Virginia Department of Health Professions
Board of Counseling

Agenda

Full Board Meeting
October 4, 2024
10:00 a.m.
9960 Mayland Dr
2nd Floor, Board Room 2
Richmond, VA 23233

10:00 a.m. Call to Order – Terry R. Tinsley, PhD, LPC, LMFT, CSOTP, Chair

- Moment of Silence
- Introductions/Establishment of Quorum
- Mission of the Board/Emergency Egress Procedures……Page 3

Adoption of Agenda

10:05 a.m. Public Hearing regarding regulatory changes mandated by Senate Bill 403 ---------- Page 5

Public Comment

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

Approval of Minutes

- August 2, 2024* Board Meeting Minutes ……..... Page 24

Agency Director Report (Verbal) – Arne Owens

Chair Report (Verbal) – Dr. Tinsley

Presentation:

"Virginia Licensed Professional Counselor Workforce: 2024"
Yetty Shobo, PhD, Executive Director, DHP Healthcare Workforce Data Center
Barbara Hodgdon, PhD, Deputy Director, DHP Healthcare Workforce Data Center

- Report: Virginia Licensed Professional Counselor Workforce: 2024 …… Page 31
- Report: Virginia Qualified Mental Health Professional Workforce: 2024……... Page 65

Legislative and Regulatory Report – Erin Barrett, JD, Department of Health Professions, Director of Legislative and Regulatory Affairs

- Chart of Regulatory Actions …… Page 93
- Consideration of Petition for rulemaking to amend LPC and LMFT regulations to allow residents to bill directly for services and receive payments directly from clients* …… Page 95
- Consideration of Petition for rulemaking to request the Board amend 18VAC115-20-52(D) to require supervisors to report the total hours of residency and evaluate an applicant's competency within a set timeframe* …… Page 134

- Adoption of exempt regulatory changes to QMHP regulations and new regulations governing BHT/BHTA registration*…. …… Page 141
- Consideration of approved training programs "recognized or approved by the Board" for QMHP, QMHP-T, BHT, and BHTA applicants* …… Page 170

Staff Reports

- **Executive Director's Report** – Jaime Hoyle, JD, Executive Director, Boards of Counseling, Psychology, and Social Work (BSU) (Verbal Report)
- **Discipline Report** – Jennifer Lang, Deputy Director, BSU……...Page 177
- **Licensing Report** – Charlotte Lenart, Deputy Director, BSU…….. Page 180

Consideration of Recommended Decisions*

Consideration of Consent Order*

Next Meeting:

- Board Meeting: January 24, 2025

Meeting Adjournment

12:30 pm Formal Hearing

*Indicates a Board Vote is required.
**Indicates these items will be discussed within closed session.

This information is in **DRAFT** form and is subject to change. The official agenda and packet will be approved by the public body at the meeting and will be available to the public pursuant to Virginia Code Section 2.2-3708(D).

Virginia Department of Health Professions
Board of Counseling

MISSION STATEMENT

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

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.

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 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.

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.

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.

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.

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

Agenda

Public Hearing
October 4, 2024
10:05 a.m.
9960 Mayland Dr
2nd Floor, Board Room 2
Richmond, VA 23233

10:05 a.m. Public Hearing

- Amendments to 18VAC115-80 regarding Qualified Mental Health Professionals pursuant to SB403
- Amendments to 18VAC115-90 regarding Behavioral Health Technicians and Behavioral Health Technician Assistants pursuant to SB403

Please note: the full Board will discuss the requirement hours for didactic training during the full Board meeting at the conclusion of the public hearings

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 as a QMHP	$30
Renewal of registration as a QMHP-trainee	$10
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 [40] 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. Requirements for registration as a qualified mental health professional-trainee.

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 [40] 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;

3. Provide a current report from the NPDB, if applicable; and

3. Submit evidence of completion of ~~20~~ eight hours of continuing education ~~consistent with requirements of 18VAC115-80-80~~ for each year in which the license has been inactive or lapsed, not to exceed 32 hours.

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.

Language below is part of a new VAC chapter for BHTs and BHTAs

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 [20] 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 [20] 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;

3. Provide a current report from the NPDB, if applicable; and

4. Submit evidence of completion of two hours of continuing education for each year in which the license has been inactive or lapsed, not to exceed eight hours.

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.

Virginia Department of Health Professions
Board of Counseling

DRAFT

Virginia Board of Counseling
Quarterly Board Meeting Minutes
Friday, August 2, 2024, at 10:00 a.m.
9960 Mayland Drive, Henrico, VA 23233
Board Room 2

PRESIDING OFFICER:	Maria Stransky, LPC, CSAC, CSOTP, Board Vice-Chairperson
BOARD MEMBERS PRESENT:	Benjamin Allison, Citizen Member Lester Paul Bernard, PhD, LPC Marlo Burdge, Citizen Member Natalie Franklin, LPC, LMFT Nakeisha Gordon, LPC Luanne Griffin, LPC Matthew Scott, LMFT Terry R. Tinsley, PhD, LPC, LMFT, CSOTP Tiffinee Yancey, PhD, LPC
BOARD MEMBERS ABSENT:	None
BOARD STAFF PRESENT:	Latasha Austin, Licensing & Operations Supervisor Shannon Brogan, Licensing Specialist Sandie Cotman, Registration Program Coordinator Jaime Hoyle, JD, Executive Director Jennifer Lang, Deputy Executive Director- Discipline Charlotte Lenart, Deputy Executive Director- Licensing
DHP STAFF PRESENT:	Erin Barrett, JD, Director of Legislative and Regulatory Affairs, Department of Health Professions James Jenkins, RN, Agency Deputy Director, Special Advisor to the Governor on Workforce Matthew Novak, Policy Analyst, Department of Health Professions
BOARD COUNSEL PRESENT:	James Rutkowski, Assistant Attorney General
PUBLIC ATTENDEES:	Kevin Headly, Germanna Community College Denise Konrad, Virginia Health Care Foundation Julianne Tripp, Department of Behavioral Health & Developmental Services Ruth Ann Walker, Department of Behavioral Health & Developmental Services
CALL TO ORDER:	Ms. Stransky called the Board Meeting to order at 10:00 a.m.
ROLL CALL/ESTABLISHMENT OF A QUORUM:	An introduction was done of all Board members and staff**.** Ten members of the Board were present at roll call; therefore, a quorum was established.
MISSION STATEMENT:	Ms. Stransky read the mission statement of the Department of Health Professions, which was also the mission statement of the Board. Ms. Stransky also read the emergency egress instructions.
ADOPTION OF AGENDA:	The agenda was adopted as presented.
PUBLIC COMMENT:	No public comment was provided.

APPROVAL OF MINUTES: The Board reviewed the minutes from the last meeting held on April 19, 2024.

Motion: Dr. Yancey made a motion, which Dr. Terry properly seconded to approve the minutes from the April 19, 2024 meeting as presented. The motion passed unanimously.

AGENCY REPORT: Mr. Jenkins welcomed Ms. Burdge to the Board. He informed the board that new security measures have taken place at the Perimeter Center that require everyone entering the building to go through a safety screening that includes passing items through an x-ray machine and walking through a magnetometer.

Mr. Jenkins informed the Board that the Governor signed the state budget on May 13, 2024. He reminded the Board that the Department of Health Professions is not a General Fund agency and does not get its funding through the General Assembly, but rather through licensing fees. However, the General Assembly still must approve the DHP budget and appropriate the funds.

Mr. Jenkins also informed the Board that an internal salary study is being conducted by Gallagher to ensure that salaries are comparable to other state agencies.

BOARD CHAIR REPORT: No report.

LEGISLATION & REGULATORY REPORT:

- **Chart of Regulatory Actions**
  Ms. Barrett reviewed with the Board the current regulatory actions for the Board of Counseling as of July 22, 2024. A copy of the chart was included in the agenda packet.

- **Regulatory actions required by passage of House Bill 329**
  Ms. Barrett reviewed and discussed with the Board House Bill 329 from the General Assembly Session, the exempt regulatory changes to 18VAC115-50-40 as required by House Bill 329, the final text or regulatory changes related to periodic review, and the fast-track text of regulatory changes related to licensure by endorsement changes.

  Ms. Barret informed the Board that HB329 conflicts with portions of the 2018 periodic review, which at this point is very old, and the Board's fast-track regulatory reduction action, which was intended to reduce endorsement requirements, but which does not make the changes dictated in HB329. She informed the Board that both actions needed to be withdrawn and that they have until September 29, 2024 to get it to the registrar office.

  Motion: Dr. Bernard made a motion, which Dr. Tinsley properly seconded to adopt exempt regulatory changes to LMFT licensure by endorsement consistent with House Bill 329. The motion passed unanimously.

  Motion: Dr. Tinsley made a motion, which Ms. Gordon properly seconded to withdraw final action resulting from 2018 periodic review. The motion passed unanimously.

  Motion: Ms. Gordon made a motion, which Ms. Franklin properly seconded to withdraw the fast-track Regulatory Reduction action from September 2022 and send LPC reductions to the regulatory committee to look at considering the changes made to LMFTs by endorsement. The motion passed unanimously.

- **Initiation of periodic review of all chapters**
  Ms. Barrett discussed with the Board that given the withdrawal of the regulatory action based on the 2018 periodic review of Chapters 20, 50, and 60, and given the length of time since other chapters have undergone periodic review, the Board should issue a new periodic review for all chapters and begin the process anew.

  It was discussed that Chapter 80, Regulations Governing the Registration of Qualified Mental Health Professionals, should not be included due to current changes being implemented pursuant to legislation.

  Motion: Dr. Bernard made a motion, which Dr. Yancey properly seconded to initiate periodic review for the following chapters:
  - Chapter 20, Regulations Governing the Practice of Professional Counseling;
  - Chapter 30, Regulations Governing the Certification of Substance Abuse Counselors;
  - Chapter 40, Regulations Governing the Certification of Rehabilitation Providers;
  - Chapter 50, Regulations Governing the Practice of Marriage and Family Therapy;
  - Chapter 60, Regulations Governing the Practice of Licensed Substance Abuse Treatment Practitioners; and
  - Chapter 70, Regulations Governing the Registration of Peer Recovery Specialists.

    The motion passed unanimously.

- **Petition for Rulemaking**
  Ms. Barrett reviewed and discussed a petition for rulemaking received 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.

  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. 6 contained complex responses that were not easily categorized. 3 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.

  The Regulatory Committee reviewed this petition at its meeting on July 19, 2024, and recommends that the petition be denied because the changes requested would impact multiple other regulations and requirements which need to be reviewed as well. The Regulatory Committee, however, intends to review the issues raised at a future meeting.

  Motion: Ms. Gordon made a motion, which Mr. Scott properly seconded, to accept the recommendation of the Regulatory Committee to deny the petition because the changes requested would impact multiple other regulations and requirements which need to be reviewed as well, but send the matter to the Regulatory Committee to review in depth. The motion passed unanimously.

REGULATORY COMMITTEE REPORT:

Dr. Tinsley gave a recap of the Regulatory Committee meeting held on July 19, 2024, and thanked Ms. Lang for gathering data for existing programs and creating a chart to assist Board members in determining registration pathways and required hours as they implement the changes required by Senate Bill 403.

- **Review of draft exempt regulatory changes pursuant to Senate Bill 403**
  Ms. Barrett reviewed and discussed with the Board draft changes made to Senate Bill 403 from the 2024 General Assembly Session; the draft regulations for new professions of behavioral health technicians and behavioral health technician assistants; and the draft regulatory changes to QMHP regulations.

  Ms. Barrett informed the Board that at its meeting on July 19, 2024, the Regulatory Committee reviewed the draft regulatory changes. She informed the Board that the remaining decisions to be made relate to the number of didactic hours of training required for registration as a BHT, BHTA, or QMHP.

  Ms. Barret informed the Board that they would review these exempt regulatory changes at the October 4, 2024 meeting, and that the Board would need to vote to adopt the regulations at that meeting, following a public hearing on the changes.

  The Board discussed the number of didactic hours of training that should be required for registration as a BHT, BHTA, and QMHP. Board staff provided information on the number of hours in existing programs as a guide.

  The Board discussed a recommended 20 hours of didactic education as a requirement for both behavioral health technicians and behavioral health technician assistants. The Board concluded that the recommended hours should be discussed again at a future meeting as the recommended hours should not be the same for both the BHT and BHTAs.

  The Board discussed a recommended 40 hours of didactic education as a requirement for qualified mental health professionals and a recommended hours of didactic education for QMHP-trainees would still need to be discussed and a future meeting.

EXECUTIVE DIRECTOR'S REPORT:

Ms. Hoyle welcomed Ms. Burdge to the Board and updated the Board on appointments. She informed the Board that Dr. Gerald Lawson resigned as he had not received notice of a reappointment. She informed the Board that Ms. Franklin's second term has ended but she will continue to serve on the Board until a new appointment has been received. She also indicated that there are currently two vacancies on the Board: one for a LMFT member and one for a LSATP member.

Ms. Hoyle informed the Board that a budget update should be available by the next meeting in October. She also reported on the growth in applications for licensure, certification and registration and that QMHP trainees has shown the largest amount of growth.

DISCIPLINE REPORT:

Ms. Lang reported on the discipline stats for the Board of Counseling from April 6, 2024-July 12, 2024, that was included in the agenda packet. She highlighted that as of July 12, 2024, the Board of Counseling has 195 open cases and another 86 cases being investigated.

She informed the board that the formal hearings scheduled for August 2, 2024, following the meeting, were both approved for continuance and Formal Hearings are scheduled for the next board meeting in October.

She thanked Christy Evans for her hard work and dedication to the board and the agency. She informed the Board that between the two of them, they are actively working on 520 open cases between the 3 behavioral science boards.

Lastly, she informed the board that Dr. Yancey has agreed to serve on a panel for the Department of Education to discuss curriculum for the CTE mental health program.

LICENSING REPORT: Ms. Lenart reported on the licensure stats for the Board of Counseling from February 2024-June 2024. A copy of the report was included in the agenda packet. She highlighted that the Board of Counseling has almost 40,000 licensee, certificate holders and registrants. She informed the Board that between 612-869 applications were received per month, which was nearly a 40% increase for the months of May and June.

