling Profession in Developing a Coherent Identity*", "In the area of supervised experience, a majority 62% (n=2) of the states **require 3000 total hours of post-master's supervised counseling experience** (ACA, 2016). Ten other states come close ranging from 2400 to 3600 hours, and five states require 4000 total hours. A majority of states, 62% (n=31) require **100 hours of supervision**. Six percent (n=3) require 180-200, 8% (n=4) require 120-150, another 8% (n=4) require between 50-80, and 17% (n=9) do not specify a number of hours of supervision" (Bohecker and Eissenstat, 2018).
With the upcoming counseling compact, why does Virginia continue to be in the minority for supervision requirements? Licensure portability is changing for the good. Can we also address the vast differences in supervision requirements alongside these changes? If 62% of the U.S. finds 3000 total hours of supervision sufficient, what's happening in Virginia which requires 4,000 total hours with the graduate level internship
The state of Virginia projects a shortage of licensed mental health providers. However, many professionals cannot stay in the field and continue their licensure process due to the constraints of low pay, work conditions,

and supervision costs. Therefore, setting new residents on a sustainable path to licensure is difficult. Lastly, MSW supervisees often work alongside LPC residents yet are required a "minimum of 3,000 hours of supervised post-masters degree experience in the delivery of "clinical social work services" and "ancillary services" meet with your supervisor for 1-4 hours per week for a total of 100 hours of individual face-to-face supervision Meet with clients face-to-face a minimum of 1,380 hours while providing clinical social work services." (Virginia Department of Health Professions Board of Social Work, 2023). MSW's have a much broader scope yet less requirements. It's time to review, adjust and bridge the gap. I agree with this petition and the need for revision.

References: Eissenstat, S. J. and Bohecker, Lynn, "United We Stand: Narrative Study to Aid the Counseling Profession in Developing a Coherent Identity" (2018). Psychology E ducat or Scholarship. 24.
https://mosaic.messiah.edu/psych_ed/24
CommentID: **222504**

Commenter: Jessica Johnson

4/11/24 1:01 pm

Residency Requirements

I agree with the proposed changes considering the state's recent acceptance of compact licensure. This will also reduce the pressure and expedite completion of the required face-to-face hours because services can be provided in a hybrid or solely telehealth model of care.

CommentID: **222509**

Commenter: Anonymous

4/12/24 11:36 am

Petition to reduce/change hours

I agree with this petition about the need to change the number of hours needed to earn LPC licensure. Mental health counselors are critically needed. As a veteran teacher of 30 years that is transitioning to the field of Clinical Mental Health Counseling, I see students struggling with mental health every day. I also hear stories of students waiting for months on a waitlist to get help because of shortages. Some families struggle to afford counseling services for their children. Even though these families may have insurance coverage, Resident Counselors pursuing their LPC can only accept insurance clients based on their supervisor's credentialing. This creates a situation where a Resident in Counseling may be available to counsel but the family cannot afford to "self pay" because the counselor cannot accept their insurance.

I fully understand the state of Virginia wanting counselors to be highly qualified. But, the excessive hours are beyond what is needed to be highly qualified.

CommentID: **222511**

Commenter: Anonymous

4/13/24 9:56 am

Adopt recommended changes

I agree with the proposed amendments to licensure hour requirements. As a Resident in Counseling I have seen first hand the difficulties imposed on both clients and licensure candidates due to current exorbitant hour requirements. Reducing the hours would make Virginia more in line with other state requirements, reduce resident burnout, and improve mental health services access to our communities. Thank you for your consideration.

CommentID: **222512**

Commenter: Anonymous

4/13/24 2:22 pm

Supervision Hours

The reduction in hours of direct client-contact to be more in line with comparable state's requirements makes sense. However, I disagree with the need to change the structure of supervision requirements. Residents typically have access to at least once per week, but often if a resident is only pursuing licensure at part-time rates, then supervision once per week does not make financial sense for either the resident or the supervisor if it is included in an employment contract. The full 200 hours could potentially be reduced. However, that conversation is much more nuanced than simply removing the overall requirement.

CommentID: **222513**

Commenter: R. Fines

4/21/24 1:58 pm

Beneficial changes

These changes would be highly beneficial for aspiring counselors. It allows them to gain practical experience more efficiently, which can lead to earlier entry into the workforce. The reduced supervision hours provide flexibility and ensure that they are adequately supported while developing their skills. This streamlined approach can help counselors reach licensure faster and start positively impacting clients sooner.

CommentID: **222519**

Commenter: Very Concerned Client

4/22/24 3:19 am

Ethics Issues

There is a significant issue going around with Licensed Counselors for some years being non--factual with information and making records corrections/adjustments/amendments exceptionally difficult. Most agencies/personnel with whom I have worked regarding my disabled child will notate whatever they want, and then IF they provide the required opportunity to address/amend/correct records, they provide a LOT of resistance, and then only maybe agree to 'amend'/correct records with an 'attachment' which is not guaranteed nor monitored. Records amendments/adjustments/corrections MUST be able to be made on Original Documentation in a way that it CANNOT be separate/d. At times I've seen agencies in collusion together to determine what THEY want (mostly in terms of billing) and document things in a way that benefits THEIR billing, and NOT what's in the best interests and/or honesty for the client. This practice needs to be stopped with STRONG policy language, CLEAR outlines/examples of violations which can constitute licensure revocation, suspension, cancellation and non-renewal. Enforcement is necessary for the safety, welfare and medical recordation for other providers and in files for collaborative services FOR the best interests of each client.

CommentID: **222520**

Commenter: Justin Jordan PhD LPC LSATP

4/23/24 9:52 am

I trust the board to weigh the positive and negatives of this change

Hello,

As others have stated, this is a very nuanced issue for counselor training. Weekly supervision throughout the residency is beneficial in ensuring client issues and resident development issues

don't "fall through the cracks", but also creates some inequity and difficulty for residents who are working to become counselors on a part time basis. 200 hours is a high bar for the residency period, but we should be holding our residents to a high bar for learning how to do this work. I am proud to be licensed in Virginia, where I know my fellow counselors have had those hours in supervision to learn and grow and tackle new situations that are unfamiliar. I am opposed to changes designed to "just make it easier" to get licensed quickly. It seems that the current set up in which residents must have one hour of supervision per 40 hours of work time seems fair to residents and supervisors. Most of all, I hope the board will be thoughtful in ensuring that Virginia maintains a high training standard for residents pursuing their LPC, especially with the Counselor Compact legislation expanding our opportunities to serve clients in other states in the years ahead.

Justin Jordan PhD LPC LSATP
CommentID: **222524**

Commenter: Anonymous 4/24/24 1:00 pm

Accompanying Jurisprudence

While I agree wholehaeartedly that the number of hours a person completes under supervision is not a direct signe of comptency and can be modified in an appropriate manner, I strongly believe that additional measure need to be intituted to ensure that new and continuing therapists are competent. While additional testing may not be the answer, I would recommend some form of skills based jurisprudence be instituted to support this change with minimal risk to consumers.

CommentID: **222531**

Commenter: Anonymous 4/29/24 7:58 pm

Maintain the requirements to uphold professional standards

Maintaining rigorous requirements for counselor licensure is crucial for upholding professional standards and ensuring the provision of high-quality mental health care. These standards not only safeguard clients' well-being but also promote continuous professional development among counselors, fostering a culture of excellence in the field. By upholding stringent requirements, we safeguard against subpar practitioners, thereby preserving the integrity and effectiveness of counseling services.

CommentID: **222552**

Commenter: Anonymous 4/29/24 8:04 pm

Maintain requirement for direct hours

While I recognize the process to be cumbersome, it does help to ensure that a resident is prepared should they choose solo practice. I believe that the 2000 direct hour requirement helps to provide that competency.

CommentID: **222553**

Commenter: Anonymous 4/29/24 8:47 pm

Proposed Changes to Residency and Supervision Requirements

As a current supervisor who has been a supervisor since 2011 in PA and since 2019 in VA, I want to share that for various reasons there are residents who can only obtain supercision hours on a biweekly basis as they are caring for family members, working full time jobs , and as there are natural breaks when holidays roll around, people are ill, or when life happens. To say that supervision would have to take place only weekly is a diservice to these individuals who cannot access supervision weekly.

Please consider having flexibility about the structure of how residents obtain supervision hours as there are many who can only participate in supervision activities biweekly.

I am opposed to the decrease in the requirements as proposed here. I strongly believe in holding our profession to the highest standards as we are in a position of providing vital specialized care to others. I see what supervision provides and equips new counselors with, how it supports the development of a high quality skillset, and feel that adequate hours and effective supervision helps new counselors and reach higher standards. To lessen the number of direct client hours required or to change the structure of supervision to "weekly" sessions will weaken the attainment of a strong clinical skillset and reduce what supervision provides new professional counselors who are just starting out. The quality of licensed professional counselors should be held in highest regard, and therefore so should their training requirements. The current requirements as they are now are effective in ensuring that newly licensed professional counselors are well equipped to practice on their own or in a group practice, and that they provide a high quality standard of care to their clients.

CommentID: **222554**

Commenter: Anonymous

4/29/24 9:08 pm

Residency Hours and Supervisors

I feel as though the hours to obtain for licensure should be reduced and mirror in both LPC and LMFT programs. The direct client time should also be reduced as well. Supervisors should be made to take a cultural competency course and do retraining’s after 5 years to ensure they meet the standards as a supervisor.

CommentID: **222556**

Commenter: Anonymous

4/29/24 10:24 pm

Comment

Looking at the DHP case decisions between 1/1/23 and 4/29/24, one will quickly find that counseling far outweighs other mental health fields (i.e., Psychology and Social Work) in ethical violations and sanctions. I don't think we are in a position to lower our standards. Further, while I agree that the process can be tedious and can feel as if it will never end at times, I think there is something to be said for meeting a certain metric when it comes to competent practice. Reducing the 3400 to 3000 may make sense, as ancillary hours can be easily met. However, I don't think direct hours should be reduced. Finally, the proposed supervision requirement is unrealistic and creates additional barriers. Not all residents see 40 clients within a week, and it is impossible to account for sickness, reschedule, and guarantee adequate coverage if a supervisor cannot meet that week. Further, supervision comes at a financial burden to the Resident - even when it is "covered" by the agency, it is how the egregiously low pay tends to be justified. I urge the board to keep the direct hours and supervision requirements as currently written. Perhaps efforts should be made to improve the requirements and training of supervisors themselves.

CommentID: **222558**

Commenter: Anonymous

4/29/24 10:34 pm

Supervision needs to be better

These adjustments reflect the evolving landscape of mental health care and acknowledge the need for flexibility in training programs. However, as we advocate for these changes, we must ensure that ethical responsibility and comprehensive training remain at the forefront.

While reducing total required residence hours and residency client contact hours can make the path to licensure more accessible, it's crucial to maintain the integrity of the counseling profession. Adequate training and supervised experience are fundamental to providing quality care to clients. Therefore, I suggest incorporating specific language within the amendments that emphasize the importance of ethical practice and ongoing professional development. To that end, real change would be improving requirements and training for those in supervisory positions.

Furthermore, while transitioning from a minimum of 200 hours of supervision to a requirement for weekly supervision with no minimum might streamline the process, I think a clearly defined minimum requirement should be attainable and realistically met. The proposed one is not.

CommentID: **222559**

Commenter: Anonymous

4/29/24 11:26 pm

Standards for LPC's should remain high to compete well with other disciplines.

Having been in the helping profession for over 35 years now, I have seen a huge lack of respect for LPC's, especially from the field of social work. We are already not taken as seriously as LCSW's and are grossly under utilized in some arenas. For example, as far as I know, we are not utilized by Medicare or Tricare/military yet. In a world where there is currently a pressing need for more therapists, we are still not seen as "good enough" compared to LCSW's. I would hate to give them one more reason to think we don't measure up. Our training is essentially the same as theirs at the moment (equal but different with some subjects), it's just laid out differently. The LCSW internship is longer, but our residency is longer. So shortening any of it may put us in question. Sometimes I wish the two disciplines would merge into one, helping is helping, therapy is therapy. The whole Hatfield & McCoy feud thing is getting old.

CommentID: **222560**

Commenter: Jill A. Hagen, LPC, LSATP

4/30/24 7:44 am

Lower standards?

I have been in the counseling field since 1974. I have always found that extensive supervision and practice makes for better service. Reducing minimums of residency and supervison will likely result in decrease in skills and increase in major oversights on the part of the Counselor. Having taught and supervised Counselors (both paraprofessional and graduate level), they are usually under prepared for the hard and sensitive work even at the current required levels. I have always been concerned that residents only need to meet minimum standards. Reducing requirements will result in deaths and LPC status undermined.

CommentID: **222561**

Commenter: Anonymous

4/30/24 8:20 am

Concerns

I am more recent in coming into the profession than some of those who have commented. I have concerns with reducing required hours. Just as we would want our medical professionals to have as comprehensive and through training as possible, as mental health professionals, I feel that we need the same. I find reduced requirements concerning.

CommentID: **222562**

Commenter: Shante Williams

4/30/24 9:05 am

Support for changes

I am in support of changing the residency and supervision requirements for LPC Residents.

CommentID: **222563**

Commenter: Anonymous

4/30/24 9:13 am

Petition

As a current graduate intern, I have found the hours to be overwhelming. I have questioned if I even want to move forward due to the time, effort, energy, and money that I will have to invest (only to be told that those going into the field should be more focused on helping others instead of making a decent livable salary). I don't think reducing the residency hours will have that great of an impact. Nor will the reduction of supervision hours. One has to remember that in addition to the residency, most (if not all) will have to had complete an internship with their program which includes supervision hours and direct contact hours as well. A potential LPC has them and those hours of experience working in a professional capacity. While the requirements are there to ensure adequate training, they are also a barrier for those who want to enter the field. Reducing the hours is not going to create a new generation of LPC's who are not ready or unable to provide quality ethical services. However, it may encourage those who are thinking about getting into the field to move forward with the process.

CommentID: **222564**

Commenter: Anonymous

4/30/24 9:32 am

Do no harm

Why would we lower our standards in a field where harm could be done. Our profession handles life and death situations, and it is proposed that inexperienced or new clinicians need less experience and supervision? That is outrageous. This proposal needs to be denied for the safety of our clients.

CommentID: **222565**

Commenter: Anonymous

4/30/24 9:48 am

Agree Do No Harm

I agree with the comments of Do No Harm. As a licensed supervisor I observe mental heath counseling is a highly nebulous field, as in no 2 cases are the same, and it is not as easy as an antibiotic, so to speak, prescription to cure. Even the best prepared LPCs on gaining licensure are still very green. Very green with much to learn. I absolutely disagree with lowering any LPC entry standards or requirements across-the-board.

CommentID: **222566**

Commenter: Anonymous

4/30/24 9:52 am

Lowering hours lowers opportunities for multi-state licenses

From what I understand VA has some of the most stringent licensing hours, so this can be viewed as a bad thing for those entering the field, but it also allows for us to more easily apply for licensing in other states. This is beneficial for expanding our businesses or if we need to move at some point in our lives. I find it a relief to know that when the counseling compact comes in to play that all the hours I spent for licensing will most likely be enough to gain more state licenses without having to gain more hours. I rather have done what's necessary in the beginning of my career rather than later. I would table this decision until the counseling compact has been fully integrated and we have a clear understanding and of the process.

CommentID: **222567**

Commenter: Anonymous

4/30/24 10:01 am

No!! Gatekeeping is there for a reason...

This is ridiculous. As a multi-state licensed trauma therapist, looking at the caliber of residents and supervisees that are coming into the field after receiving their training online during COVID, residents/supervisees need MORE supervision, not less. What happened to being the "gatekeepers" of the profession? We are the LOWEST paid medical professionals that are held to the HIGHEST standards of care and we want to reduce supervision? This petition is the reason we are not taken seriously in the greater medical community!

I firmly DISAGREE with lowering our standards further.

CommentID: **222568**

Commenter: Anonymous

4/30/24 10:14 am

Supervision

I do not agree that lowering hours is a good idea - we need all the training and support we can get as we enter into a field as demanding and challenging as counseling. However - I would propose we make WEEKLY supervision a thing while keeping 200 hours of supervision as a requirement. BOTH AND.

CommentID: **222569**

Commenter: Anonymous

4/30/24 10:38 am

Agree, makes the licensure process comparable to other states.

I highly encourage folks to check out licensure requirements for LCSW, and LPCs in other states- to include MD and DC. VA has extremely rigorous requirements. Residents typically pay for supervision as well; making it an expensive investment as well as a time consuming one. Many residents work other jobs while working to obtain licensure because the sites they work at do not pay a livable wage.

According to white paper completed by Motivo Health—57% of graduates never even complete the licensure process! Which means the massive crisis we are facing with the shortage in clinicians is starting as soon students leave grad school. “https://motivohealth.com/whitepaper-the-57-percent-who-never-attain-licensure/?utm_campaign=0323-whitepaper&utm_source=website&utm_medium=banner

My own journey toward licensure has taken many years longer than my graduate school peers because the counseling jobs I needed to work to get hours did not pay enough for me to live in Northern VA as a single person. I’ve been working full time in my daytime career unrelated to counseling and then part time as a therapist to get my hours—it’s exhausting and expensive and time consuming! This is the reality for many of us who do not have family to support us or live in dual income homes.

I think this would be a welcome change to people who really are passionate about this field but have been challenged by the financial burden of getting toward licensure.

CommentID: **222570**

Commenter: LPC for 25 years

4/30/24 11:02 am

NO!!!! Against the changes...

With the current world falling apart and changes occurring by the second (not good ones , mind you), being a therapist has become more and more challenging. Once we had the "walking wounded", now, there is a plethora of very serious and deep issues therapists have to deal with . Do no harm. And to live by that , the rules need to stay the same....maybe even add more...for quality training. Would you go to a surgeon that had less training?

Where is this coming from? Is this the new generation that has had things handed to them and now want it easy? Poor babies...well, tough toenails....WE ALL PAID THE DUES, PUT IN TIME AND HAD FINANCIAL BURDENS!!! And somehow we managed....WE DID IT AND SO CAN YOU!! Time to grow up.

CommentID: **222571**

Commenter: Suzan K. Thompson, Ph.D., LPC

4/30/24 12:04 pm

LPC since 1996

Every profession evolves, hopefully for the better with each iteration. I am honored to have a license from Virginia -- the first state to license COUNSELORS separately from psychologists and social workers! As a former full-time faculty member, current LPC supervisor and private practice counselor, I believe it is time for Virginia to align with the majority of states in its requirements, especially with the Counseling Compact in effect now AND the shortage of qualified LPCs. Times have changed and regulations have changed slowly -- now it's time for Virginia to make appropriate changes to requirements to earn the LPC.

CommentID: **222572**

Commenter: Sophia Sills-Tailor

4/30/24 12:43 pm

Time for Change

I agree that these changes need to be made.

CommentID: **222573**

Commenter: LPC, LCPC of 12+ years

4/30/24 1:46 pm

Keep the requirements.

2,000 direct hours is an average of 9.6 hours per week over 4 years. Or, an average of 19.23 hours over 2 years. A full time caseload for most independently practicing therapists is typically considered 20 hours per week. So, essentially we are asking residents to work an equivalent of two years' worth of full time direct clinical hours in order to minimally consider them as competent and independently licensed.

I think that's beyond reasonable. Especially in a field where our scope of knowledge is so broad, and more and more we're realizing our clients are multi-faceted and often co-occurring. Depression, anxiety, ADHD, Autism, OCD, psychosis, substance abuse, trauma, eating disorders, peri/postpartum, etc. We should not be rushing through the process. Too often I see clients who have been ineffectively treated in the past due to a lack of general knowledge by previous therapists to simply screen for various conditions and refer out as needed. We're not expected to be experts in everything, but I am not convinced that LESS experience and supervision is appropriate or wouldn't cause harm.

I also think that the current board's requirement for a minimum ratio of 1 hour of supervision per 40 hours of experience is appropriate. Realistically, with holidays and time off, the actual calendar week equivalent is less than 1 hour per week when averaged out, so there is flexibility there (it's just messy to calculate/track). A work week looks different for different providers, whether part-time or otherwise, so I strongly advise against the petitioner's recommendation for a flat 1 hour of supervision per week.

For those referencing the desire for residents to be less financially burdened and be free of their dependence on toxic workplaces, I will say I completely understand from personal experience. However, that is another matter to address independent of the need to ensure competent therapists ready to practice independently upon issue of their medical license.

CommentID: **222574**

Commenter: Anonymous

4/30/24 2:33 pm

Times Have Changed

As a current Resident in Counseling I am in favor of lowering the amount of required hours for licensure. The number 3,400 seems arbitrary and is not indicative of someone's ability to work with clients effectively. Not to mention there is a shortage of therapists nationally and more than 50% of potential clinicians who start residency are not able to complete it.

CommentID: **222575**

Commenter: Shelby DeBause

4/30/24 2:59 pm

Long time supervisor, and I do not support these changes

As a person who has been supervising for 8 years, I typically see that residents need the full amount of hours of experience, hours, and supervision that are the current standards. I understand that the road to licensure is seen by many as long and challenging, but frankly, it is meant to be so that only those truly dedicated and ready to serve pass through the gates into independent licensure. I would hate to see our profession fall into lowering our standards, and urge people to think about the reputational damage this may have on counseling long term. To protect clients, clinicians, and the field itself, I warn against these changes.

CommentID: **222576**

Commenter: William Moncure

4/30/24 3:52 pm

Mixed - Current Supervision Hours Excessive, Consider Slight Reduction

Currently, if a Resident receives one hour of supervision a week, it would take them nearly four years to finish their hours. If they work 40 hours a week with one hour of supervision, they would end up with 8,000 total hours before finishing their supervision hours. Even if they receive two hours of supervision per week, they would end up with 4,000 total hours, which is in excess of current requirements (regardless of whether they are reduced as this petition requests). I have known many Residents who have finished all of their clinical hours, but have to stay as Residents for months (costing them thousands of dollars) only to complete supervision hours. I think we should consider 150 supervision hours as a requirement instead of 200.

In addition, graduates of CACREP Doctoral programs can count their Internship hours for "up to 900 hours of the residency requirement and up to 100 of the required hours of supervision". One option that would help out some people would be to also count the same number of Practicum and Internship hours from non-CACREP accredited Doctoral degrees in Counseling and related fields, provided that the individual applying for licensure already has a Master's degree that meets the Board's requirements for licensure as an LPC. This change would help recognize already obtained valuable experiences these individuals have and help increase access to mental healthcare in Virginia.

I have more mixed feelings about reducing total hours and direct hours, but I do know that our requirements are much higher than some other states.

Some commenters here have mentioned that our current standards make it easier to become licensed in other states, but an accurate understanding of the Counseling Compact is that one only has to be licensed in their home state to practice under the Compact - the goal is that we do not need to meet licensure requirements in other states. With that said, even with some of these changes, such as the number of supervision hours, we would still have higher requirements than the vast majority of states. Thank you for considering my thoughts.

CommentID: **222577**

Commenter: Suzanne Nixon

4/30/24 7:15 pm

in support

I support these changes. VA requirements are not in alignment with other states, and I believe the hours are overly extensive.

CommentID: **222578**

Commenter: Anonymous

4/30/24 7:45 pm

Easier for clinicians moving from out of state

Hello! The requested change of requirements would match other states. I am moved to Virginia from Tennessee and am licensed in TN. I have not reached the 2 year mark for post licensure, so I am having to do extra supervision to reach Virginia's standards. I think it makes more sense for all states to generally have the same requirements.

CommentID: **222579**

Commenter: Anonymous

5/1/24 7:21 am

Petition comment

To Whom It May Concern,

I am writing today to support some of the changes and wish that the rules would read this way:

For the comments 1 and 2, I believe that the Supervisor should be required to approve the acceleration for the individual resident. Mechanically the requirement would remain 3400 hours and 2000 hours respectively. Yet, the supervisor could petition the board when the resident reaches 2800 & 1300 hours to recommend the resident be approved at 3000 and 1500 hours. Not all residents are prepared for an early release of hours, but most/many will and therefore should be allowed to become fully licensed.

3. I think this change is critical as sometimes its difficult to manage schedules to ensure the "When" of a supervision hour occurs and all hours by a resident should be counted even if illness/vacation etc delay a supervision appointment. Also, a smart resident will increase their supervision in the beginning of residency when its truly needed, and relax the supervision frequency near the end of residency. They should be granted the opportunity to do what's best and right for their needs.

CommentID: **222580**

Commenter: Anonymous

5/1/24 11:19 am

Support

I think adjusting based on current times is appropriate. We spend so much money to get the degree and then sometimes have to pay absurd amounts for supervision. That's another area that should be governed. We're not saying make it so that anyone can decide to get licensed however, make it doable.

CommentID: **222581**

Commenter: Sharon Watson, LPC, LMFT, LSATP, NCC, ACS

5/1/24 12:12 pm

Strongly support with a caveat

There are several reasons why I support this petition with one caveat: change the "weekly" requirement for supervision to 100 hours which can still be a combination of individual and group supervision and change .

I have supervised many supervisees/residents since 1995 in the public system in various roles, in private practice as employees, and those in their own private practices. As I continue to do so, my recommendation is:

- 3000 hours total work

- 1500 hours face-to-face/direct work
- 100 hours of supervision with a minimum of 1 hour per 40 hours of work
- Supervision provided only by a trained LPC supervisor

#1. LCSWs in Virginia are only required to have 100 hours of supervision, 3000 hours of work experience with 1,380 hours of face-to-face supervised work experience. If the Virginia Department of Health Professions feels that's adequate for social workers, they should be adequate for professional counselors. It would be interesting to find out why the requirements were made so much more rigorous for counselors in the first place. Was it because, as the first state in the U.S. to license counselors they wanted to be sure they could support the requirements for licensure? Or could it have been that at the time there were no specified graduate programs (like CACREP) that would make the training consistent over the various graduate programs and they wanted to be sure counselors were adequately trained? In any case, that is no longer an issue. For that reason, the current imbalance of requirements between LCSWs and LPCs is extremely unfair because it: a.) burdens LPCs with the additional extreme financial expense of paying for twice as much supervision and b.) with the higher total work time requirement it postpones the resident's licensure and ability to take insurance (if wanted) in order to earn a livable wage?

#2. Understandably there are some who may suggest that we, as LPCs, want to have a higher standard for counselors than social workers. However, in the real world, is the public (our clients) making the choice of social worker vs counselor for therapy because of the licensure requirements? It's unlikely that the public has any idea about the difference. The way to maintain a high standard and consistency in our field is for LPC supervision to be provided only by LPC supervisors and not LMFTs who have different educational requirements or LCSWs (as was suggested in a recent petition to be an option again), who have even a greater difference in educational requirements and educational focus.

#3. As was outlined in a previous comment, many states require much less than 200 hours of supervision for LPCs with most only requiring 100 hours. The fact that the Counseling Compact (which includes Virginia) will allow only LPCs (not LMFTs) to request and be granted a privilege to practice in another Compact state, it's important for us to maintain the integrity of professional counselor licensure. This is another reason to eliminate LMFTs as LPC supervisors. So, changing Virginia's licensure requirements to be more in line with many other states would be a timely and welcome change.

Lastly, the reason supervision should not be based on a weekly schedule is because some residents work part-time or very limited hours. It would be unreasonable to expect, for instance, someone working 10 hours per week to be required to have the same one hour of supervision as someone working 40 hours per week. Some residents who have difficulty finding clients, especially when starting their practice, shouldn't have to pay for the same amount of supervision as a resident who has a full caseload and works full time.
CommentID: **222582**

Commenter: Anonymous

5/1/24 1:23 pm

Maintain standards

I agree that the 200 hour requirement for supervision can be challenging to meet within a reasonable timeframe if you consider 1 hour of weekly supervision over the course of residency. Lowering the required hours of supervision makes sense to me.

Lowering the required hours of client contact however, makes no sense to me given how much there is to master over the course of a residency to truly serve various client populations well. Over the 20+ years that I have been in the field I have seen the complexity of the issues clients are

presenting with only grow and being thoroughly trained and equipped to work with these clients is essential for those who want to be mental health counselors.
CommentID: **222585**

Commenter: Anonymous

5/1/24 2:26 pm

Support change

I am in support of the proposed changes.

CommentID: **222586**

Commenter: Anonymous

5/1/24 7:16 pm

Agree with the proposal except for the weekly supervision meetings

I support the proposed changes except for the weekly supervision meetings. The number of supervision hours should be reduced but not all residents are working full time and some will have to have a break in their schedule because of maternity leave, caring for an ill or dying family member, or recovering from surgery. You may not be able to get in any hours or you may be able to get in a few hours during this time.

CommentID: **222587**

Commenter: Anonymous

5/2/24 2:40 pm

Support in part

I don't support decreasing the total required hours, but I do support decreasing the direct supervision hours. I'll be starting my residency next month. I could get my 3,400 hours and 2,000 direct hours in 85 weeks, but to get 200 direct supervision hours in 85 weeks, I'd have to get about 2.5 hours of supervision weekly. That's hard to do. Change it to one hour minimum per week, regardless of the length of the residency.

CommentID: **222591**

Commenter: Anonymous

5/2/24 9:48 pm

FULLY SUPPORT THE CHANGES!

I worked in schools as a licensed school counselor for 12 years then began my LPC residency. I have been working on that for over two years so far and still have half a year to finish the hours. If required direct hours are reduced then qualified residents can be done much sooner and make a living wage. Residents don't make enough money to support themselves much less purchase health insurance. I support the proposed changes.

CommentID: **222592**

Commenter: Student

5/3/24 10:46 am

Please change requirements

I am in support of the following:

1. Reduce the total required residence hours from 3,400 to 3,000;
2. Reduce residency client contact hours from 2,000 to 1,500; and
3. Change supervision requirements from a minimum of 200 hours to a requirement for weekly supervision with no minimum.

Having received my master's in counseling, professional experience in the field and now taking three more courses to pursue my residency in the state of VA, the current requirements seem unnecessarily high. If programs are CACREP approved students should be receiving the education and experience they need. Graduate students also receive supervision during their 600 hours of internship.

If requirements stay the same, supervision should be free and counselors in residency should be paid a livable salary. Thank you.
CommentID: **222593**

Commenter: Anonymous 5/5/24 4:09 pm

In full support

Removing the minimum hours for supervision means since residents have to remain under supervision the entirety of the residency anyway. No matter how many hours per 200 they accrue. Also, my residents work multiple jobs to get face face hours. Many are burnt out before they get the LPC and are thinking about other avenues of work. So reducing hour requirements for face to face and total hours sounds fair.

CommentID: **222594**

Commenter: Pedro A 5/6/24 10:45 am

In full support.

I am in full support of modifying the requirements for full licensure. I do not believe it will compromise the quality of care. Moreover, it will help expedite fielding much needed licensed practitioners.

CommentID: **222595**

Commenter: Jasmine Johnson, The Up center 5/6/24 5:08 pm

Support

I support!