Ms. Lenart reported on the recent changes to the requirements for licensure that were included in the agenda packet. She informed the Board that staff has updated forms, handbooks, FAQs, internal systems and instructions related to the changes and an email blast was distributed to licensees informing them of the changes.

Ms. Lenart informed the Board that she continues to coordinate the Behavioral Science Boards Business Process Engineering efforts to make application processes more efficient. She thanked Ms. Stransky for reviewing numerous QMHP coursework descriptions. She also thanked staff for their hard work and dedication, which is reflected in the 95.6% customer service satisfaction survey results for the quarter.

ELECTIONS: Dr. Tinsley indicated that he was willing to serve as Chairperson for the Board of Counseling.

Motion: Dr. Yancey moved, which was properly seconded, to nominate Dr. Tinsley as the Chairperson of the Board of Counseling. The motion passed unanimously.

Mr. Jenkins, Ms. Barret, Mr. Novak, and all public attendees left the meeting at 11:19a.m.

RECOMMENDED DECISIONS: Attachment "A"

NEXT MEETING DATES: The next meeting is scheduled for Friday, October 4, 2024. The next Regulatory meeting will be Friday, October 18, 2024.

ADJOURNMENT: Ms. Stransky adjourned the August 2, 2024, meeting at 11:27 a.m.

_____

Terry R. Tinsley, PhD, LPC, LMFT, CSOTP, Board Chairperson

_____

Jaime Hoyle, JD, Executive Director

ATTACHMENT A

CONSIDERATION OF RECOMMENDED DECISIONS
August 2, 2024

BOARD MEMBERS IN ATTENDANCE:

Maria Stransky, LPC, CSOTP, Vice-Chairperson
Benjamin Allison, Citizen Member
L Paul Bernard, Ph.D., LPC
Marlo Burdge, Citizen Member
Natalie Franklin, LPC, LMFT
Nakeisha Gordon, LPC
Luanne Griffin, LPC
Matthew Scott, LMFT
Terry Tinsley, Ph.D., LPC, LMFT, CSOTP
Tiffinee Yancey, Ph.D., LPC

CLOSED MEETING:

Dr. Yancey moved that the Board of Counseling convene in closed session pursuant to §2.2-3711(A)(27) of the *Code of Virginia* to consider an agency subordinate recommendation. She further moved that James Rutkowski, Jaime Hoyle, Jennifer Lang, Charlotte Lenart, Latasha Austin, Sandie Cotman, and Shannon Brogan attend the closed meeting because their presence in the meeting was deemed necessary and would aid the Board in its consideration of the matters. The motion was seconded and passed unanimously.

RECOMMENDATIONS:

Ashley Watson, Resident in Counseling
Case No.: 218735
Ashley Watson did not appear before the board and did not submit a written response. The board considered the agency subordinate's recommendation to issue a reprimand and a monetary penalty.

Robyn LeRoy-Istre, LPC
Case No.: 219217
Robyn LeRoy-Istre did not appear before the board and did not submit a written response. The board considered the agency subordinate's recommendation to place certain terms and conditions on Robyn LeRoy-Istre's license to practice as a professional counselor.

Janet Wiley, Applicant for registration as a QMHP-Trainee
Case No.: 230186
Janet Wiley did not appear before the board and did not submit a written response. The board considered the agency subordinate's recommendation to approve Janet Wiley's application for registration as a QMHP-Trainee.

Tanya Glanzman, Applicant for registration as a QMHP-A
Case No.: 230187
Tanya Glanzman did not appear before the board and did not submit a written response. The board considered the agency subordinate's recommendation to deny Tanya Glanzman's application for registration as a QMHP-A.

Amelia Bindas, LPC Reinstatement Applicant

Case No.: 231801

Amelia Bindas did not appear before the board and did not submit a written response. The board considered the agency subordinate's recommendation to deny Amelia Bindas' application for reinstatement of the license to practice professional counseling.

Lauren Dierkes, Applicant for licensure as a Resident in Counseling

Case No.: 233859

Lauren Dierkes did not appear before the board and did not submit a written response. The board considered the agency subordinate's recommendation to deny Lauren Dierkes' application for licensure as a Resident in Counseling.

Tiffanee Roberts, QMHP-A

Case No.: 234618

Tiffanee Roberts did not appear before the board and did not submit a written response. The board considered the agency subordinate's recommendation to indefinitely suspend Tiffanee Roberts' registration to practice as a QMHP-A.

Jessalin Good, Applicant for licensure as a Resident in Counseling

Case No.: 236216

Jessalin Good did not appear before the board and did not submit a written response. The board considered the agency subordinate's recommendation to deny Jessalin Good's application for licensure as a Resident in Counseling.

Travis Grant, Applicant for licensure as a Resident in Counseling

Case No.: 237952

Travis Grant did not appear before the board and did not submit a written response. The board considered the agency subordinate's recommendation to deny Travis Grant's application for licensure as a Resident in Counseling.

RECONVENE:

Dr. Yancey certified that pursuant to §2.2-3712 of the *Code of Virginia*, the Board of Counseling heard, discussed or considered only those public business matters lawfully exempted from open meeting requirements under the Virginia Freedom of Information Act and only such public business matters as identified in the original motion.

DECISION:

Mr. Scott made a motion to accept the recommendations of the agency subordinate. The motion was seconded and passed unanimously.

Virginia's Licensed Professional Counselor Workforce: 2024

Healthcare Workforce Data Center

July 2024

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

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

More than 8,800 Licensed Professional Counselors voluntarily participated in this survey. *Without their efforts, the work of the center would not be possible. The Department of Health Professions, the Healthcare Workforce Data Center, and the Board of Counseling express our sincerest appreciation for their ongoing cooperation.*

Thank You!

Virginia Department of Health Professions

Arne E. Owens, MS
Director

James L. Jenkins, Jr., RN
Chief Deputy Director

Healthcare Workforce Data Center Staff:

Yetty Shobo, PhD	Barbara Hodgdon, PhD	Rajana Siva, MBA	Christopher Coyle, BA	Ashlyn Cole,
Director	*Deputy Director*	*Data Analyst*	*Research Assistant*	*Summer Intern*

Virginia Board of Counseling

Chair

Vacant

Vice-Chair

Maria Stransky, LPC, CSAC, CSOTP
Richmond

Members

Benjamin Allison
Forest

Lester Paul Bernard, PhD, LPC
Lynchburg

Marlo Burdge
Richmond

Natalie Franklin, LPC, LMFT
Newport News

Nakeisha Gordon, LPC
Richmond

Luanne Griffin, LPC
Alexandria

Matthew Scott, LMFT
Lynchburg

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

Tiffinee Yancey, PhD, LPC
Suffolk

Executive Director

Jaime H. Hoyle, JD

Contents

The Licensed Professional Counselor Workforce At a Glance:

The Workforce

Licensees:	9,987
Virginia's Workforce:	7,957
FTEs:	6,498

Survey Response Rate

All Licensees:	89%
Renewing Practitioners:	97%

Demographics

Female:	83%
Diversity Index:	46%
Median Age:	46

Background

Rural Childhood:	31%
HS Degree in VA:	51%
Prof. Degree in VA:	64%

Education

Masters:	89%
Doctorate:	11%

Finances

Median Income:	$70k-$80k
Health Insurance:	57%
Under 40 w/ Ed. Debt:	67%

Current Employment

Employed in Prof.:	96%
Hold 1 Full-Time Job:	54%
Satisfied?:	97%

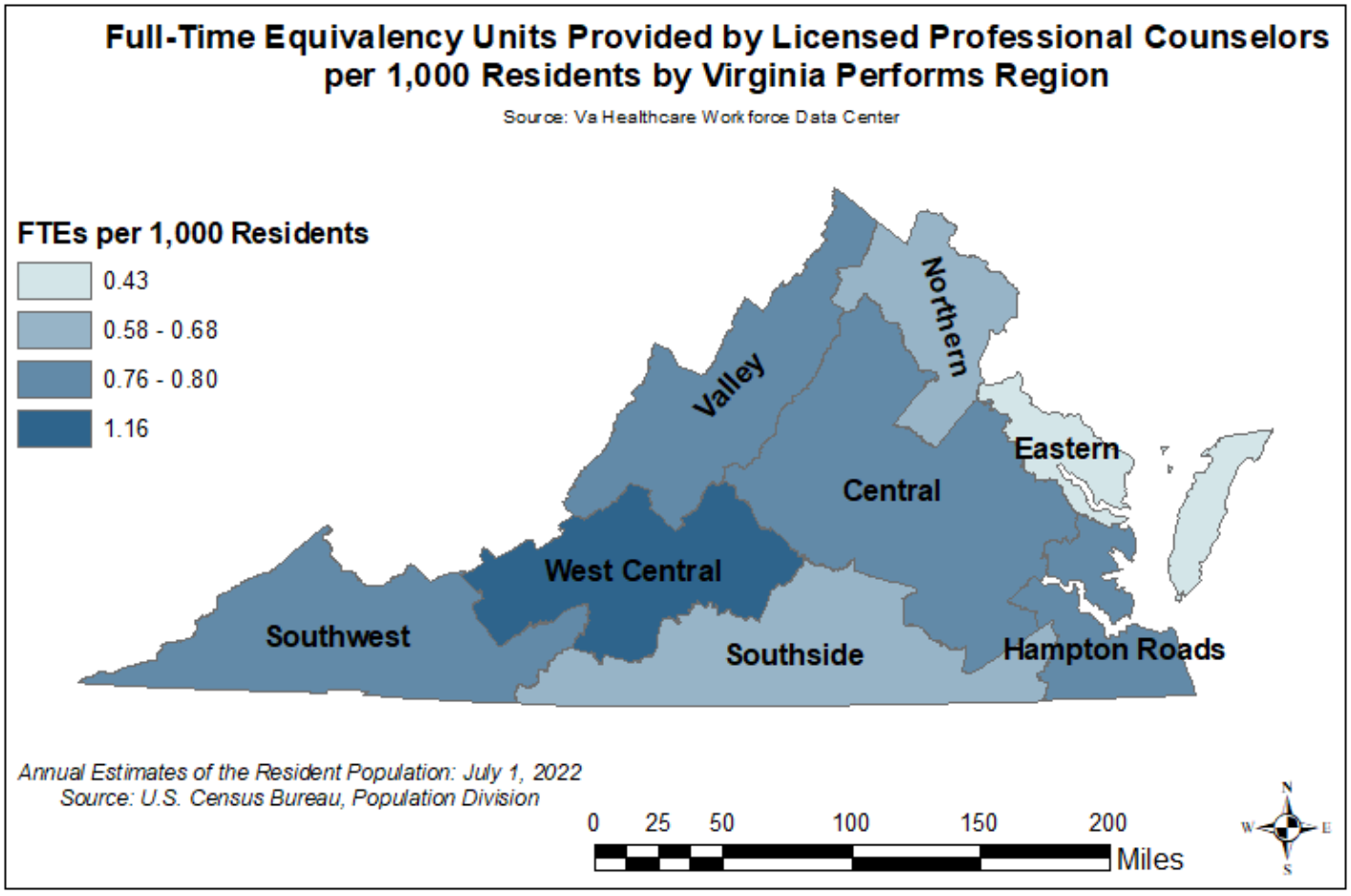
Job Turnover

Switched Jobs:	6%
Employed Over 2 Yrs.:	66%

Time Allocation

Patient Care:	70%-79%
Administration:	10%-19%
Patient Care Role:	64%

Source: Va. Healthcare Workforce Data Center



Results in Brief

This report contains the results of the 2024 Licensed Professional Counselor (LPC) Workforce Survey. In total, 8,847 LPCs voluntarily participated in this survey. The Virginia Department of Health Professions' Healthcare Workforce Data Center (HWDC) administers the survey during the license renewal process, which takes place every June for LPCs. These survey respondents represent 89% of the 9,987 LPCs who are licensed in the state and 97% of renewing practitioners.

The HWDC estimates that 7,957 LPCs participated in Virginia's workforce during the survey period, which is defined as those LPCs who worked at least a portion of the year in the state or who live in the state and intend to work as a LPC at some point in the future. Over the past year, Virginia's LPC workforce provided 6,498 "full-time equivalency units," which the HWDC defines simply as working 2,000 hours per year.

More than four out of every five LPCs are female, including 86% of those LPCs who are under the age of 40. In a random encounter between two LPCs, there is a 46% chance that they would be of different races or ethnicities, a measure known as the diversity index. This diversity index increases to 49% for those LPCs who are under the age of 40. For Virginia's population as a whole, the comparable diversity index is 60%. Nearly one-third of all LPCs grew up in a rural area, and 22% of those LPCs who grew up in a rural area currently work in a non-metro area of Virginia. In total, 9% of all LPCs work in a non-metro area of the state.

Among all LPCs, 96% are currently employed in the profession, 54% hold one full-time job, and 39% work between 40 and 49 hours per week. More than four out of every five LPCs work in the private sector, including 67% who work in the for-profit sector. The median annual income of Virginia's LPC workforce is between $70,000 and $80,000, and 53% receive this income as a salary. In addition, more than seven out of every ten wage and salaried LPCs receive at least one employer-sponsored benefit, including 57% who have access to health insurance. Among all LPCs, 97% indicated that they are satisfied with their current work situation, including 71% who indicated that they are "very satisfied."

Summary of Trends

In this section, all statistics for the current year are compared to the 2014 LPC workforce. The number of licensed LPCs in Virginia has increased by 149% (9,987 vs. 4,003). In addition, the size of Virginia's LPC workforce has increased by 123% (7,957 vs. 3,564), and the number of FTEs provided by this workforce has increased by 103% (6,498 vs. 3,208). Virginia's renewing LPCs are more likely to respond to this survey (97% vs. 89%).

The percentage of all LPCs who are female has increased (83% vs. 77%), while the median age of this workforce has fallen (46 vs. 52). The diversity index of Virginia's LPC workforce has increased (46% vs. 27%), and this is also the case among LPCs who are under the age of 40 (49% vs. 36%). The percentage of LPCs who grew up in a rural area has increased (31% vs. 28%), and LPCs who grew up in a rural area are more likely to work in a non-metro area of Virginia (22% vs 20%). However, there has been no change in the overall percentage of LPCs who work in a non-metro area of the state (9%). LPCs are more likely to hold a master's degree (89% vs. 84%) than a doctorate degree (11% vs. 16%) as their highest professional degree. In addition, LPCs are also more likely to carry education debt (50% vs. 34%), and the median outstanding balance among those LPCs with education debt has increased ($90k-$100k vs. $40k-$50k).