CommentID: **222598**

Commenter: Graduate Intern 5/6/24 6:03 pm

Support Petition for changes

Let me start off by saying that if I did not think this was my calling, I would not be attempting to complete this whole process. When I initially looked at the requirements, I put of enrolling in school for a year because I wasn't convinced the payoff would be worth the sacrifice. I have had to quit a well-paying job to find a way to incorporate my internship hours. And now I'm hearing about the discord around counselors being told they shouldn't get into the field for money??? So, after

racking up student loans and literally working years to get licensed we shouldn't expect to make a livable salary?? This is why people are not looking at getting into this field. Students get burned out before we are even able to have the benefit of saying we have a license and then we get slapped on the hand if we mention that we would like to be able to afford our necessities, but work/life balance is preached from the rooftops-but not for us. I know friends who have left the field to pursue jobs in IT or other fields that pay way more and have less stress. And that will continue to be the case if things are not changed. There is already a shortage of mental health professionals, and it is projected to only get worse in the next couple of years.

Those who have commented that they have been in the field for decades and that they were able to figure it out and make it work, well done. That was then. However, just because that is the way it was does not mean that is the way it needs to remain. If the petition had been made then to reduce the hours, I'm sure some would have jumped at it but don't be bitter because it wasn't, and you had to suck it up. This "generation" isn't lazy. We aren't lacking work ethic. We have been provided the opportunity to look at a requirement that may be more detrimental than beneficial to bringing good talent into the field. A reduction in hours does not automatically mean an influx of unqualified LPC's. Are we saying that other states that have less direct contact/supervision hours are producing subpar LPC's? I have met some counselors who have gone through the process and are horrible at their job but stay because of the money and time invested. It is the person doing the work. Either they have a passion, or they don't. If changes are not made, the outcome will be a loss of talent and those who do "suck it up" will be coming in burned out and questioning their life decisions. With these changes, no one is being handed a license on a silver platter. Time, effort and energy will still have to be invested so please stop gatekeeping.
CommentID: **222599**

Commenter: Anonymous

5/6/24 8:27 pm

Do not support

Like all health professions residency allows for the necessary training to become proficient in the field. We should not lower LPC standards as this does not benefit clients. Lower the standards will increase liability.

CommentID: **222600**

Commenter: Kristi

5/6/24 9:29 pm

Do Not Support Lowering Standards

The standards set are to ensure that people entering the field are ready to work safely, ethically, and independently. The hours required give residents the opportunity to explore different areas and populations as well as to become proficient in various therapeutic modalities. This training is to certify that clients have experienced therapists to work with.

Additionally, the field of counseling has been working hard to be seen as having skills and knowledge commensurate with social workers and other similar fields. Lowering standards will not help us to establish equitable training and skill sets.

CommentID: **222601**

Commenter: Anonymous

5/7/24 9:13 am

Anonymous

Support the change. If approved, implement required trainings every few months to stay up to date with following clinical practices, laws, and ethics.

CommentID: **222604**

Commenter: Anonymous

5/7/24 2:36 pm

In Support of Proposed Changes

I endorse the proposed amendments to licensure hour requirements. As a Resident in Counseling, I've directly observed the burdens placed on both clients and licensure candidates by the current excessively high hour requirements. Decreasing these demands would not only bring Virginia more in line with other state standards but also address the critical issue of limited availability of mental health services in our communities. Your careful consideration of these changes is deeply appreciated.

CommentID: **222605**

Commenter: Julie Sayre

5/7/24 6:04 pm

Maintain the current standards

The proposed changes represent a significant decrease in the practices that have shown to produce competent therapists. I have been a clinical supervisor/instructor in a well-structured program with a rigorous curriculum; and a graduate of that program. Practicum hours provide a solid clinical foundation; individual and group supervision enhance this learning journey with guidance and support. I remember the relief in finishing my hours, and shared with many others as they happily completed their requirements. Never once in over twenty years have I heard a single practitioner assert the belief that they knew all they needed to know at 75% of completion of their contact hours (1500 vs. 2000) or halfway through their required supervision (200 hours vs 100 - i.e., weekly for a couple of years). We risk compromising clinical competence with a lowering of the licensing requirements.

CommentID: **222607**

Commenter: Another concerned Resident

5/8/24 7:12 am

Full Support

Please consider these changes at least in part, if not all. Some providers don’t keep up with the changes in the field and industry and this evident in the comments. We are on the brink of the counseling compact. Other providers licensed in other states will be able to practice in VA with the rules of the compact. Are we going to gatekeep this as well because their requirements didn’t ours. Thats just one update. It’s time to review this. I understand there are providers who had to do 8,000 hours for licensure 20 years ago, but we’ve got more education, better theoretical perspectives and training now. For goodness sake, look at the strides we’ve taking in trauma therapy over the past 20 years. The field is evolving. Please review this for change. Thank you.

CommentID: **222610**

Commenter: LeeAnn Gumulauskas, LPC

5/8/24 11:40 am

Support Changes

As an LPC licensed in multiple states and LPC Supervisor in Virginia and Wisconsin, I support these changes. As others have stated in their feedback, I would suggest a wording change that residents complete 100 hours of supervision, rather than "weekly" supervision, as weekly is subjective and residents see clients a wide variety of hours in a week.

With the improvement of education and more rigorous requirements of CACREP training, clinicians are entering the field more prepared than previously. A reduction in requirements is NOT a reduction in quality of practice. I see it as bringing Virginia in line with other states as the counseling compact becomes usable.

I would like to see:

- 3000 hours work total
- 1500 hours face to face/direct work
- 100 hours of supervision (minimum of 1 per 40 hours of work)
- Supervision by LPC trained supervisor
- Can not complete residency/ apply for LPC in less than 2 years.
- Successful passing of NCMHCE or NCE

CommentID: **222612**

Commenter: Anonymous 5/8/24 12:04 pm

Petition for Change in LPC Supervision Requirements

I am fully supportive of this decision and I hope the board makes the right decision

CommentID: **222613**

Commenter: Kellie McCall 5/8/24 12:09 pm

Support changes

I support the recommended changes for LPC residency requirements! As a resident, I have much to say about this experience and would be open to conversations with anyone who would like to take the time.

Thank you.

CommentID: **222614**

Commenter: Anonymous 5/8/24 12:15 pm

Revised Opinion

I am appreciating reading other perspectives on this issue and wish to change my vote. I can align with what Sharon and others are saying and agree that part, the number of total hours required needs to be in line with other states. Thank you.

CommentID: **222615**

Commenter: Alexa Malatesta, PWC Emergency Services 5/8/24 12:19 pm

Change in Supervision/Residency Requirements 72

I fully support this decision to lower the hours required for supervision and residency! The goal of residency is to become as experienced and well-rounded as possible. That being said, the number of hours required can take a very big toll on those seeking licensure and can lead to burnout. Thank you to the Board for this consideration!

CommentID: **222616**

Commenter: Anonymous 5/8/24 12:27 pm

Fully Support change

Fully support reducing current expectations of hours. Currently hours are excessive.

CommentID: **222617**

Commenter: Anonymous 5/8/24 12:48 pm

Support the jours reduction/ Make it easier for out of State clinicians

-Make it easier for clinicians moving from out of state to count their hours from out of state and consider that some states Grauduate school hours differ and should not stop person from obtaining RIC in VA. The repsonse should not be go back to school when the person already holds an acredited masters degree and the intern hours are fewer than what expected in VA. They should be able to make up difference in hours as a RIC .

- Im for the reduction in hours

CommentID: **222618**

Commenter: Susan McAlister 5/8/24 1:11 pm

Changes to Supervision/Licensure Requirements

I fully support changes that would lesson the burden on residents who are working to become LPC's in the state of VA.

To bring the VA requirements more in line with other states will increase the likelihood of license portability down the road so that we can have an overall standard for the industry.

The need for counselors is great and retaining a robust but reasonable (more in line with other states) process, benefits us all.

Finally, with the economy we have now, and the requirements in place now, it can take a resident in counseling on average of 3 years of lower pay and increased expenses to gain all the hours required. We are losing people due to the economic ramifications of this process. These changes would be a step in the right direction.

CommentID: **222619**

Commenter: Tiara Robinson 5/8/24 1:13 pm

Change is needed

I fully support the changes to the required licensure hours to be changed. I believe this change will benefit and help many residents who are trying to finally finish the needed hours promptly.

CommentID: **222620**

Commenter: Anonymous 5/8/24 1:15 pm

Support changes

I am in full support of this decision. As a single mom working towards licensure, with a full time position where clients are unreliable, I am unable to fully meet these requirements without having to now, secure a part time position. This has created a bit more stress for me because I have so little resources. Knowing that my requirements may possibly be shortened, will be a huge weight off my shoulders. Please consider all suggestions diligently.

CommentID: **222621**

Commenter: Sharon Watson, LPC, LMFT, LSATP, NCC, ACS 5/8/24 1:35 pm

Strongly support with a caveat - Additional comments

I would like to add to my initial comment submitted 5/1/24 after reading subsequent comments in order to correct some misinformation and address some of the commentors' concerns.

I would like to correct my initial sentence from 5/1/24 to read:
There are several reasons why I support this petition with one caveat: change the "weekly" requirement for supervision to 100 hours which can still be a combination of individual and group supervision.

1. LPCs are now able to take Medicare clients if they so choose.
2. LPCs have been able to take Tricare for several years.
3. "Reducing requirements will result in deaths" seems a catastrophizing conclusion. With that logic are we to assume that LCSWs, because they're only required to have 100 hours of supervision, have more client deaths than if they were required to have 200 hours of supervision?
4. Re the concern there are more case decisions against LPCs than LCSWs. It's possible this is a skewed assessment. First of all, some of the case decisions during that period are for QMHPs not LPCs. Second, some case decisions were not for client care, but were fines for failing to meet the CE requirement (still not acceptable, of course). Third, is it that almost all LPCs are practicing as therapists/counselors whereas it's possible that many LCSWs are working in social services and not doing counseling and therefore less likely to have a complaint against them? Regardless of these possibilities, it's problematic to assume there are many more complaints in counseling than social work without researching the issue.
5. For the individual who wrote "one hour of supervision per 40 of work time seems fair" and then did not support the petition is incorrectly calculating the requirement. The current requirement is 3,400 hours of total work. If that is divided by 40 hours of total work with one hour of supervision per 40 it would mean the resident would only have 85 hours of supervision when the current requirement is 200. So why not support the petition requiring 100 hours of supervision? Its likely many people don't know the history of the requirements and subsequent changes. When the regulations for licensure were set up in Virginia, the 200 hours of supervision were initially based on a supervisee working full time (40 hours) over the course of 2 years (104 weeks minus likely 4 weeks of vacation) totaling 4000 hours (40 x 100 = 4000). Those 4000 hours were then reduced to 3,400 when the regulations were changed to include the 600 hours of internship in graduate school. So, to reach the 200 hours of supervision now required, a resident has to receive 2 hours of supervision per week. Therefore, reducing the hours to 100 is actually what the petitioner is suggesting.

6. For the individual who wrote reducing supervision hours would result in “subpar” LPCs, would that mean that LCSWs, who only have 100 hours of supervision, are SUBPAR?
7. For the individual who said “I have seen a huge lack of respect for LPCs, especially from the field of social work”, I agree that I have sometimes experienced the same. Isn’t it possible, though, that the lack of respect may be due to social workers being first in the field as counselors (because LPCs didn’t exist at the time) and that LPC licensure coming onto the landscape was possibly threatening to their livelihoods, their professional philosophies, or because LPCs were using different theories or practices due to the differences in graduate programming/educational requirements and not because of our licensure/residency requirements? In any case, I suggest we don’t allow the perception that some social workers may not respect LPCs to define who we are as LPCs and cloud our decisions on what licensure requirements we should support for ourselves.
8. For “Do No Harm” who said lowering the standards is “outrageous” and “needs to be denied for the safety of our clients”: are you saying that LCSWs who only have 100 hours of supervision are affecting the safety of clients? Have you put in a petition to the Board of Social Work to increase the required 100 hours of supervision for LCSWs to 200 hours so their current low requirements won’t be “outrageous”?
9. For “Lowering hours lowers opportunities for multi-state licenses,” relating that to the Counseling Compact needs to be clarified. Every state that passes the Compact legislation has agreed to accept the standards (the number of supervision hours, total work hours, and F2F hours) that are required for LPC licensure in every other Compact state whether the requirements are higher or lower than their own. Also, importantly, it will not require applying for licensure (and meeting individual state requirements) which is the purpose of the Compact. It will entail requesting a “privilege to practice” in another Compact state regardless of what requirements you’ve met in your own home state. What you’ve suggested that may be true, is that it may make it easier to be grandfathered into another state’s licensure if you move to a non-Compact state.
10. For “LPC for 25 years” so, because the requirements were hard for you, you want to make sure that others suffer like you did? I was licensed and in the field 30 years ago. I had 400 hours of supervision: 300 for LPC (because at the time group was counted for half, i.e. I had 200 hours of group and 100 hours of individual) and then I had an additional 100 hours of supervision for my CSAC. Despite that, I’m still supporting this petition with my caveat (100 hours of supervision and not weekly) because as one writer noted “we have evolved” in that our graduate programs are better, supervisors are required to have 20 hours of supervision training, and I believe our field is better monitored now than it was in the past.
11. The idea of “weekly” supervision does not meet the needs of some residents who have very small practices due to various reasons. I’ve had residents that had to have supervision over the course of 5 years due to having only a few clients because of personal circumstances (with granted extensions) because they needed to reach 200 hours. When put in that perspective 200 hours of supervision seems excessive.

“Very Concerned Client” – Is not addressing the petition. But to clarify, based on my training in the public sector, any diagnoses, charting, and progress noting CANNOT be changed because they are part of the permanent record and are date stamped. If they were changeable, a clinician that actually did something inappropriate would be able to go back and modify the record to make it appear they did nothing wrong. So, those who are declining to change the record are doing so because of the fact that the record cannot be changed. A client is allowed however, to write anything about how and why they dispute the accuracy of the record and ask for what they write to be added to the record.
CommentID: **222622**

Commenter: Leah Tharp

5/8/24 2:11 pm

Strongly Support Changes

I am in full support of making changes to the LPC training requirements. I believe that with CACREP standards, we are entering residency well equipped and are becoming ready for full licensure sooner as a result. By bringing Virginia more in line with other states, we would be acknowledging the hard work of Virginia residents without compromising the integrity of the training piece. I am in support of 3,000 total hours, 1500 face to face, and 100 supervision hours. I am surrounded by competent residents who are ready for licensure but are forced to continue as a resident due to the outdated number of hours needed currently. Not to mention that shortening these requirements will ease a financial burden on residents!

CommentID: **222623**

Commenter: Nettia Banton

5/8/24 2:53 pm

Partial Support of Changes

I am a current resident and at the end of my residency. I support the first two items on the petition:

1. Reduce the total required residence hours from 3,400 to 3,000
2. Reduce residency client contact hours from 2,000 to 1,500

I do not support the third change mentioned:

1. Change supervision requirements from a minimum of 200 hours to a requirement for weekly supervision with no minimum.

I think this requirement is too restrictive, and does not align with the practical experience for many residents. I think the standing requirement is better suited for residents to obtain supervision proportionate to clinical practice. Also, if the client contact hours are reduced, I would suggest also reducing the required supervision hours as well (possibly to 185 hours).

CommentID: **222624**

Commenter: Anonymous

5/8/24 8:35 pm

Support to make changes

I am in support of the proposed changes to reduce residency client contact hours to 1,500. As a Resident in Counseling, I have experience working in an outpatient mental health practice as well as an intensive in-home agency. There are several barriers throughout the licensure process in regard to fulfilling the requirements. In outpatient practices, clients typically prefer a licensed clinician who is more likely to take their insurance and are less likely to want to pay out-of-pocket for a clinician who has less experience. This makes it difficult and a timely process to gain a full caseload and places financial strain on the resident who only receives payment for client contact hours. In community mental health settings, Medicaid reimbursements are also low and Residents burn out quickly as they are working many hours with clients with high needs and may not receive the adequate support and supervision to best support their clients and themselves. Virginia's residency requirements are more stringent than most states, and I believe that they prevent passionate students and residents from obtaining full licensure due to financial hardships, lack of adequate supervision/support, and difficulty accruing hours in some cases. These factors are not indicative of the capability and competency of the resident to provide quality care, but rather external factors that exacerbate the challenges of obtaining licensure. I believe that 1,500 client contact hours still provides residents with a comprehensive and learned background to enter licensure more confidently, while allowing residents to have more self-efficacy in completing residency and contributing to more residents remaining in the counseling profession. Research suggests that approximately 40-50% of residents do not complete residency, which contributes to

the current mental health crisis and a lower quality of care in the mental health fields because licensed clinicians are overbooked and burned out or have long waiting lists. I believe that these changes would allow newer clinicians to contribute positively to the counseling profession by increasing the likelihood of remaining in the field.
CommentID: **222625**

Commenter: Anonymous 5/8/24 9:04 pm

In Support of the Changes

It has been extremely difficult to accrue all of the hours needed for licensure in Virginia while raising a family, working, and being in school. Additionally, reducing the required hours would not only help increase the number of mental health professionals who can accept various insurances but also reduce the workforce deficit in the field across the State.

CommentID: **222627**

Commenter: Anonymous 5/8/24 9:10 pm

Partial Agreement

I am a current resident at the beginning of my residency. I support the first two items on the petition:

1. Reduce the total required residence hours from 3,400 to 3,000
2. Reduce residency client contact hours from 2,000 to 1,500

I do not support the third change mentioned:

1. Change supervision requirements from a minimum of 200 hours to a requirement for weekly supervision with no minimum.

The weekly requirement is too restrictive, especially for new residents who may not have many clients. I also suggest if contact hours are reduced supervision hours also be reflectively reduced.

CommentID: **222629**

Commenter: Anonymous 5/8/24 9:41 pm

Change is needed.

As someone who is going through their second LPC residency, I believe change is needed again. When I started my first post-graduate job at a Virginia CSB in 02/2007, most LPC's were not open to providing supervision and were selective in what jobs qualified for supervision. If you wanted residency supervision, you had to pay for it. There were Residents in Counseling who could not afford LPC supervision at that time. So, they gained experience but were unable to count the hours without supervision. I have at least 9 years of post-graduate experience at this time. 6.5 of those years do not count towards my current residency because they were either completed prior to 2012 or I did not have a supervisor for licensure. During the past decade, we have overcome the limited availability of licensed supervisors by requiring direct supervisors to be licensed. Now that there are supervisors available, the way in which face-to-face hours are counted has drastically changed.

The reason change is still needed is that overall residency hours may have been reduced from 4000 hours to 3400; however, face-to-face hours are still 2000. It was never about how many total hours were needed. The main hurdle is the 2000 face-to-face hours needed. The Virginia Board of

Counseling distinguishes between direct services and face-to-face services, which limits the amount of hours that are allowed to be counted toward the 2000. For comparison purposes, here are requirements for licensure by state:

Alabama: 3,000 hours of supervised experience in professional counseling with board approved supervision.

Alaska: 2 years or 3,000 hours of post-master's supervised experience in professional counseling, including 1,000 hours of direct client contact and 100 hours of face-to-face supervision.

Arizona: 2 years/3,200 hours of full-time post-master's supervised work experience in psychotherapy, including assessment, diagnosis, and treatment. 100 hours of clinical supervision and 1,600 hours of direct client contact are required.

Arkansas: 3 years or 3,000 hours of post- Master's supervised counseling experience (1 year = 1,000 hours).

Colorado: 2 years/2,000 hours of post- Master's practice in applied psychotherapy under board approved supervision. 100 hours of supervision are required, 70 of which must be individual supervision.

Connecticut: 1 year/3,000 hours of post- Master's supervised experience in professional counseling. A minimum of 100 hours of direct supervision by an appropriately licensed individual is required.

District of Columbia: 2 years/3,500 hours of post- Master's supervised professional counseling experience. 200 hours of supervision must be under an LPC (100 hours must be immediate supervision).

Idaho: 1,000 hours of supervised experience in counseling, with 400 hours of direct client contact and a minimum of 1 hour face-to-face supervision for every 20 hours of experience. Supervised practicum and/or internship taken at the graduate level may be utilized.

Louisiana: 2 years/3,000 hours of post-Master's supervised experience in professional mental health counseling under the clinical supervision of a board approved supervisor, to be completed in no more than 7 years. Hours to include: 1,900 - 2,900 hours of direct client contact in individual or group counseling. A maximum of 1,000 hours additional client contact, counseling related activities or education at the graduate level in the field of mental health. A minimum of 100 hours of face-to-face supervision. Only 50 hours may be group supervision. 500 hours of supervised experience may be gained for each 30-graduate semester hours beyond Master's degree, but must have no less than 2,000 hours of supervised.

Pennsylvania: 3 years/3,600 hours of supervised clinical experience after completing 48 graduate-level credits (or 72 quarter hours).

South Carolina: 2 years/1,500 hours of full-time post-Master's supervised clinical experience in the practice of professional counseling. The 1,500 hours must be direct counseling with individuals, couples, families, or groups. A minimum of 150 hours of the 1,500 hours must be clinical supervision provided by a board approved LPC supervisor (100 hours must be individual supervision).

Texas: 3 years/3,000 hours of post- master's supervised experience, including 1,500 hours of direct client contact.

When you ask yourself why there are not enough LPC's to meet the increased demands of placed on the Virginia mental health system, please realize that the requirements in face-to-face hours limits a majority of RIC's from being licensed in 3 years.

The Board of Counseling states that residency hours must be completed within four years. There are no current provisions about the time period in which COVID was a major health concern. COVID limited face-to-face contact and reduced the amount of services provided to clients. I will

say that my first year of residency during COVID resulted in less than 100 face-to-face hours and I work in a program that operates 24/7 regardless of weather, pandemic, etc.
CommentID: **222630**

Commenter: Anonymous

5/8/24 9:44 pm

Comments

The petitioner requests that the Board of Counseling amend 18VAC115-20-52 to:

1. Reduce the total required residence hours from 3,400 to 3,000;

2. Reduce residency client contact hours from 2,000 to 1,500; and

3. Change supervision requirements from a minimum of 200 hours to a requirement for weekly supervision with no minimum.

I am open to keeping the residency hours the same or reducing the hours from 3400 to 3000 post graduate hours as long as minimum clinical hours are required during the internship.

I do not concur with reducing the client contact hours or the minimum supervision hours.

If someone is working 35 to 40 hours in a clinical setting then their work should be primarily working with clients (performing screening, intake, orientation, counseling etc) and obtaining hours should not be attainable in a 2 year period.

My concern as a clinical supervisor is that many recent residents show little proficiency in basic counseling skills, diagnosing, understanding theory or the application of theory. Much of the growth and skills are developed with hands on experience and quality supervision.

My suggestions would be to include a mini-exam or case conceptualization once a year to demonstrate what they learn on the job and how they apply their skills.

Other issues to be addressed may include school programs not adequately preparing individuals with foundational skills, supervisors are having to spend more time teaching basic concepts or are too busy to provide quality supervision. Finally, a large percentage of residents are in positions/roles that are not primarily clinical. The hands on experience is a must.

I think there has to be larger conversation around if and how to revise the requirements while ensuring that quality is being maintained.

CommentID: **222631**

Commenter: Anonymous

5/8/24 9:45 pm

Comments

The petitioner requests that the Board of Counseling amend 18VAC115-20-52 to:

1. Reduce the total required residence hours from 3,400 to 3,000;

2. Reduce residency client contact hours from 2,000 to 1,500; and

3. Change supervision requirements from a minimum of 200 hours to a requirement for weekly supervision with no minimum.

I am open to keeping the residency hours the same or reducing the hours from 3400 to 3000 post graduate hours as long as minimum clinical hours are required during the internship.

I do not concur with reducing the client contact hours or the minimum supervision hours.

If someone is working 35 to 40 hours in a clinical setting then their work should be primarily working with clients (performing screening, intake, orientation, counseling etc) and obtaining hours should be attainable in a 2 year period.

My concern as a clinical supervisor is that many recent residents show little proficiency in basic counseling skills, diagnosing, understanding theory or the application of theory. Much of the growth and skills are developed with hands on experience and quality supervision.

My suggestions would be to include a mini-exam or case conceptualization once a year to demonstrate what they learn on the job and how they apply their skills.

Other issues to be addressed may include school programs not adequately preparing individuals with foundational skills, supervisors are having to spend more time teaching basic concepts or are too busy to provide quality supervision. Finally, a large percentage of residents are in positions/roles that are not primarily clinical. The hands on experience is a must.

I think there has to be a larger conversation around if and how to revise the LPC requirements while ensuring that quality is being maintained.
CommentID: **222632**

Commenter: Anonymous

5/8/24 10:23 pm

Support This Change

There have been some comments regarding "people dying" and the safety of clients declining if changes are made to licensure requirements. To those that have made those comments, do you know the Virginia state code for someone who is a danger to themselves, others or is unable to independently care for themselves due to mental illness? Do you know what requirements are needed to hospitalize someone involuntarily for mental health reasons? The Department of Behavioral Health and Developmental Services (DBHDS) does not require a person to be licensed by the Board of Counseling or Board of Social Work. DBHDS has educational and certification requirements/trainings to make decisions regarding involuntary inpatient admission. The notion that changes to licensure requirements will cause more deaths or a decline in the safety of clients is illogical. The state has checks and balances that protect clients from harm.

CommentID: **222633**

Commenter: Breanna Matthews

5/8/24 10:44 pm

I Fully Support

I fully support the change being brought before the Board to change the required licensure hours. This change will allow many residents to obtain their required hours more efficiently and still provide effective services to clients.

CommentID: **222634**

Virginia Administrative Code
Title 18. Professional And Occupational Licensing
Agency 115. Board of Counseling
Chapter 20. Regulations Governing the Practice of Professional Counseling

Part II. Requirements for Licensure as a Professional Counselor

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 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 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.

Statutory Authority

§§54.1-2400 and 54.1-3505 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 16, Issue 13, eff. April 12, 2000; amended, Virginia Register 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 36, Issue 2, eff. October 16, 2019; Volume 37, Issue 20, eff. June 23, 2021.

Agenda Item: Review of draft exempt regulatory changes pursuant to Senate Bill 403

Included in your agenda package:

- SB403 from the 2024 General Assembly Session;
- Draft regulations for new professions of behavioral health technicians and behavioral health technician assistants; and
- Draft regulatory changes to QMHP regulations.

Staff Note: These draft regulatory changes will be reviewed by the Regulatory Committee. The Regulatory Committee may make recommendations and amendments consistent with SB403. The Regulatory Committee will not vote on these regulations at this time.

The full Board will review these exempt regulatory changes at its meeting on October 4, 2024. The Board will vote to adopt the regulations at that meeting, following a public hearing on the changes.

Action needed:

- None.

CHAPTER 595

An Act to amend and reenact §§ 54.1-3500 and 54.1-3505 of the Code of Virginia and to amend the Code of Virginia by adding in Chapter 35 of Title 54.1 an article numbered 4, consisting of sections numbered 54.1-3518 through 54.1-3521, relating to behavioral health technicians; behavioral health technician assistants; qualified mental health professionals; qualified mental health professional-trainees; scope of practice, supervision, and qualifications.

[S 403]

Approved April 5, 2024

Be it enacted by the General Assembly of Virginia:

1. That §§ 54.1-3500 and 54.1-3505 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Chapter 35 of Title 54.1 an article numbered 4, consisting of sections numbered 54.1-3518 through 54.1-3521, as follows:

§ 54.1-3500. Definitions.

As used in this chapter, unless the context requires a different meaning:

"Appraisal activities" means the exercise of professional judgment based on observations and objective assessments of a client's behavior to evaluate current functioning, diagnose, and select appropriate treatment required to remediate identified problems or to make appropriate referrals.

"Art therapist" means a person who has (i) completed a master's or doctoral degree program in art therapy, or an equivalent course of study, from an accredited educational institution; (ii) satisfied the requirements for licensure set forth in regulations adopted by the Board; and (iii) been issued a license for the independent practice of art therapy by the Board.

"Art therapy" means the integrated use of psychotherapeutic principles, visual art media, and the creative process in the assessment, treatment, and remediation of psychosocial, emotional, cognitive, physical, and developmental disorders in children, adolescents, adults, families, or groups.

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

"Behavioral health technician" means a person who has completed, at a minimum, an associate degree and registered with the Board to practice in accordance with the provisions of § 54.1-3518 and regulations of the Board and provides collaborative behavioral health services. A "behavioral health technician" shall provide such services as an employee or independent contractor of the Department of Behavioral Health and Developmental Services, the Department of Corrections, or the Department of Education or a provider licensed by the Department of Behavioral Health and Developmental Services.

"Behavioral health technician assistant" means a person who has completed a high school diploma or equivalent, at a minimum, and registered with the Board to practice in accordance with the regulations of the Board and the provisions of § 54.1-3519 to provide collaborative behavioral health services. A "behavioral health technician assistant" shall provide such services as an employee or independent contractor of the Department of Behavioral Health and Developmental Services, the Department of Corrections, or the Department of Education or a provider licensed by the Department of Behavioral Health and Developmental Services.

"Board" means the Board of Counseling.

"Certified substance abuse counseling assistant" means a person certified by the Board to practice in accordance with the provisions of § 54.1-3507.2.

"Certified substance abuse counselor" means a person certified by the Board to practice in accordance with the provisions of § 54.1-3507.1.

"Collaborative behavioral health services" means those supportive services that are provided by a registered behavioral health technician, registered behavioral health technician assistant, registered qualified mental health professional, or registered qualified mental health professional-trainee under the direction of and in collaboration with either a mental health professional licensed in the Commonwealth or a person under supervision as a prerequisite for licensure who has been approved by the Board of Counseling, Board of Psychology, or Board of Social Work.

"Counseling" means the application of principles, standards, and methods of the counseling profession in (i) conducting assessments and diagnoses for the purpose of establishing treatment goals and objectives and (ii) planning, implementing, and evaluating treatment plans using treatment interventions to facilitate human development and to identify and remediate mental, emotional, or behavioral disorders and associated distresses that interfere with mental health.

"Licensed substance abuse treatment practitioner" means a person who: (i) is trained in and engages in the practice of substance abuse treatment with individuals or groups of individuals suffering from the effects of substance abuse or dependence, and in the prevention of substance abuse or dependence; and (ii) is licensed to provide advanced substance abuse treatment and independent, direct, and unsupervised treatment to such individuals or groups of individuals, and to plan, evaluate, supervise, and direct substance abuse treatment provided by others.

"Marriage and family therapist" means a person trained in the appraisal and treatment of cognitive, affective, or behavioral mental and emotional disorders within the context of marriage and family systems through the application of therapeutic and family systems theories and techniques.

"Marriage and family therapy" means the appraisal and treatment of cognitive, affective, or behavioral mental and emotional disorders within the context of marriage and family systems through the application of therapeutic and family systems theories and techniques and delivery of services to individuals, couples, and families, singularly or in groups, for the purpose of treating such disorders.

"Practice of counseling" means rendering or offering to render to individuals, groups, organizations, or the general public any service involving the application of principles, standards, and methods of the counseling profession, which shall include appraisal, counseling, and referral activities.

"Practice of marriage and family therapy" means the appraisal and treatment of cognitive, affective, or behavioral mental and emotional disorders within the context of marriage and family systems through the application of therapeutic and family systems theories and techniques, which shall include assessment, treatment, and referral activities.

"Practice of substance abuse treatment" means rendering or offering to render substance abuse treatment to individuals, groups, organizations, or the general public.

"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.

"Qualified mental health professional" ~~includes qualified mental health professionals-adult and qualified mental health professionals-child~~ *means a person who has (i) completed, at a minimum, a bachelor's degree; (ii) registered with the Board to practice in accordance with the provisions of § 54.1-3520 and the regulations of the Board; and (iii) a combination of work, training, or experience in providing collaborative behavioral health services for youth or adults. A "qualified mental health professional" includes a qualified mental health professional-adult and qualified mental health professional-child. A "qualified mental health professional" shall provide such services as an employee or independent contractor of the Department of Behavioral Health and Developmental Services, the Department of Corrections, or the Department of Education or a provider licensed by the Department of Behavioral Health and Developmental Services.*

~~"Qualified mental health professional-adult" means a qualified mental health professional who provides collaborative mental health services for adults. A qualified mental health professional-adult shall provide such services as an employee or independent contractor of the Department of Behavioral Health and Developmental Services or the Department of Corrections, or as a provider licensed by the Department of Behavioral Health and Developmental Services.~~

~~"Qualified mental health professional-child" means a person who by education and experience is professionally qualified and registered by the Board to provide collaborative mental health services for children and adolescents up to 22 years of age. A qualified mental health professional-child shall provide such services as an employee or independent contractor of the Department of Behavioral Health and Developmental Services or the Department of Corrections, or as a provider licensed by the Department of Behavioral Health and Developmental Services.~~

"Qualified mental health professional-trainee" means a person who is receiving supervised training to qualify as a qualified mental health professional *in accordance with the provisions of § 54.1-3521* and is registered with the Board. *A "qualified mental health professional-trainee" shall provide such services as an employee or independent contractor of the Department of Behavioral Health and Developmental Services, the Department of Corrections, or the Department of Education or a provider licensed by the Department of Behavioral Health and Developmental Services.*

"Referral activities" means the evaluation of data to identify problems and to determine advisability of referral to other specialists.

"Registered peer recovery specialist" means a person who by education and experience is professionally qualified and registered by the Board to provide collaborative services to assist individuals in achieving sustained recovery from the effects of addiction or mental illness, or both. A registered peer recovery specialist shall provide such services as an employee or independent contractor of the Department of Behavioral Health and Developmental Services, a provider licensed by the Department of Behavioral Health and Developmental Services, a practitioner licensed by or holding a permit issued from the Department of Health Professions, or a facility licensed by the Department of Health.

"Residency" means a post-internship supervised clinical experience registered with the Board.

"Resident" means an individual who has submitted a supervisory contract to the Board and has

received Board approval to provide clinical services in professional counseling under supervision.

"Substance abuse" and "substance dependence" mean a maladaptive pattern of substance use leading to clinically significant impairment or distress.

"Substance abuse treatment" means (i) the application of specific knowledge, skills, substance abuse treatment theory, and substance abuse treatment techniques to define goals and develop a treatment plan of action regarding substance abuse or dependence prevention, education, or treatment in the substance abuse or dependence recovery process and (ii) referrals to medical, social services, psychological, psychiatric, or legal resources when such referrals are indicated.

"Supervision" means the ongoing process, performed by a supervisor, of monitoring the performance of the person supervised and providing regular, documented individual or group consultation, guidance, and instruction with respect to the clinical skills and competencies of the person supervised. *Supervisors may only supervise activities within their scope and area of Board-defined competency. Supervision provided by nonlicensed supervisors shall not be a replacement for the direction of services and collaboration with the licensed mental health professional or licensed eligible mental health professional required to perform collaborative behavioral health services.*

§ 54.1-3505. Specific powers and duties of the Board.

In addition to the powers granted in § 54.1-2400, the Board shall have the following specific powers and duties:

1. To cooperate with and maintain a close liaison with other professional boards and the community to ensure that regulatory systems stay abreast of community and professional needs.

2. To conduct inspections to ensure that licensees conduct their practices in a competent manner and in conformance with the relevant regulations.

3. To designate specialties within the profession.

4. To administer the certification of rehabilitation providers pursuant to Article 2 (§ 54.1-3510 et seq.) of this chapter, including prescribing fees for application processing, examinations, certification and certification renewal.

5. [Expired.]

6. To promulgate regulations for the qualifications, education, and experience for licensure of marriage and family therapists. The requirements for clinical membership in the American Association for Marriage and Family Therapy (AAMFT), and the professional examination service's national marriage and family therapy examination may be considered by the Board in the promulgation of these regulations. The educational credit hour, clinical experience hour, and clinical supervision hour requirements for marriage and family therapists shall not be less than the educational credit hour, clinical experience hour, and clinical supervision hour requirements for professional counselors.

7. To promulgate, subject to the requirements of Article 1.1 (§ 54.1-3507 et seq.) of this chapter, regulations for the qualifications, education, and experience for licensure of licensed substance abuse treatment practitioners and certification of certified substance abuse counselors and certified substance abuse counseling assistants. The requirements for membership in NAADAC: the Association for Addiction Professionals and its national examination may be considered by the Board in the promulgation of these regulations. The Board also may provide for the consideration and use of the accreditation and examination services offered by the Substance Abuse Certification Alliance of Virginia. The educational credit hour, clinical experience hour, and clinical supervision hour requirements for licensed substance abuse treatment practitioners shall not be less than the educational credit hour, clinical experience hour, and clinical supervision hour requirements for licensed professional counselors. Such regulations also shall establish standards and protocols for the clinical supervision of certified substance abuse counselors and the supervision or direction of certified substance abuse counseling assistants, and reasonable access to the persons providing that supervision or direction in settings other than a licensed facility.

8. To maintain a registry of persons who meet the requirements for supervision of residents. The Board shall make the registry of approved supervisors available to persons seeking residence status.

9. To promulgate*, subject to the requirements of Article 4 (§ 54.1-3518 et seq.),* regulations for the ~~registration of qualified mental health professionals, including qualifications, education, and experience necessary for such registration, and for the registration of persons receiving supervised training in order to qualify as a qualified mental health professional~~ *qualifications, training, supervision, and experience for the registration of behavioral health technicians, behavioral health technician assistants, qualified mental health professionals, and qualified mental health professional-trainees*.

10. To promulgate regulations for the registration of peer recovery specialists who meet the qualifications, education, and experience requirements established by regulations of the Board of Behavioral Health and Developmental Services pursuant to § 37.2-203.

11. To promulgate regulations for the issuance of temporary licenses to individuals engaged in a counseling residency so that they may acquire the supervised, postgraduate experience required for licensure.

Article 4.

Behavioral Health Technicians and Qualified Mental Health Professionals.

§ 54.1-3518. Scope of practice, supervision, and qualifications of registered behavioral health technicians.

A. A registered behavioral health technician shall be (i) qualified to perform, under Board-approved supervision, collaborative behavioral health services, training on prevention of mental health and substance use disorders, and mental health literacy and the supportive functions of screening, intake, orientation, care coordination, client education, and recordkeeping and (ii) after three years of practicing as a behavioral health technician in good standing and completion of the required behavioral health technician supervisor training set forth by the Board, qualified to supervise, as part of a collaborative team, behavioral health technicians and behavioral health technician assistants. A registered behavioral health technician shall not engage in independent or autonomous practice and shall only perform collaborative behavioral health services.

B. Such registered behavioral health technician shall be supervised by a mental health professional licensed by the Department of Health Professions, a person under supervision that has been approved by the Board of Counseling, Board of Psychology, or Board of Social Work as a prerequisite for licensure who has completed the required supervisor training, or a registered qualified mental health professional who has practiced for three years and completed the required supervisor training.

C. Pursuant to regulations adopted by the Board, an applicant for registration as a behavioral health technician shall submit evidence satisfactory to the Board that the applicant has (i) completed a specified number of hours of didactic education in a program or programs recognized or approved by the Board and (ii) received, at a minimum, an associate degree from an institution of higher education accredited by an accrediting agency recognized by the Board. A bachelor's degree shall not be a requirement for registration as a behavioral health technician.

§ 54.1-3519. Scope of practice, supervision, and qualifications of registered behavioral health technician assistants.

A. A registered behavioral health technician assistant shall be qualified to perform, under Board-approved supervision, collaborative behavioral health services, training on prevention of mental health and substance use disorders, and mental health literacy and the supportive functions of screening, intake, orientation, care coordination, client education, and recordkeeping. A registered behavioral health technician assistant shall not engage in independent or autonomous practice and shall only provide collaborative behavioral health services.

B. Such registered behavioral health technician assistants shall be supervised by either a mental health professional licensed by the Department of Health Professions who has completed the required supervisor training, a person under supervision that has been approved by the Board of Counseling, Board of Psychology, or Board of Social Work as a prerequisite for licensure who has completed the required supervisor training, a registered qualified mental health professional who has practiced for three years and completed the required supervisor training, or a registered behavioral health technician who has practiced for three years and completed the required supervisor training.

C. Pursuant to regulations adopted by the Board, an applicant for registration as a behavioral health technician assistant shall submit evidence satisfactory to the Board that the applicant has (i) received, at a minimum, a high school diploma or its equivalent and (ii) completed a specified number of hours of didactic education in a program recognized or approved by the Board.

§ 54.1-3520. Scope of practice, supervision, and qualifications of qualified mental health professionals.

A. A qualified mental health professional shall be qualified to perform, under Board-approved supervision, collaborative behavioral health services, including the supportive functions of (i) screening; (ii) intake; (iii) orientation; (iv) care coordination; (v) client education; (vi) referral activities; (vii) initiating crisis de-escalation; (viii) gathering histories of mental and physical health conditions, alcohol and drug use, past mental health treatment, and interactions with the criminal justice system; (ix) providing psychosocial skills development; (x) implementing interventions as assigned on individual plans of care and documenting the interventions for the purposes of recordkeeping; and (xi) prevention of mental health and substance use disorders. A registered qualified mental health professional shall not engage in independent or autonomous practice and shall only perform collaborative behavioral health services.

B. Such registered qualified mental health professionals shall be supervised by either a mental health professional licensed by the Department of Health Professions who has completed the required supervisor training, a person under supervision that has been approved by the Board of Counseling, Board of Psychology, or Board of Social Work as a prerequisite for licensure who has completed the required supervisor training, or a registered qualified mental health professional who has practiced for three years and completed the required supervisor training. Registered qualified mental health professionals who have met the supervisor requirements may supervise activities within their scope. This supervision must occur under the broader required direction of and in collaboration with the licensed mental health professional or licensed eligible mental health professional.

C. Pursuant to regulations adopted by the Board, an applicant for registration as a qualified mental health professional shall submit evidence satisfactory to the Board that the applicant has (i) completed a

specified number of hours of didactic education in a program or programs recognized or approved by the Board; (ii) received, at a minimum, a bachelor's degree from an institution of higher education accredited by an accrediting agency recognized by the Board; and (iii) accumulated a specified number of hours of Board-approved supervised experience.

§ 54.1-3521. Scope of practice, supervision, and qualifications of qualified mental health professional-trainees.

A. A qualified mental health professional-trainee shall be qualified to perform, under Board-approved supervision, collaborative behavioral health services, including the supportive functions of (i) screening; (ii) intake; (iii) orientation; (iv) care coordination; (v) client education; (vi) referral activities; (vii) initiating crisis de-escalation; (viii) gathering histories of mental and physical health conditions, alcohol and drug use, past mental health treatment, and interactions with the criminal justice system; (ix) providing psychosocial skills development; (x) implementing interventions as assigned on individual plans of care and documenting the interventions for the purposes of recordkeeping; and (xi) prevention of mental health and substance use disorders. A registered qualified mental health professional-trainee shall not engage in independent or autonomous practice and shall only perform collaborative behavioral health services.

B. Such registered qualified mental health professional-trainees shall be supervised by a mental health professional licensed by the Department of Health Professions who has completed the required supervisor training, a person under supervision that has been approved by the Board of Counseling, Board of Psychology, or Board of Social Work as a prerequisite for licensure and who has completed the required supervisor training, or a registered qualified mental health professional who has practiced for three years and completed the required supervisor training.

C. Pursuant to regulations adopted by the Board, an applicant for registration as a qualified mental health professional-trainee shall submit evidence satisfactory to the Board that the applicant has (i) completed a specified number of hours of didactic education in a program or programs recognized or approved by the Board and (ii) received, at a minimum, a bachelor's degree from an institution of higher education accredited by an accrediting agency recognized by the Board or is actively enrolled and in good standing in a bachelor's degree program from an institution of higher education accredited by an accrediting agency recognized by the Board.

2. That the Board of Counseling's initial adoption of regulations necessary to implement the provisions of this act shall be exempt from the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia), except that the Board of Counseling shall provide an opportunity for public comment on the regulations prior to adoption of such regulations.

3. That the Department of Behavioral Health and Developmental Services shall promulgate regulations that align with the regulations adopted by the Board of Counseling in accordance with this act. The Department of Medical Assistance Services shall promulgate any necessary regulations and submit any necessary State Plan amendments that align with changes made by the Department of Behavioral Health and Developmental Services and the Board of Counseling. The initial adoption of these regulations shall be exempt from the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia), except that the Department of Behavioral Health and Developmental Services and the Department of Medical Assistance Services shall provide an opportunity for public comment on the regulations prior to adoption of such regulations.

4. That the Board of Counseling shall promulgate regulations in accordance with this act by November 1, 2024.

Part I

General Provisions

18VAC115-90-10. Definitions.

A. The following words and terms when used in this chapter shall have the meaning ascribed to them in 54.1-3500, 54.1-3518, and 54.1-3519 of the Code of Virginia:

"Board"

"Behavioral health technician"

"Behavioral health technician assistant"

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

"DBHDS" means the Virginia Department of Behavioral Health and Developmental Services.

"NPDB" means the National Practitioner Data Bank.

"Supervision" means the ongoing process performed by a supervisor who monitors the performance of the person supervised.

"Supervisor" means an individual who assumes responsibility for the activities of a person under supervision and who provides supervision consistent with the training and experience of both the supervisor and the person under supervision and with the type of services being provided.

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

A. The Board has established fees for the following:

Registration as a behavioral health technician	$40
Registration as a behavioral health technician assistant	$25
Renewal of registration	$30
Late renewal	$20
Reinstatement of a lapsed registration	$75
Duplicate certificate of registration	$10
Returned check or dishonored credit card or debit card	$50
Reinstatement following revocation or suspension	$500

B. Unless otherwise established by the board, all fees shall be nonrefundable.

18VAC115-90-30. Current name and address.

A. Each registrant shall furnish a current name and address of record to the Board.

B. Registrants shall notify the Board in writing within 60 days of:

1. Any name change; or

2. Any change of address of record or of the registrant's public address if different from the address of record.

Part II

Requirements for Registration

18VAC115-90-40. Requirements for registration as a behavioral health technician.

An applicant for registration as a behavioral health technician shall submit:

1. A completed application on forms provided by the board and any applicable fee as prescribed in 18VAC115-90-20;

2. An associate's degree or higher verified by an official transcript from an institution of higher education accredited by the U.S Department of Education or an accrediting agency recognized by the board;

3. Evidence of completion of __ hours of didactic education in a program recognized or approved by the Board;

4. A current report from the NPDB, if applicable; and

5. Verification of any other mental health or health professional license, certification, or registration ever held in Virginia or another jurisdiction. An applicant for registration as a behavioral health technician shall have no unresolved disciplinary action on any license, certification, or registration in any jurisdiction. The board will consider a history of disciplinary action on a case-by-case basis as grounds for denial under 18VAC115-90-90.

18VAC115-90-50. Requirements for registration as a behavioral health technician assistant.

An applicant for registration as a behavioral health technician assistant shall submit:

1. A completed application on forms provided by the board and any applicable fee as prescribed in 18VAC115-90-20;

2. Evidence of a high school diploma or equivalent;

3. Evidence of completion of __ hours of didactic education in a program recognized or approved by the Board;

4. A current report from the NPDB, if applicable; and

5. Verification of any other mental health or health professional license, certification, or registration ever held in Virginia or another jurisdiction. An applicant for registration as a behavioral health technician assistant shall have no unresolved disciplinary action on any license, certification, or registration in any jurisdiction. The board will consider a history of disciplinary action on a case-by-case basis as grounds for denial under 18VAC115-90-90.

Part III

Renewal of Registration

18VAC115-90-60. Annual renewal of registration

All registrants as a behavioral health technician or a behavioral health technician assistant shall renew their registrations on or before June 30 of each year. The registrant shall submit:

1. A completed form for renewal of the registration;

2. An attestation to completion of two hours of continuing education in ethics; and

2. The renewal fee prescribed in 18VAC115-90-20.

Part IV

Standards of Practice, Disciplinary Action, and Reinstatement

18VAC115-90-70. Standards of practice

A. The protection of the public health, safety, and welfare and the best interest of the public shall be the primary guide in determining the appropriate professional conduct of all persons whose activities are regulated by the board.

B. Persons registered by the board shall:

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

2. Practice only within the competency area for which they are qualified by training or experience and shall not provide clinical mental health services for which a license is required pursuant to Chapters 35 (§ 54.1-3500 et seq.), 36 (§ 54.1-3600 et seq.), and 37 (§ 54.1-3700 et seq.) of the Code of Virginia.

3. Report to the board known or suspected violations of the laws and regulations governing the practice of behavioral health technicians or behavioral health technician assistants.

4. Neither accept nor give commissions, rebates, or other forms of remuneration for the referral of clients for professional services and make appropriate consultations and referrals based on the interest of patients or clients.

5. Stay abreast of new developments, concepts, and practices that are necessary to providing appropriate services.

C. In regard to confidentiality and client records, persons registered by the board shall:

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

2. Disclose client records to others only in accordance with applicable law.

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

4. Maintain timely, accurate, legible, and complete written or electronic records for each client, to include dates of service and identifying information to substantiate services provided, progress, and termination.

D. Persons registered by the board shall:

1. Not engage in dual relationships with clients or former clients that are harmful to the client's well-being, that would impair the practitioner's objectivity and professional judgment, or that would increase the risk of client exploitation. This prohibition includes such activities as providing services to close friends, former sexual partners, employees, or relatives or engaging in business relationships with clients.

2. Not engage in sexual intimacies or romantic relationships with current clients. For at least five years after cessation or termination of professional services, practitioners shall not engage in sexual intimacies or romantic relationships with a client or those included in collateral therapeutic services. Because sexual or romantic relationships are potentially exploitative, the practitioner shall bear the burden of demonstrating that there has been no exploitation. A client's consent to, initiation of, or participation in sexual behavior or involvement with a practitioner does not change the nature of the conduct nor lift the regulatory prohibition.

3. As necessary, persons registered by the board shall recognize conflicts of interest and inform all parties of obligations, responsibilities, and loyalties to third parties.

18VAC115-90-80. Grounds for revocation, suspension, restriction, or denial of registration

The board may revoke, suspend, restrict, or decline to issue or renew a registration based upon the following conduct:

1. Conviction of a felony, or of a misdemeanor involving moral turpitude, or violation of or aid to another in violating any provision of Chapter 35 (§ 54.1-3500 et seq.) of Title 54.1 of the Code of Virginia, any other statute applicable to the practice of qualified mental health professionals, or any provision of this chapter;

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

3. Conducting one's practice in such a manner so as to make it a danger to the health and welfare of one's clients or to the public, or if one is unable to practice with reasonable skill and safety to clients by reason of illness or abusive use of alcohol, drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition;

4. Violating or abetting another person in the violation of any provision of any statute applicable to the practice of behavioral health technicians or behavioral health technician assistants, or any regulation in this chapter;

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

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

8. Action taken against a health or mental health license, certification, registration, or application in Virginia or other jurisdiction;

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

10. Failure to report evidence of child abuse or neglect as required in § 63.2-1509 of the Code of Virginia or elder abuse or neglect as required in § 63.2-1606 of the Code of Virginia.

18VAC115-90-100. Late renewal and reinstatement

A. A person whose registration as a behavioral health technician or behavioral health technician assistant has expired may renew it within one year after its expiration date by paying the late renewal fee and the registration fee as prescribed in 18VAC115-90-20 for the year in which the registration was not renewed.

B. A person who fails to renew registration as a behavioral health technician or behavioral health technician assistant after one year or more shall:

1. Apply for reinstatement;

2. Pay the reinstatement fee for a lapsed registration.

C. A person whose registration has been suspended or who has been denied reinstatement by board order, having met the terms of the order, may submit a new application and fee for reinstatement of registration as prescribed in 18VAC115-90-20. Any person whose registration has been revoked by the board may, three years subsequent to such board action, submit a new application and fee for reinstatement of registration as prescribed in 18VAC115-90-20. The board in its discretion may, after an administrative proceeding, grant the reinstatement sought in this subsection.

Part I
General Provisions

18VAC115-80-10. Definitions.

~~"Accredited" means a school that is listed as accredited on the U.S. Department of Education College Accreditation database found on the U.S. Department of Education website. If education was obtained outside the United States, the board may accept a report from a credentialing service that deems the degree and coursework is equivalent to a course of study at an accredited school.~~

~~"Applicant" means a person applying for registration as a qualified mental health professional.~~

"Board" means the Virginia Board of Counseling.

~~"Collaborative mental health services" means those rehabilitative supportive services that are provided by a qualified mental health professional, as set forth in a service plan under the direction of and in collaboration with either a mental health professional licensed in Virginia or a person under supervision that has been approved by the Board of Counseling, Board of Psychology, or Board of Social Work as a prerequisite for licensure.~~

"DBHDS" means the Virginia Department of Behavioral Health and Developmental Services.

"Face-to-face" means the physical presence of the individuals involved in the supervisory relationship or the use of technology that provides real-time, visual, and audio contact among the individuals involved.

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

~~"Qualified mental health professional" or "QMHP" includes qualified mental health professionals-adult and qualified mental health professionals-child.~~

~~"Qualified mental health professional-adult" or "QMHP-A" means a qualified mental health professional who provides collaborative mental health services for adults. A qualified mental health professional-adult shall provide such services as an employee or~~

~~independent contractor of the Department of Behavioral Health and Developmental Services or the Department of Corrections, or as a provider licensed by the Department of Behavioral Health and Developmental Services.~~

~~"Qualified mental health professional-child" or "QMHP-C" means a person who by education and experience is professionally qualified and registered by the board to provide collaborative mental health services for children and adolescents up to 22 years of age. A qualified mental health professional-child shall provide such services as an employee or independent contractor of the Department of Behavioral Health and Developmental Services or the Department of Corrections, or as a provider licensed by the Department of Behavioral Health and Developmental Services.~~

~~"Qualified mental health professional-trainee" means a person who is receiving supervised training to qualify as a qualified mental health professional and is registered with the board.~~

~~"Registrant" means a QMHP registered with the board.~~

18VAC115-80-20. Fees required by the board.

A. The board has established the following fees applicable to the registration of qualified mental health professionals:

Registration as a QMHP~~-A~~	$50
~~Registration as a QMHP-C~~	~~$50~~
Registration as a QMHP-trainee	$25
Renewal of registration <u>as a QMHP</u>	$30
<u>Renewal of registration as a QMHP-trainee</u>	<u>$10</u>
Late renewal	$20
Reinstatement of a lapsed registration	$75
Duplicate certificate of registration	$10
Returned check or dishonored credit card or debit card	$50
Reinstatement following revocation or suspension	$500

B. Unless otherwise provided, fees established by the board shall not be refundable.

18VAC115-80-30. Current name and address.

Each registrant shall furnish a current name and address of record to the board ~~his current name and address of record~~. Any change of name or address of record or public address if different from the address of record shall be furnished to the board within 60 days of such change. ~~It shall be the duty and responsibility of each registrant to inform the board of his current address.~~

18VAC115-80-35. (Repealed) ~~Requirements for registration as a qualified mental health professional-trainee.~~

~~A. Prior to receiving supervised experience toward registration as a QMHP-A, an applicant for registration as a QMHP-trainee shall provide a completed application, the fee prescribed in 18VAC115-80-20, and verification of one of the following:~~

~~1. A master's degree in psychology, social work, counseling, substance abuse, or marriage and family therapy verified by an official transcript from an accredited college or university;~~

~~2. A master's or bachelor's degree in human services or a related field verified by an official transcript from an accredited college;~~

~~3. Current enrollment in a master's program in psychology, social work, counseling, substance abuse, marriage and family therapy, or human services with at least 30 semester or 45 quarter hours as verified by an official transcript;~~

~~4. A bachelor's degree verified by an official transcript from an accredited college in an unrelated field that includes at least 15 semester credits or 22 quarter hours in a human services field;~~

~~5. Licensure as a registered nurse in Virginia; or~~

~~6. Licensure as an occupational therapist.~~

~~B. Prior to receiving supervised experience toward registration as a QMHP-C, an applicant for registration as a QMHP-trainee shall provide a completed application, the fee prescribed in 18VAC115-80-20, and verification of one of the following:~~

~~1. A master's degree in psychology, social work, counseling, substance abuse, or marriage and family therapy verified by an official transcript from an accredited college or university;~~

~~2. A master's or bachelor's degree in a human services field or in special education verified by an official transcript from an accredited college;~~

~~3. Current enrollment in a master's program in psychology, social work, counseling, substance abuse, marriage and family therapy, human services, or special education with at least 30 semester or 45 quarter hours as verified by an official transcript;~~

~~4. Licensure as a registered nurse in Virginia; or~~

~~5. Licensure as an occupational therapist.~~

~~C. An applicant for registration as a QMHP-trainee shall have no unresolved disciplinary action against a mental health or health professional license, certification, or registration held in any jurisdiction. The board will consider a history of disciplinary action on a case-by-case basis as grounds for denial under 18VAC115-80-100.~~

~~D. Registration as a QMHP-trainee shall expire five years from date of issuance.~~

Part II
Requirements for Registration

18VAC115-80-40. Requirements for registration as a qualified mental health professional-~~adult~~.

A. An applicant for registration shall submit:

1. A completed application on forms provided by the board and any applicable fee as prescribed in 18VAC115-80-20;

2. A bachelor's degree from an institution of higher education listed as accredited on the U.S. Department of Education College Accreditation database found on the U.S. Department of Education website or accredited by another accrediting agency recognized by the board;

3. Evidence of completion of __ hours of didactic education in a program recognized or approved by the board, unless such evidence was provided to the board to obtain a registration as a QMHP-trainee;

4. Evidence of 1,500 hours of supervised experience to be obtained within a five-year period immediately preceding application for registration;

5. A current report from the National Practitioner Data Bank (NPDB); and

6. Verification of any other mental health or health professional license, certification, or registration ever held in Virginia or another jurisdiction. An applicant for registration as a QMHP ~~A~~ shall have no unresolved disciplinary action. The board will

consider a history of disciplinary action on a case-by-case basis as grounds for denial under 18VAC115-80-100.

~~B. An applicant for registration as a QMHP-A shall provide evidence of:~~

~~1. A master's degree in psychology, social work, counseling, substance abuse, or marriage and family therapy, as verified by an official transcript, from an accredited college or university with an internship or practicum of at least 500 hours of experience with persons who have mental illness;~~

~~2. A master's or bachelor's degree in human services or a related field, as verified by an official transcript, from an accredited college with no less than 1,500 hours of supervised experience to be obtained within a five-year period immediately preceding application for registration and as specified in subsection C of this section;~~

~~3. A bachelor's degree, as verified by an official transcript, from an accredited college in an unrelated field that includes at least 15 semester credits or 22 quarter hours in a human services field and with no less than 3,000 hours of supervised experience to be obtained within a five-year period immediately preceding application for registration and as specified in subsection C of this section;~~

~~4. A registered nurse licensed in Virginia with no less than 1,500 hours of supervised experience to be obtained within a five-year period immediately preceding application for registration and as specified in subsection C of this section; or~~

~~5. A licensed occupational therapist with an internship or practicum of at least 500 hours with persons with mental illness or no less than 1,500 hours of supervised experience to be obtained within a five-year period immediately preceding application for registration and as specified in subsection C of this section.~~

C. Experience required for registration.

1. To be registered as a QMHP~~-A~~, an applicant ~~who does not have a master's degree as set forth in subdivision B 1 of this section~~ shall provide documentation of experience in providing direct services to individuals as part of a population of adults or children with mental illness in a setting where mental health treatment, practice, observation, or diagnosis occurs. The services provided shall be appropriate to the practice of a QMHP.~~-A and under the supervision of~~

2. The following may serve as a supervisor for a QMHP-trainee:

a. A licensed mental health professional licensed by a board of the Department of Health Professions who has completed the required supervisor training;

b. A person under supervision that has been approved by the Board of Counseling, Board of Psychology, or Board of Social Work and who has completed the required supervisor training; or

c. A registered QMHP who has (i) practiced for three years and (ii) has completed the required supervisor training. ~~as a prerequisite for licensure~~.

3. Supervision obtained in another United States jurisdiction shall be provided by a mental health professional ~~licensed in Virginia or~~ licensed in that jurisdiction.

4. Supervision shall consist of face-to-face training in the services of a QMHP~~-A~~ until the supervisor determines competency in the provision of such services, after which supervision may be indirect in which the supervisor is either onsite or immediately available for consultation with the person being trained.

5. Hours obtained in a bachelor's or master's level internship or practicum in a human services field may be counted toward completion of the required hours of experience.

~~4. Supervised experience obtained prior to meeting the education requirements of subsection B of this section shall not be accepted.~~

18VAC115-80-50. (Repealed.) ~~Requirements for registration as a qualified mental health professional-child.~~

~~A. An applicant for registration shall submit:~~

~~1. A completed application on forms provided by the board and any applicable fee as prescribed in 18VAC115-80-20;~~

~~2. A current report from the National Practitioner Data Bank (NPDB); and~~

~~3. Verification of any other mental health or health professional license, certification, or registration ever held in another jurisdiction. An applicant for registration as a QMHP-C shall have no unresolved disciplinary action. The board will consider a history of disciplinary action on a case-by-case basis as grounds for denial under 18VAC115-80-100.~~

~~B. An applicant for registration as a QMHP-C shall provide evidence of:~~

~~1. A master's degree in psychology, social work, counseling, substance abuse, or marriage and family therapy, as verified by an official transcript, from an accredited college or university with an internship or practicum of at least 500 hours of experience with persons who have mental illness;~~

~~2. A master's or bachelor's degree in a human services field or in special education, as verified by an official transcript, from an accredited college with no less than 1,500 hours of supervised experience to be obtained within a five-year period immediately preceding application for registration and as specified in subsection C of this section;~~

~~3. A registered nurse licensed in Virginia with no less than 1,500 hours of supervised experience to be obtained within a five-year period immediately preceding application for registration and as specified in subsection C of this section; or~~

~~4. A licensed occupational therapist with an internship or practicum of at least 500 hours with persons with mental illness or no less than 1,500 hours of supervised experience to be obtained within a five-year period immediately preceding application for registration and as specified in subsection C of this section.~~

~~C. Experience required for registration.~~

~~1. To be registered as a QMHP-C, an applicant who does not have a master's degree as set forth in subdivision B 1 of this section shall provide documentation of 1,500 hours of experience in providing direct services to individuals as part of a population of children or adolescents with mental illness in a setting where mental health treatment, practice, observation, or diagnosis occurs. The services provided shall be appropriate to the practice of a QMHP-C and under the supervision of a licensed mental health professional or a person under supervision that has been approved by the Board of Counseling, Board of Psychology, or Board of Social Work as a prerequisite for licensure. Supervision obtained in another United States jurisdiction shall be provided by a mental health professional licensed in Virginia or licensed in that jurisdiction.~~

~~2. Supervision shall consist of face-to-face training in the services of a QMHP-C until the supervisor determines competency in the provision of such services, after which supervision may be indirect in which the supervisor is either onsite or immediately available for consultation with the person being trained.~~

~~3. Hours obtained in a bachelor's or master's level internship or practicum in a human services field may be counted toward completion of the required hours of experience.~~

~~4. Supervised experience obtained prior to meeting the education requirements of subsection B of this section shall not be accepted.~~

18VAC115-80-60. Reserved.