LPCs are more likely to be employed in the profession (96% vs. 93%) and hold two or more positions (29% vs. 26%). At the same time, LPCs are relatively more likely to work between 30 and 39 hours per week (21% vs. 14%) than between 40 and 49 hours per week (39% vs. 44%). LPCs are also less likely to have worked at their primary work location for at least two years (66% vs. 73%). Virginia's LPCs are more likely to work in the for-profit sector (67% vs. 53%) but less likely to work in either the non-profit sector (15% vs. 18%) or a state/local government (16% vs. 26%). The median annual income of Virginia's LPCs has increased ($70k-$80k vs. $50k-$60k), and LPCs are relatively more likely to receive this income as an hourly wage (16% vs. 13%) than as a salary (53% vs. 58%). At the same time, wage and salaried LPCs are less likely to receive at least one employer-sponsored benefit (71% vs. 74%), including those LPCs who have access to health insurance (57% vs. 63%). Virginia's LPCs are more likely to indicate that they are satisfied with their current work situation (97% vs. 94%), including those who indicated that they are "very satisfied" (71% vs. 70%).

A Closer Look:

Licensees		
License Status	**#**	**%**
Renewing Practitioners	8,605	86%
New Licensees	1,097	11%
Non-Renewals	285	3%
All Licensees	**9,987**	**100%**

Source: Va. Healthcare Workforce Data Center

HWDC surveys tend to achieve very high response rates. Among all renewing LPCs, 97% submitted a survey. These represent 89% of the 9,987 LPCs who held a license at some point during the survey period.

Definitions

1. **The Survey Period:** The survey was conducted in June 2024.
2. **Target Population:** All LPCs who held a Virginia license at some point between July 2023 and June 2024.
3. **Survey Population:** The survey was available to LPCs who renewed their licenses online. It was not available to those who did not renew, including LPCs newly licensed in 2024.

Response Rates			
Statistic	**Non Respondents**	**Respondents**	**Response Rate**
By Age			
Under 35	303	1,028	77%
35 to 39	195	1,464	88%
40 to 44	148	1,436	91%
45 to 49	103	1,186	92%
50 to 54	91	998	92%
55 to 59	79	844	91%
60 to 64	61	662	92%
65 and Over	160	1,229	89%
Total	**1,140**	**8,847**	**89%**
New Licenses			
Issued in Past Year	622	475	43%
Metro Status			
Non-Metro	68	665	91%
Metro	721	6,469	90%
Not in Virginia	351	1,712	83%

Source: Va. Healthcare Workforce Data Center

Response Rates	
Completed Surveys	**8,847**
Response Rate, All Licensees	**89%**
Response Rate, Renewals	**97%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Licensed LPCs

Number:	9,987
New:	11%
Not Renewed:	3%

Response Rates

All Licensees:	89%
Renewing Practitioners:	97%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Workforce

Virginia's LPC Workforce:	7,957
FTEs:	6,498

Utilization Ratios

Licensees in VA Workforce:	80%
Licensees per FTE:	1.54
Workers per FTE:	1.22

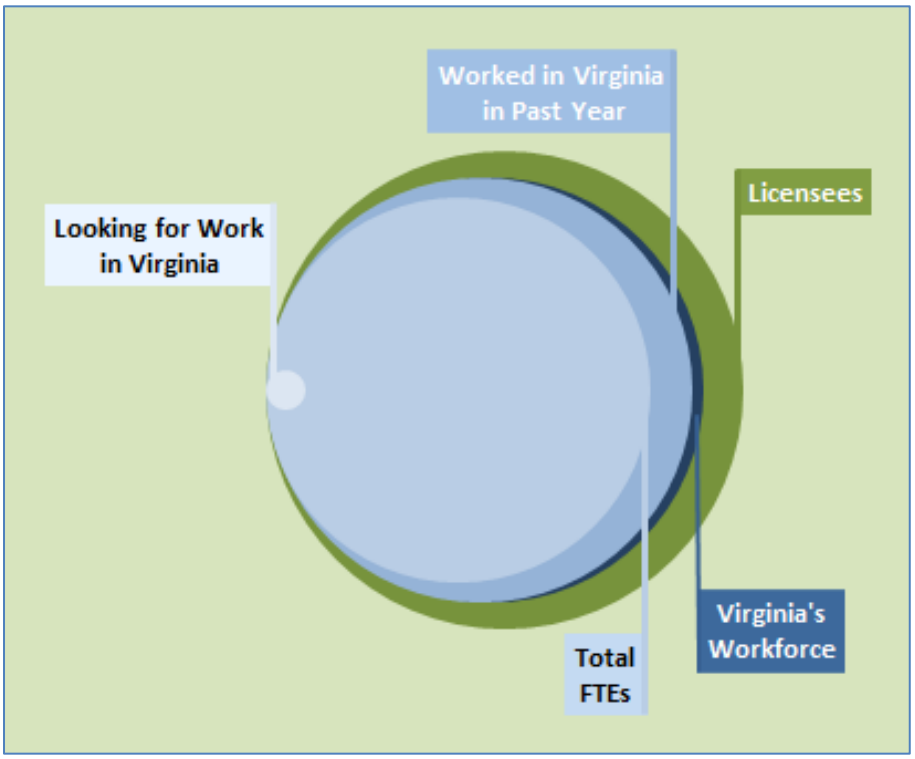
Source: Va. Healthcare Workforce Data Center

Definitions

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

Virginia's LPC Workforce		
Status	**#**	**%**
Worked in Virginia in Past Year	7,891	99%
Looking for Work in Virginia	66	1%
Virginia's Workforce	**7,957**	**100%**
Total FTEs	**6,498**	
Licensees	**9,987**	

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

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

A Closer Look:

Age & Gender						
Age	Male		Female		Total	
	#	% Male	#	% Female	#	% in Age Group
Under 35	114	11%	886	89%	1,000	15%
35 to 39	178	16%	940	84%	1,118	17%
40 to 44	149	15%	867	85%	1,016	16%
45 to 49	130	16%	701	84%	831	13%
50 to 54	110	16%	581	84%	690	11%
55 to 59	121	20%	474	80%	595	9%
60 to 64	103	22%	366	78%	469	7%
65 and Over	236	29%	589	71%	825	13%
Total	**1,141**	**17%**	**5,404**	**83%**	**6,545**	**100%**

Source: Va. Healthcare Workforce Data Center

Race & Ethnicity					
Race/ Ethnicity	Virginia*	LPCs		LPCs Under 40	
	%	#	%	#	%
White	59%	4,673	71%	1,460	69%
Black	18%	1,204	18%	368	17%
Asian	7%	123	2%	48	2%
Other Race	1%	56	1%	6	0%
Two or More Races	5%	173	3%	87	4%
Hispanic	10%	340	5%	148	7%
Total	**100%**	**6,569**	**100%**	**2,117**	**100%**

*Population data in this chart is from the U.S. Census, Annual Estimates of the Resident Population by Sex, Race, and Hispanic Origin for the United States, States, and Counties: July 1, 2022.

Source: Va. Healthcare Workforce Data Center

At a Glance:

Gender

% Female:	83%
% Under 40 Female:	86%

Age

Median Age:	46
% Under 40:	32%
% 55 and Over:	29%

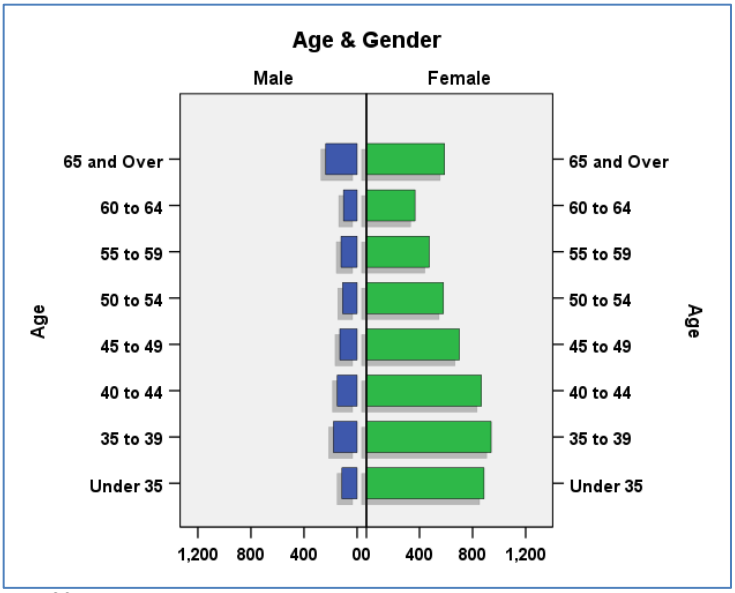
Diversity

Diversity Index:	46%
Under 40 Div. Index:	49%

Source: Va. Healthcare Workforce Data Center

In a chance encounter between two LPCs, there is a 46% chance that they would be of different races or ethnicities, a measure known as the diversity index. For Virginia's population as a whole, the comparable diversity index is 60%.

Nearly one-third of all LPCs are under the age of 40, and 86% of LPCs who are under the age of 40 are female. In addition, the diversity index among LPCs who are under the age of 40 is 49%.



Source: Va. Healthcare Workforce Data Center

At a Glance:

Childhood

Urban Childhood:	14%
Rural Childhood:	31%

Virginia Background

HS in Virginia:	51%
Prof. Edu. in VA:	64%
HS or Prof. Edu. in VA:	74%

Location Choice

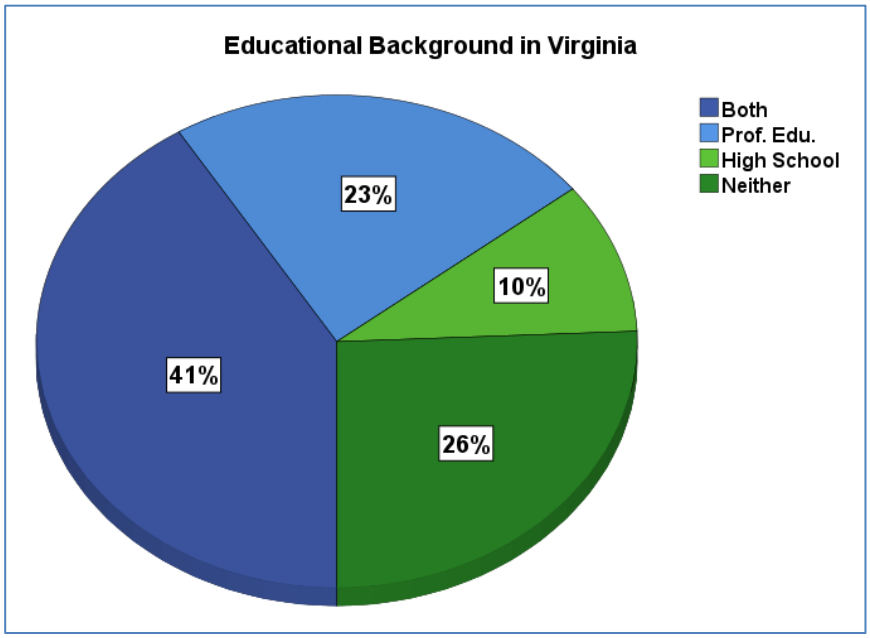
% Rural to Non-Metro:	22%
% Urban/Suburban to Non-Metro:	4%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Primary Location: USDA Rural Urban Continuum		Rural Status of Childhood Location		
Code	Description	Rural	Suburban	Urban
	Metro Counties			
1	Metro, 1 Million+	21%	61%	18%
2	Metro, 250,000 to 1 Million	42%	48%	10%
3	Metro, 250,000 or Less	40%	51%	9%
	Non-Metro Counties			
4	Urban, Pop. 20,000+, Metro Adjacent	67%	23%	10%
6	Urban, Pop. 2,500-19,999, Metro Adjacent	69%	25%	7%
7	Urban, Pop. 2,500-19,999, Non-Adjacent	93%	7%	1%
8	Rural, Metro Adjacent	60%	36%	4%
9	Rural, Non-Adjacent	60%	36%	4%
	Overall	**31%**	**55%**	**14%**

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

Among all LPCs, 31% grew up in a self-described rural area, and 22% of LPCs who grew up in a rural area currently work in a non-metro county. In total, 9% of all LPCs in the state currently work in a non-metro county.

Top Ten States for Licensed Professional Counselor Recruitment

Rank	All LPCs			
	High School	#	Init. Prof. Degree	#
1	Virginia	3,303	Virginia	4,145
2	New York	324	Minnesota	202
3	Pennsylvania	294	Washington, D.C.	191
4	Maryland	277	Maryland	191
5	North Carolina	224	Pennsylvania	147
6	Outside U.S./Canada	216	North Carolina	146
7	Florida	172	Kentucky	130
8	New Jersey	148	Florida	128
9	Ohio	128	New York	112
10	California	101	Texas	83

Source: Va. Healthcare Workforce Data Center

Among all LPCs, 51% received their high school degree in Virginia, while 64% received their initial professional degree in the state.

Among LPCs who have obtained their initial license in the past five years, 51% received their high school degree in Virginia, while 62% received their initial professional degree in the state.

Rank	Licensed in the Past Five Years			
	High School	#	Init. Prof. Degree	#
1	Virginia	1,505	Virginia	1,809
2	New York	133	Minnesota	128
3	Maryland	122	Washington, D.C.	88
4	Pennsylvania	115	Kentucky	86
5	North Carolina	103	Maryland	80
6	Outside U.S./Canada	95	Pennsylvania	79
7	Florida	91	North Carolina	68
8	New Jersey	62	Florida	64
9	Ohio	50	New York	57
10	Texas	49	Arizona	39

Source: Va. Healthcare Workforce Data Center

Among all licensees in Virginia, 20% did not participate in the state's LPC workforce during the past year. Among licensed LPCs who did not participate in the state's LPC workforce, 93% worked at some point in the past year, including 87% who currently work in a job related to the behavioral sciences.