18VAC115-80-65. <u>Requirements for registration as a qualified mental health professional-trainee.</u>

Prior to receiving supervised experience toward registration as a QMHP, an applicant for registration as a QMHP-trainee shall provide a completed application, the fee prescribed in 18VAC115-80-20, and verification of the following:

1. Enrollment in or completion of a bachelor's degree program from an institution of higher education listed as accredited on the U.S. Department of Education College Accreditation database found on the U.S. Department of Education website or accredited by another accrediting agency recognized by the board;

2. Evidence of completion of __ hours of didactic education in a program recognized or approved by the Board;

3. Verification of any other mental health or health professional license, certification, or registration ever held in Virginia or another jurisdiction. An applicant for registration as a QMHP-trainee shall have no unresolved disciplinary action. The board will consider a history of disciplinary action on a case-by-case basis as grounds for denial under 18VAC115-80-100.

Part III
Renewal of Registration

18VAC115-80-70. Annual renewal of registration.

All registrants as a QMHP~~-A or a QMHP-C~~ or QMHP-trainee shall renew ~~their registrations~~ registration on or before June 30 of each year. Along with the renewal form, the registrant shall submit the renewal fee as prescribed in 18VAC115-80-20.

18VAC115-80-80. Continued competency requirements for renewal of registration for qualified mental health professionals.

A. Qualified mental health professionals shall be required to have completed a minimum of eight contact hours of continuing education for each annual registration renewal. ~~Persons who hold registration both as a QMHP-A and QMHP-C shall only be required to complete eight contact hours.~~ A minimum of one of these hours shall be in a course that emphasizes ethics.

B. Qualified mental health professionals shall complete continuing competency activities that focus on increasing knowledge or skills in areas directly related to the services provided by a QMHP.

C. The following organizations, associations, or institutions are approved by the board to provide continuing education, provided the hours are directly related to the provision of mental health services:

1. Federal, state, or local governmental agencies, public school systems, licensed health facilities, or an agency licensed by DBDHS; and

2. Entities approved for continuing education by a health regulatory board within the Department of Health Professions.

D. ~~Attestation of completion~~ Completion of continuing education is not required for the first renewal following initial registration in Virginia.

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

F. The board may grant an exemption for all or part of the continuing education requirements due to circumstances beyond the control of the registrant, such as temporary disability, mandatory military service, or officially declared disasters, upon written request from the registrant prior to the renewal date.

G. All registrants shall maintain ~~original~~ documentation of official transcripts showing credit hours earned or certificates of participation for a period of three years following renewal.

H. The board may conduct an audit of registrants to verify compliance with the requirement for a renewal period. Upon request, a registrant shall provide documentation as follows:

1. Official transcripts showing credit hours earned; or

2. Certificates of participation.

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

Part IV
Standards of Practice, Disciplinary Action, and Reinstatement

18VAC115-80-90. Standards of practice.

A. The protection of the public health, safety, and welfare and the best interest of the public shall be the primary guide in determining the appropriate professional conduct of all persons whose activities are regulated by the board.

B. Persons registered by the board shall:

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

2. Practice only within the competency area for which they are qualified by training or experience and shall not provide clinical mental health services for which a license is required pursuant to Chapters 35 (§ 54.1-3500 et seq.), 36 (§ 54.1-3600 et seq.), and 37 (§ 54.1-3700 et seq.) of the Code of Virginia.

3. Report to the board known or suspected violations of the laws and regulations governing the practice of qualified mental health professionals.

4. Neither accept nor give commissions, rebates, or other forms of remuneration for the referral of clients for professional services and make appropriate consultations and referrals based on the interest of patients or clients.

5. Stay abreast of new developments, concepts, and practices that are necessary to providing appropriate services.

C. In regard to confidentiality and client records, persons registered by the board shall:

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

2. Disclose client records to others only in accordance with applicable law.

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

4. Maintain timely, accurate, legible, and complete written or electronic records for each client, to include dates of service and identifying information to substantiate treatment plan, client progress, and termination.

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

1. Not engage in dual relationships with clients or former clients that are harmful to the client's well-being, that would impair the practitioner's objectivity and professional

judgment, or that would increase the risk of client exploitation. This prohibition includes such activities as providing services to close friends, former sexual partners, employees, or relatives or engaging in business relationships with clients.

2. Not engage in sexual intimacies or romantic relationships with current clients. For at least five years after cessation or termination of professional services, practitioners shall not engage in sexual intimacies or romantic relationships with a client or those included in collateral therapeutic services. Because sexual or romantic relationships are potentially exploitative, the practitioner shall bear the burden of demonstrating that there has been no exploitation. A client's consent to, initiation of, or participation in sexual behavior or involvement with a practitioner does not change the nature of the conduct nor lift the regulatory prohibition.

3. Recognize conflicts of interest and inform all parties of obligations, responsibilities, and loyalties to third parties.

E. Upon learning of evidence that indicates a reasonable probability that another mental health service provider, as defined in § 54.1-2400.1 of the Code of Virginia, is or may be guilty of a violation of standards of conduct as defined in statute or regulation, persons registered by the board shall advise their clients of the client's right to report such misconduct to the Department of Health Professions in accordance with § 54.1-2400.4 of the Code of Virginia.

18VAC115-80-100. Grounds for revocation, suspension, restriction, or denial of registration.

~~In accordance with subdivision 7 of § 54.1-2400 of the Code of Virginia, the~~ The board may revoke, suspend, restrict, or decline to issue or renew a registration based upon the following conduct:

1. Conviction of a felony, or of a misdemeanor involving moral turpitude, or violation of or aid to another in violating any provision of Chapter 35 (§ 54.1-3500 et seq.) of Title 54.1 of the Code of Virginia, any other statute applicable to the practice of qualified mental health professionals, or any provision of this chapter;

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

3. Conducting one's practice in such a manner so as to make it a danger to the health and welfare of one's clients or to the public, or if one is unable to practice with reasonable skill and safety to clients by reason of illness or abusive use of alcohol, drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition;

4. Violating or abetting another person in the violation of any provision of any statute applicable to the practice of qualified mental health professionals or any regulation in this chapter;

5. Performance of functions outside the board-registered area of competency;

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

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

8. Action taken against a health or mental health license, certification, registration, or application in Virginia or other jurisdiction;

9. 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;

~~9.~~ 10. Failure to cooperate with an employee of the Department of Health Professions in the conduct of an investigation; or

~~10.~~ 11. Failure to report evidence of child abuse or neglect as required in § 63.2-1509 of the Code of Virginia or elder abuse or neglect as required in § 63.2-1606 of the Code of Virginia.

18VAC115-80-110. Late renewal and reinstatement.

A. A person whose registration ~~as a QMHP-A or a QMHP-C~~ has expired may renew it within one year after its expiration date by paying the late renewal fee and the registration fee as prescribed in 18VAC115-80-20 for the year in which the registration was not renewed and by providing documentation of completion of continuing education as prescribed in 18VAC115-80-80.

B. A person who fails to renew registration ~~as a QMHP-A or a QMHP-C~~ after one year or more shall:

1. Apply for reinstatement;

2. Pay the reinstatement fee for a lapsed registration; and

3. Submit evidence of completion of 20 hours of continuing education consistent with requirements of 18VAC115-80-80.

C. A person whose registration has been suspended or who has been denied reinstatement by board order, having met the terms of the order, may submit a new application and fee for reinstatement of registration as prescribed in 18VAC115-80-20. Any person whose registration has been revoked by the board may, three years subsequent to such board action, submit a new application and fee for reinstatement of registration as prescribed in 18VAC115-80-20. The board in its discretion may, after an administrative proceeding, grant the reinstatement sought in this subsection.

Discussion of Board-Approved Training Pursuant to SB403 (Durant)

July 19, 2024

New Profession: Behavioral Health Technician Assistant (BHTA)

Behavioral Health Technician Assistant (BHTA): Education Prerequisite and Scope of Practice

- Completed minimum of **high school diploma or equivalent;**
- Under Board-approved supervision provide:
  - collaborative behavioral health services;
  - training on prevention of mental health and substance use disorders;
  - mental health literacy; and,
  - supportive functions of screening, intake, orientation, care coordination, client education, and recordkeeping.

New Profession: Behavioral Health Technician (BHT)

Virginia Department of Health Professions

Behavioral Health Technician (BHT) Education Prerequisite and Scope of Practice

- Completed minimum an **associate's degree;**
- Registered with Board of Counseling;
- Under Board-approved supervision provide Board-approved supervision provide:
  - collaborative behavioral health services;
  - training on prevention of mental health and substance use disorders and mental health literacy;
  - supportive functions of screening, intake, orientation, care coordination, client education, and recordkeeping
  - supervise, as part of a collaborative team, behavioral health technicians and behavioral health technician assistants
    - after 3 years of practicing as a BHT in good standing and completion of the supervisor training.

QMHP Restructuring

QMHP Scope of Practice

- **Problem**: Neither the Code nor the Regulations define **the** scope of practice for QMHPs.
- **SB 403 Solution:** More clearlyy outlines the scope of practice. Under Board-approved supervision QMHPs can provide collaborative behavioral health services including the supportive functions of:
- screening;
- intake;
- orientation;
- care coordination;
- client education;
- referral activities;
- initiating crisis de-escalation;
- gathering histories of mental and physical health conditions, alcohol and drug use, past mental health treatment, and interactions with the criminal justice system;
- providing psychosocial skills development;
- implementing interventions as assigned on individual plans of care and documenting the interventions for the purposes of recordkeeping; and,
- prevention of mental health and substance use disorders.

Training Prerequisites

- For each profession, registration requires meeting the education level requirement and completion of “specified number of hours of didactic education in a program recognized or approved by the Board”.
- For each profession, what will the board approve for a minimum curriculum and a minimum number of hours?
  - BHTA – High School Diploma/GED
  - BHT – Associate’s Degree
  - QMHP – Bachelor’s Degree
  - QMHP – Trainee – Enrolled in a Bachelor’s Degree Program
- What exists?
  - Career and Technical Education (CTE) Program
    - How many high schools currently offer and future prospects
    - Anything similar in Adult Education courses
  - DBHDS State Facility New Employee Orientation & Training
  - Workforce Development Class in Human Services – Germanna/RACSB partnership
  - DBHDS Behavioral Health Training Academy
  - VHWDA Community Health Worker Training Program
  - American Association of Psychiatric Technicians, Psychiatric Technician Level 1 Certification
  - Crisis Intervention Training
  - Mental Health First Aid
  - Military Training
  - Peer Recovery Training
  - Community Health Worker Training
- Are there other possibilities?
- Accessibility?

DBHDS Behavioral Health Academy

- BH Academy Content
  - Understanding Developmental and Cognition Conditions and Supporting Individuals with to Thrive
  - Understanding Mental Health and Mental Health Conditions and Co-Occurring Disorders
  - Engaging Therapeutically and Interviewing Basics initiating crisis de-escalation
  - From Yesteryear to Today: Trauma-Informed, Person-Centered, Relationship-Based, RecoveryOriented Care (Includes Self-Care and Team Care) Care Coordination
  - Ethics, Rights, Privacy, Outreach, and Advocacy: Removing Barriers & Stigma
  - Cultural Appreciation in Care and Diversity in the Workforce
  - Understanding the Service Array and Working Within an Interdisciplinary Team: Settings, Roles and
  - Responsibilities Care Coordination
  - Progress Measurement, Screening Basics, Intake, Orientation, and Documentation Prevention, Early Detection, Client Education, and Treatment Engagement (WRAP Plans/Advanced Directives)

AAPT Certifications

- Define psychiatric technicians as:
  - Mental health employees who provide hands-on care to people with varying degrees of mental illnesses and/or developmental disabilities.
  - Can participate in planning and implementation of treatment plans.
  - May be responsible for admitting and interviewing patients, record-keeping, administering medications, and conducting therapy sessions.
- Certification requires passage of an exam – level one is an open book, multiple choice exam.
- Level 1: high school diploma or GED.
- Level 2: Completion of 480 hours of college courses, plus 1 year experience working in field of mental health or developmental disabilities.
- Level 3: Completion of 960 hours of college courses, plus 2 years of work experience in the field of mental health or development disabilities.
- Level 4: Requires a bachelor's degree in a mental health or developmental disabilities field and three years of experience in the mental health field.

Supervision Training

Who Can Supervise Whom?

- Licensed Mental Health Professional can supervise:
  - BHTs
  - QMHPs and BHTAs after completion of supervision training
- Person under supervision that has been approved by the Board of Counseling, Board of Psychology, or Board of Social Work as a prerequisite for licensure can supervise:
  - QMHPS, BHTs, BHTAs after completion of supervision training
- QMHPs can supervise
  - QMHPs, BHTs, BHTAs after 3 years practice and completion of supervision training
- BHTs can supervise:
  - BHTs and BHTAs after 3 years practice and completion of supervision training

- BHTAs and QMHP-Trainees cannot supervise

Supervision Training

- What is the minimum amount of supervision training required to supervise each level?
- What should it include?

Other Considerations

- Are there other pathways for QMHP applicants to reach the board that do not include being a Trainee that we need to consider?
- Are we giving credit for those that follow the pathway?
  - Overlap of QMHP-Trainee and BHT?
    - Trainee has broader scope
    - BHT training requirements count for QMHP registration?
- Do the training requirements for any of the professions inadvertently exclude anyone?
  - Career switchers
  - Veterans
- Are we excluding any valuable training programs/pathways?
- Does citing a minimum curriculum address these considerations or is that unnecessarily burdensome for applicants/staff?
- Process for becoming a board-approved training program

Next Steps

- By October 4, Board meeting, Board will adopt a Guidance Document that indicates board-approved training and supervision programs.

Reference Materials

J SARGEANT REYNOLDS
BH TECH CSC
16 semester credits

Reynolds Community College Catalog 2024-2025

Catalog Search

Entire Catalog

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Catalog Navigation

Behavioral Health Technician CSC (221-480-32)

Return to: Programs by Degree

Curriculum

- SDV 100 - College Success Skills **Credit Hours: 1**

HMS 100 - Introduction to Human Services

HMS 100 - Introduction to Human Services

Credit Hours: 3

Introduces human service agencies, roles and careers. Presents an historical perspective of the field as it relates to human services today. Additional topics include values clarification and needs of target populations.

Lecture Hours: Lecture 3 hours per week.
Semester(s) Offered: Fall Spring Summer

MEN 101 - Mental Health Skill Training I [1]

MEN 101 - Mental Health Skill Training I

Credit Hours: 3

Develops skills necessary to function as a mental health worker, with emphasis on guided practice in counseling skills as well as improved self-awareness. Includes training in problem-solving, goal-setting, and implementation of appropriate strategies and evaluation techniques relating to interaction involving a variety of client needs. Part I of II.

Lecture Hours: Lecture 3 hours per week.
Semester(s) Offered: Fall Spring Summer

MEN 102 - Mental Health Skill Training II [1]

MEN 102 - Mental Health Skill Training II

Credit Hours: 3

Develops skills necessary to function as a mental health worker, with emphasis on guided practice in counseling skills as well as improved self-awareness. Includes training in problem-solving, goal-setting, and implementation of appropriate strategies and evaluation techniques relating to interaction involving a variety of client needs. Part II of II.

Lecture Hours: Lecture 3 hours per week.
Semester(s) Offered: Fall Spring Summer
Prerequisites: MEN 101.

HMS 226 - Helping Across Cultures

HMS 226 - Helping Across Cultures

Credit Hours: 3

Provides an historical overview of selected cultural and racial groups. Promotes understanding of group differences and the impact on counseling services.

Lecture Hours: Lecture 3 hours per week.
Semester(s) Offered: Fall Spring Summer

- ENG 111 - College Composition I **Credit Hours: 3**
  Workforce Credential: with the completion of the Behavioral Health Technician CSC you are eligible to sit for the Registered Behavior Technician (RBT) certification exam. Speak with a Human Services instructor for more information.

Total: 16 Credit Hours

[1] MEN 101 and MEN 102: total number of approved agency practicum observation hours in MEN 101 and MEN 102 combined must total at least 40 hours.

Return to: Programs by Degree

GERMANNA COMM COLLEGE

CERTIFICATE IN PARAPROFESSIONAL COUNSELING

21 semester credits

Paraprofessional Counseling, Career Studies Certificate Program-221-480-55

Return to: Pathways - Programs of Study

Purpose: The Career Studies Certificate in Paraprofessional Counseling is designed to prepare students to work as mental health paraprofessionals. Students will receive a basic background in psychology and theories of counseling. Upon completion of the program, students will be prepared to pursue entry-level positions within the human services field or to continue their education.

Occupational Objectives: Counselor Aides, Gerontology Assistants, Mental Health Technicians, Nursing Home Assistants, Social Services Assistants, Substance Abuse Counselor Aides.

Admission Requirements: All students will be required to demonstrate college readiness through transcript review or informed self-placement. Based on this review students may request or be required to enroll in prerequisite or corequisite math and/or English courses. Students are urged to consult with counselors or faculty advisors in planning their programs.

Paraprofessional Counseling Curriculum:

Program Requirements

PSY 120: Human Relations

PSY 120: Human Relations

Credits: 3

Introduces the theory and practice of effective human relations. Increases understanding of self and others and interpersonal skills needed to be a competent and cooperative communicator.

Lecture Hours: 3 hours per week.

PSY 200: Principles of Psychology

PSY 200: Principles of Psychology

Credits: 3

Surveys the basic concepts of psychology. Covers the scientific study of behavior and mental processes, research methods, biological bases of behavior, sensation and perception, developmental psychology, learning, memory, thinking, intelligence, personality, social psychology, and psychological disorders and treatment. The assignments in the course require college-level reading fluency and coherent communication through written reports. This is a Passport Transfer course.

Lecture Hours: 3 hours per week.
NOTE: Students who take PSY 200 cannot receive credit for either PSY 201 or PSY 202.

PSY 215: Abnormal Psychology

Credits: 3

Explores historical views and current perspectives of abnormal behavior. Emphasizes major diagnostic categories and criteria, individual and social factors of maladaptive behavior, and types of therapy. Includes methods of clinical assessment and research strategies.

Prerequisite(s): Completed PSY 200
Lecture Hours: 3 hours per week.

PSY 230: Developmental Psychology

PSY 230: Developmental Psychology

Credits: 3

Studies the development of the individual from conception to death. Follows a life-span perspective on the developmental of the person's physical, cognitive, and psychosocial growth.

Lecture Hours: 3 hours per week.
NOTE: Students cannot receive credit for both PSY 235 and PSY 230.

PSY 226: Introduction to Counseling Relationships [1]

PSY 226: Introduction to Counseling Relationships

Credits: 3

Introduces counseling theories and provides opportunity for their application through role-playing and supervised paraprofessional counseling experiences.

Prerequisite(s): Completed a minimum of 9 credit hours in Psychology or instructor approval.
Lecture Hours: 3 hours per week.

PSY 290: Coordinated Internship [2]

PSY 290: Coordinated Internship

Supervises on-the-job training in selected business, industrial or service firms coordinated by the College. Credit/practice ratio maximum 1:5 hours.

Prerequisite(s): Completed PSY 226. Open only to students in Paraprofessional Counseling Career Studies Certificate program.
May be repeated for credit. Variable hours.

- PSY Elective - Any PSY course

Total Minimum Credits: 21

[1] Students must complete 9 credits in psychology before taking PSY 226.

[2] Students must complete PSY 226, 12 credit hours and gain the approval of the Paraprofessional Counseling Program Head prior to registering for PSY 290. Students should contact the four-year institution(s) to which they may transfer to determine how credit might be awarded for any PSY elective.

Suggested Sequence of Courses:

Students should begin with PSY 200.

Return to: Pathways - Programs of Study

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GERMANNA COMM COLLEGE

CERTIFICATE IN BEHAVIORAL HEALTH TECHNICIAN

GERMANNA LAUNCHES BEHAVIORAL HEALTH TECHNICIAN CERTIFICATION PROGRAM

Add new comment

Share Story

Germanna Community College and the Rappahannock Area Community Services Board (RACSB) are excited to collaborate in the development and delivery of a Behavioral Health Technician program that is being funded by the Claude Moore Charitable Foundation.

This workforce program is an entry-level certification program which allows students to enter the mental health workforce career pathway through a program which combines curriculum, internships/field experiences, and required trainings to prepare them for employment in the behavioral health field. At the completion of the program, students will take a Mental Health Technician certification exam.

The Spring 2024 Behavioral Health Technician program will run from March 21, 2024 to June 27, 2024. Class meetings will take place every other week on Thursday evenings from 6:30 p.m. to 8:30 p.m. at the Fredericksburg Area Campus in Spotsylvania. Asynchronous instructional activities will be available to complete on the alternate weeks.

In addition to the coursework, accepted students will be onboarded by RACSB to become an employee during this program. Through this "earn while you learn" program, students will work up to 20 hours per week. Students may also be eligible for permanent, full-time employment following successful completion of this program.

Reply

Submitted by Kelsey navarro (not verified) on Tue, 06/18/2024 - 03:35 Permalink

hello I wanted more information on how I can become a psychiatric technician and if there are any certifications or programs that can help with that pathway. thank you!

Reply

Submitted by John Stroffolino (not verified) on Tue, 06/18/2024 - 10:24 Permalink

The link to the interest form is https://forms.gle/nhBKDxuURk5WuTd7A. Our faculty checks this as we look to enroll each class to provide information about the program.

Reply

Add new comment

Your name

Subject

Comment

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#GERMANNA

CAREER AND TECHNICAL EDUCATION (CTE) HIGH SCHOOL

MENTAL HEALTH TECHNICIAN

Mental Health Assisting Careers (14002-II)

Virginia Assignment Code: 8332

Suggested Grade Level: 12

Duration: 36 weeks

Hours: 280

Credits: 2

Prerequisites: 8331

CTSO: HOSA-Future Health Professionals

Course Description:

Students experience classroom instruction and hands-on learning in preparation for a career as a mental health technician or in the mental health field. Students gain understanding of routine care and therapeutic procedures, responding to emergency situations, patient rehabilitation, and patient recreational activities. Students prepare to assist physicians, therapists, and other mental health professionals in hospitals, outpatient clinics, and community mental health facilities. Contextual instruction and student participation in co-curricular career and technical student organization (CTSO) activities will develop leadership, interpersonal, and career skills. High-quality work-based learning (HQWBL) will provide experiential learning opportunities related to students' career goals and/or interests, integrated with instruction, and performed in partnership with local businesses and organizations. (https://www.dhp.virginia.gov/nursing/leg/CNA_02272014.doc)

Credentials, Course Sequences, and Career Clusters/Pathways can be found here:

https://www.cteresource.org/career-clusters/human-services/mental-health-assisting-careers/ (https://www.cteresource.org/career-clusters/human-services/mental-health-assisting-careers/)

Collapse All

Demonstrating Personal Qualities and Abilities

- Demonstrate creativity and innovation.
- Demonstrate critical thinking and problem-solving.
- Demonstrate initiative and self-direction.
- Demonstrate integrity.
- Demonstrate work ethic.
- WorkplaceReadinessSkillsPoster2019.pdf

Demonstrating Interpersonal Skills

- Demonstrate conflict-resolution skills.
- Demonstrate listening and speaking skills.
- Demonstrate respect for diversity.
- Demonstrate customer service skills.
- Collaborate with team members.

Demonstrate creativity and innovation.

Demonstration includes

- discussing the importance of creativity and innovation in the workplace
- brainstorming and contributing ideas, strategies, and solutions
- developing and/or improving products, services, or processes
- identifying and allocating available resources.

Process/Skill Questions:

- What are creativity and innovation? Why are they important in the workplace?
- Why is it important to brainstorm and contribute ideas within a team?
- How might one improve a product, service, or process in a career pathway?
- What resources are needed to solve a problem? How should these resources be allocated?

Demonstrate critical thinking and problem-solving.

Demonstration includes

- recognizing and analyzing problems
- evaluating potential solutions and resources
- using a logical approach to make decisions and solve problems
- implementing effective courses of action.

Process/Skill Questions:

- What is an example of a situation where one could use a reasoning model to make a decision?
- What steps might one take to make a decision or solve a problem?
- What are examples of questions one might ask when analyzing problems?
- How can potential solutions be evaluated?
- What are the advantages and disadvantages of using a reasoning approach to make a decision or solve a problem?

Demonstrate initiative and self-direction.

Demonstration includes

- recognizing the importance of proactive, independent decision making
- identifying workplace needs
- completing tasks with minimal direct supervision
- applying solutions.

Process/Skill Questions:

- What is the difference between initiative and self-direction?
- Why is self-direction important in the workplace?
- What is an example of applying initiative?
- How can tasks be completed with minimal direct supervision?

Demonstrate integrity.

Demonstration includes

- defining *integrity*
- recognizing the importance of having integrity in the workplace
- complying with local, state, and federal laws
- adhering to workplace policies and procedures
- exhibiting honesty, fairness, and respect toward self, others, and property.

Process/Skill Questions:

- What is a recent example of an employer failing to comply with the law?
- Where can one find information on local, state, and federal laws?
- How can workplace policies and rules affect employees' personal lives?
- How does one demonstrate integrity?
- How should an employee respond when he/she sees a coworker failing to comply with a workplace policy or procedure?

Demonstrate work ethic.

Demonstration includes

- defining *work ethic*
- recognizing the importance of having a strong work ethic
- demonstrating diligence (e.g., working with persistence to accomplish a task)
- maintaining dependability (e.g., being reliable)
- accounting for one's decisions and actions
- accepting the consequences of decisions and actions.

Process/Skill Questions:

- What is the difference between responsibility and accountability?
- What are the consequences of not being prepared for a school or workplace assignment?
- What are some examples of positive work ethic?
- Why is a positive work ethic valued by teachers and employers?
- What are the consequences of having a poor work ethic?

Demonstrate conflict-resolution skills.

Demonstration includes negotiating diplomatic solutions to interpersonal and workplace issues (e.g., due to personality, culture, work style, or performance).

Process/Skill Questions:

- What is an example of an appropriate approach to address a workplace conflict?
- What factors should one take into consideration when determining the best approach to resolve an interpersonal or workplace conflict?
- How can one maintain a good working relationship with a colleague one does not like?
- How might one approach a supervisor with whom one disagrees?
- How do personality issues affect workflow?

Demonstrate listening and speaking skills.

Demonstration includes

- defining *nonverbal cues*

- employing active listening techniques (e.g., asking clarifying questions, paraphrasing what was said)
- exhibiting public speaking skills (e.g., making presentations)
- articulating ideas in a manner appropriate to the setting and audience (e.g., considering the chosen communication method and audience's level of knowledge).

Process/Skill Questions:

- Why is it important to use active listening techniques?
- What is paraphrasing? How can paraphrasing help achieve clarity?
- What are some ways that one can improve public speaking skills?
- Why is it important to know one's audience when delivering a presentation?

Demonstrate respect for diversity.

Demonstration includes

- defining *diversity* and discussing its importance
- identifying individual differences (e.g., age, gender, ethnicity, culture, race, viewpoints, socioeconomic status, and ability)
- showing respect for and valuing individual differences in the workplace
- being self-aware and mindful of one's own bias
- collaborating with people of diverse backgrounds, viewpoints, and experiences.

Process/Skill Questions:

- What is bias? What are different forms of workplace bias?
- What is the difference between sympathy and empathy?
- How is having respect for diversity different from being aware of diversity?
- How does one bridge generation gaps in the workplace?
- Why is collaboration with people of diverse backgrounds, viewpoints, and experiences important?
- What are the benefits of having diversity in the workplace? What are the consequences of a lack of diversity in the workplace?

Demonstrate customer service skills.

Demonstration includes

- defining *customer service* (e.g., *internal customer service*; *external customer service*)
- identifying the benefits of providing helpful, courteous, and knowledgeable customer service
- prioritizing customer service (both within an organization and to external customers and stakeholders)
- anticipating needs of customers and coworkers
- demonstrating how to provide helpful, courteous, and knowledgeable service to address customer and/or coworker needs.

Process/Skill Questions:

- How does internal customer service influence organizational productivity?
- What is an example of a time when a customer service representative anticipated and addressed a customer's needs?
- Why is it important to receive helpful, courteous, and knowledgeable service?
- Why is soliciting feedback important?
- Why is cultivating relationships important?

Collaborate with team members.

Collaboration should include

- defining *collaboration* and *teamwork*
- discussing the benefits of teamwork
- establishing expectations, roles, and goals
- contributing to the success of the team by sharing responsibility
- respecting the thoughts, opinions, and contributions of other team members.

Process/Skill Questions:

- What are some benefits of collaborating to accomplish a goal?
- What expectations and roles might a group set as they begin collaborating?
- What does sharing responsibility mean?
- How and when should one appropriately ask for help?
- Why is it important to respect the thoughts, contributions, and opinions of other team members?

Demonstrate big-picture thinking.

Demonstration includes

- defining *big-picture thinking* as an understanding of one's role in fulfilling the mission of the workplace and a consideration of the social, economic, and environmental effects of one's actions
- identifying the organization's structure, culture, policies, and procedures, as well as its role and position within the community, industry, and economy.

Process/Skill Questions:

- Why is it important to understand where one fits within the family, school, workplace, and the community?
- How might a person's actions affect the school, community, and workplace?
- How do an organization's vision and mission statements help people understand the organization's big picture?
- How can knowledge of the big picture of an industry help with career planning?

Demonstrate career- and life-management skills.

Demonstration includes

- recognizing the importance of education and career planning (e.g., minimum job qualifications, advancement and professional-development opportunities)
- identifying available benefits and professional resources (e.g., labor unions, professional organizations, employee-assistance programs, insurance and retirement benefits)
- managing personal growth and wellness (e.g., stress management, self-care, financial planning)
- setting goals (e.g., specific, measurable, attainable, realistic, time-bound [SMART] goals).

Process/Skill Questions:

- Where can one find entry-level requirements for a specific career?
- Why is it important to continuously update a career plan?
- What is the difference between a short-term and long-term goal?
- Why is it important to create a personal financial plan?
- What resources are available to assist with achieving personal education, career, financial, and health goals?

Demonstrate continuous learning and adaptability.

Demonstration includes

- describing the importance of continuous learning
- identifying resources for continuous learning (e.g., publications, trade organizations, professional networking, workshops/classes)
- modifying work performance based on feedback (i.e., being coachable)
- acquiring industry-related professional skills and knowledge (e.g., credentials/certifications)
- adapting to changing job requirements.