At a Glance:

Not in VA Workforce

Total:	2,029
% of Licensees:	20%
Federal/Military:	6%
Va. Border State/D.C.:	21%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Highest Professional Degree		
Degree	**#**	**%**
Bachelor's Degree	6	0%
Master's Degree	5,645	89%
Doctor of Psychology	132	2%
Other Doctorate	579	9%
Total	**6,363**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

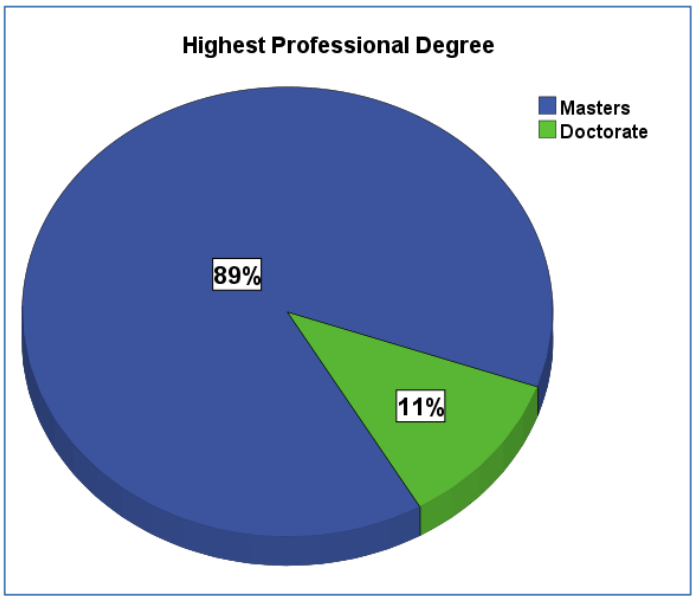
Education

Masters: 89%
Doctorate/PhD: 11%

Education Debt

Carry Debt: 50%
Under Age 40 w/ Debt: 67%
Median Debt: $90k-$100k

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

Education Debt				
Amount Carried	**All LPCs**		**LPCs Under 40**	
	#	**%**	**#**	**%**
None	2,743	50%	564	33%
Less than $10,000	199	4%	61	4%
$10,000-$29,999	288	5%	113	7%
$30,000-$49,999	260	5%	125	7%
$50,000-$69,999	260	5%	135	8%
$70,000-$89,999	325	6%	165	10%
$90,000-$109,999	367	7%	183	11%
$110,000-$129,999	261	5%	125	7%
$130,000-$149,999	201	4%	68	4%
$150,000 or More	599	11%	184	11%
Total	**5,503**	**100%**	**1,723**	**100%**

Source: Va. Healthcare Workforce Data Center

One half of all LPCs carry education debt, including 67% of those LPCs who are under the age of 40. For those LPCs with education debt, the median outstanding balance is between $90,000 and $100,000.

At a Glance:

Primary Specialty

Mental Health:	67%
Child:	5%
Behavioral Disorders:	5%

Secondary Specialty

Substance Abuse:	15%
Behavioral Disorders:	14%
Mental Health:	14%

Source: Va. Healthcare Workforce Data Center

Two out of every three LPCs have a primary specialty in mental health. In addition, another 14% of LPCs have a secondary specialty in mental health.

A Closer Look:

Specialties				
Specialty	Primary		Secondary	
	#	%	#	%
Mental Health	4,201	67%	745	14%
Child	339	5%	414	8%
Behavioral Disorders	330	5%	746	14%
Substance Abuse	290	5%	762	15%
Marriage	123	2%	324	6%
Family	115	2%	366	7%
School/Educational	92	1%	191	4%
Forensic	49	1%	40	1%
Sex Offender Treatment	25	0%	66	1%
Health/Medical	14	0%	36	1%
Vocational/Work Environment	14	0%	29	1%
Rehabilitation	12	0%	32	1%
Neurology/Neuropsychology	8	0%	24	0%
Industrial-Organizational	3	0%	13	0%
Gerontologic	3	0%	10	0%
Social	2	0%	31	1%
Public Health	2	0%	19	0%
Experimental or Research	1	0%	3	0%
General Practice (Non-Specialty)	445	7%	957	18%
Other Specialty Area	216	3%	435	8%
Total	**6,285**	**100%**	**5,245**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Employment

Employed in Profession: 96%
Involuntarily Unemployed: < 1%

Positions Held

1 Full-Time: 54%
2 or More Positions: 29%

Weekly Hours:

40 to 49: 39%
60 or More: 5%
Less than 30: 22%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Current Work Status		
Status	**#**	**%**
Employed, Capacity Unknown	5	< 1%
Employed in a Behavioral Sciences-Related Capacity	6,062	96%
Employed, NOT in a Behavioral Sciences-Related Capacity	127	2%
Not Working, Reason Unknown	0	0%
Involuntarily Unemployed	5	< 1%
Voluntarily Unemployed	57	1%
Retired	66	1%
Total	**6,322**	**100%**

Source: Va. Healthcare Workforce Data Center

Among all LPCs, 96% are currently employed in the profession, 54% hold one full-time job, and 39% work between 40 and 49 hours per week.

Current Weekly Hours		
Hours	**#**	**%**
0 Hours	128	2%
1 to 9 Hours	189	3%
10 to 19 Hours	438	7%
20 to 29 Hours	743	12%
30 to 39 Hours	1,271	21%
40 to 49 Hours	2,428	39%
50 to 59 Hours	671	11%
60 to 69 Hours	231	4%
70 to 79 Hours	55	1%
80 or More Hours	27	0%
Total	**6,181**	**100%**

Source: Va. Healthcare Workforce Data Center

Current Positions		
Positions	**#**	**%**
No Positions	128	2%
One Part-Time Position	954	15%
Two Part-Time Positions	316	5%
One Full-Time Position	3,334	54%
One Full-Time Position & One Part-Time Position	1,215	20%
Two Full-Time Positions	76	1%
More than Two Positions	172	3%
Total	**6,195**	**100%**

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Annual Income		
Income Level	**#**	**%**
Volunteer Work Only	39	1%
Less than $20,000	228	5%
$20,000-$29,999	158	3%
$30,000-$39,999	211	4%
$40,000-$49,999	297	6%
$50,000-$59,999	463	9%
$60,000-$69,999	615	12%
$70,000-$79,999	742	15%
$80,000-$89,999	605	12%
$90,000-$99,999	465	9%
$100,000 or More	1,245	25%
Total	**5,068**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Earnings
Median Income: $70k-$80k

Benefits
(Salary/Wage Employees Only)
Health Insurance: 57%
Retirement: 54%

Satisfaction
Satisfied: 97%
Very Satisfied: 71%

Source: Va. Healthcare Workforce Data Center

Job Satisfaction		
Level	**#**	**%**
Very Satisfied	4,363	71%
Somewhat Satisfied	1,582	26%
Somewhat Dissatisfied	158	3%
Very Dissatisfied	39	1%
Total	**6,142**	**100%**

Source: Va. Healthcare Workforce Data Center

The typical LPC earns between $70,000 and $80,000 per year. Among LPCs who receive either an hourly wage or a salary as compensation at their primary work location, 71% receive at least one employer-sponsored benefit, including 57% who have access to health insurance.

Employer-Sponsored Benefits			
Benefit	**#**	**%**	**% of Wage/Salary Employees**
Paid Vacation	2,526	42%	62%
Health Insurance	2,366	39%	57%
Retirement	2,280	38%	54%
Dental Insurance	2,248	37%	55%
Paid Sick Leave	2,117	35%	52%
Group Life Insurance	1,652	27%	42%
Signing/Retention Bonus	431	7%	11%
At Least One Benefit	**3,031**	**50%**	**71%**

*From any employer at time of survey.

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Employment Instability in the Past Year		
In the Past Year, Did You . . .?	**#**	**%**
Experience Involuntary Unemployment?	34	< 1%
Experience Voluntary Unemployment?	245	3%
Work Part-Time or Temporary Positions, but Would Have Preferred a Full-Time/Permanent Position?	169	2%
Work Two or More Positions at the Same Time?	2,046	26%
Switch Employers or Practices?	497	6%
Experience at Least One?	**2,552**	**32%**

Source: Va. Healthcare Workforce Data Center

Less than 1% of Virginia's LPCs experienced involuntary unemployment at some point during the past year. By comparison, Virginia's average monthly unemployment rate was 2.8% during the same time period.[1]

Location Tenure				
Tenure	**Primary**		**Secondary**	
	#	**%**	**#**	**%**
Not Currently Working at This Location	79	1%	60	3%
Less than 6 Months	272	4%	150	9%
6 Months to 1 Year	500	8%	221	13%
1 to 2 Years	1,197	20%	381	22%
3 to 5 Years	1,867	31%	531	31%
6 to 10 Years	1,003	17%	217	12%
More than 10 Years	1,134	19%	179	10%
Subtotal	**6,051**	**100%**	**1,739**	**100%**
Did Not Have Location	79		6,117	
Item Missing	1,827		101	
Total	**7,957**		**7,957**	

Source: Va. Healthcare Workforce Data Center

Among all LPCs, 53% are salaried employees, while 23% receive income from their own business or practice.

At a Glance:

Unemployment Experience

Involuntarily Unemployed: < 1%
Underemployed: 2%

Turnover & Tenure

Switched Jobs: 6%
New Location: 19%
Over 2 Years: 66%
Over 2 Yrs., 2nd Location: 53%

Employment Type

Salary/Commission: 53%
Business/Practice Income: 23%

Source: Va. Healthcare Workforce Data Center

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

Employment Type		
Primary Work Site	**#**	**%**
Salary/Commission	2,352	53%
Hourly Wage	708	16%
By Contract	354	8%
Business/Practice Income	1,045	23%
Unpaid	18	0%
Subtotal	**4,477**	**100%**
Did Not Have Location	79	
Item Missing	3,401	

Source: Va. Healthcare Workforce Data Center

[1] As reported by the U.S. Bureau of Labor Statistics. Over the past year, the non-seasonally adjusted monthly unemployment rate has fluctuated between a low of 2.3% and a high of 3.2%. At the time of publication, the unemployment rate for June 2024 was still preliminary.

At a Glance:

Concentration

Top Region:	29%
Top 3 Regions:	70%
Lowest Region:	1%

Locations

2 or More (Past Year):	30%
2 or More (Now*):	27%

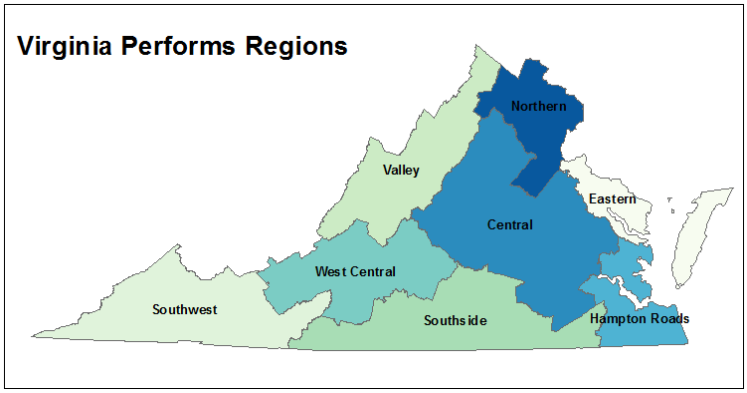
Source: Va. Healthcare Workforce Data Center

Seven out of every ten LPCs in the state work in Northern Virginia, Central Virginia, and Hampton Roads.

A Closer Look:

Regional Distribution of Work Locations				
Virginia Performs Region	Primary Location		Secondary Location	
	#	%	#	%
Central	1,323	22%	393	22%
Eastern	62	1%	28	2%
Hampton Roads	1,224	20%	369	21%
Northern	1,740	29%	448	25%
Southside	220	4%	63	4%
Southwest	274	4%	63	4%
Valley	373	6%	96	5%
West Central	775	13%	208	12%
Virginia Border State/D.C.	26	0%	29	2%
Other U.S. State	69	1%	90	5%
Outside of the U.S.	3	0%	4	0%
Total	**6,089**	**100%**	**1,791**	**100%**
Item Missing	1,789		49	

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

Number of Work Locations				
Locations	Work Locations in Past Year		Work Locations Now*	
	#	%	#	%
0	66	1%	124	2%
1	4,231	69%	4,326	71%
2	1,019	17%	999	16%
3	739	12%	646	11%
4	41	1%	18	0%
5	11	0%	7	0%
6 or More	24	0%	10	0%
Total	**6,130**	**100%**	**6,130**	**100%**

*At the time of survey completion, June 2024.

Source: Va. Healthcare Workforce Data Center

Among all LPCs, 27% currently have multiple work locations, while 30% have had multiple work locations over the past year.

A Closer Look:

Location Sector				
Sector	Primary Location		Secondary Location	
	#	%	#	%
For-Profit	3,751	67%	1,291	80%
Non-Profit	825	15%	192	12%
State/Local Government	895	16%	102	6%
Veterans Administration	21	0%	4	0%
U.S. Military	94	2%	8	0%
Other Federal Government	51	1%	9	1%
Total	**5,637**	**100%**	**1,606**	**100%**
Did Not Have Location	79		6,117	
Item Missing	2,241		234	

Source: Va. Healthcare Workforce Data Center

At a Glance:
(Primary Locations)

Sector

For-Profit:	67%
Federal:	3%

Top Establishments

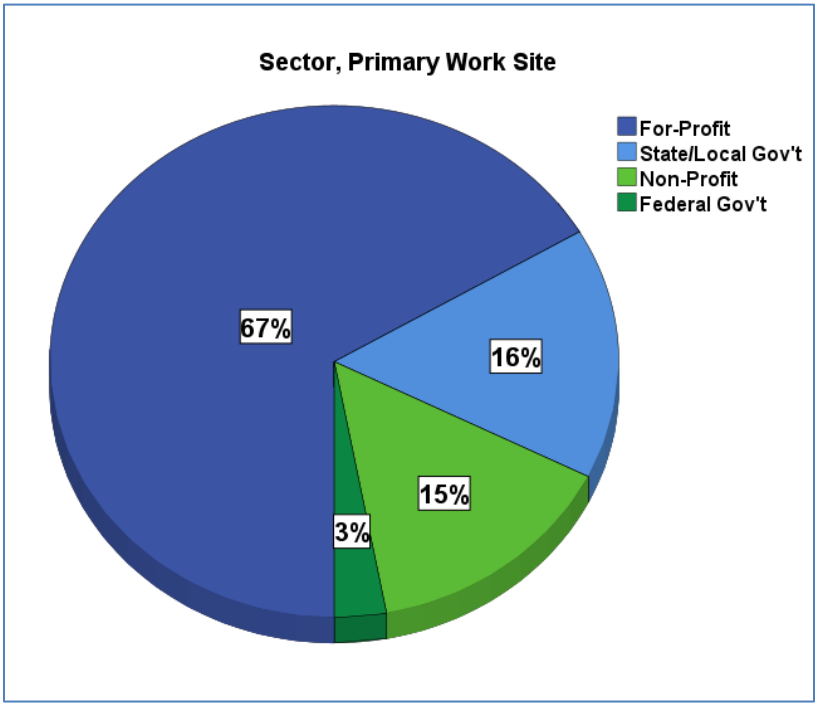
Private Practice, Group:	24%
Private Practice, Solo:	22%
Mental Health Facility:	15%

Payment Method

Cash/Self-Pay:	64%
Private Insurance:	55%

Source: Va. Healthcare Workforce Data Center

More than four out of every five LPCs work in the private sector, including 67% who work in the for-profit sector. Another 16% of LPCs work for a state or local government.



Source: Va. Healthcare Workforce Data Center

Location Type				
Establishment Type	Primary Location		Secondary Location	
	#	%	#	%
Private Practice, Group	1,357	24%	405	26%
Private Practice, Solo	1,242	22%	433	28%
Mental Health Facility, Outpatient	809	15%	195	13%
Community Services Board	656	12%	71	5%
Community-Based Clinic or Health Center	352	6%	110	7%
School (Providing Care to Clients)	258	5%	22	1%
Academic Institution (Teaching Health Professions Students)	143	3%	81	5%
Residential Mental Health/Substance Abuse Facility	92	2%	19	1%
Hospital, General	77	1%	16	1%
Corrections/Jail	75	1%	8	1%
Hospital, Psychiatric	63	1%	27	2%
Administrative or Regulatory	52	1%	13	1%
Physician Office	23	0%	1	0%
Rehabilitation Facility	17	0%	8	1%
Residential Intellectual/Development Disability Facility	10	0%	1	0%
Long-Term Care Facility, Nursing Home	8	0%	1	0%
Home Health Care	5	0%	4	0%
Other Practice Setting	317	6%	127	8%
Total	**5,556**	**100%**	**1,542**	**100%**

Source: Va. Healthcare Workforce Data Center

Group and solo private practices employ 47% of all LPCs in Virginia. Another 15% of LPCs work at outpatient mental health facilities.

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

Accepted Forms of Payment		
Payment	#	% of Workforce
Cash/Self-Pay	5,128	64%
Private Insurance	4,407	55%
Medicaid	2,799	35%
Medicare	1,516	19%

Source: Va. Healthcare Workforce Data Center

At a Glance:
(Primary Locations)

Languages Offered

Spanish:	13%
French:	4%
Arabic:	4%

Means of Communication

Other Staff Members:	45%
Virtual Translation:	40%
Respondent:	28%

Source: Va. Healthcare Workforce Data Center

Among all LPCs, 13% are employed at a primary work location that offers Spanish language services for patients.

A Closer Look:

Languages Offered		
Language	**#**	**% of Workforce**
Spanish	1,067	13%
French	314	4%
Arabic	307	4%
Chinese	300	4%
Korean	284	4%
Hindi	261	3%
Vietnamese	258	3%
Persian	237	3%
Tagalog/Filipino	234	3%
Urdu	234	3%
Pashto	209	3%
Amharic, Somali, or Other Afro-Asiatic Languages	201	3%
Others	224	3%
At Least One Language	**1,252**	**16%**

Source: Va. Healthcare Workforce Data Center

Means of Language Communication		
Provision	**#**	**% of Workforce with Language Services**
Other Staff Member is Proficient	566	45%
Virtual Translation Services	504	40%
Respondent is Proficient	350	28%
Onsite Translation Service	259	21%
Other	39	3%

Source: Va. Healthcare Workforce Data Center

Nearly half of all LPCs who are employed at a primary work location that offers language services for patients provide it by means of a staff member who is proficient.

At a Glance:
(Primary Locations)

Typical Time Allocation

Patient Care:	70%-79%
Administration:	10%-19%
Supervisory:	1%-9%

Roles

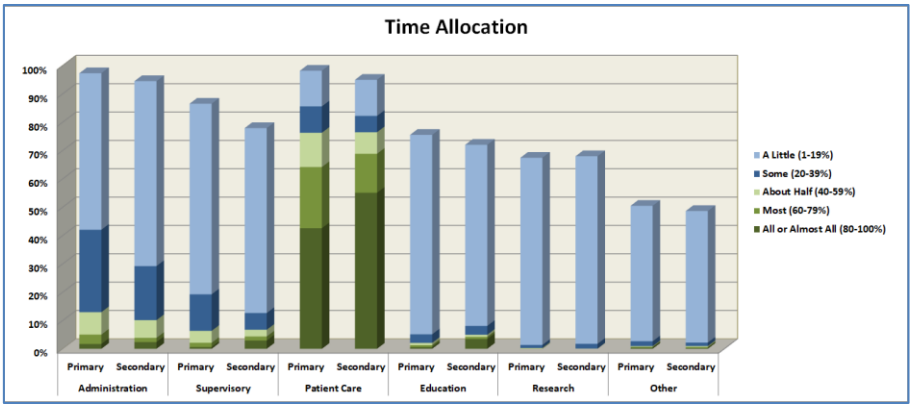
Patient Care:	64%
Administration:	5%
Supervisory:	2%

Patient Care LPCs

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

Source: Va. Healthcare Workforce Data Center

A Closer Look:



Source: Va. Healthcare Workforce Data Center

LPCs spend approximately three-fourths of their time treating patients. In fact, 64% of all LPCs fill a patient care role, defined as spending 60% or more of their time on patient care activities.

Time Allocation												
Time Spent	Admin.		Supervisory		Patient Care		Education		Research		Other	
	Pri. Site	Sec. Site	Pri. Site	Sec. Site	Pri. Site	Sec. Site	Pri. Site	Sec. Site	Pri. Site	Sec. Site	Pri. Site	Sec. Site
All or Almost All (80-100%)	2%	2%	1%	3%	43%	55%	1%	3%	0%	0%	0%	0%
Most (60-79%)	3%	1%	1%	1%	22%	14%	1%	1%	0%	0%	0%	0%
About Half (40-59%)	8%	6%	4%	2%	12%	8%	1%	1%	0%	0%	0%	0%
Some (20-39%)	29%	19%	13%	6%	9%	6%	3%	3%	1%	2%	2%	1%
A Little (1-19%)	55%	65%	67%	65%	13%	13%	70%	64%	66%	66%	48%	46%
None (0%)	3%	6%	14%	22%	2%	5%	25%	28%	33%	32%	50%	51%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Patients Per Week				
# of Patients	Primary Location		Secondary Location	
	#	%	#	%
None	362	6%	174	11%
1 to 24	3,629	65%	1,257	80%
25 to 49	1,496	27%	114	7%
50 to 74	96	2%	17	1%
75 or More	41	1%	5	0%
Total	**5,624**	**100%**	**1,567**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

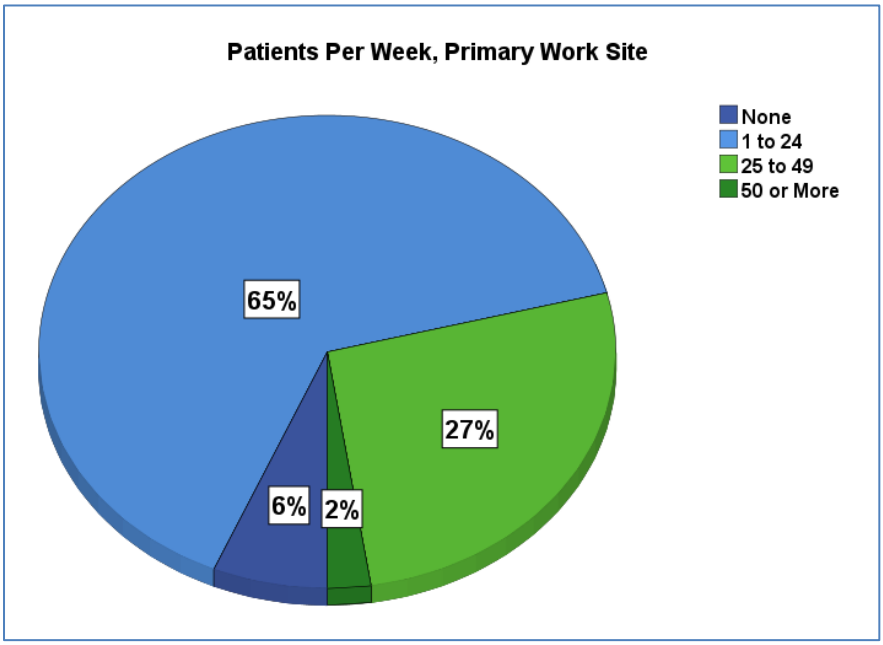
Patients Per Week

Primary Location: 1-24

Secondary Location: 1-24

Source: Va. Healthcare Workforce Data Center

Nearly two-thirds of all LPCs treat between 1 and 24 patients per week at their primary work location. Among those LPCs who also have a secondary work location, 80% treat between 1 and 24 patients per week.



Source: Va. Healthcare Workforce Data Center

At a Glance:
(Primary Locations)

Typical Patient Allocation

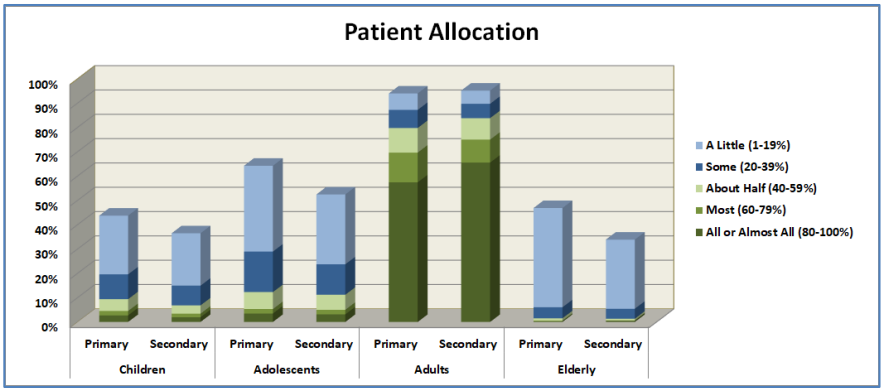
Children:	None
Adolescents:	1%-9%
Adults:	80%-89%
Elderly:	None

Roles

Children:	5%
Adolescents:	5%
Adults:	70%
Elderly:	1%

Source: Va. Healthcare Workforce Data Center

A Closer Look:



Source: Va. Healthcare Workforce Data Center

In general, most patients seen by LPCs at their primary work location are adults. In addition, 70% of LPCs serve an adult patient care role, meaning that at least 60% of their patients are adults.

Patient Allocation								
Time Spent	Children		Adolescents		Adults		Elderly	
	Pri. Site	Sec. Site	Pri. Site	Sec. Site	Pri. Site	Sec. Site	Pri. Site	Sec. Site
All or Almost All (80-100%)	3%	2%	3%	3%	57%	66%	0%	1%
Most (60-79%)	2%	1%	2%	2%	12%	9%	0%	0%
About Half (40-59%)	5%	3%	7%	6%	10%	9%	1%	1%
Some (20-39%)	10%	8%	17%	13%	7%	6%	5%	4%
A Little (1-19%)	24%	22%	35%	29%	7%	5%	41%	28%
None (0%)	56%	64%	36%	48%	6%	5%	53%	66%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Telehealth Services		
	#	%
Providing Telehealth Services		
In Virginia	4,442	71%
Outside of Virginia	45	1%
Both	926	15%
Total Providing Telehealth Services	**5,413**	**86%**
Not Providing Telehealth Services		
Total Not Providing Telehealth Services	**863**	**14%**
Total		
Total	**6,277**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

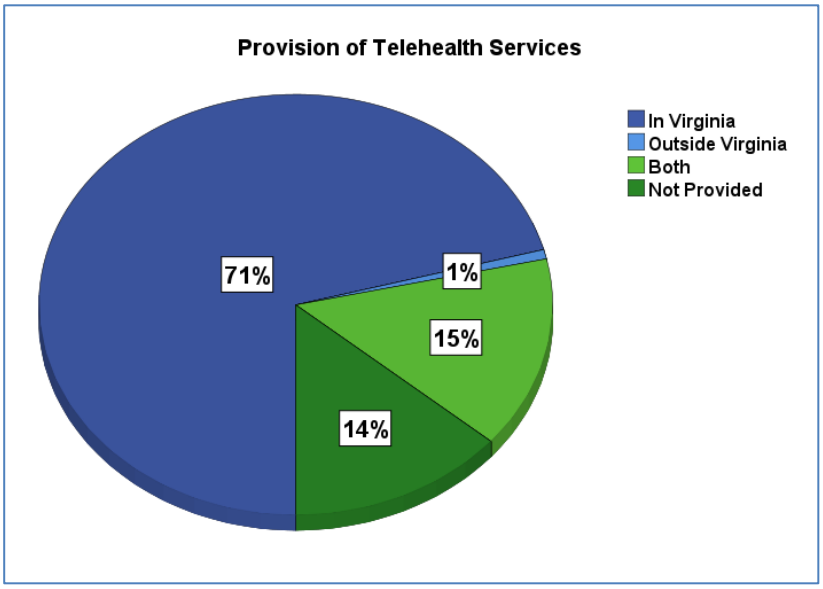
Telehealth Services

% Providing Telehealth: 86%

Telehealth Workload

Less than Half: 60%
More than Half: 20%
All: 20%

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

More than four out of every five LPCs provide telehealth services, including 71% of LPCs who provide telehealth services only in Virginia.

Two out of every five LPCs work at a practice that provides more than half or all of their health care services via telehealth.