Process/Skill Questions:

- Why is it important to have an open mind and be flexible when confronted with change?
- How does one benefit from constructive feedback?
- What strategies are helpful for modifying work performance after receiving feedback?
- What actions can an employee take to become eligible for promotion in a given career?
- What resources might one use to keep current in a specific career field?

Manage time and resources.

Management should include

- defining *efficiency* and *productivity* as they relate to time and resource management
- developing a plan of work
- differentiating between high- and low-priority tasks
- adapting work goals based on time and resources
- considering resources
    - human (personnel)—capitalizing on strengths; respecting professional goals
    - capital—maintaining equipment to ensure longevity and efficiency
    - natural—using responsible and sustainable practices.

Process/Skill Questions:

- What is time management? How does it affect the workplace?
- What happens when an employee is not given enough time to accomplish a task?
- Why is it important to prioritize work tasks?
- How are efficiency and productivity related?
- Why is it important to maintain equipment? What are possible consequences of not doing so?
- What are examples of responsible and sustainable practices in the workplace?

Demonstrate information-literacy skills.

Demonstration includes

- defining *information literacy*
- locating and evaluating credible and relevant sources of information
- using information effectively to accomplish work-related tasks.

Process/Skill Questions:

- What is *information literacy*?
- How should sources of information be evaluated and verified for credibility?
- Where can one locate credible and relevant information sources within a potential career cluster?

Demonstrate an understanding of information security.

Demonstration includes

- identifying various information types/formats (e.g., paper, electronic)
- describing cybersecurity (e.g., risks, threats, vulnerabilities)

- using technology ethically (e.g., appropriately using social networks, managing personal information)
- abiding by workplace policies (e.g., acceptable use policy [AUP])
- protecting confidentiality (e.g., protecting login information and customer information)
- following workplace security procedures.

Process/Skill Questions:

- What is *cybersecurity*? Why is it important?
- What information is considered sensitive? How can a person protect sensitive information?
- What are the possible consequences of failing to protect confidentiality?
- What are the possible consequences of an employee failing to adhere to a company's AUP?

Maintain working knowledge of current information-technology (IT) systems.

Maintaining working knowledge of current IT systems may include, but is not limited to,

- hardware and devices (e.g., peripherals)
- software and applications
- cloud-based services
- file-sharing techniques
- emerging technologies
- troubleshooting protocols and techniques.

Process/Skill Questions:

- What technology systems are common within a given industry?
- How does one keep current with information technology?
- What steps should be taken if there is a problem with technology in the workplace?

Demonstrate proficiency with technologies, tools, and machines common to a specific occupation.

Demonstration includes selecting and using technology, tools, and machines to accomplish work.

Process/Skill Questions:

- What technology, tools, or machines are common in a given industry?
- How are technology, tools, or machines used to accomplish job tasks efficiently?
- Why is it important to be proficient with industry-specific technology, tools, and machines?

Apply mathematical skills to job-specific tasks.

Application could include

- performing calculations (e.g., percentages, fractions, addition, subtraction, averages, measurement, conversions, monetary transactions)
- applying mathematical processes to accomplish job-specific tasks (e.g., estimating required supplies, completing expense reports)
- managing personal finance (e.g., understanding wage rates, paycheck deductions, taxes, sales receipts).

Process/Skill Questions:

- What mathematical skills are required to attain an entry-level job in a specific field? What mathematical skills are required for higher-level jobs within that field?
- What resources are available to assist in the improvement of mathematical skills?
- Why are mathematical skills considered communication skills?

Demonstrate professionalism.

Demonstration includes

- defining *professionalism*
- practicing punctuality and attendance
- adhering to work-schedule expectations
- exercising etiquette (e.g., language, manners, and behaviors suitable for the workplace and online; appropriate verbal and nonverbal communication)
- exhibiting professional self-representation (e.g., using a firm handshake, introducing oneself, making eye contact)
- maintaining professional appearance (e.g., maintaining personal hygiene, adhering to a dress code).

Process/Skill Questions:

- What is professionalism? How is it demonstrated?
- How can a person make a positive first impression? Why is this important?
- Why is professional appearance important in the workplace?
- Why is punctuality and attendance important in the workplace?
- What are some examples of workplace schedule expectations?
- How do behavior and communication expectations differ between home and school? How might these expectations differ in the workplace?

Demonstrate reading and writing skills.

Demonstration includes

- reading and interpreting workplace documents
- effectively writing workplace documents, considering
    - ability to convey messages with clarity
    - professional tone, appropriate to audience
    - grammar
    - forms and conventions (e.g., formatting documents, using an email signature).

Process/Skill Questions:

- What level of reading and writing skills are required for an entry-level job in a given industry?
- How do reading and writing skills help a person succeed as an individual, family member, and citizen?
- How would written correspondence differ among friends vs. between an applicant and a prospective employer?
- Why is it important for an employee to gain knowledge of preferred forms and conventions in the workplace?

Demonstrate workplace safety.

Demonstration includes, but is not limited to,

- adhering to Occupational Safety and Health Administration (OSHA) standards and instructor and manufacturer guidelines
    - interpreting safety data sheets (SDS)
    - identifying and using personal protective equipment (PPE)
- maintaining universal precautions (e.g., to protect against bloodborne pathogens)
- identifying risks and hazards in the workplace
- following emergency protocols (e.g., evacuation routes).

Process/Skill Questions:

- What is OSHA? Under what federal department does it fall?
- How does OSHA help employees identify risks and hazards in the workplace?
- Where might one find an SDS?

- How do emergency protocols differ within the school, the workplace, and the home?

Examine aspects of planning within an industry/organization.

Examination should include

- development of vision and mission statements
- setting of performance goals and objectives
- review of previous performance (e.g., productivity, profit)
- evaluation of current assets
- formulation of strategic and operational plans
- use of planning tools (e.g., market research, budget analysis, decision-making models, competitive analyses)
- determination of human, natural, technology, and capital resource needs
- forecasting of trends
- anticipation of changes in the business climate (e.g., economic factors, laws, regulations, taxes)
- anticipation of and compensation for organizational and industry risk.

Process/Skill Questions:

- Where can you find examples of strategic plans that align with a business or industry in your area of interest?
- What lessons can you learn by comparing successful and unsuccessful businesses?
- What might be some consequences of inadequate business planning?

Examine aspects of management within an industry/organization.

Examination should include

- effect of the organization's structure and culture on operations
- process for accomplishing goals, using available human, natural, technology, and capital resources
- ways of ensuring open communication channels
- ways of enabling workers to fulfill their responsibilities
- evaluation of workers' performance
- provision of training and job-growth opportunities to workers
- assurance of worker equity, access, and safety
- resolution of conflicts
- performance of employment functions (e.g., recruiting, hiring, retaining, discharging).

Process/Skill Questions:

- What opportunities and/or activities can provide experience in management?
- What are your personal characteristics, habits, and activities that would be helpful in a professional management position?

Examine aspects of financial responsibility within an industry/organization.

Examination should include

- accounting processes
- financial decision-making processes, including budget development
- methods of acquiring capital
- management of financial operations, including payroll, transactions, records, and reports.

Process/Skill Questions:

- What resources are available to assist you with the various financial functions?
- What are possible consequences of not having in place checks and balances for the full range of a business's finances?

Examine technical and production skills required of workers within an industry/organization.

Examination should include

- industry-related technical skills (e.g., communication, mathematics, science, technology, time-management, and creative-thinking skills)
- industry-related production skills (specific skills used for production of goods or services)
- industry-related interpersonal and team-player skills.

Process/Skill Questions:

- How can you, as a worker, determine the necessity to develop and/or upgrade industry-related production skills?
- What are some consequences of using good communication skills? Of using poor communication skills?
- What is the importance of having more than one person analyze information in order to make decisions?
- What steps can you take to develop industry-related interpersonal and team-player skills?

Examine principles of technology that underlie an industry/organization.

Examination should include

- technological systems used in the industry
- mathematical, scientific, social, ethical, and economic principles underlying the technological systems
- impact of energy systems, fuel sources, and other technological systems on the production of goods and services
- use of emerging and alternative energy resources in the production of goods and services
- generation and distribution of energy to industries/organizations for use in creating goods and services.

Process/Skill Questions:

- What are examples of ethical issues related to technologies?
- Why are energy systems so important to industries/organizations?
- Why is it important to maintain technological systems?
- How does energy transmission affect technological systems?
- What are the possible effects of alternative energy sources on industries?
- What would life be like without a reliable source of energy?
- What would be the effect of using electric vehicles to transport/deliver/ship goods?

Examine labor issues related to an industry/organization.

Examination should include

- workers' rights and responsibilities (e.g., wages, benefits, working conditions)
- role of employment contracts and agreements
- role of certification, licensure, and other requirements for specific jobs/occupations
- role of labor organizations and other worker advocacy groups (e.g., professional/trade associations).

Examine community issues related to an industry/organization.

Examination should include

- the effects of the organization on the community (e.g., provision of jobs, tax revenue, and goods/services; involvement in community programs/activities; environmental impact)
- the effects of the community on the organization (e.g., employee base; local taxes and regulations; local government services such as roads, schools, utilities; other local services).

Process/Skill Questions:

- In what ways can an industry enhance the community in which it is located?
- How can members of the community effectively communicate their needs and concerns to a local industry?
- What are examples of programs that bring together businesses and communities?

Examine health, safety, and environmental issues related to an industry/organization.

Examination should include

- responsibility for workers' health and safety
- laws/regulations and practices affecting workers' health and safety
- health and safety hazards
- health and safety programs
- responsibility for the environment
- laws/regulations and practices affecting the impact on the environment
- sustainability initiatives.

Process/Skill Questions:

- What environmental concerns should an industry address?
- What environmentally-friendly practices and resources are available to an industry?
- What methods can be used to motivate employees to become involved in effective health, safety, and environmental practices?
- What forewarnings and preventive measures are available to lessen the likelihood or impact of emergencies such as personal illness or injury, tornadoes, fires, nuclear accidents, floods, and incidences of employee rage or violent behavior?

Identify the purposes and goals of the student organization.

Identification of the purposes of the student organization should include

- providing opportunities for personal development and preparation for adult life
- providing opportunities for making decisions and assuming responsibilities
- encouraging democracy through cooperative action
- preparing for multiple, nontraditional roles in society
- promoting greater understanding between youth and adults.

Identification of the goals of the student organization should include

- promoting personal growth and leadership development
- helping students develop life skills in the areas of character development and ethical behavior, creative and critical thinking, interpersonal communication, practical knowledge, and career preparation.

Explain the benefits and responsibilities of membership in the student organization as a student and in professional/civic organizations as an adult.

Explanation of benefits should include

- development of leadership and other life skills, including planning, goal setting, problem solving, decision making, and interpersonal communication
- opportunities for school and community service
- development of interpersonal relationships
- opportunities for experiential learning
- opportunities to compete in student events on local, state, and national levels
- access to professional information and opportunities
- opportunities for career development.

Explanation of responsibilities should include

- contributory participation in the student organization as a student and in professional/civic organization activities as an adult
- display of appropriate conduct in all activities and events related to the student organization and professional/civic organizations.

Demonstrate leadership skills through participation in student organization activities, such as meetings, programs, and projects.

Demonstration should include contributory participation in activities such as meetings, fund- raising projects, school and community-service projects, and competitive events.

Identify Internet safety issues and procedures for complying with acceptable use standards.

Identification should include the following:

- The school division's acceptable use policy
- Laws and guidelines governing Internet usage, including those about copyright and file sharing
- Techniques that illegitimate parties use to solicit personal information
- Techniques that help protect a computer user against cyber predators
- Software applications and user techniques that help protect against security attacks
- Review the Virginia Department of Education Links to an external site.guidelines for instructional programs related to Internet safety.

Identify the types of work-based learning (WBL) opportunities.

Identification includes

- job shadowing
- mentorship
- externship
- school-based enterprise
- entrepreneurship
- internship
- service learning
- clinical experience
- cooperative education
- Youth Registered Apprenticeship
- Registered Apprenticeship
- Supervised Agricultural Experience.

Explore career opportunities related to the WBL experience.

Exploration includes

- listing possible careers related to this course
- describing each career
- determining the education and experience required
- exploring job opportunities, salaries, and benefits.

Explore the evolution of U.S. mental health care delivery.

Exploration should include

- major historical events
- major contributors to the evolution of modern mental health care
- current trends in mental health care.

Differentiate among the types of mental health facilities.

Differentiation should include types of

- acute care settings
- long-term care settings
- settings for transitioning to mainstream society
- outpatient facilities.

Describe the roles and responsibilities of each member of the mental healthcare team.

Description should include

- responsibilities of each member
- accepted local scopes of practice.

Identify roles and limitations of assistive personnel in the mental healthcare field.

Identification should include activities that the mental health technician (MHT) can do independently and where the MHT can provide support in assisting in the delivery of care.

Explain the qualifications needed for success as a mental healthcare professional.

Explanation should include

- educational requirements
- certification and licensing requirements
- personal qualities
- membership in professional organizations.

Differentiate between mental health and mental illness.

Differentiation should include

- description of optimal mental health
- description of general term *mental illness*.

Explain the development of personality.

Explanation should include the following psychological theories:

- Maslow's hierarchy of human needs
- Erikson's stages of psychosocial development
- Freud's theory of personality development
- Piaget's theory of cognitive development

Explain defense mechanisms.

Explanation should include

- definitions of common defense mechanisms and examples of each
- purpose of defense mechanism
- consequences of overuse.

Identify major types of anxiety disorders.

Identification should include

- descriptions of major anxiety disorders
- signs and symptoms.

Identify major types of affective disorders.

Identification should include

- descriptions of major affective disorders
- signs and symptoms.

Identify major types of psychotic disorders.

Identification should include

- descriptions of major psychotic disorders
- signs and symptoms.

Identify major types of personality disorders.

Identification should include

- descriptions of major personality disorders
- signs and symptoms.

Identify major types of substance abuse.

Identification should include

- descriptions of types of chemical and substance abuse
- signs and symptoms.

Identify eating disorders.

Identification should include

- anorexia nervosa and bulimia nervosa
- signs and symptoms.

Identify major types of developmental anomalies and disorders.

Identification should include

- names and descriptions of major anxiety disorders
- signs and symptoms.

Identify conditions associated with confusion and dementia.

Identification should include

- Alzheimer's disease and other causes of dementia
- signs and symptoms.

Explain institutional policies and procedures that impact the assistant in mental health care.

Explanation should include

- identification of policies and procedures common to many mental healthcare facilities that impact the MHT
- hierarchy of organizational responsibilities.

- Curriculum requirements can be found at the Virginia Department of Health Professions Board of Nursing (https://www.dhp.virginia.gov/media/dhpweb/docs/nursing/forms/education/NurseAide_Ed_Program_Curriculum.docLinks to an external site.).
- Requirements for certification by Virginia Board of Nursing. Regulations can be found at http://law.lis.virginia.gov/vacodefull/title54.1/chapter30/article4Links to an external site..

Explain legal policies affecting the MHT.

Explanation should include

- information about the licensed personnel that are responsible for actions of the MHT
- legal implications of failure to follow policies.

Identify methods of assisting patients in exercising and protecting their rights.

Identification should include

- ways the MHT can assist the patient in exercising the Patient's Bill of Rights
- importance of maintaining confidentiality
- difficulties encountered in protecting rights of the patient in need of mental healthcare services.

Explain the importance of hand hygiene and Standard Precautions.

Explanation should include

- procedure for effective hand hygiene
- implementation procedures for adhering to Standard Precautions
- use of personal protective equipment (PPE).

Describe the procedures for responding to medical emergencies and mental health crises in the mental healthcare setting.

Description should include

- differentiating between medical emergencies (e.g., seizures, heart attacks) and mental health crises (e.g., suicide ideation, hostile/aggressive behavior)
- activating the Emergency Medical System (EMS)
- surveying the scene for safety/hazards
- surveying the patient to determine need for care
- performing cardiopulmonary resuscitation (CPR), as needed.

Discuss procedures for maintaining the safety of the patient during outings, social events, and other activities.

Discussion should include

- responsibilities of the healthcare team during such activities
- description of appropriate activities
- response to a patient elopement.

Define various legal holds and when they might be used.

Definitions should include

- general laws regarding holds
- 48- or 72-hour hold
- 14-day hold
- temporary conservatorship.

Communicate effectively with patients, staff, and non-facility personnel.

Communication should include

- written
- verbal
- nonverbal
- electronic
- social media
- role expectations

- overcoming barriers.

Interpret the meaning of nonverbal behavior.

Interpretation should include

- body language meanings
- observing for consistency in a specific nonverbal behavior
- clarifying the meaning of nonverbal behavior.

Describe therapeutic interactions for the MHT.

Description should include

- one-to-one interactions
- assisting the patient in meeting goals and priorities
- strategies for therapeutic interactions. (e.g., paraphrasing and clarifying, listening skills, asking open-ended questions).

Facilitate interaction between patients and visitors.

Facilitation should include

- avoidance of making assumptions and having expectations
- communication of milieu rules and expectations
- provision of privacy according to care plan.

Identify methods of conflict resolution.

Identification should include

- recognizing signs of escalating behaviors
- steps in conflict resolution
- problem-solving techniques
- maintaining a positive attitude.

Explain specific techniques for managing stress.

Explanation should include

- impact of stress on the body
- techniques for managing stress
- healthy guidelines for reducing stress.

Explain the role of the MHT in the delivery of care and treatment of various types of mental illness.

Explanation should include general care provided by the MHT for in-patient and for out-patient care for

- psychotic disorders
- anxiety disorders
- affective disorders
- personality disorders
- eating disorders
- substance abuse
- developmental anomalies and disorders
- conditions associated with confusion and dementia.

Observe patient progress.

Observation should include reporting and

- physical illness
- neurological check
- vital signs
- response to medication
- normal vs. abnormal behaviors.

Provide physical and emotional care in accordance with the patient's individual treatment plan.

Provision should include

- monitoring activities of daily living (ADL) (e.g., changes in personal care)
- assisting with ADL
- facilitating interactions with other patients and staff
- facilitating interactions with visitors, including family members.

Prepare patient reports as required.

Preparation should include

- flowcharts and records as deemed appropriate by institutional policy
- shift reports
- admission, discharge, and transfer records.

Identify behavior that signals impending crisis, including suicidal and assaultive behavior.

Identification should include

- signals of impending crisis
- suicidal ideation
- violent behavior.

Explain the assault cycle.

Explanation should include

- stages of the assault cycle
- appropriate response for the MHT during each stage of the assault cycle.

Explain effective responses to assaultive behaviors.

Explanation should include use of seclusion and restraints and other effective responses to assaultive behavior.

Differentiate between seclusion and time-out.

Differentiation should include

- definition of *seclusion*
- definition of *time-out*
- behavior where seclusion and time-out might be used.

Assist with recreational activities.

Assistance should include activities that are structured and unstructured.

Escort patient to and from activities.

Escort should include following established procedures for transporting patient to and from social and recreational activities within and outside the facility.

Identify measures for responding when a patient is missing.

Identification should include

- facility and grounds checks
- response to elopement
- knowing emergency alerts/codes.

Explain how to assist a patient with money management.

Explanation should include

- counting money
- setting up a budget
- balancing a checkbook
- making a bank deposit and withdrawal.

Assist a patient with school activities, if a student.

Assistance should include

- reading skills
- writing skills
- mathematics skills
- physical activity
- selection of healthy lunches and snacks.

Assist in conducting rehabilitative group activities.

Assistance should include

- maintaining the safety of patients
- ensuring compliance to rules.

Describe the history and current state of the opioid crisis in the United States.

Description should include

- the relationship between opioid prescribing and illicit opioid use to overall opioid overdose deaths
- the prevalence of co-occurring mental health disorders
- the shift in attitudes in the 1990s toward pain management and use of opioids, including the role of pharmaceutical marketing
- the stigma associated with addiction and the changing view of addiction from a moral failing to a chronic, relapsing disease
- statistics, trends, and demographics surrounding the crisis
- population health and other public health aspects of the crisis, including its effects on family and neonates, as well as overall health costs.

Describe the history and current state of the opioid crisis in Virginia.

Description should include

- the relationship between opioid prescribing and illicit opioid use to overall opioid overdose deaths
- the prevalence of co-occurring mental health disorders
- the shift in attitudes in the 1990s toward pain management and use of opioids, including the role of pharmaceutical marketing
- the stigma associated with addiction and the changing view of addiction from a moral failing to a chronic, relapsing disease
- statistics, trends, and demographics surrounding the crisis
- population health and other public health aspects of the crisis, including its effects on family and neonates, as well as overall health costs
- the Virginia Department of Health's Declaration of a Public Health EmergencyLinks to an external site. on November 21, 2016
- proposed legislation to address the crisis in Virginia (i.e., House Bill 2161Links to an external site. and Senate Bill 1179Links to an external site., which require the secretary of health and human resources to convene a workgroup to establish educational guidelines for training healthcare providers in the safe prescribing and appropriate use of opioids)
- the development of curricula and educational standards regarding opioid addiction.

Define the pharmacological components and common uses of opioids.

Definition should include

- plant-based opioids (e.g., opium from poppy seeds)
- names of legal and illegal opioids
- heroinLinks to an external site.
- names of the most common opioids
- fentanylLinks to an external site.

- medical diagnoses and injuries associated with opioid prescriptions
- commonly used termsLinks to an external site..

Examine the science of addiction.

Examination should include

- biopsychosocial aspects of addiction
- the role of endorphins and dopamine
- the role of religious beliefs
- behavioral aspects of addiction
- life cycle of addiction
- misuse of opioids.

Explain prevention and early intervention strategies.

Explanation should include

- risk and protective factors in opioid addiction
- specific populations at risk of addiction
- motivational interviewing and other communication strategies
- naloxone co-prescribing
- roles of family and social institutions in prevention and early intervention.

Identify addiction and its behavioral elements, as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-5).

Identification should include

- DSM-5 Criteria for Substance Use Disorders
- American Society of Addiction Medicine (ASAM) Criteria (i.e., the Six Dimensions of Multidimensional Assessment)

- CONTINUUM, The ASAM Criteria Decision Engine
- clinical and behavioral aspects of addiction
- practice-appropriate screening tools, including co-morbidity screening.

Describe the treatment models of addiction therapy.

Description should include

- a recognition that addiction is a chronic disease
- evidence-based treatment models for addiction in general and opioid addiction in particular
- medication-assisted treatment
- the continuum of care in opioid addiction treatment
- how and when to make a referral for treatment
- the roles in an interdisciplinary addiction team
- the role of peers in the treatment of addiction
- the difference between drug culture and recovery culture
- the management of patients in recovery, including factors contributing to relapse.

Describe the medication management antidote used to prevent fatal opioid overdoses.

Description should include

- availability and use of naloxone
- naloxone training (e.g., REVIVE!Links to an external site.)
- naloxone training agencies
- monitoring of concurrent prescriptions.

Explain the science of physiological and mental pain.

Explanation should include

- definition of pain from the International Association for the Study of Pain (IASP)
- neurobiological basis of pain
- biopsychosocial model of pain

- types of pain (e.g., neuropathic)
- acute, sub-acute, and chronic pain, including pain generation
- spinal and brain modulation, behavioral adaptation and maladaptation, and the continuum from acute to chronic disabling pain
- the underlying science of pain relief.

Describe the diagnostic tools used in developing pain management plans.

Description should include

- pain-related health history and examination
- understanding the role of family in supporting individuals in need of pain management
- practice-appropriate screening tools that include aspects such as mood and function
- the use and limitations of pain scales
- differential diagnosis of pain and its placement on the pain continuum.

Describe pain treatment options available to various populations of patients.

Description should include

- special populations in pain management, such as palliative/end-of-life care patients, patients with cancer, pediatric patients, and geriatric populations
- non-pharmacologic treatment of pain, including active care and self-care, evidence- and non-evidence-based approaches, and multimodal pain management
- non-opioid pharmacologic management of pain
- the challenges in discussing the psychological aspects of pain and the role of the central nervous system
- adverse drug event prevention for all pain medications
- the roles in an interdisciplinary pain management team
- the significance of issues such as anxiety, depression, and sleep deprivation in pain management
- the placebo effect
- goals and expectations in the treatment of pain, based on diagnosis and pain continuum
- when to make a pain referral and to whom.

Describe the effects of opioid dependency on the human body systems.

Description should include the short- and long-term effects of opioids on the following:

- Nervous system
- Respiratory system
- Circulatory system
- Digestive system
- Skeletal system

Explain the mechanism and physical effects of opioids on the human body.

Explanation should include the following:

- Mechanism of action and metabolism of opioids
- Development of tolerance, dependence, and addiction
- Health consequences of drug misuse
    - HIV, hepatitis, and other infectious diseases
    - Cancer
    - Cardiovascular effects
    - Respiratory effects
    - Gastrointestinal effects
    - Musculoskeletal effects
    - Kidney damage
    - Liver damage
    - Neurological effects
    - Hormonal effects
    - Prenatal effects
    - Other health effects
    - Mental health effects
    - Death
- Withdrawal
    - Causes
    - Timeframe (i.e., peaks of withdrawal symptoms)
    - Physical signs (e.g., nausea, diarrhea, vomiting, cold flashes)

Explain the use of opioids in practice settings, the role of opioids in pain management, and risk factors associated with the use of the medication.

Explanation should include

- appropriate use of different opioids in various practice settings
- the interactions, risks, and intolerance of prescription opioids
- the role and effectiveness of opioids in acute, sub-acute, and chronic pain
- a reassessment of opioid use based on stage of pain
- contemporary treatment guidelines, best practices, health policies, and government regulations related to opioid use
- use of opioids in pain management of patients with substance abuse disorders, in recovery, and in palliative/end-of-life care.

Describe the withdrawal and tapering side effects of opioid use.

Description should include

- characteristics of acute and protracted withdrawal from opioid dependence or addiction
- tapering
- pain contracts or agreements.

Describe storage and disposal options for opioids.

Description should include

- medicine take-back options (e.g., National Drug Take Back DayLinks to an external site.)
- disposal in the household trash and flushing certain potentially dangerous medicines down the toilet.

Explain community resources for education about opioid use.

Explanation should include key components of and resources for patient education in the use of opioids, including

- risks
- benefits
- side effects
- tolerance
- signs of sedation or overdose
- naloxone, including its storage and disposal.

Describe key communication topics involving opioids for patients.

Description should include

- benefits and risks of opioids
- opioid risk screening (i.e., taking a social, medical, and financial history)
- risk mitigation (e.g., naloxone, safe storage, pain contracts)
- medication tapers and/or discontinuation of therapy.

Describe communication topics for caregivers and family members.

Description should include

- basic knowledge about opioids
- signs of addiction
- treatment options for addiction
- naloxone training for caregivers
- legal issues related to misuse.

← Back To Credentials

Mental Health Technician Certification (MHTC) Examination

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danielle@amcaexams.com

Website:
www.AMCAexams.com

Credential Contractor

Credential Contractor:
Same as source

Contact:
Same as source

Phone:
Same as source

Email:
Same as source

Test Administration

Test Site:

- School: Online
- Contractor's location
- Testing facility

Paper & Pencil

Yes

Can the instructor take this test?:

Yes

Number of Test Items:

100

Time Allowed (minutes):

120

Passing Score (percent):

70

Cost Per Test:

$119

Test Specifics:

https://www.amcaexams.com/exam-candidates/certification-exam/mental-health-technician-certification/

Additional information:

The active certification age requirement is being lowered to 17 as of January 1, 2023.

Possible Preparatory Courses

- **Medical Assistant I**
- **Medical Assistant II**
- **Mental Health Assisting Careers**
- **Patient Care Technician**

Accommodations: Students with Disabilities

Timing

Multiple test sessions:	No
Time of day	Yes
Order of tasks	No
Planned breaks during test	No
Is extended time an option for the test-taker?	No

Setting

Test location	Yes
Adaptive or special furniture	Yes
Special lighting	Yes

Presentation

Written directions accompanying oral directions	Yes
Specific verbal prompts	No
Visual aids	No
Amplification equipment	No
Headphones, earmuffs, or earplugs	No
Large-print test	Yes
Braille test	No
Read-aloud test	Yes
Audio test	No
Interpreting/transliterating testing directions	Yes
Interpreting/Transliterating the test	No

Response

Enlarged copy of the answer document	No
Communication board or choice cards	No
Examiner records responses	No
Brailler	No
Word processor or word processor with speech-to-text	No
Augmentative communication device	No
Word prediction software	No
Spelling aids	No
English dictionary	No
Dictation using a recording device	No
Dictation to a scribe	No

Read back student response	No
Calculator and arithmetic tools	No
Calculator with additional functions	No
Math aids	No
Dry erase board	No
Additional writing implements	No

Accommodations: English Learners

Audio test	No
Bilingual dictionary	No
Dictation to a scribe	No
English dictionary	No
Examiner records responses	No
Flexible Schedule	Yes
Is extended time an option for the test-taker?	No
Multiple test sessions	No
Read-aloud test	Yes
Test directions delivery	Yes
Visual aids	No

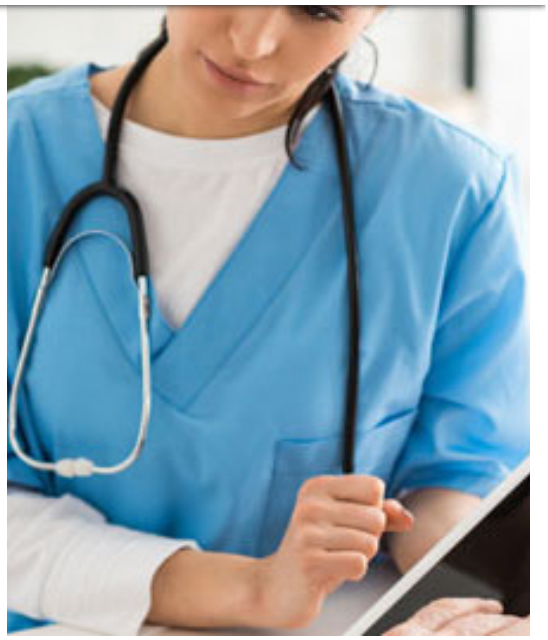
Mental Health Technician Certification (MHTC)

Role of a Mental Health Technician

A Mental Health Technician cares for individuals with mental or emotional conditions or disabilities, following the instructions of physicians or other health practitioners. A Mental Health Technician may monitor patients' physical and emotional well-being and report to medical staff, or participate in rehabilitation and treatment programs, help with personal hygiene, and administer oral or injectable medications.

<https://www.amcaexams.com>

- Modality available: Online, Paper/Pencil
- Live Remote Proctoring Available: Yes
- Cost: $119.00 (Study material included)
- **AMCA MHTC Exam Statistics < https://www.amcaexams.com/wp-content/uploads/2021/01/MHTC-Pass-Fail-through-2020.pdf>**



Competencies

- Process & Procedure (9%)
- Psychological Development (57%)
- Pharmacology (19%)
- Medical Office/Patient Care Skills (12%)
- Practice Settings (3%)

For more information, please view the **Certification Program Outline < https://www.amcaexams.com/wp-content/uploads/2020/01/MHTC-Certification-Program-Outline.pdf>** and **Exam Blueprint < https://www.amcaexams.com/wp-content/uploads/2020/01/MHTC-Exam-Blueprint.pdf>** .