Telehealth Workload		
Percentage	**#**	**%**
Less than Half	3,501	60%
More than Half	1,169	20%
All	1,187	20%
Total	**5,857**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Interstate Compact
% in Compact: 4%

Compact Affiliation
Counseling: 96%
PSYPACT: 1%

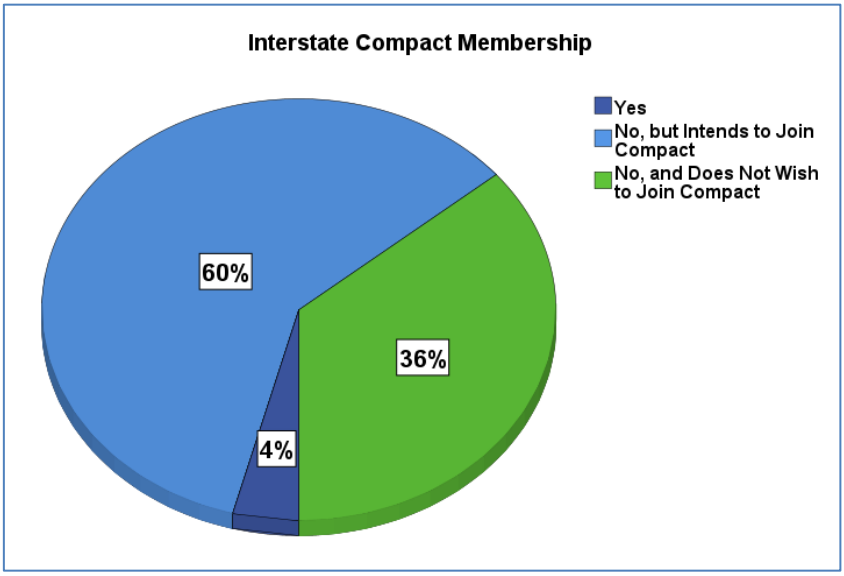
Source: Va. Healthcare Workforce Data Center

A Closer Look:

Interstate Compact		
	#	%
In Compact		
Total in Compact	**249**	**4%**
Not in Compact		
Intends to Join Compact	3,587	60%
Does Not Wish to Join Compact	2,165	36%
Total Not in Compact	**5,752**	**96%**
Total		
Total	**6,001**	**100%**

Source: Va. Healthcare Workforce Data Center

While 4% of LPCs are currently a part of an interstate compact, another 60% intend to join an interstate compact in the future.



Source: Va. Healthcare Workforce Data Center

Compact Affiliation		
Affiliation	**#**	**%**
Counseling Compact	225	96%
Psychology Interjurisdictional Compact (PSYPACT)	3	1%
Social Work Licensure Compact	0	0%
Other	6	3%
Total	**234**	**100%**

Source: Va. Healthcare Workforce Data Center

Nearly all LPCs currently in an interstate compact are affiliated with the Counseling Compact.

A Closer Look:

Retirement Expectations				
Expected Retirement Age	All LPCs		LPCs 50 and Over	
	#	%	#	%
Under Age 50	70	1%	-	-
50 to 54	142	3%	12	1%
55 to 59	340	7%	62	3%
60 to 64	911	18%	245	12%
65 to 69	1,563	30%	595	28%
70 to 74	939	18%	519	24%
75 to 79	425	8%	271	13%
80 or Over	190	4%	121	6%
I Do Not Intend to Retire	624	12%	304	14%
Total	5,203	100%	2,129	100%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Retirement Expectations

All LPCs

Under 65: 28%

Under 60: 11%

LPCs 50 and Over

Under 65: 15%

Under 60: 3%

Time Until Retirement

Within 2 Years: 5%

Within 10 Years: 19%

Half the Workforce: By 2049

Source: Va. Healthcare Workforce Data Center

Among all LPCs, 28% expect to retire before the age of 65. Among those LPCs who are age 50 or over, 15% expect to retire by the age of 65.

Within the next two years, 14% of LPCs expect to increase their patient care hours, and 12% expect to pursue additional educational opportunities.

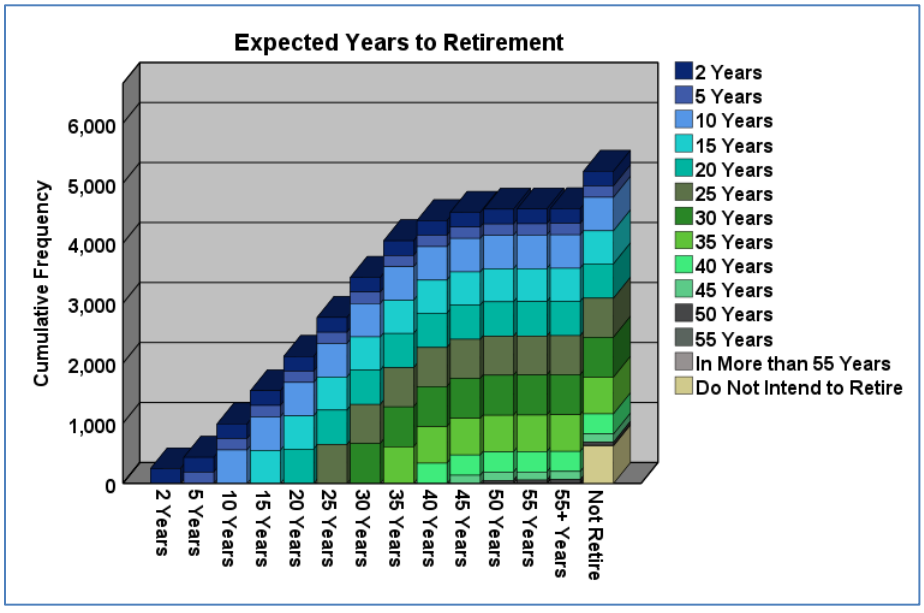
Future Plans		
Two-Year Plans:	#	%
Decrease Participation		
Leave Profession	76	1%
Leave Virginia	211	3%
Decrease Patient Care Hours	699	9%
Decrease Teaching Hours	25	0%
Increase Participation		
Increase Patient Care Hours	1,130	14%
Increase Teaching Hours	581	7%
Pursue Additional Education	917	12%
Return to the Workforce	28	0%

Source: Va. Healthcare Workforce Data Center

By comparing retirement expectation to age, we can estimate the maximum years to retirement for LPCs. While 5% of LPCs expect to retire in the next two years, 19% expect to retire in the next ten years. Half of the current workforce expect to retire by 2049.

Time to Retirement			
Expect to Retire Within. . .	**#**	**%**	**Cumulative %**
2 Years	245	5%	5%
5 Years	189	4%	8%
10 Years	558	11%	19%
15 Years	551	11%	30%
20 Years	573	11%	41%
25 Years	649	12%	53%
30 Years	668	13%	66%
35 Years	610	12%	78%
40 Years	337	6%	84%
45 Years	137	3%	87%
50 Years	51	1%	88%
55 Years	4	0%	88%
In More than 55 Years	6	0%	88%
Do Not Intend to Retire	624	12%	100%
Total	**5,203**	**100%**	

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

Using these estimates, retirement will begin to reach 10% of the current workforce starting in 2034. Retirement will peak at 13% of the current workforce around 2054 before declining to under 10% of the current workforce again around 2064.

At a Glance:

FTEs

Total: 6,498
FTEs/1,000 Residents[2]: 0.748
Average: 0.82

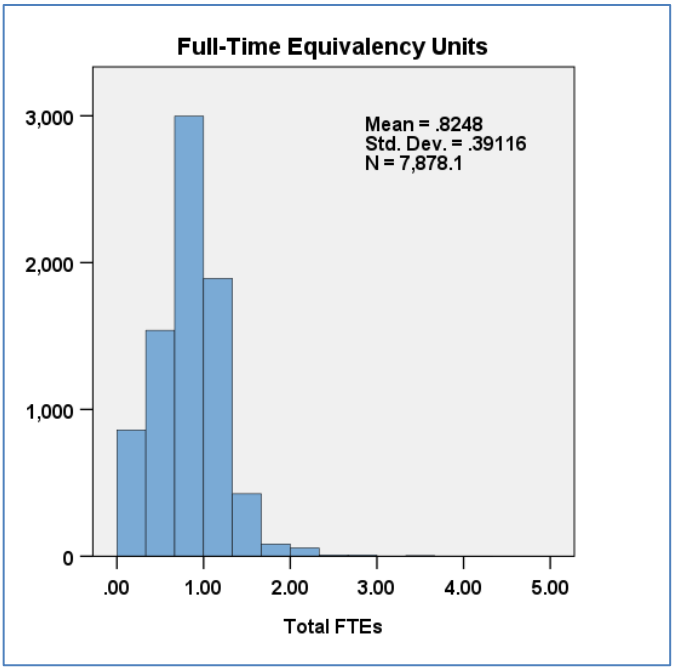
Age & Gender Effect

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

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

Source: Va. Healthcare Workforce Data Center

A Closer Look:

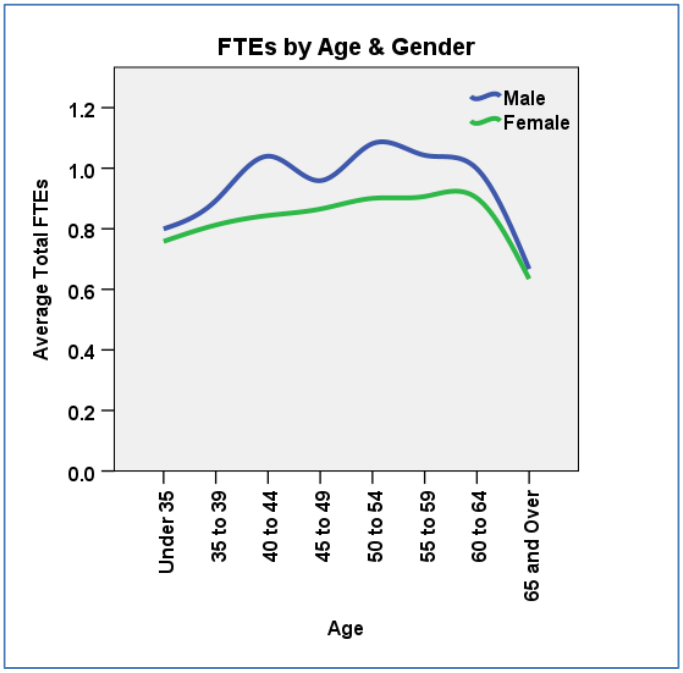


Source: Va. Healthcare Workforce Data Center

The typical (median) LPC provided 0.83 FTEs over the past year, or approximately 33 hours per week for 50 weeks. Although FTEs appear to vary by age and gender, statistical tests did not verify that a difference exists.[3]

Full-Time Equivalency Units		
Age	**Average Age**	**Median Age**
Under 35	0.74	0.71
35 to 39	0.84	0.92
40 to 44	0.84	0.80
45 to 49	0.86	0.78
50 to 54	0.91	0.83
55 to 59	0.89	0.81
60 to 64	0.98	1.05
65 and Over	0.64	0.65
Gender		
Male	0.91	0.94
Female	0.82	0.83