Additional Information

If you would like to learn more about the role of a Mental Health Technician, please visit the **Bureau of Labor Statistics < https://www.bls.gov/oes/current/oes292053.htm>** or the **Occupational Information Network (O*NET) < https://www.onetonline.org/link/summary/29-2053.00>** .

< https://www.bls.gov/oes/current/oes292053.htm> **<**

https://www.onetonline.org/link/summary/29-2053.00>

State Guidelines

The laws and regulations pertaining to minimum requirements and the allied health industry vary by state. It is highly recommended that test candidates familiarize themselves with their particular states rules and regulations regarding certification requirements.

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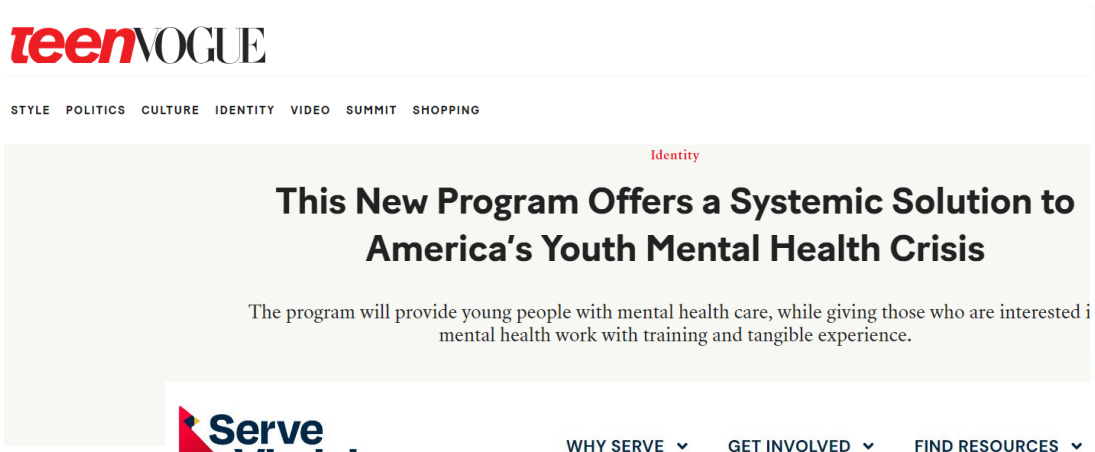
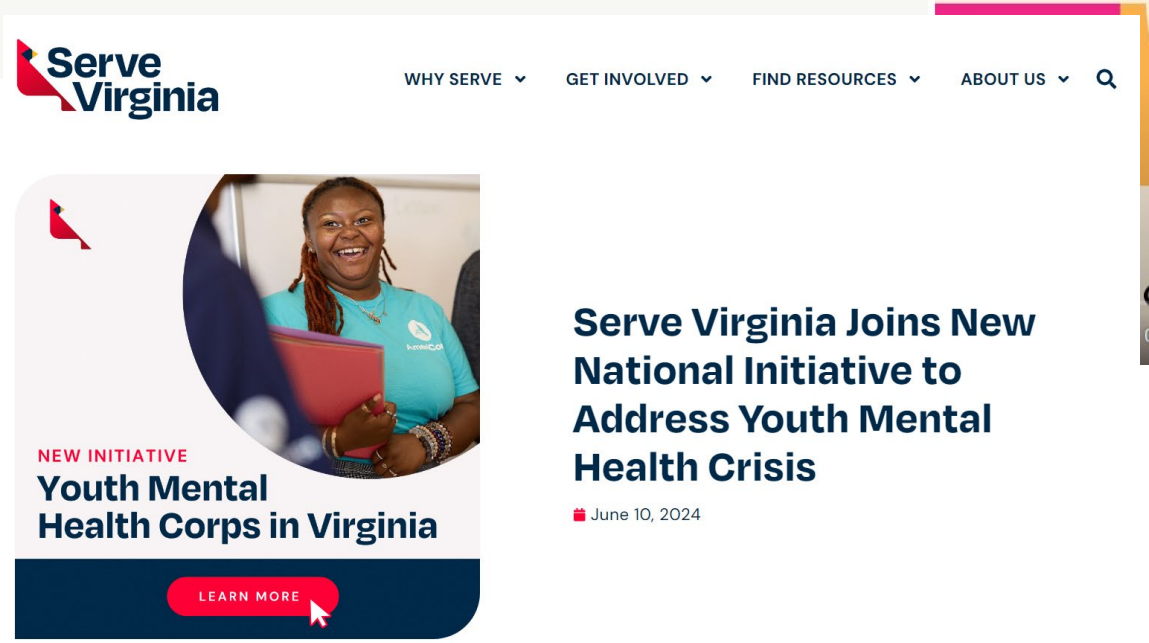
YOUTH MENTAL HEALTH CORPS

Serve Virginia

Youth Mental Health Corps

National Launch: Youth Mental Health Corps





Virginia Youth Mental Health Corps

- Develop opportunities and training for Youth Mental Health Corps members to engage in and become the next generation of leaders and practitioners in the mental and behavioral health fields

- Partner with state experts to design a national service (AmeriCorps) program model that will engage young Virginians aged 18-23 in service opportunities that will directly benefit youth and leverage existing resources to enhance resources to meet critical community needs.

- Articulate and develop future opportunities to incentivize national service, including service-to-credit pathways, higher education incentives, and networking opportunities with Schools and Employers of National Service to offer additional benefits for members that earn certifications through these pathways.

Leveraging National Service for Youth Mental Health

- Gathering stakeholders to identify ways to align YMHC efforts with other plans and initiatives

Updates:

- Engaging with the First Lady's Office *(YMHC plugged at her regional events, discussing opportunities for future events to promote the program)*
- Connecting with other community leaders to understand potential for alignment *(VFN, promoting within our partner network, launching the initiative at the Virginia Volunteerism Summit)*

YMHC Program Model

Pathways:

- Community Health Workers addressing mental health
- Peer Recovery Specialists
- School-based mental health roles

Updates:

- Exploring integrations with current AmeriCorps programs
- Initial conversations with state government colleagues and community partners like Communities in Schools, other interested nonprofits

Service to Career Pathways

- Assess current landscape of credentials with experts
- Determine training, credential, and credit opportunities for members

Updates:

- Discussing with programs piloting similar initiatives *(Germanna CC behavioral health tech pilot, VDOE Office of Behavioral Health and Wellness re workforce development)*
- Inventorying current opportunities *(existing credentials, potential to design new credential as a stair step for entry into the field)*

Youth Mental Health Corps in Virginia

Leveraging AmeriCorps resources to address critical community needs, the Youth Mental Health Corps in Virginia will serve thousands of youth and young adults who are affected by mental health challenges while also building "service-to-career" pathways for Virginians to gain experience in the behavioral health field.

The Youth Mental Health Corps is a unified, multi-sector partnership designed to address the youth mental health crisis and the mental health workforce shortage in the United States.

In Virginia, the Corps will use a near-peer model to engage young adults in local AmeriCorps service opportunities to support youth. Corps members will complete certifications and credentials—such as Peer Recovery Specialist or Community Health Worker—to prepare them for careers in behavioral healthcare, creating expanded mental health services for youth.

Planning for Greater Impact

Serve Virginia, with the support of a planning grant from the Schultz Family Foundation and Pinterest, invites leaders, stakeholders, and community members to join the process of bringing this idea to reality. As planning begins for the Youth Mental Health Corps in Virginia, we invite partners to help us consider ways to:

- Design service opportunities that benefit youth and leverage existing resources
- Consider organizations to host AmeriCorps members for these service opportunities
- Build and expand on partnerships across state, regional, and local agencies and organizations to support AmeriCorps members serving youth
- Explore formalizing a school-based stackable credential for members to earn during their service
- Assess additional resources programs will need to support youth and members

Youth Mental Health in Virginia

Mental health risks and substance use disorder affect young Virginians at higher rates than elsewhere:

48th

Virginia ranks 48th out of 51 for youth mental health risk factors, indicating heightened mental health risks & lower accessibility of care than in other states.

Mental Health America

Between 2015-2021, negative mental health markers steadily increased among Virginia youth, accompanied by decreases in positive mental health levels:

38% felt sad or hopeless for extended periods

1 in 5 seriously considered suicide

52% strongly agree or agree that they feel good about themselves

Virginia Department of Health, 2021 Youth Risk Behavior Survey

To learn more about ways to get involved in this initiative, please contact Serve Virginia Statewide Engagement Officer Analise Gammel at analise.gammel@dss.virginia.gov.

Youth Mental Health Corps in Virginia

National Service Infrastructure for Youth Mental Health Corps in Virginia

As the state service commission, Serve Virginia convenes partners in the Governor's administration, state agencies, nonprofit networks, and other stakeholder groups to promote the role of national and community service to help meet critical community needs through strategies, like the Youth Mental Health Corps, that leverage state and federal resources for a maximized impact on the overall wellbeing of Virginians.

Currently, Serve Virginia supports over 295 AmeriCorps members that serve more than 11,000 youth and young adults in schools and through afterschool settings to promote academic achievement, support post-secondary success, and offer opportunities for social emotional learning. In addition, more than 30 AmeriCorps members currently provide resources and support to those impacted by substance use disorder and other chronic health challenges as peer recovery specialists and community health workers.

RIGHT HELP.
RIGHT NOW.
Transforming Behavioral Health Care for Virginians

Mobilized by the current crisis in youth mental health, many leaders and stakeholders have mobilized to create solutions. In recognition of the rising mental and behavioral health needs, Governor Youngkin created the *Right Help, Right Now* plan in 2022 to reform the behavioral health system. The plan includes a youth mental health strategy, with proposed solutions such as expanding school-based mental health services for youth while and prioritizing investments to strengthen the behavioral health profession. In addition to the Right Help, Right Now plan, youth mental health is a priority area across the strategic plans of many state agencies, including VDSS, DBHDS, and VDOE, to name a few.

As an AmeriCorps program, the Youth Mental Health Corps in Virginia will engage new subgrantees and host sites for a minimum of **75 AmeriCorps members** who will:

- Receive **high-quality training** from a network of state and local organizations
- Learn through **hands-on experience** with youth and young adults ages 13-18
- Engage in a new **school-based stackable certification pathway**
- **Serve youth** in schools, out-of-school time programs, and community-based youth organizations in communities with limited access to mental health services

Serve Virginia will collaborate with stakeholders to identify primary organizations to extend the model in Virginia's communities, and establish service-to-career pathways to help strengthen the talent pipeline for behavioral health.

AmeriCorps members serving in the Youth Mental Health Corps will engage in professional development, including trainings like Youth Mental Health First Aid, as well as explore credentials and certifications related to their service. Members will enhance their current experience working with youth by participating in these trainings and will be prepared to translate their service after their term is over to continue to strengthen outcomes for Virginia's youth.

Youth Mental Health Corps member benefits will include living stipends, education scholarships, and networking with other AmeriCorps members serving youth through existing AmeriCorps State programs. Other supports for members will be identified in the planning process.

Program Summary:
Serve Virginia will design a statewide Youth Mental Health Corps program to serve thousands of youth and young adults affected by mental health challenges. The new program will utilize a near-peer model to engage young adults in national service opportunities to deliver expanded and enhanced services to youth, resulting in expanded mental health services for youth, workforce development opportunities for young adults, and a stronger Commonwealth for all Virginians. Serve Virginia will also establish "service-to-career" pathways for national service programs and members, increasing the number of individuals with voluntary certifications who choose to work in the behavioral health field.

Over the planning period, May-December 2024, Serve Virginia will:

- Partner with state experts to design a national service (AmeriCorps) program model that will engage young Virginians aged 18-23 in service opportunities that will directly benefit youth and leverage existing resources to enhance resources to meet critical community needs.

- Survey potential partners and members about resource and support needs to make this program successful and explore options for engaging host sites.

- Identify leaders and key stakeholders to ensure sustainability and investment in the success of the program moving forward.

- Develop opportunities and training for Youth Mental Health Corps members to engage in and become the next generation of leaders and practitioners in the mental and behavioral health fieldsm

- Articulate and develop future opportunities to incentivize national service, including service-to-credit pathways, higher education incentives, and networking opportunities with Schools and Employers of National Service to offer additional benefits for members that earn certifications through these pathways.

ABOUT SERVE VIRGINIA
Serve Virginia aspires to build a culture of service and volunteerism in all corners of the Commonwealth by inspiring individuals and organizations to engage, connecting them with the resources they need to make a difference and celebrating the tremendous impacts we make together. As the state service commission for the Commonwealth of Virginia, Serve Virginia acts as a catalyst for service and volunteerism, cultivating sustainable infrastructure and resources to foster and support community engagement. In addition to overseeing the annual grant competition that awards funding to AmeriCorps State and other community service programs, Serve Virginia actively works to determine community needs, set policy and program priorities, provide training and assistance, support national days of service and actively recognize individuals and organizations for their contributions within their communities.

YOUTH MENTAL HEALTH IN VIRGINIA

The statistics are clear: mental health and substance use disorder affects young Virginians at higher rates than peers in other states, as the prevalence of youth experiencing mental illness rises and the availability of licensed providers fails to meet the demand. According to Mental Health America (MHA), Virginia ranks 48th out of 51 for youth mental health risk factors, indicating that young Virginians are more likely to experience mental illness and have lower rates of access to care than youth in other states. The 2021 Youth Risk Behavior Survey, collected and analyzed by the Virginia Department of Health, demonstrates an increase in the percentage of students that report feeling sad or hopeless and have seriously considered attempting suicide. MHA reported that 60% of youth experiencing a major depressive episode in Virginia do not receive treatment and are at risk for poorer outcomes than peers that receive consistent treatment. The impact of worsening mental health is magnified by a shortage of mental health providers available across the state.

This shortage affects families that are often also facing geographic or transportation barriers to accessing care, and may have limited access to insurance that covers mental and emotional problems. According to the State Office on Rural Health, 88% of Virginia communities are rural and often experience inadequate health services, especially readily available mental health care. Recent policy briefs by the Virginia State Office on Rural Health, a department of the Virginia Department of Health, cite startling statistics about the lack of access to care and disparately high rates of suicide and overdose experienced by rural residents. In gathering community feedback for the 2022-2026 Virginia Rural Health Plan, the State Office on Rural Health found that access to care was unanimously identified as an issue or barrier that community members faced, inhibiting their ability to achieve optimal health and wellbeing. Across Virginia, there are 82 jurisdictions that have communities designated as mental “Health Professional Shortage Areas”. It is estimated that an additional 83 FTE psychiatrists are needed to address current shortages, without accounting for expected increases in needs for services.

Addressing this need is a high priority for many across the state. Stakeholders are starting to come together from every corner of Virginia to find ways to leverage resources to support improved outcomes for all youth by investing and transforming the system of care in the Commonwealth. Most notably, the Governor of Virginia created a three-year “Right Help Right Now” plan in 2023 to reform the behavioral health system and support individuals in crisis by the end of 2025. As part of achieving the plan’s goals of supporting Virginians before, during, and after a behavioral health crisis, the administration launched a “Youth Mental Health Strategy” that includes expanding eligibility for school-based mental health services and increasing access to resources, including services like tele-behavioral health for public school students. The plan also includes prioritizing investments into a “best in class behavioral health workforce” and investing in strategies to strengthen the profession. In addition to “Right Help Right Now” efforts, improving youth mental health is a priority of the strategic plans of many state agencies, including the Virginia Department of Social Services, Virginia Department of Behavioral Health and Developmental Services, and the Virginia Department of Education.

Serve Virginia, the state service commission for the Commonwealth, sits at the nexus of many public and private partnerships and is uniquely positioned to convene and catalyze partners from state agencies and local, regional, and statewide networks to cultivate sustainable infrastructure to meet community needs. Serve Virginia works alongside partners in the Governor's administration, First Lady of Virginia's Office, state agencies, nonprofit networks, and other stakeholders to promote the role of national and community service to help meet critical community needs, and leverage state and federal resources for a maximized impact on the overall wellbeing of Virginians.

The commission also currently supports national service strategies in partnership with nonprofit organizations, institutions of higher education, and local government that support Virginians through education and promoting healthy futures. Currently, over 295 AmeriCorps members serve more than 11,000 youth and young adults in schools and through afterschool settings to promote academic achievement, support post-secondary success, and offer opportunities for social emotional learning. In addition, more than 30 AmeriCorps members currently provide resources and support to those impacted by substance use disorder and other chronic health challenges as peer recovery specialists and community health workers.

Guided by the 2022-2024 State Service Plan, Serve Virginia is already exploring ways to leverage incentives for promoting national service opportunities and meeting critical community needs with an equity lens, as well as strategies directly related to exercising the commission's role and positionality as a convener and catalyst to create more strategic and effective partnerships. Cultivating stronger service-to-career pathways furthers progress in meeting community needs now while building capacity to strengthen the sector overall.

YOUTH MENTAL HEALTH CORPS

To extend the reach and impact of national service, Serve Virginia plans to develop a "Youth Mental Health Corps" program opportunity to engage new subgrantees and new host sites to reach more students with specific behavioral and mental health supports provided by future AmeriCorps members. This program will be designed to engage 75 members that will serve across the state providing mental health resources and services to students. During their term of service, Youth Mental Health Corps members will engage in a new school-based stackable certification pathway, and serve youth in schools, out-of-school time programs, and community-based youth organizations in communities with limited access to mental health services. Serve Virginia will collaborate with leaders in the sector to identify primary organizations to extend the model in Virginia's communities, administering operational funds and reducing the burden on host sites. This intermediary model will align with the program design used statewide and increase the places and spaces for members to serve, such as smaller, rural communities, without requiring the direct ability to manage federal funds.

Youth Mental Health Corps members will receive high quality training from a network of state and local agencies and organizations, learn through hands-on experience with youth and young adults ages 13-18, and benefit from networking with other AmeriCorps members serving youth through other AmeriCorps State programs. Other supports for members will be identified through the planning process.

PREPARING FOR SUCCESS

There is momentum across the state to address the youth mental health crisis, which both serves to support this endeavor and creates a greater need for a partner like Serve Virginia to help align individual projects and programs to create greater impact. As state agencies, local governments, and community partners employ existing resources to address the issue, there is a great opportunity to leverage this moment in time and these available assets to make a greater impact on youth and families through coordinated efforts. To accomplish this, there must be increased capacity to effectively facilitate among partners and create a strong and responsive state foundation to meet community needs.

In addition to support from state agencies and the administration, Serve Virginia is also directly connected with advocates and experts to inform the work and identify opportunities to make the most progress over the grant period. Serve Virginia facilitates the Virginia Volunteer Center Network, brings together over 150 unique organizations and 300 individuals from across the state for training and technical assistance related to service and volunteerism, and manages an AmeriCorps State portfolio of over 15 programs to distribute over $8 million. Through capacity building and direct service support, Serve Virginia partners with a wide array of partners to most effectively leverage service and volunteerism to meet critical needs.

Serve Virginia supports the Virginia Governor's Advisory Board on Service and Volunteerism, the national service commissioners for the Commonwealth. Members include the Assistant State Superintendent of Public Instruction, who will work alongside the director of the recently developed Office on Behavioral Health and Wellness at the Virginia Department of Education. Also, the commission is housed in the Department of Social Services alongside the team that focuses on Substance Use Disorder and has partnered closely with the Virginia Department of Behavioral Health and Developmental Services on establishing the Peer Recovery Specialist certification. Serve Virginia has supported this team on multiple statewide Health Equity initiatives with VISTA support, most directly through placing three AmeriCorps VISTA members from the project sponsored by Serve Virginia to create a statewide action plan that supports at-risk youth who have lost their parents to substance use and overdose. These stakeholders, as well as many other partners across the state, will help Serve Virginia leverage the current environment to make meaningful progress through this planning grant.

TO LEARN MORE, PLEASE VISIT SERVEVIRGINIA.ORG/MENTAL-HEALTH

MILITARY TRAINING

CRISIS INTERVENTION TEAM PROGRAMS (CIT)

Essential Elements for the Commonwealth of Virginia's

Crisis Intervention Team Programs (CIT)

CIT Program Development Guidance
Department of Criminal Justice Services
and Department of Behavioral Health and Developmental Services

Developed in Collaboration with the Virginia CIT Coalition Leadership Committee
and Virginia CIT Stakeholders
September 8, 2011 (Updated October 1, 2014)

Introduction: The CIT Concept

Crisis Intervention Teams (CIT) are programs that bring together local stakeholders, including law enforcement officers, emergency dispatchers, mental health treatment providers, consumers of mental health services and others (such as hospitals, emergency medical care facilities, non-law enforcement first responders, and family advocates). The goal is to improve multi-systems' response to persons experiencing behavioral health crises who come into contact with law enforcement first responders. Such individuals may come to the attention of law enforcement and other first responders or corrections and jail personnel due to exhibiting symptoms or behaviors that are misinterpreted as criminal in nature, inappropriate, dangerous or violent. Additionally, law enforcement officers routinely interact with individuals with behavioral health disorders as a result of the statutory structure of Virginia's civil commitment process. In many of these situations, it is necessary to help such persons access mental health treatment, or place such persons in custody and seek either mental health treatment referral or incarceration for criminal acts.

Effective CIT programs enhance community collaboration, develop a stable infrastructure and provide outstanding training to improve criminal justice and mental health system response to individuals with mental health issues. The CIT model was originally developed by the Memphis, Tennessee Police Department, and has subsequently spread throughout the country. The impetus for its development was an incident in which a man with mental illness was fatally shot by police during a confrontation. The incident created a public uproar and the community began to examine its procedures in such cases, seeking alternative means of addressing these situations. Eventually, through the development of a widely representative stakeholders' task force, Memphis created a program to provide specialized training for a select cadre of patrol officers, as well as training all police dispatchers, and established a therapeutic treatment site as an alternative to incarceration. The 40-hour training enabled officers to more effectively communicate with and understand the particular needs of individuals with mental illness. In so doing, officers were able to reduce the potential for misunderstanding and enhance their ability to de-escalate situations involving persons with mental illness. Additionally, with education about treatment options and access to a therapeutic assessment site, officers were able to connect individuals with needed treatment, in lieu of incarceration, consistent with the needs of public safety and addressing the underlying issue of mental illness.

Development of CIT in Virginia

In the past 25 years, this approach has spread internationally. The concept was first developed in Virginia in 2001 by what became the New River Valley Crisis Intervention Team (NRVCIT). This program drew together 14 local law enforcement agencies in five localities to create the nation's first multi-jurisdictional, rural adaptation of the Memphis CIT model. Police departments, sheriffs' offices, and two local campus police departments worked together with the local Community Services Board (New River Valley Community Services), the Mental Health Association of the New River Valley, the New River Valley Medical Center and the local chapter of the National Alliance on Mental Illness to establish their

CIT program. The initiative was developed using federal grant funds from the Substance Abuse and Mental Health Services Administration (SAMSHA) over a three-year period.

In 2007, NRVCIT received a line item allocation from the Virginia General Assembly through the Department of Criminal Justice Services to focus on statewide expansion of CIT initiatives. NRVCIT utilized the funds to develop a Train the Trainer program for Virginia, as well as provide technical assistance and provide initial 40 hour training for representatives of communities interested in starting a CIT Program. NRVCIT worked predominantly with the Thomas Jefferson Area (TJACIT) and Mt. Rogers CIT programs, leveraging the impact of those programs' Byrne Memorial Grant fund allocations for CIT, administered through DCJS. Faculty from the NRVCIT and TJACIT programs then assisted with the development of the Hampton-Newport News CIT (HNNCIT) program. These three programs (NRVCIT, TJACIT, and HNNCIT) worked together, utilizing this model, to continue Virginia's statewide CIT expansion initiative. There are currently a number of state recognized CIT program initiatives underway in Virginia. Together, they make up the ever growing Virginia CIT Coalition, under the leadership of the three initial programs, representatives from the Virginia Beach and Henrico County programs, and staff from the Department of Criminal Justice Services (DCJS) and the Department of Behavioral Health and Developmental Services (DBHDS).

Legislative Initiative for CIT in Virginia

The 2009 Virginia General Assembly, through Senate Bill 1294, amended Sections 9.1-102, 187, 188, 189 and 190 of the *Code of Virginia* to direct the Department of Criminal Justice Services in conjunction with the Department of Behavioral Health and Developmental Services to "…support the establishment of crisis intervention team programs in areas throughout the Commonwealth." It also established numerous criteria for the departments to use in implementing its provisions, and directed that a status report be submitted November 2009 to the Joint Commission on Health Care, and further, that a report assessing the effectiveness of Crisis Intervention Team programs be submitted to the Joint Commission on Health Care in November 2009, 2010, and 2011. The new and amended code sections are:

§9.1-102. Powers and Duties of the Board and the Department of Criminal Justice Services

> The Department, under the direction of the Board, which shall be the policy-making body for carrying out the duties and powers hereunder, shall have the power and duty to: … 51. Assess and report, in accordance with §9.1-190, the crisis intervention team programs established pursuant to §9.1-187.

§ 9.1-187. Establishment of crisis intervention team programs

> A. By January 1, 2010, the Department of Criminal Justice Services and the Department of Behavioral Health and Developmental Services, utilizing such federal or state funding as may be available for this purpose, shall support the development and establishment of crisis intervention team programs in areas throughout the Commonwealth. Areas may be composed

of any combination of one or more counties, cities, towns, or colleges or universities contained therein that may have law-enforcement officers as defined in § 9.1-101, or campus police officers appointed pursuant to the provisions of Chapter 17 (§ 23-232 et seq.) of Title 23. The crisis intervention teams shall assist law-enforcement officers in responding to crisis situations involving persons with mental illness, substance abuse problems, or both. The goals of the crisis intervention team programs shall be:

1. Providing immediate response by specially trained law-enforcement officers;
2. Reducing the amount of time officers spend out of service awaiting assessment and disposition;
3. Affording persons with mental illness, substance abuse problems, or both, a sense of dignity in crisis situations;
4. Reducing the likelihood of physical confrontation;
5. Decreasing arrests and use of force;
6. Identifying underserved populations with mental illness, substance abuse problems, or both, and linking them to appropriate care;
7. Providing support and assistance for mental health treatment professionals;
8. Decreasing the use of arrest and detention of persons experiencing mental health and/or substance abuse crises by providing better access to timely treatment;
9. Providing a therapeutic location or protocol for officers to bring individuals in crisis for assessment that is not a law-enforcement or jail facility;
10. Increasing public recognition and appreciation for the mental health needs of a community;
11. Decreasing injuries to law-enforcement officers during crisis events;
12. Reducing inappropriate arrests of individuals with mental illness in crisis situations;
13. Decreasing the need for mental health treatment in jail.

B. The Department, in collaboration with the Department of Behavioral Health and Developmental Services, shall establish criteria for the development of crisis intervention teams that shall include assessment of the effectiveness of the area's plan for community involvement, training, and therapeutic response alternatives and a determination of whether law-enforcement officers have effective agreements with mental health care providers and all other community stakeholders.

C. By November 1, 2009, the Department, and the Department of Behavioral Health and Developmental Services, shall submit to the Joint Commission on Health Care a report outlining the status of the crisis intervention team programs, including copies of any requests for proposals and the criteria developed for such areas.

§ 9.1-188. Crisis intervention team training

The Department, in consultation with the Department of Behavioral Health and Developmental Services and law-enforcement and mental health stakeholders, shall develop a training program

for all persons involved in the crisis intervention team programs, and all team members shall receive this training. The curriculum shall be approved for Department-certified in-service training credits for law-enforcement officers from each crisis intervention team and shall include four hours of mandatory training in legal issues.

§ 9.1-189. Crisis intervention team protocol

Each crisis intervention team shall develop a protocol that permits law-enforcement officers to release a person with mental illness, substance abuse problems, or both, whom they encounter in crisis situations from their custody when the crisis intervention team has determined the person is sufficiently stable and to refer him for emergency treatment services.

§ 9.1-190. Crisis intervention team program assessment

The Department, and the Department of Behavioral Health and Developmental Services, shall assess and report on the impact and effectiveness of the crisis intervention team programs in meeting the program goals. The assessment shall include, but not be limited to, consideration of the number of incidents, injuries to the parties involved, successes and problems encountered, the overall operation of the crisis intervention team programs, and recommendations for improvement of the program. The Department, and the Department of Behavioral Health and Developmental Services, shall submit a report to the Joint Commission on Health Care by November 15, 2009, 2010, and 2011.

Program Description for CIT in Virginia

At its core, CIT provides 1) law enforcement-based crisis intervention training for assisting individuals with a mental illness; 2) a forum to promote effective problem solving regarding interaction between the criminal justice and mental health care system; and 3) improved community-based solutions to enhance access to services for individuals with a mental illness. Successful CIT programs improve officer and consumer safety, and appropriately redirect individuals with mental illness from the criminal justice system to the health care system.

Essential Elements for Virginia's CIT Programs

DCJS and DBHDS require that CIT programs adhere to a limited number of uniform requirements, referred to as the "Essential Elements of CIT", to assure that the basic structure of all CIT programs is consistent throughout the state. To support the growth and development in all aspects of CIT programs as well as fully and effectively integrate CIT's statutory and policy goals in CIT programs throughout the Commonwealth, the departments created the Virginia CIT Coalition (VACIT). Membership in VACIT is encouraged for all programs. DBHDS, DCJS and the VACIT leadership and coalition members worked together to establish these essential elements for the development and operation of CIT programs:

- Community stakeholder collaboration and oversight;
- CIT Coordinator;
- 40 hour DCJS-certified CIT core training for law enforcement personnel;
- Train-the-trainer classes for CIT program sustainability;
- Dispatcher training;
- Policies and procedures;
- Therapeutic assessment location (not a law enforcement or jail facility), or procedures, to streamline access to services in lieu of incarceration (when appropriate); and
- Collection of data to monitor statutory outcome measures.

These elements are central to the success of CIT programs and the achievement of CIT program goals. What follows are the minimally required essential elements established for Virginia CIT programs and a brief description of the necessary components of each element.

1. Community Stakeholder Collaboration and Oversight

Central to the formation and ongoing success of Crisis Intervention Team programs is the creation of fully integrated, collaborative community partnerships. At a minimum these partnerships need to include representatives from:

- *Law Enforcement* – local police departments, sheriffs' offices, campus police departments, other relevant law enforcement agencies and other first responders.
- *Mental Health* – local community services boards, educators and private providers within the mental health treatment and provider community.
- *Community* – dynamic community involvement should reflect the composition of the local community, with particular emphasis on the inclusion of persons with mental illness. Historically, consumer advocacy organizations (National Alliance on Mental Illness or Mental Health America) are highly involved in the development of CIT programs. However, some communities within the Commonwealth do not have operating consumer advocacy organizations. Therefore, at a minimum, all CIT programs should have a strategy for consumer and family member involvement, and, where possible, should also include consumer advocacy organizations. Involvement of all other appropriate community partners is highly suggested, to include but not limited to: judges, magistrates, special justices, attorneys, emergency department directors, psychiatric hospitals, local human rights organizations, etc.

A community oversight committee of critical community partners and stakeholders is essential in order to guide the initial planning and implementation of a CIT program and provide ongoing oversight of the program's continued operation and sustainability, including critical incident review, funding and community outreach and education. These committees have taken a variety of names across the Commonwealth, including oversight committee, advisory committee, task force, etc.