Source: Va. Healthcare Workforce Data Center

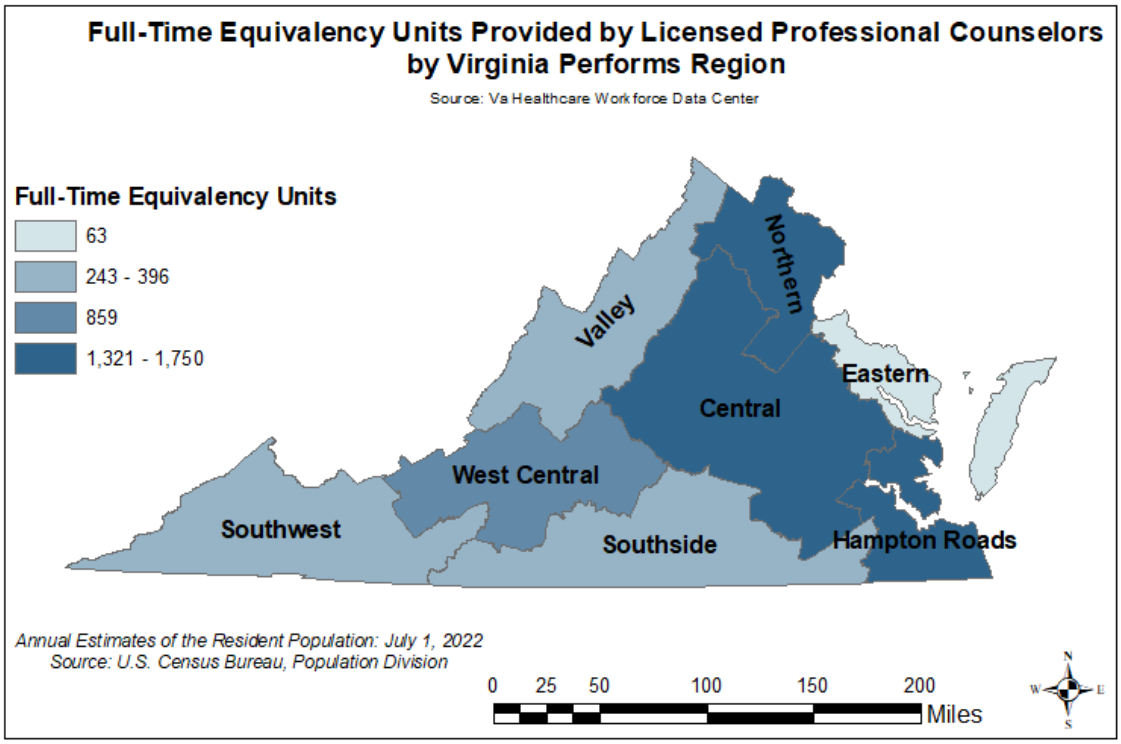


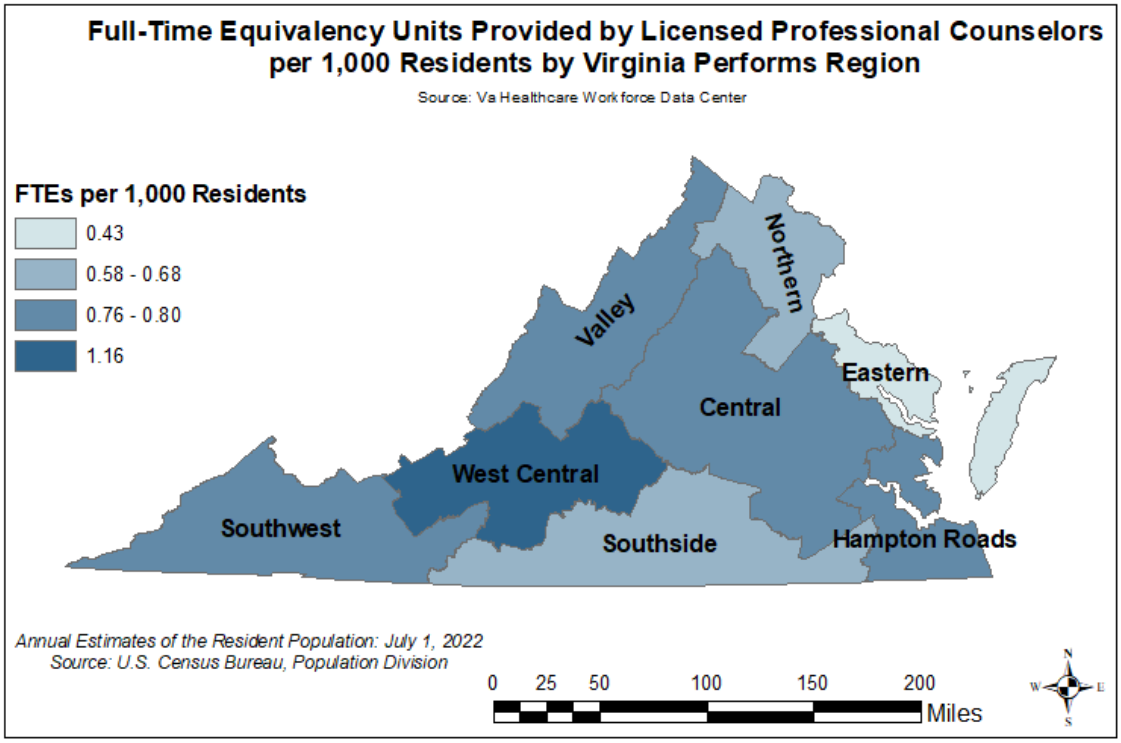
Source: Va. Healthcare Workforce Data Center

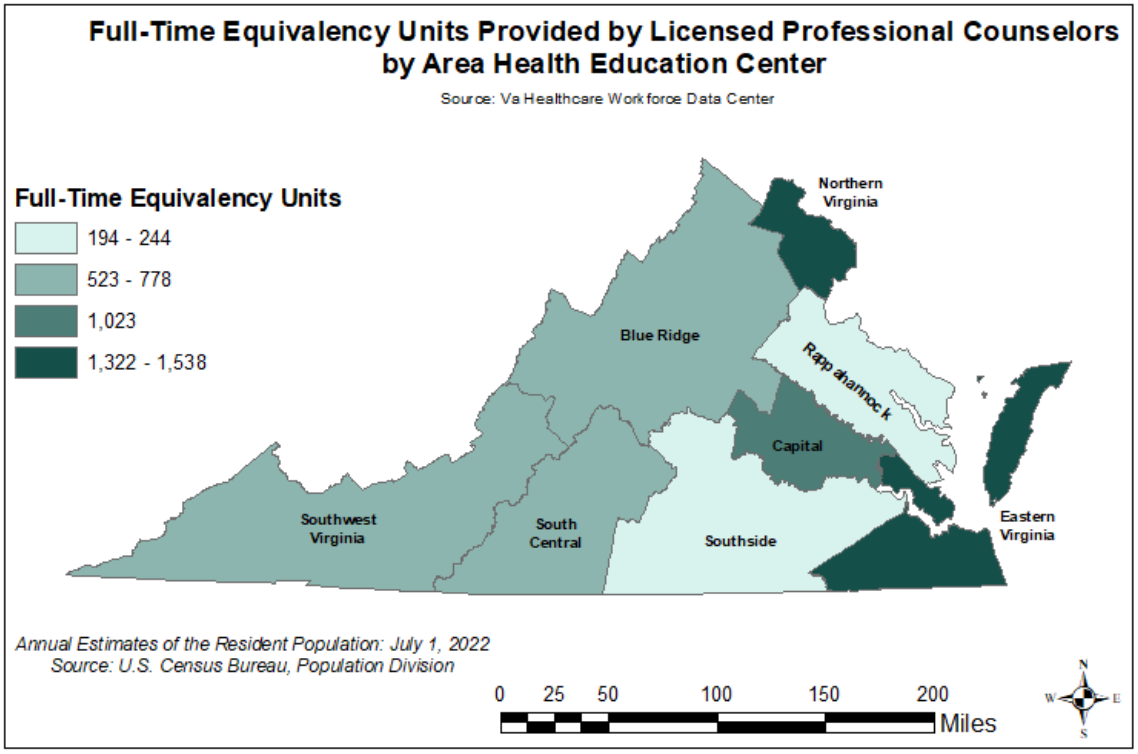
[2] Number of residents in 2022 was used as the denominator.
[3] Due to assumption violations in Mixed between-within ANOVA (Levene's Test and Interaction effect were significant).