2. CIT Coordinator

Each CIT program requires a designated individual or individuals to serve as CIT Coordinator(s) in order to manage the various training and program elements, including day-to-day logistics of inter-departmental communication, data collection and management, scheduling trainings and working with the community oversight committee.

The existence of both the CIT Coordinator(s) and a community task force are critical in achieving program goals and objectives. CIT programs bring together professionals from mental health treatment, from criminal justice and public safety, and from consumers and community members in a new and unique partnership. This requires close coordination, collaboration, problem-solving, and negotiation. Without at least one person tasked with facilitating this process and a local task force of the key stakeholders to work out details, reach consensus on local policies and procedures and provide ongoing program review and adjustments, CIT programs are significantly challenged.

The ideal candidate for the position of CIT Coordinator will possess a basic understanding of the issues confronting law enforcement and emergency services and should have pre-existing relationships and connections to the law enforcement and mental health communities. Refer to Appendix A for a job description for the CIT Coordinator.

3. 40 Hour CIT Core Training for Law Enforcement Personnel

Community stakeholders and law enforcement have debated what makes a CIT Program a “true” Crisis Intervention Team Program. Different regions have different issues which require flexibility to develop a diverse and regionally effective version of the CIT program model. Just as Virginia has adapted the Memphis Model to its laws and needs, so, too, have rural and urban localities made additional adaptations to suit their needs. However, there are central tenets of the training which must be maintained.

The following are absolute minimum standards, although programs are strongly encouraged to exceed and expand these to enhance the scope or depth of their individual programs.

a. 40 Consecutive Hours

A basic requirement of the CIT Core training program is 40 consecutive hours of training delivered over five days. Breaking the training up into blocks with a lapse of time in between interferes with the CIT training’s goals, namely to build program cohesion, instill in officers a deeper awareness of the needs of individuals with mental illness and the capacity to utilize and integrate their newly developed skills.

b. Maximum Class of 30

Class size will vary from locality to locality in regards to the maximum number of students that can be provided with effective instruction and sufficient opportunity to engage in role play

exercises. Experience across Virginia demonstrates that a class size of 20-25 is ideal, and minimal standards require that no class shall exceed 30 students. Programs should always keep in mind that a larger class size can constrain students obtaining the maximum functionality of role play exercises and participation in discussion.

c. Didactic Component

Didactic CIT training must include modules on Basic Mental Heath Diagnoses or Clinical States, Basics of Substance Abuse and the Medical Model, Basics of Intellectual and Developmental Disabilities, Psychiatric Medications, Verbal De-escalation and/or Crisis Intervention Skills, Suicidality, Legal Issues (e.g., liability, CIT Code provisions, etc.) and Civil Commitment, Overview of Special Populations, and Cultural Diversity. Other topics such as Adolescent Issues, Veterans Issues, and Geriatric Issues, or other region specific or topical areas should be added by programs as needed, and as long as the basic core curriculum is provided. Required module length may vary from program to program with the exception that Legal Issues and Civil Commitment must be four hours and Cultural Diversity must be two hours , based on legislative or departmental requirements and in order to provide the full 2 years of credit for DCJS officer training requirement.

d. Experiential Component

An important goal of CIT training is to increase sensitivity and awareness through direct experience. The Memphis Model utilizes the second day of the 40 hour training for site visits and other interaction with consumers to provide a personalized perspective not otherwise achievable. Virginia will continue to utilize this approach. Training modules must include consumer and family presentations and virtual experience programs such as Hearing Disturbing Voices by Pat Deegan (preferred). This portion of the curriculum and its timing greatly enhance the overall experience of the 40-hour training.

e. Practical Component

Role Play within CIT seeks to build upon the foundation of didactic and experiential information provided earlier in the training week. Role play within CIT will in all cases begin with an overview of 'The Four Coaching Plays' of CIT. These are the essential tools for developing de-escalation and relationship building skills. Role play exercises are to be integrated into the training over each of the program's final three days with each day increasing in intensity and difficulty. This ensures practical knowledge and skill building lessons are turned into useable abilities for the CIT student. The role plays are to be utilized both as a practical experience for the officers involved and as a learning opportunity for the rest of the class by their observation and feedback in each of the exercises. Additionally, each role play must utilize a specially trained feedback panel. The feedback panel must include at least one law enforcement officer and one mental health representative and may also include consumer representatives when feasible to provide appropriate feedback and foster growth of the officer's confidence and abilities. Role players should be law enforcement officers and CIT program stakeholders using

scenarios that will be created from real life experiences and NOT utilize students or professional actors.

Prior to role play exercises, students will be asked to secure any weapons that may be in their possession. The use of weapons, including inert weapons, by students shall not be permitted during role play exercises. Also, students are not permitted to go “hands on” (use physical force/defensive tactics) during role play exercises. Should a student feel that the circumstances of the exercise require them to use force, they will be instructed to raise their hand and indicate how they would proceed if the scenario were real. There are plenty of valid arguments for the use of weapons and defensive tactics during role play exercises. However, the focus of CIT training and role play exercises is for law enforcement personnel to develop and utilize communication skills. Furthermore, the use of force and weapons in the classroom pose potential safety concerns.

f. Presentation Order

As noted above, the flow and order of the training units is significant. Therefore, all 40 hour core CIT trainings will follow these guidelines for the placement and timing of specific units:

Monday

- Introduction to CIT
- Basic Mental Health Diagnoses (Clinical States)
- Hearing Voices Practical Exercise

Tuesday

- Site Visits

Wednesday

- Basic Crisis Intervention Skills & The Four Coaching Plays (must take place immediately before Basic Role Play Exercises)
- Basic Role Play Exercises

Thursday

- Intermediate Role Play Exercises

Friday

- Advanced Role Play Exercises

g. Training Attire

Law enforcement personnel are strongly encouraged to wear civilian clothes throughout the duration of the training. However, it is understood that officers may have to be uniformed on occasion because of a court appearance or other obligation. On the day that site visits are conducted, civilian clothing is mandatory.

4. CIT Train the Trainer Training (TTT)

Just as Crisis Intervention Team Core Training has basic elements, so does CIT Train the Trainer Training (TTT). TTT develops the local 40 hour training faculty to enhance their capacity and expertise to provide the 40 hour CIT training consistently for their team. CIT TTT ensures uniformity among trainers involved with creating and participating in CIT Role Play, developing effective presentation and proficient feedback skills for students. Subject Matter Experts instructing clinically-focused didactic modules are not required to take a TTT course as there is a line between didactic classroom instruction and the practical methodology of CIT skill building. However, mental health instructors who are involved in the 40 hour role play training component are to participate in the TTT course. Officer instructors need special attention to ensure they understand and emulate the proper CIT role play model. Mental Health instructors engaging in role play likewise require special attention to ensure that their message carries the proper tone, being neither too clinical nor too simplistic, for the trainees. It is important to note that while a student taking the CIT TTT class will be adequately prepared to assist with a 40 hour Core CIT Training; it will require ongoing observation, assistance and tutoring with TTT veteran instructors before that student is a veteran instructor and sufficiently prepared to teach a TTT class.

The CIT TTT is a 20 consecutive hour program, provided over two and a half days, for no more than 18 students at a time. Individualized attention is critical, hence the required smaller class size. The first day consists of classroom instruction on CIT fundamentals of theory, public presentation, and methodology required to instruct CIT Core students. Elements that are required include CIT theory from a process perspective, public speaking, effective role play, feedback skills and 'The Four Coaching Plays.'

The second and third day will focus on CIT role play development and implementation. Students will develop, plan and perform scenarios developed under instructor supervision. Student developed scenarios will gradually increase in complexity to better prepare the class to teaching in a full CIT Core class. Instructors will act as mock students to ensure that participants are exposed to a wide variety of potential situations and problems.

Prerequisite for the TTT is successful completion of the CIT 40 hour core training to ensure that officers have the message and foundational skills that the TTT will further develop and build upon. It is strongly recommended that students have a solid experience base after becoming a CIT Officer before attending the CIT TTT. Six months as a CIT Officer is generally felt to be adequate to put into practice in the field the foundational training.

5. CIT Dispatcher Training

Dispatcher training is an important piece of CIT that ensures trained officers on duty are properly utilized in the community. Dispatcher training in Virginia is minimally a four hour course whose key elements include basic CIT concepts, Clinical States, Experiential Exercises and Role Play. Role plays for dispatchers must provide for no visual contact between dispatcher trainee and subject. Some CIT programs in Virginia offer CIT Dispatcher training as six, eight or sixteen hours. A longer more intensive training program is advantageous and more desirable. It should be noted that CIT Dispatcher training of four hours is viewed as an absolute minimum that may be built upon. Four hours to instruct 10 students is adequate where four hours to instruct 20 is not. A larger class will require more time and coordination of these efforts should be made accordingly.

6. Policies and Procedures

Policies and procedures are a necessary component of CIT. They provide a set of local guidelines that direct the actions of law enforcement, dispatch and mental health providers. Due to the large number of stakeholders in CIT, it is important that these guidelines be designed by all agencies and individuals affected.

Each CIT program or law enforcement agency will develop their own policies regarding the size of their CIT-trained patrol division. The number of trained CIT officers available to each shift must be adequate to meet the crisis response needs of the community. Experience suggests that a successful CIT program will, at a minimum, have trained 20—25% of the agency's patrol division, which will likely result in 24/7 CIT officer coverage. There are differences that exist between large urban communities and small rural communities. Smaller agencies may need to train a higher percentage of officers. The ultimate goal is to have an adequate number of patrol officers trained in order to ensure that CIT-trained officers are available at all times. Additionally, 100% of dispatchers should be trained to appropriately elicit sufficient information to identify and respond to a mental health-related crisis.

Training 100% of an agency's patrol personnel in CIT is discouraged, except as necessary to achieve 24/7 coverage. Just as officers for other specialty areas in law enforcement are not equally suited to every job, so it is with CIT officers. CIT is a training that demands officers have certain skills and experience in order to be effective. For example, because CIT asks officers to take a very different approach in dealing with certain situations, it is beneficial to train officers who are extremely comfortable with their basic policing skills and procedures and have been on the road for a significant period of time. Additionally, CIT training is NOT effective as a means of 'fixing' an officer who may not have a well developed set of interpersonal skills. Therefore, it is essential that programs only train those officers who are:

1. Self-selected;
2. Supervisor-approved; and
3. Experienced.

Within the law enforcement community, policies are needed in order to provide guidelines regarding how to safely and respectfully transport consumers and how to develop supportive program infrastructure through a system of partnerships and inter-agency agreements. Policies must be in place to address the actions of both emergency dispatchers and patrol officers. Emergency dispatcher policies should clearly define and describe the role of dispatchers in the CIT program, which is to identify and dispatch the nearest available CIT Officer to respond to the crisis. Additionally, the responding CIT Officer leads the intervention, regardless of rank, except under unique or complicated circumstances that dictate otherwise. Policies and procedures that maximize the CIT Officer's discretion are critical. CIT Officers should be allowed to integrate their wide range of law enforcement training when handling CIT calls. Refer to Appendix B for a sample law enforcement agency CIT policy.

Within the mental health community, policies must accommodate the serving of individuals in the least restrictive setting and allow for a wide range of inpatient and outpatient referral sources. Barriers that prevent officers from accessing immediate mental healthcare for an individual should be examined and processes put in place to reduce or eliminate the amount of time officers spend off the road when involved in a mental health call.

7. Therapeutic Assessment Location or Procedures to Streamline Access to Services

While the statewide model for CIT is currently built upon the Memphis CIT model and the utilization of a therapeutic assessment center, each community must assess their available resources, context, and the practicality or reality of operating a fully functioning receiving facility. Each locality or program at a minimum must develop a diversion mechanism or protocol that is an agreement-based process incorporating the community's strengths, resources and needs, in order to divert individuals into community care and treatment while also reducing officer involved time.

A therapeutic treatment alternative may consist of an actual physical location to which persons experiencing a mental health crisis may be taken for emergency treatment or stabilization, or it may consist of some other set of alternative means for handling people in this situation. Sometimes, it is a combination of the two. CIT programs must not use criminal justice facilities for assessing or triaging the treatment needs of mental health clients, absent a significant threat to public safety or incarceration on criminal charges.

The ideal for a CIT program is to have a physical location that is *not* a jail or criminal lock-up always available to which an officer can deliver a person in crisis and turn over custody to someone trained to assist that person. This releases the officer to return to other duties and provides the treatment options needed by the consumer. A person for whom a therapeutic, community-based alternative is not appropriate due to the nature of the crime charged, may well need mental health treatment and care provisions at the jail to which he or she is taken. Under those circumstances, effective utilization of de-escalation skills by a CIT officer is likely to reduce the difficulties which a jail might encounter.

The following six components represent the ideal elements which are necessary to achieve the most successful type of triage/assessment site:

- 24/7 availability of the assessment site for law enforcement to use as an access point for services which is an alternative to incarceration
- 24/7 availability at that site of emergency services/clinical personnel who can determine clinical status and assess treatment needs for the individual
- 24/7 availability of security to support the site/program in accepting transfer of the individual and to provide for the safety of all persons involved
- 24/7 ready availability of medical screening
- 24/7 ready access to dispositional options including TDO beds, crisis stabilization, detox, and other community based service
- 24/7 availability of peer support for individuals awaiting evaluation or transportation to dispositional options

Therapeutic treatment alternative sites are often the most challenging element for a CIT program to establish. The concept of a secure local facility available around the clock for civil commitment assessment under an Emergency Custody Order is new to Virginia. They are not common in most localities, utilize different protocols where they do exist and are often challenged when it comes to providing appropriate staffing levels, both from a security and a treatment perspective. As such, while the ideal standard is a site that operates 24/7, a community's inability to fund 24/7 site coverage should not preclude their pursuit of developing a site. There are numerous programs that operate sites on a 12 or 16-hour model, 7 days a week. The Department of Behavioral Health and Developmental Services supports the development of alternative therapeutic crisis assessment sites for all localities in Virginia.

8. Data Collection

Data collection is critical to measuring the progress and impact of CIT programs. It is made difficult by many factors, including the diversity of local data gathering systems and sharing capacities. Each locality has a great deal of autonomy in the design and functioning of their law enforcement and public safety agencies. This has led to development of localized communications and management information systems that are not required to be uniform and consistent from one locality to the next, even in the same county. While all incidents handled by law enforcement officers are typically reported and captured in some data bank, the elements of an incident which may identify it as involving a person with mental illness are not always known or identifiable. Without a CIT program in place in a community, it is believed that many incidents that typically lead to arrest and injuries may have resulted from contact with persons experiencing a mental health crisis for which responding officers were not well trained or prepared to handle with alternatives to physical arrest. Identifying such incidents and emphasizing alternative resolutions is critical to measuring the success of a CIT program.

In Virginia, CIT programs are required to develop capacity to implement a statewide data collection process targeting the key statutory concerns in mental health-related calls: 1) how CIT Officers are linked to such calls; 2) how long a CIT Officer remains involved in the call; 3) the number of injuries involved, if any; 4) the final disposition of the call.

The required data elements for CIT Programs are:

1. Call Type:
    a. Dispatched MH Call
    b. Dispatched ECO
    c. Dispatched Wellness Check
    d. Self Initiated Call

2. Time in Service for Call [1]:
    a. Less than 30 min
    b. 30 min- 2 hours
    c. 2 – 4 hours
    d. More than 4 hours

3. On-Scene Injuries:
    a. None
    b. Officer
    c. Individual(s)
    d. Both

4. Primary Field Disposition
    a. Cleared on scene
    b. Voluntary transport
    c. ECO
    d. Criminal charge and arrest

5. Primary Field Disposition Location
    a. CIT assessment site
    b. Other location
    c. Jail/Criminal justice

Additionally, programs are required to utilize a pre and post training test to measure trainees' self assessment of their knowledge and skills in mental health crisis incidents. A standardized format is available on the Virginia CIT Coalition website.
http://vacitcoalition.org/evaluation/40HR_TRAININGS/40hr_PreTraining_Test.pdf
http://vacitcoalition.org/evaluation/40HR_TRAININGS/40hr_PostTraining_Test.pdf

Waiver of Requirements

Although each of the foregoing elements is required by these policies, the very nature of CIT demands that localities be afforded some flexibility in the development of their programs as community needs

[1] When possible, actual start time and end time should be captured. Start time should begin when the Officer arrives on the scene, not when the call was received.

and resources may dictate. To that end, in any case where a program wishes to obtain a waiver of a specific required element, it shall do so by notifying the VACIT leadership through its DCJS or DBHDS representatives, as indicated on the Coalition web site (www.vacitcoalition.org), and submitting their request on the simple form located there. The leadership team will work with the program to resolve the matter in a timely manner. Refer to Appendix C for a copy of the waiver form.

Recommended optional components of CIT programs in Virginia

- Crisis Intervention training for jail and custodial personnel: While CIT was originally created as a law enforcement based first responder program, there is a large population of incarcerated persons with mental illness in Virginia jails who are not appropriate for jail diversion through CIT. Utilization of the 40-hour core CIT training curriculum for jail and custodial staff can have a positive impact for local jails. CIT training and utilization of de-escalation techniques for local jail personnel may diminish the risk of injuries to consumers and jail staff as well as reducing the incidence of persons receiving additional charges as a result of symptomatic behaviors.
- Crisis Intervention training for non-law enforcement first responders and mental health treatment personnel: Elements of CIT may easily be applied to other first responders dealing with consumers in the community. While CIT is primarily designed for law enforcement, Virginia should continue to offer training to these other groups to enhance the effectiveness and safety of all public service persons and the public.
- Advanced and In-service Training Courses for all CIT Trained Persons.
- Active participation of program coordinators and other key program personnel in statewide coalition (VACIT) meetings and events.

APPENDIX A:

CIT Coordinator Job Duties

The Crisis Intervention Team (CIT) Coordinator is responsible for organizing and standardizing CIT trainings within the Program. This position can be under either a behavioral health agency or a law enforcement agency or both. Building on the CIT Training model, the CIT Coordinator is responsible for the following duties:

1. managing the logistics and coordination of training presenters and activities;
2. developing and producing a training manual for participants;
3. overseeing course evaluations and enhancing the quality of the training;
4. gathering and analyzing data;
5. working with the planning committee to develop smaller, more focused trainings for other criminal justice players such as probation/parole officers, dispatchers, and EMS;
6. educating the community about the goals and purpose of the program.;
7. enhancing community awareness as well as following state mandates and protocols;
8. interfacing with the criminal justice system, county and private social services, mental health services, state and other systems.;
9. maintaining and completing all appropriate records related to logistics and planning, preparing written reports, entering statistical data;
10. conducting program evaluation and monitoring.

The Coordinator will develop close working relationships with various agencies including (but not limited to) the Police Department, Magistrates, Sheriff's Office, Probation and Parole, Commonwealth's Attorney and Public Defender's Office. The Coordinator must be able to communicate and understand the many complexities that arise from interaction with different systems.

QUALIFICATION REQUIREMENTS

Minimum: Bachelor's degree in Criminal Justice, Sociology, Psychology, Social Work, Communications, Business Administration or related field plus one year's experience working with criminal justice system and or mental health.

Substitution: Additional qualifying experience may substitute for educational requirement on a year for year basis. Directly-related higher level criminal justice degrees may substitute for the Bachelor's degree, education requirement and one year of experience.

Desirables:
a) experience with law enforcement, criminal justice system and logistics;
b) experience in developing and training professionals;
c) experience in general knowledge regarding mental health and community based mental health programs.

APPENDIX B:

SAMPLE LAW ENFORCEMENT CIT POLICY

This policy is for Department use only and shall not apply in any criminal or civil proceedings. The Department policy should not be construed as a creation of a higher legal standard of safety or care in an evidentiary sense with respect to third party claims. Violations of this directive will be basis for Department administrative sanctions. Violations of law will form the basis for civil and criminal sanctions in a recognized judicial setting.

I. **PURPOSE**

The Department will exercise leadership in the community in responding to incidents involving persons with a mental illness who are in crisis. An immediate and well-executed response can make a major difference in the proper disposition of the case and enhance the quality of life of all concerned.

II. **POLICY**

It is the policy of the Department to promptly respond to and seek to resolve calls where a citizen with a mental illness is in need of services. It is the duty of police officers responding to a mental illness call to provide for the safety of all persons, and attempt to assist the individual through the immediate crisis. When the person remains in crisis and exhibits signs that they are a danger to themselves or others, officers shall take the person into emergency custody and transport them to a health care professional. In cases that do not warrant an emergency custody detention, officers will endeavor to assist the individual by providing reference materials related to mental health care providers for their continued well being beyond the immediate call for assistance.

III. **PROCEDURE**

A. **Definitions**

1. Crisis Intervention Team Officer (CIT): An officer who has received specialized training in recognizing symptoms of mental illness, identifying persons who are in crisis, and communication skills to assist in de-escalating potentially dangerous situations.

2. Crisis: A person is in crisis when they are unable to cope with internal or external stimuli creating an inability to function at a reasonable level, thus creating a risk of harm to themselves or others.

3. Mental Illness: A condition described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV) in which a person may experience random or disorganized thought patterns, or demonstrate bizarre or unusual behavior.

4. Emergency Custody Order (see General Order titled Legal Process and COV § 37.1-67.01).(VA Code 37.2-808 for adults and 16.1-340 for juveniles)

5. Temporary Detention Order (see General Order titled Legal Process and COV § 37.1-67.1).(VA Code 37.2-809 for adults and 16.1-340.1 for juveniles)

B. Communication Center Responsibilities

1. Because the Communication Officer is likely to be the first person to receive a call, the Communication Officer becomes a vital link in recognizing calls where CIT officers should be dispatched. These calls include suspected mental illness, ECO service, and persons with prior Department contact who officers suspect or have reason to believe have issues related to their mental health.

2. When a Communication Officer receives a CIT call they shall advise the Uniform Division supervisor on duty and dispatch any available on duty CIT officer. A list of CIT officers is maintained in the Communication Center.

3. The Communication Officer is responsible for dispatching a call's priority which is assigned by CAD. The Communication Officer will, when possible, gather the following information to aid in determining the appropriate call type:

   a. type of incident reported,

   b. location of incident,

   c. name of assailant,

   d. if a weapon is involved,

   e. have any persons at the address been injured,

   f. if any protective orders, injunctions, ECO or TDO's are in effect, and

   g. call history including previous CIT officer involvement.

4. If there is evidence of an injury, the presence of a weapon, or a crime is in progress, the call will be assigned as a Priority I. The Communication Officer will keep the complainant on the phone if possible and obtain additional information, such as:

   a. the assailant's whereabouts, (if not known, obtain direction of travel and elapsed time), and

   b. are alcohol, drugs, or medications involved.

5. The Communication Officer will attempt to maintain telephone contact until the officers arrive in order to advise the victim of the Department's response and to monitor the incident and provide support to the victim.

C. **Sworn Officer's Responsibilities**

1. CIT Officers should respond and should be the primary officers on all calls for service which pertain to subjects with a suspected mental illness. These include but are not limited to ECO service.

2. The shift supervisor will monitor dispatched calls involving suspected mental illness and ECO service. Supervisors should assign a CIT Officer in place of, or in addition to, the CAD assigned officer.

3. All officers who respond to calls involving a subject with a suspected mental illness will complete a CIT Report form. The primary officer who is not CIT trained, but is required to handle a call due to unavailability of CIT personnel, will complete the form as accurately as possible for potential follow-up by CIT.

D. **Supervisor's Responsibilities**

1. A copy of all CIT reports will be forwarded to the CIT program supervisor for review and possible follow-up.

2. The CIT program supervisor will maintain a log of CIT contacts with subjects and any assigned follow-up. The logbook will be maintained by the CIT program supervisor in a locked file cabinet. The CIT supervisor will submit a yearly evaluation of the CIT program to the Chief no later than the end of January for each preceding calendar year. This report will include, at a minimum:

   a) the number of CIT calls to which officers responded,

   b) the number and percentage of these calls in which, CIT officers were assigned as primary responders,

   c) the number of CIT officers that conducted call follow-ups,

   d) any other information relative to the evaluation of the CIT function, and an assessment of the effectiveness of the CIT program.

3. The CIT program supervisor will be responsible for updating the CAD premise hazard log in the Communication Center using the information obtained from the CIT contact logbook.

4. The CIT program supervisor will normally be available by pager for CIT officers to consult on appropriate courses of action.

E. **ECO DECISION**

1. Once officers have assessed the situation, they must make a determination whether or not to take the person into emergency custody. The decision is made based on the belief that the individual is a danger to themselves or others.

2. Even when the officer is able to assist the individual through a crisis, the individual will be encouraged to seek additional professional assistance. This should be accomplished by having a family member or friend take them to a health care provider for a voluntary committal, or referral back to their counselor the next day.

3. The CIT program supervisor may assign a Team member for follow-up when it is deemed that it could be beneficial. While not qualified to provide treatment or make a diagnosis, the CIT Officer's goal will be to serve as a resource to the individual when possible.

END OF GENERAL ORDER 10.9.1
4th Edition CALEA References 55.1.3 (a, d)

APPENDIX C:

Virginia Crisis Intervention Team Coalition

Essential Elements for Virginia CIT
Waiver of Requirement Form

CIT Program:_____

CIT Program Contact:_____

Street Address:_____

City:_____ **State:**_____ **Zip Code:**_____

Phone:_____ **Email:**_____

Please explain the essential element of concern to your program.

_____

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Please explain the modification your program is requesting.

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PEER RECOVERY TRAINING

VIRGINIA CERTIFICATION BOARD

Certified Peer Recovery Specialist (CPRS)

DOWNLOAD APPLICATION

CPRS CANDIDATE GUIDE

APPLY ONLINE

Looking for Initial CPRS Training?

The Office of Recovery Services is pleased to announce a new website portal for information about Peer Recovery Specialist (PRS) trainings. At this site, you will be able to see PRS classes that are being offered, find a list of all DBHDS-approved PRS trainers and submit an application for training.

Visit www.vaprs.org for more information.

The Certified Peer Recovery Specialist (CPRS) is credential for individuals with personal, lived experience in their ov recovery or experience as a family member or loved one. CPRS services are an important component in recovery-oriented systems of care. By offering insight into the recovery process based on their own experience, CPRSs are able to provide a unique perspective to those with similar life experiences.

The role of the CPRS reflects a collaborative and strength-based approach, with the primary goal being to assist individuals and family members in achieving sustained recovery from the effects of substance use and/or menta health issues. CPRSs are not clinicians; they serve in a supportive role within the community and/or treatment setting. They do not replace other professional services; they complement the existing array of support services.

The CPRS is not a sponsor, case manager or a therapist but rather a role model, mentor, advocate and motivator.

Services provided by the CPRS are a critical component of services that will substantially improve an individual's ability to sustain recovery and wellness.

REQUIREMENTS:

For more in depth information on the requirements please review the downloadable application above.

Formal Education: Minimum high school diploma/GED.

Peer Work Experience: 500 hours of volunteer or paid experience specific to peer recovery services.

Current Job Description: Copy of current peer recovery specialist job description, obtained from current employe and which must be signed by both the applicant and their immediate supervisor.

On-The-Job Supervision: 25 hours of on-the-job supervision of qualifying work experience in the peer recovery specialist domains.

Education/Training: 72-hour DBHDS CPRS Training Curriculum

Examination: Once application is approved, applicant must pass the IC&RC Examination for Peer Recovery Specialists (PR examination).

VHWDA COMMUNITY HEALTH WORKER TRAINING

COMMUNITY HEALTH WORKER (CHW) TRAINING

What Is A Community Health Worker?

A community health worker (CHW) is a frontline public health professional who serves as a bridge between communities and healthcare services, providing education, outreach, and advocacy to improve community well-being and access to quality care.

VHWDA Community Health Worker Training Program

VHWDA is proud to offer a community health worker training program which includes:

1. 12-week course with 17 asynchronous, online, interactive modules (80 hours of didactic lessons)

Virginia Certification Board for Virginia CHW Certification.

2. Access to our Area Health Education Centers (AHECs) for potential supervision, experiential learning
3. Convenient technical assistance from a VHWDA team member

The 12-week course is available through Moodle, a global learning management system built for distance learning. Students will navigate through each didactic module, which consists of relevant readings, videos, discussion board assignments, case studies, and assessments to help them prepare for careers as community health workers, health advocacy or other similarly skilled careers. Students can also utilize the training as an introduction to healthcare.

CHW Curriculum Modules

Module 1 – Course Introduction and Orientation	Module 10 – Understanding Trauma
Module 2 – Intro to CHW	Module 11 – Vaccines & Immunizations
Module 3 – Health Equity and SDOH	Module 12 – Outreach and Advocacy
Module 4 – Health Literacy	Module 13 – Care Coordination and Systems Navigation
Module 5 – Public Health Concepts	Module 14 – Documentation and Reporting

Lifestyles	Professional Conduct
Module 7 – Teaching to Promote Health Behavior Change	Module 16 – Stress Management and Self-Care
Module 8 – Chronic Disease Management	Module 17 – Professional Skills
Module 9 – Mental Health and Substance Use Disorder	

DEMO COURSE

Who Should Take This Course?

The CHW training course is designed for:

- Aspiring community health workers, including those wishing to complete CHW certification through the Virginia Certification Board.
- Students of all levels who want to gain practical knowledge and experience in healthcare.
- Current clinicians, nurses, clinical social workers, and other health professionals who want to enhance their skills in community-based care and outreach.
- Community advocates and those involved in community-based advocacy looking to understand current healthcare challenges better.
- Anyone passionate about promoting health and wellness in their communities and aiming to make a positive impact on the health and well-being of others.

Cost

Discounts apply for group enrollment and scholarships are available. The cost includes 12 weeks of unlimited access to all didactic course material, 1-on-1 technical assistance, and CHW certification preparation.

For more information please contact chw@vhwda.org.

Ready to enroll?

*For individual enrollment

ENROLL HERE

Group Enrollment

*For groups of 5 or more, please use this link to enroll your participants

SUBMIT YOUR PAYMENT HERE

!-*Please review our sales policy prior to payment.-->

Need more information before enrolling?

Sign up for a 1-hour virtual info session with the CHW Program Manager, Henry Lewis:

SIGN UP HERE

Certified Community Health Worker (CCHW)

CCHW APPLICATION

CCHW CONTENT OUTLINE

CCHW TRAINING ENTITY APPLICATION

CCHW TRAINING ENTITY RENEWAL APPLICATION

APPLY ONLINE

Approved CCHW Training Providers

- CE Impact/Virginia Pharmacists Association
- CHW Liberation Consulting, LLC
- CHW Strength
- IMPaCT Center (Formerly Penn Center)
- Institute for Public Health Innovation
- James Madison University Institute of Innovation of Health and Human Services
- MHP Salud
- Piedmont Virginia Community College/Blue Ridge Health District (PVCC-BRHD)
- Richmond City Health District
- Virginia Community Health Workers Association
- Virginia Healthcare Workforce Development Authority

The Virginia Community Health Worker Advisory Group and Virginia Community Health Worker Association submit this document in support of certification of Community Health Workers (CHWs) working in Virginia. Seven (7) domain areas have been identified and defined to ensure that individuals seeking to become "certified communit health workers" in the Commonwealth have been trained and have experience in the domains. The term "community health worker," includes but is not limited to other titles such as outreach worker, lay health promoter family advocate, peer leader, promotores de salud, and others. Individuals interested in becoming a "certified community health worker" are defined as: *Individual(s) who (i) applies his(her) unique understanding of the experience, language, and culture of the populations he(she) serves to promote healthy living and to help people take greater control over their health and lives and (ii) is trained to work in a variety of community settings, partnering in the delivery of health and human services to carry out one or more of the following roles: (a) providi culturally appropriate health education and information; (b) linking people to direct service providers, including informal counseling; (c) advocating for individual and community needs, including identification of gaps and existing strengths and actively building individual and community capacity.*

REQUIREMENTS:

For more in depth information on the requirements please review the downloadable application above.

Community Health Experience: One (1) year of full-time or 2000 hours of part-time volunteer or paid employmen within the last 3 years of application date.

Current Volunteer/Job Description: Copy of current community health worker volunteer/job description, obtaine from current organization, and which must be signed by both the applicant and their immediate supervisor.

Supervision: 50 hours of supervision of qualifying work experience in the community health worker domains.

Education/Training: 60 total hours specific to all of the domains within the last three years. All 60 hours must be from a VCB accredited CHW training provider.

SUPERVISION TRAINING

Tool 7. Clinical Supervision Policy and Procedure

Underlying Principles

Clinical supervision is a powerful tool for managing and ensuring continuous improvement in service delivery. Clinical supervision is comprised of balancing four distinct functions: administrative, evaluative, supportive, and clinical. Fundamental structures include a positive working relationship, client-centered approach, commitment to professional development, and accountability. The following principles ensure high-quality clinical supervision:

- A safe, trusting working relationship that promotes a learning alliance.
- A counselor-centered program with a culturally and contextually responsive focus.
- Active promotion of professional growth and development.
- Shared clinical responsibility ensuring that the client's treatment goals are addressed.
- A rigorous process that ensures ethical and legal responsibility.
- An individualized approach based on the learning needs and style of the supervisee.
- Congruence with the values and philosophy of the agency.

Terms

A healthy **working relationship** is built on shared vision and goals, clear expectations, and the belief in the good intentions of staff members. It demonstrates reciprocal communication where all parties provide comprehensive, timely information that is respectful. Each person is responsible for providing relevant information critical to his or her job function and the mission of the agency. The working relationship recognizes the importance of the chain of command throughout all agency levels. The agency expects that this chain of command supports structure, appropriate boundaries, and decisionmaking at all levels. The chain of command is followed to ensure effective and efficient communication.

Trust is central to the working relationship. This is manifested in several ways: (1) people are accountable to their work and job responsibilities, (2) confidentiality is maintained, (3) decisions are respected, and (4) misunderstandings are pursued to clarify miscommunication, seek to understand the other person, air emotions, and reach resolution.

The **learning alliance** is based on the belief that the supervisee has specific learning needs and styles that must be attended to in supervision. The relationship between supervisor and supervisee is best formulated and maintained when this frame of reference is predominant. Supervisees participate in a mutual assessment based on a combination of direct and indirect observations.

Guidelines for Clinical Supervision

The principles of clinical supervision are made explicit by a clear contract of expectations, ongoing review and feedback, and a commitment to professional development.

Clear contract of expectations
It is critical that both the supervisor and supervisee share their expectations about the process, method, and content of clinical supervision. This can advance the development and maintenance of a trusting, safe relationship. The following information should be discussed early in the working relationship:

- Models of supervision and treatment.
- Supervision methods and content.
- Frequency and length of supervisory meetings.
- Ethical, legal, and regulatory guidelines.
- Access to supervision in emergencies.
- Alternative sources of supervision when the primary supervisor is unavailable.

The supervisee will be provided with a job description that outlines essential duties and performance indicators. Additionally, each supervisee will receive an assessment of core counseling skills based on the TAP 21 competencies and other appropriate standards.

Documentation
Supervisory sessions are recorded as notes that indicate the focus of the session, the issues discussed, solutions suggested, and agreed upon actions. Supervisors will maintain a folder for each of their supervisees. The folder will contain the IDP, clinical supervision summaries, and personnel actions (e.g., memos, commendations, other issues). Supervisees are allowed full access to the folders.

Tool 7. Clinical Supervision Policy and Procedure (continued)

Clinical supervision frequency
Each supervisee will receive 4 hours of supervision monthly. A combination of individual and group supervision may be used. Supervisors are to ensure that a minimum of 50 percent of this time is devoted to clinical, as opposed to administrative, supervision.

Ongoing review and feedback
The supervisee will be given an annual performance evaluation that reviews both job expectations and the clinical skills learning plan. Written records of the supervisee will be reviewed on a regular basis. Supervisees will be given specific written feedback regarding their strengths and areas for improvement. The supervision system operates through direct observation of clinical work. This ensures that direct, focused feedback will be provided, increases the degree of trust and safety, and provides an accurate evaluation of skills development progress. Observations will be pre-arranged and take the form of sitting in on a session, co-facilitating, or videotaping. The supervisee will present a case at a minimum of once per month.

Commitment to ongoing professional development
The supervisee's learning plan should document goals, objectives, and methods to promote professional development. The plan should be completed within the first 6 months of employment and updated annually. Ongoing supervision should focus on achieving the identified goals. The agency supports supervisees' participation in training to achieve their professional development goals.

Source: Adapted from unpublished Basics, Inc. materials

The Supervision Contract

A supervision contract protects the rights of the agency, the supervisor, and supervisee. A written contract between supervisor and supervisee, stating the purpose, goals, and objectives of supervision is important. Tool 8 is a template for supervision contracts. In addition to the contract, for the purposes of informed consent, it is useful to have a supervision consent form signed by both the supervisor and supervisee, indicating the supervisee's awareness and agreement to be supervised (see Tool 4).

Tool 8. Supervision Contract Template

This document serves as a description of the supervision provided by (supervisor name, credentials, title) to (supervisee, credentials, title).

Primary Purpose, Goals, and Objectives

- Monitor and ensure client welfare
- Facilitate professional development
- Evaluate job performance

Provision

- (Frequency) of individual supervision at (day and time)
- (Supervision model and case review format) will be used
- Clients of the counselor will give informed consent for supervision of their case
- Counselor will have a minimum of (amount) of supervision for every (number) of client contact hours
- All client cases will be reviewed on a rotating basis based on need

Documentation

- (Form name) will be used to document the content and progress of the supervision
- Informal feedback will be provided at the end of each session
- Written formal evaluation will be provided (frequency)
- Supervision notes will be shared (at the supervisor's discretion or at request of counselor)

Tool 8. Supervision Contract Template (continued)

Duties and Responsibilities

The supervisor at a minimum will:

- Review all psychosocial histories, progress notes, treatment plans, and discharge plans.
- Question the counselor to justify approach and techniques used.
- Present and model appropriate clinical interventions.
- Intervene directly if client welfare is at risk.
- Ensure that ethical guidelines and legal statutes are upheld.
- Monitor proficiencies in working with community resources and networking with community agencies.

The counselor at a minimum will:

- Uphold all ethical guidelines and legal statutes.
- Be prepared to discuss all client cases.
- Discuss approaches and techniques used and any boundary issues or violations that occur.
- Consult supervisor or designee in emergencies.
- Implement supervisor directives.
- Adhere to all agency policies and procedures.

Procedural Consideration

- The Individual Development Plan's goals and objectives will be discussed and amended if necessary.
- The quality of the supervisory relationship will be discussed and conflicts resolved.
- If conflicts cannot be resolved, (name) will be consulted.
- In the event of an emergency, the counselor is to contact the supervisor. If unavailable, contact (alternate's name, title, and other relevant back-up information).
- Crises or emergency consultations will be documented.
- Due process procedures (as explained in the agency's policy and procedure handbook) have been reviewed and will be discussed as needed.

Supervisor's Scope of Competence

- Title/date of credentials/licensure.
- Formal supervisory training and credentials.
- Years providing supervision.
- Current supervisory responsibilities.

This agreement is subject to revision at any time on request of either person. Revision will be made only with consent of the counselor and approval of the supervisor. We agree to uphold the directives outlined in this agreement to the best of our ability and to conduct our professional behavior according to the ethical principles and codes of conduct of our professional associations.

Supervisor_____ Title_____ Date_____

Supervisee_____ Title_____ Date_____

This agreement is in effect from (current date) to (annual date of review or termination)

Source: Mattel, 2007

Another sample supervision contract form can be found in Campbell (2000), p. 285.

The Initial Supervision Sessions

An initial supervision sessions checklist documents the topics to be covered in initial sessions by the supervisor and supervisee. The goal is that as part of establishing the supervisory relationship, the supervisor and supervisee should discuss the basic issues in substance abuse counseling and in supervision. For new supervisors and for administrators to monitor the implementation of supervision, a checklist, such as Tool 9, can ensure that the important issues are discussed. The example below can aid in setting a preliminary structure for supervision, clarifying goals and expectations, and incorporating feedback so as to promote a sense of openness, trust, and safety. It is understood that not all of these topics can be covered in the first few sessions, but these topics are important considerations in initiating clinical supervision.

Documentation and Recordkeeping

Documentation is unquestionably a crucial risk-management tool for clinical supervisors and is no longer optional in supervision. Legal precedents suggest that organizations are both ethically and legally responsible for quality control of their work, and the supervision evaluation, documentation, and record-keeping systems are a useful and necessary part of that professional accountability. However, in contrast with the myriad clinical forms and documentation required, there is a paucity of tools for documentation in supervision. Most organizations rely on the personal style and records of individual supervisors, and do not have an organization-wide standardized system of record keeping for supervision. Documenting supervision should not be burdensome, but it should be systematic and careful. Key components of what should be documented and how it should be documented are provided in the following paragraphs.

A record of supervision sessions needs to be maintained that documents: when supervision was conducted, what was discussed, what recommendations were provided by the supervisor, and what actions resulted. A supervisor should maintain a separate file on each counselor supervised, including:

- Caseloads.
- Notes on particular cases.
- Supervisory recommendations and impressions.
- The supervision contract.
- A brief summary of the supervisee's experience, training, learning needs, and learning styles.
- The individual development plan.
- A summary of all performance evaluations.
- Notations of supervision sessions, particularly concerning duty-to-warn situations, cases discussed, and significant decisions made.
- Notations of canceled or missed supervision sessions.
- Significant issues encountered in supervision and how they were resolved.

By far, the most comprehensive documentation system for clinical supervisors is Falvey's FoRMSS system (2002*a*), which includes emergency contact information, supervisee profiles, a log sheet for supervision, an initial case overview, a supervision record, and a termination summary that records the circumstances of client termination, client status at termination, and any followup or referrals needed. The FoRMSS system alerts supervisors to potential clinical, ethical, or legal risks associated with cases.

Records of supervision must be retained for the period required by the State and pertinent accreditation bodies. The American Psychological Association's guidelines (2007) recommend retaining clinical and supervisory records for at least 7 years after the last services were delivered. Organization policy may differ from this. Administrators should check with local and State statutes regarding record-keeping requirements. It is prudent for an organization and supervisor to retain supervision records for at least as long as required by the State and accreditation bodies.

Tool 9. Initial Supervision Sessions Checklist

Education, Training, and Clinical Experience

_____ Educational background

_____ Training experience

_____ Setting(s), number of years

_____ Theoretical orientation

_____ Clinical competence with various issues, models, techniques, populations, presenting problems, treatment modalities

_____ Sense of mission and purpose in the field

_____ Educational plans and professional goals of the supervisee

_____ Training and awareness of cultural and contextual issues in counseling

_____ Training and awareness of community networking in counseling

Philosophy of Supervision

_____ Philosophy of therapy and change

_____ Purpose of supervision

Previous Supervision Experiences

_____ Previous supervision experiences (e.g., format, setting)

_____ Strengths and weaknesses as counselor and as supervisee

_____ Supervisee's competence with stages of counseling process

_____ Supervisee's level of development in terms of case planning, notes, collateral support, and networking

_____ Supervisory competence with various issues, models, techniques, populations, therapy groups, and modalities

_____ Methods for managing supervisor-supervisee differences

Supervision Goals

_____ Goals (personal and professional)

_____ Process of goal evaluation and timeframe

_____ Requirements for which supervisee is seeking supervision (e.g., licensure, professional certification)

_____ Requirements to be met by supervision (e.g., total hours, individual or group supervision)

Supervision Style and Techniques

_____ Specific expectations the supervisee or supervisor has of the parties involved (e.g., roles, hierarchy)

_____ Type of supervision that would facilitate clinical growth of the supervisee

_____ Preferred supervision style (didactic, experiential, collegial)

_____ Parallels between therapy and supervision models

_____ Supervision focus (e.g., counselor's development, cases)

_____ Manner of case review (e.g., crisis management, in-depth focus)

_____ Method (e.g., audio- or videotaping, direct observation)

Theoretical Orientation

_____ Models and specific theories in which supervisee and supervisor have been trained, practice, and or conduct supervision

_____ Extent to which these models have been used clinically

_____ Populations, presenting problems, and/or family forms with which the models have been most effective

_____ Interest in learning new approaches

Tool 9. Initial Supervision Sessions Checklist (continued)

Legal and Ethical Considerations

_____ Ultimate responsibility for clients discussed in supervision in different contexts (e.g., licensed vs. unlicensed counselor, private practice vs. public agency)

_____ Number of cases for which the supervisor will be responsible

_____ Emergency and back-up procedures

_____ Awareness of professional ethical codes

_____ Confidentiality regarding the information discussed in supervision

_____ Confidentiality issues when more than one supervisee is involved

_____ Specific issues in situations where dual relationships exist (e.g., former client)

_____ Process for addressing supervisee issues (e.g., burnout, countertransference)

Other

What do we need to know about each other that we have not already discussed?

Source: Adapted from Falvey, 2002b. Permission pending.

Tools 10–12 are sample documentation forms. (See also Campbell, 2000.)

Tool 10. Supervision Note Sample
Professional Development Plan Current Focus

Goal/TAP Competencies	Objective	Date of Expected Completion

Supervision Content			
Issue	Discussion	Recommendation/ Action	Followup

Progress on Professional Development Plan Objectives

_____

_____

Other_____

Supervisor_____ Counselor_____ Date_____

Source: Porter and Gallon, 2006.

Tool 11. Current Risk-Management Review

Case:_____ Date::_____

ISSUES

- ☐ Informed Consent
- ☐ Parental Consent
- ☐ Confidentiality
- ☐ Recordkeeping
- ☐ Records Security
- ☐ Child Abuse/Neglect
- ☐ Risk of Significant Harm
- ☐ Duty to Warn
- ☐ Medical Exam Needed
- ☐ Supervisee Expertise
- ☐ Supervisor Expertise
- ☐ Institutional Conflict
- ☐ Dual Relationship
- ☐ Sexual Misconduct
- ☐ Releases Needed
- ☐ Voluntary/Involuntary Hospitalization
- ☐ Utilization Review Discharge/Termination

Discussion:

_____

_____

_____

Recommendation:

_____

_____

_____

Action:

_____

_____

_____

Signature_____Date_____

Title_____

Source: Based on Falvey, 2002b.

Tool 12. Supervisory Interview Observations		
STATEMENTS/BEHAVIORS		**COMMENTS**
Step 1 SET AGENDA Decrease anxiety Involve counselor		
Step 2 GIVE FEEDBACK Empower Individualize		
Step 3 TEACH and NEGOTIATE Share agenda Clarify knowledge, skills, attitude Identify learning steps Agree upon methods of learning		
Step 4 SECURE COMMITMENT Clarify expectations Clarify responsibility Create mutual accountability		

LOOK FOR	OBSERVATIONS, BEHAVIORS, NOTES
SUMMARY OBSERVATIONS	
Interview structure followed?	
Time managed effectively?	
Established nurturing and supportive environment?	
Stayed on course?	
Resistance? Power struggle?	
Agreement secured?	
Followup plan created?	
NOTES:	

Source: Based on Porter & Gallon, 2006.

Evaluation of Counselors and Supervisors

Evaluation of counselors and supervisors is both formative (ongoing and evolving over time) and summative (periodic and formal). Nowhere else in supervision does the power differential between the supervisor and supervisee become more evident than in the evaluation process. Feedback and evaluation are necessary and important in an organization's risk-management procedures. Agencies need a formal procedure and criteria for staff evaluation. When supervisors conduct supervisee evaluations, counselors need to understand there is a level of subjectivity in the process. There is no psychometrically valid tool to assess counselor competence. An element of the supervisor's judgment is always involved.

Most evaluation guidelines and tools identify general areas of competence to assess—knowledge, skills, and attitudes—but specific criteria for making an evaluation are left to the individual supervisor and the organization. It is important that the evaluation of staff be closely linked to job descriptions, the supervision contract, and the specific needs of the agency. Levels of competence and fitness for duty should be established by the individual organization, with consideration given to the credentialing and accreditation requirements of the agency. Supervisee triads also offer another option to assist in the evaluation process. A grievance and appeals process should be defined. Finally, supervisors need to be reminded that they are the gatekeepers for the agency, providing feedback, remediation as needed, and dismissal of personnel if indicated.

Tools 13 and 14 aid the supervisee in evaluating the supervisor and the supervisor in assessing the counselor.

Tool 13. Counselor Evaluation of the Supervisor

This evaluation form gives the supervisor valuable feedback while it gives the counselor a sense of responsibility and involvement in the design and development of supervision.

Use a 7-point rating scale where:
1 = strongly disagree
4 = neither agree nor disagree
7 = strongly agree

	Rating
1. Provides useful feedback regarding counselor behavior	
2. Promotes an easy, relaxed feeling in supervision	
3. Makes supervision a constructive learning process	
4. Provides specific help in areas needing work	
5. Addresses issues relevant to current clinical conditions	
6. Focuses on alternative counseling strategies to be used with clients	
7. Focuses on counseling behavior	
8. Encourages the use of alternative counseling skills	
9. Structures supervision appropriately	
10. Emphasizes the development of strengths and capabilities	
11. Brainstorms solutions, responses, and techniques that would be helpful in future counseling situations	
12. Involves the counselor in the supervision process	
13. Helps the supervisee feel accepted and respected as a person	
14. Appropriately deals with affect and behavior	
15. Motivates the counselor to assess counseling behavior	

Tool 13. Counselor Evaluation of the Supervisor (continued)	
This evaluation form gives the supervisor valuable feedback while it gives the counselor a sense of responsibility and involvement in the design and development of supervision. Use a 7-point rating scale where: 1 = strongly disagree 4 = neither agree nor disagree 7 = strongly agree	
	Rating
16. Conveys a sense of competence	
17. Helps to use tests constructively in counseling	
18. Appropriately addresses interpersonal dynamics between self and counselor	
19. Can accept feedback from counselor	
20. Helps reduce defensiveness in supervision	
21. Encourages expression of opinions, questions, and concerns about counseling	
22. Prepares the counselor adequately for the next counseling session	
23. Helps clarify counseling objectives	
24. Provides an opportunity to discuss adequately the major difficulties the counselor is facing with clients	
25. Encourages client conceptualization in new ways	
26. Motivates and encourages the counselor	
27. Challenges the counselor to perceive accurately the thoughts, feelings, and goals of the client	
28. Gives the counselor the chance to discuss personal issues as they relate to counseling	
29. Is flexible enough to encourage spontaneity and creativity	
30. Focuses on the implications and consequences of specific counseling behaviors	
31. Provides suggestions for developing counseling skills	
32. Encourages the use of new and different techniques	
33. Helps define and achieve specific, concrete goals	
34. Gives useful feedback	
35. Helps organize relevant case data in planning goals and strategies with clients	
36. Helps develop skills in critiquing and gaining insight from counseling tapes	
37. Allows and encourages self-evaluation	
38. Explains the criteria for evaluation clearly and in behavioral terms	
39. Applies criteria fairly in evaluating counseling performance	
40. Addresses cultural issues of supervisee in a helpful manner.	
41. Discusses cultural and contextual issues of the client, family, and wider systems that open up new resources and avenues for support.	
Source: Adapted from Powell and Brodsky, 2004.	

Tool 14. Counselor Competency Assessment
Based on TAP 21, Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice (CSAT, 2006)

Competency Area	Needs Improvement	Able to Perform Skill	Proficient	Consistent Mastery
Understand Substance Use Disorders • Models and theories • Recognize complex context of substance abuse				
Treatment Knowledge • Philosophies • Practices • Outcomes				
Application to Practice • DSM-IV-TR • Repertoire of helping strategies • Familiar with medical and pharmacological resources				
Diversity and Cultural Competence • Understand diversity • Use client resources • Select appropriate strategies				
Clinical Evaluation • Screening • Assessment				
Assess Co-Occurring Disorders • Symptomatology • Course of treatment				
Treatment Planning • Based on assessment • Individualized • Ensure mutuality • Reassessment • Team participation				
Referral and Followup • Evaluate referrals • Ongoing contact • Evaluate outcome				
Case Management				

Tool 14. Counselor Competency Assessment (continued)
Based on TAP 21, Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice (CSAT, 2006)

Competency Area	Needs Improvement	Able to Perform Skill	Proficient	Consistent Mastery
Group Counseling • Group theory • Describe, select, and use appropriate strategies • Understand and work with process and content • Facilitate group growth				
Family, Couples Counseling • Theory and models • Understand characteristics and dynamics • Describe, select, and use appropriate strategies				
Individual Counseling • Theory of individual counseling • Describe, select, and use appropriate strategies • Understand functions and techniques of individual counseling				
Client, Family, and Community Education • Culturally relevant • Provide current information • Teach life skills				
Documentation • Knowledge of regulations • Prepare accurate, concise notes • Write comprehensive, clear psychosocial narrative • Record client progress in relation to treatment goals • Discharge summaries				
Professional and Ethical Responsibilities • Adhere to code of ethics • Apply to practice • Participate in supervision • Participate in performance evaluations • Ongoing professional education				

Source: Porter & Gallon, 2006.

Other useful resources are:

- Bernard and Goodyear, 2004: Supervision Instruments (pp. 317–326).
- Campbell, 2000: Generic Rating Sheet and Evaluation Form, Supervisee's Basic Skills and Techniques (p. 263); Sample Generic Supervisee Evaluation Form (p. 275).
- Powell and Brodsky, 2004: Evaluation of the Counselor, adapted from Stoltenberg and Delworth, 1987 (p. 351).
- Powell and Brodsky, 2004: Counselor Assessment Forms (p. 373–379).
- Northwest Frontier Addiction Technology Transfer Center Performance Rubric available online at http://www.nfattc.org.

Individual Development Plan

After the supervisor and counselor have agreed on goals, they should formulate an individual development plan (IDP) or professional development plan. It should address the expectations for supervision, the counselor's experience and readiness for the position, procedures to be used to observe and assess the counselor's competencies, and the counselor's professional development goals. Some IDP formats follow the 12 Core Functions taking into account the stage of development of the counselor. Other formats might use the competencies in TAP 21. Tool 15 outlines the generic knowledge, skills, and attitudes to be addressed as part of one's professional development plan. Whatever format is adopted, the IDP should provide the counselor with a road map for learning goals.

Tool 15. Professional Development Plan

Staff_____ Position _____ Date _____

Practice Dimension: _____

Competency number and page from TAP 21: _____

Present level of competence from TAP 21 Rating Form:

1 Understands	2 Developing	3 Competent	4 Skilled	5 Master
1 = Understands 2 = Developing 3 = Competent 4 = Skilled 5 = Master		Comprehends the tasks and functions of counseling Applies knowledge and skills inconsistently Consistent performance in routine situations Effective counselor in most situations Skillful in complex counseling situations		

Describe the counselor's strengths and challenges for this rating: _____

_____

_____

Expected level of competency to be achieved with this learning plan:

1 Understands	2 Developing	3 Competent	4 Skilled	5 Master

Describe the goal for this learning plan in observable terms:_____

_____

Tool 15. Professional Development Plan (continued)

List the Knowledge, Skills, and Attitudes relevant to achieving the target competency.

Knowledge_____

_____

Skills _____

_____

Attitudes _____

_____

State the performance goal in specific behavioral terms: _____

_____

What activities will the counselor complete in order to achieve the stated goal? _____

How will progress be evaluated? How will proficiency be demonstrated? _____

Supervisor Signature _____ Date _____

Counselor Signature _____ Date _____

UPDATE

Date of "re-observation" _____

Demonstration of knowledge and skills successful? _____ Yes _____ No

If "No," demonstration needs the following correction and followup demonstration rescheduled:

Supervisor Signature _____ Date _____

Counselor Signature _____ Date _____

Source: Adapted from Porter & Gallon, 2006.

Outline for Case Presentations

Counselors often need to be taught how to present cases in supervision. The counselor needs to think about the goals he or she would like to achieve for the client and his or her particular concerns about the case. It is possible to use the case presentation format for a variety of purposes: to explore the client's clinical needs, to aid in case conceptualization, to process relational issues in counseling (transference and countertransference), to identify and plan how to use specific clinical strategies, and to promote self-awareness for the counselor. In the beginning, the supervisor should structure the case presentation procedures to ensure consistency and conformity to agency guidelines. Tool 16 can be adapted to the particular theoretical model of the agency and the specific needs of the supervisee and organization.

Tool 16. Sample Case Consultation Format

Name of presenter:_____

Date:_____

Identifying data about the client (age, marital status, number of marriages, number and ages of children, occupation, employment status)

Presenting problem:_____

Short summary of the session:_____

_____

Important history or environmental factors (especially cultural or diversity issues):_____

_____

Tentative assessment or problem conceptualization (diagnosis):_____

_____

Plan of action and goals for treatment (treatment plan):_____

_____

Intervention strategies:_____

_____

Concerns or problems surrounding this case (e.g., ethical concerns, relationship issues):_____

_____

Source: Adapted from Campbell, 2000.

Audio- and Videotaping

To ensure competence, the agency should provide instruction on audio- and videotaping to all staff. Instruction should include the overall purpose of taping, how to inform the client about the taping procedure, how to use the recording equipment, the placement of taping devices, how to ensure client confidentiality and obtain signed releases, how to begin the actual session while recording, and how to process the tapes after recording. Tool 17 provides helpful hints for successful audio- and/or videotaping.

Tool 17. Instructions for Audio and Videotaping

1. **Use quality equipment.** Check the sound quality, volume, and clarity. It is best to use equipment with separate clip-on microphones unless you are in a sound studio with a boom microphone. Clip-on microphones are inexpensive and easy to obtain.
2. **Buy good quality tapes**. It is not necessary to buy top-of-the-line tapes, but avoid the cheapest. Better tapes give better sound and picture and can be reused.
3. **Placement of equipment matters**. Use a tripod for the video camera. Check the angle of camera, seating, volume, and the stability of the picture.

Tool 17. Instructions for Audio and Videotaping (continued)

4. **Check the background sound and volume.** Choose a quiet, private place to do this, both to protect confidentiality and to improve recording quality. Do not use an open space, an office with windows facing the street, or a place subject to interruption. Loud air-conditioning fans, ringing phones and pagers, street noise, and office conversations all disrupt the quality of taping.

5. **Know how to use the equipment.** Conduct a dry run. Be sure to check the placement of chairs, video camera angles, and picture quality before you begin. If the supervisee is especially anxious or unfamiliar with the equipment, have him or her make a practice tape. Be sure those in the picture are the persons agreed on by the supervisor and supervisee.

6. **Protect the confidentiality** of the supervisee and the client. Choose a private, controlled space for taping. Keep the tapes in a locked cabinet and don't include identifying data on the outside of the tape. When finished with supervision, erase the tape completely before reusing; do not just tape over the previous session.

7. **Process with the supervisee any anxiety** or concern generated by taping. Three areas of potential anxiety are the technical aspects (equipment and room availability), concern for the client (confidentiality), and the effect of taping on the session (critical evaluation of performance by the supervisor).

8. **Explain taping,** its goals, and its purpose to the client at least one session before proceeding. Review with the client any concerns about confidentiality. Remember that the more comfortable and enthusiastic the supervisor and the supervisee are with the value of taping, the more comfortable the client will be. Sometimes just reassuring the client that the tape can be turned off at any point if the client is uncomfortable increases a sense of control and reduces anxiety. Usually after the first few minutes of taping, both the client and counselor forget its presence, and this option is rarely used. If the client appears resistant, a decision should be made as to the appropriateness of using this particular method of supervision in this situation.

9. **Get a written release** from the client. Be sure the release includes a description of the purpose of the tape, limits of confidentiality, identities of those viewing the tape, and assurance of erasure of the tape afterward. If the tape is to be used in group supervision or a staffing seminar, the client should be informed of that fact.

10. Before beginning the actual session, **check the equipment** by making a short practice tape covering background material on the client. Then, rewind the tape and play it to check sound, volume, camera angle, and picture. When satisfied, begin the actual session.

Source: Adapted from Campbell, 2000.

Further, it is essential that an organization provide documentation to protect the confidentiality of information and to preserve patients' rights. This is especially important if direct observation of clinical sessions is to occur using audio or videotaping. Tool 18 explains the benefits and procedures of taping and can be read by the counselor to the client. The consent form, Tool 19, should be signed and dated prior to taping.

Tool 18. Confidentiality and Audio- or Videotaping

Video recording of clinical processes will be conducted with the client's written, informed consent for each taping. Clients understand that no taping will occur without their consent. A process already in place will ensure the security and destruction of DVDs or erasure of VHS tapes.

The purpose of videotaping is to improve counselors' clinical skills through supervision and teaching.

Counselor benefits of videotaping include:
- Improving therapeutic skills.
- Improving treatment team cohesion.
- Improving assessment, treatment planning, and delivery of services.
- Improving clinical supervision.

Procedure:

The client's counselor will explain and fully disclose the reason, policy, and procedure for videotaping the client. Both will sign a specific videotaping release form. The counselor should also explain that refusal to be taped will not affect the client's treatment at the agency.

1. The client must be 18 years old to sign the consent. Those under 18 must have a parent's signature in addition to their own.
2. Respecting the client's concerns is always the priority. Should any client or family member show or verbalize concerns about taping, those concerns need to be addressed.
3. All taping devices will be fully visible to clients and staff while in use.
4. A video camera will be set up on a tripod, consistent with safety standards and in full view of each client. Clients will be notified when the camcorder is on or off.
5. The tape will be labeled when the session is completed, and no copies will be made.
6. Clinical review for supervision or training: The treatment team will review the tape and assess clinical skills for the purpose of improving clinical techniques.
7. The tape will be turned over to the Medical Records Department (if available) for sign out.
8. Tapes and DVDs will be stored in a locked drawer in the Medical Records Department. Within 2 weeks of taping, tapes will be erased and DVDs destroyed in the presence of two clinical staff members who attest to this destruction on a form to be kept for 3 years.
9. Tapes and DVDs may not be taken off premises.

Tool 19. Audio or Video Recording Consent

I , _____, consent to be recorded or filmed for supervision purposes. I also agree to allow the clinical staff to review the film as a resource to facilitate staff development for the enhancement of clinical procedures. I understand that any film in which I am a participant will be erased within 2 weeks of the date of filming. I understand that no copies will be made of such film.

Patient Signature _____ Date _____

Witness Signature _____ Date _____