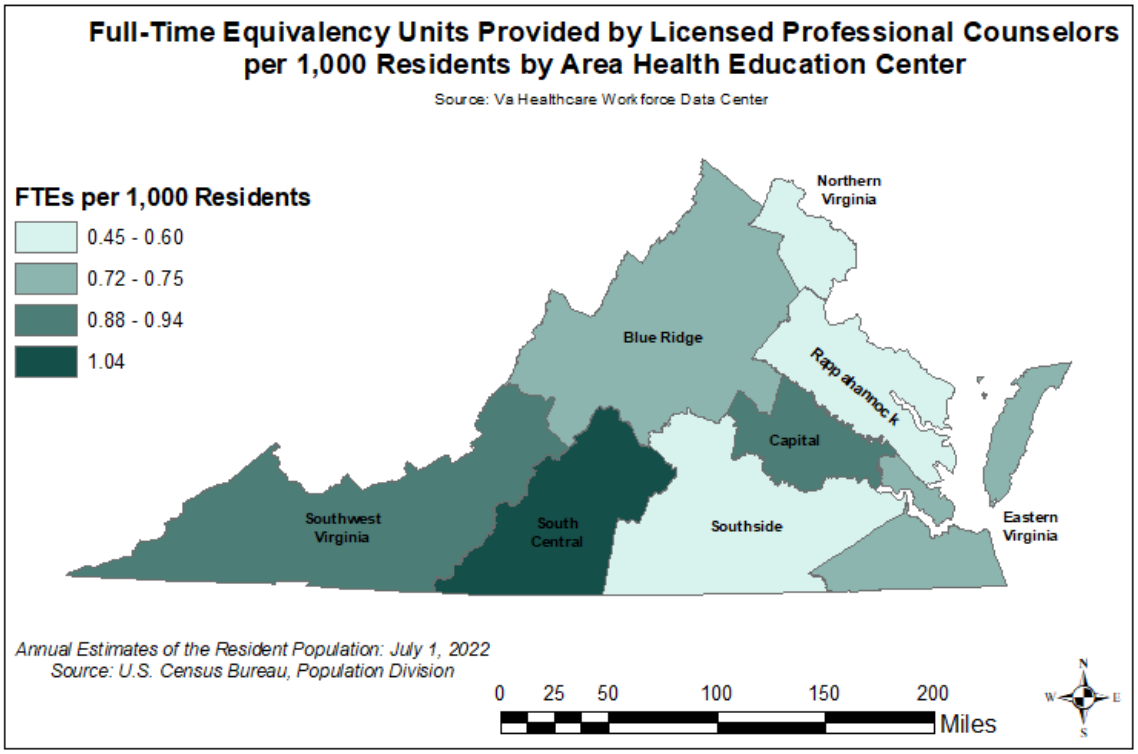
Maps

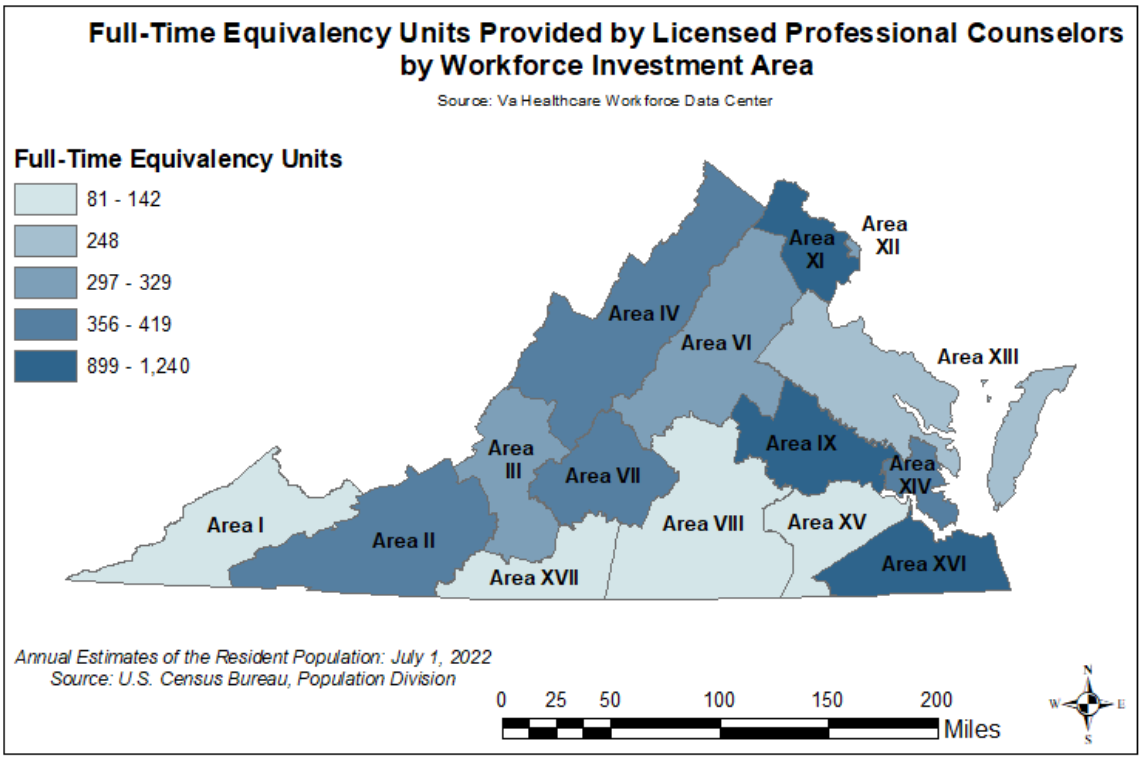
Virginia Performs Regions

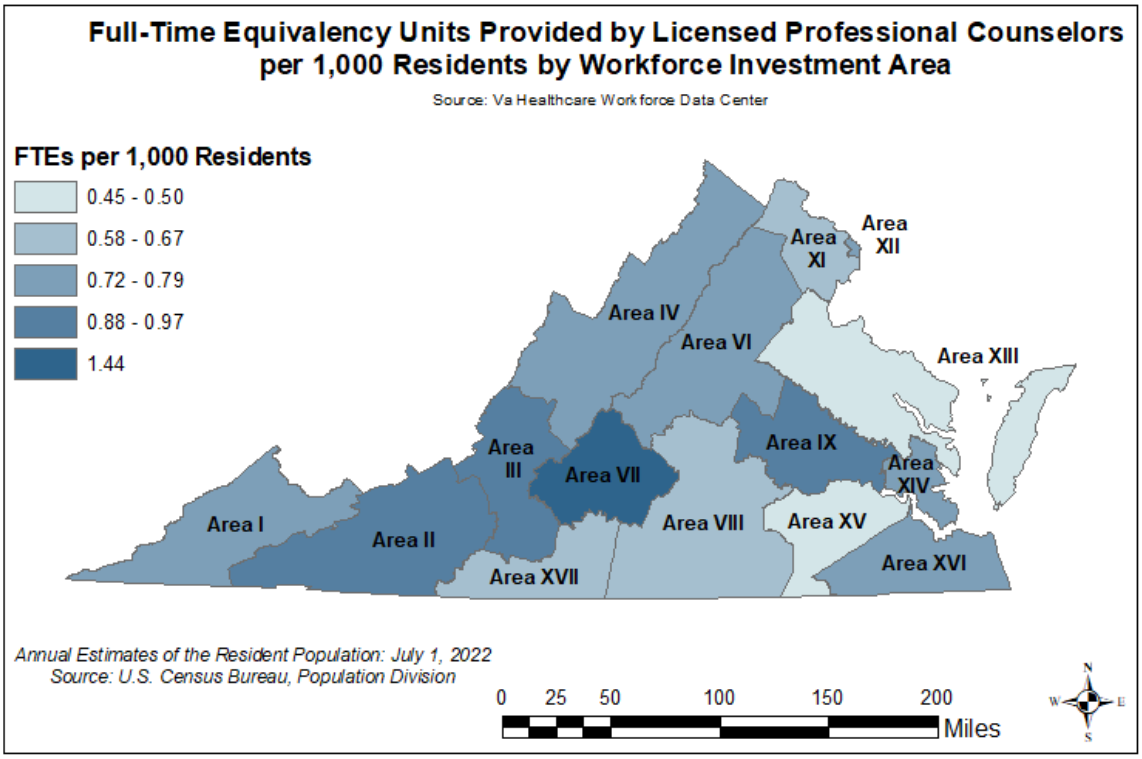


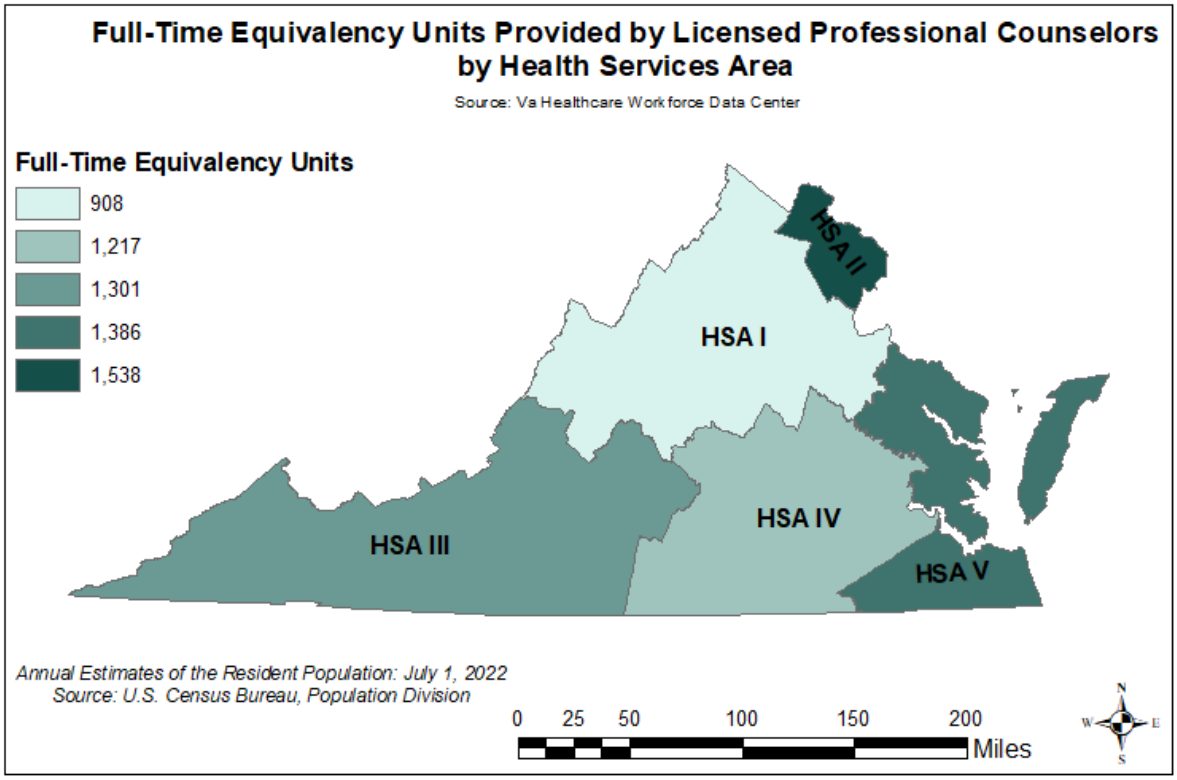


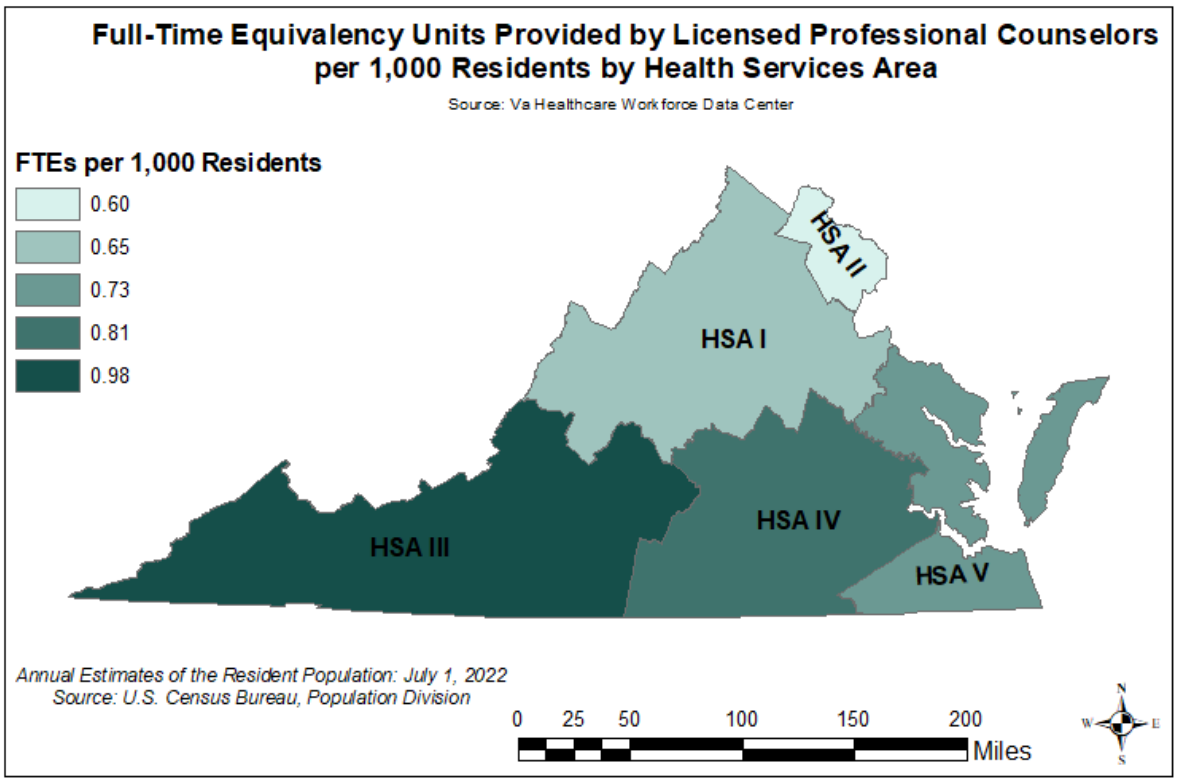

Full-Time Equivalency Units Provided by Licensed Professional Counselors by Area Health Education Center
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
194 - 244
523 - 778
1,023
1,322 - 1,538
Northern Virginia
Blue Ridge
Rappahannock
Capital
Southwest Virginia
South Central
Southside
Eastern Virginia
Annual Estimates of the Resident Population: July 1, 2022
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S

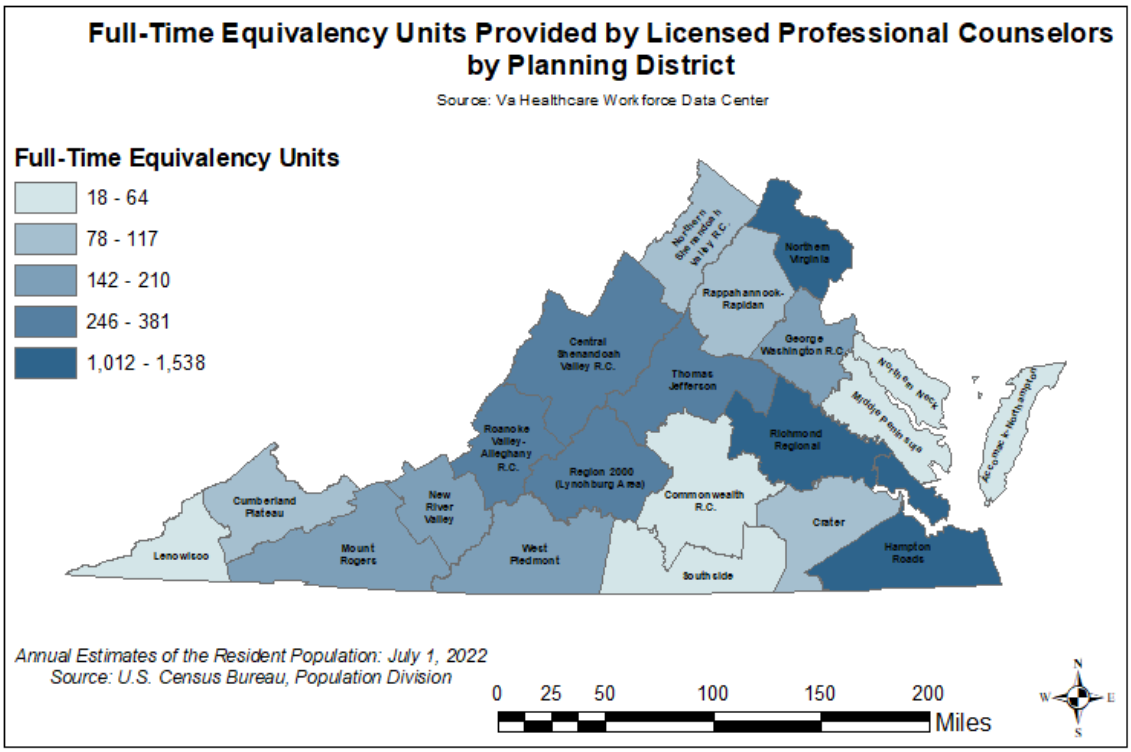

Full-Time Equivalency Units Provided by Licensed Professional Counselors per 1,000 Residents by Area Health Education Center
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.45 - 0.60
0.72 - 0.75
0.88 - 0.94
1.04
Northern Virginia
Blue Ridge
Rappahannock
Capital
Southwest Virginia
South Central
Southside
Eastern Virginia
Annual Estimates of the Resident Population: July 1, 2022
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S

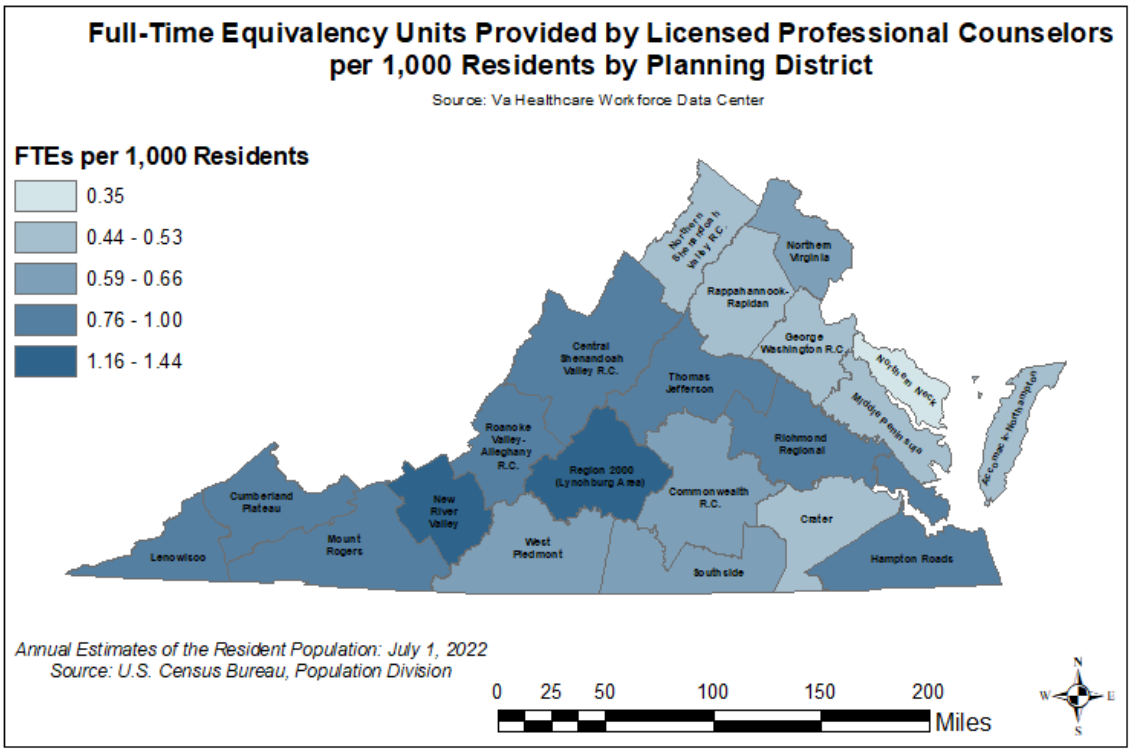

Full-Time Equivalency Units Provided by Licensed Professional Counselors by Workforce Investment Area
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
81 - 142
248
297 - 329
356 - 419
899 - 1,240
Area I
Area II
Area III
Area IV
Area VI
Area VII
Area VIII
Area IX
Area XI
Area XII
Area XIII
Area XIV
Area XV
Area XVI
Area XVII
Annual Estimates of the Resident Population: July 1, 2022
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full-Time Equivalency Units Provided by Licensed Professional Counselors per 1,000 Residents by Workforce Investment Area
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.45 - 0.50
0.58 - 0.67
0.72 - 0.79
0.88 - 0.97
1.44
Area I
Area II
Area III
Area IV
Area VI
Area VII
Area VIII
Area IX
Area XI
Area XII
Area XIII
Area XIV
Area XV
Area XVI
Area XVII
Annual Estimates of the Resident Population: July 1, 2022
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full-Time Equivalency Units Provided by Licensed Professional Counselors by Health Services Area
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
908
1,217
1,301
1,386
1,538
HSA I
HSA II
HSA III
HSA IV
HSA V
Annual Estimates of the Resident Population: July 1, 2022
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full-Time Equivalency Units Provided by Licensed Professional Counselors per 1,000 Residents by Health Services Area
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.60
0.65
0.73
0.81
0.98
HSA I
HSA II
HSA III
HSA IV
HSA V
Annual Estimates of the Resident Population: July 1, 2022
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full-Time Equivalency Units Provided by Licensed Professional Counselors by Planning District
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
18 - 64
78 - 117
142 - 210
246 - 381
1,012 - 1,538
Northern Shenandoah Valley R.C.
Northern Virginia
Rappahannock-Rapidan
George Washington R.C.
Central Shenandoah Valley R.C.
Thomas Jefferson
Northern Neck
Middle Peninsula
Accomack-Northampton
Roanoke Valley-Alleghany R.C.
Richmond Regional
Region 2000 (Lynchburg Area)
Commonwealth R.C.
Crater
Cumberland Plateau
New River Valley
Mount Rogers
West Piedmont
Lenowisco
South side
Hampton Roads
Annual Estimates of the Resident Population: July 1, 2022
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full-Time Equivalency Units Provided by Licensed Professional Counselors per 1,000 Residents by Planning District
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.35
0.44 - 0.53
0.59 - 0.66
0.76 - 1.00
1.16 - 1.44
Northern Shenandoah Valley R.C.
Northern Virginia
Rappahannock-Rapidan
George Washington R.C.
Central Shenandoah Valley R.C.
Thomas Jefferson
Northern Neck
Middle Peninsula
Accomack-Northampton
Roanoke Valley-Alleghany R.C.
Richmond Regional
Region 2000 (Lynchburg Area)
Commonwealth R.C.
Crater
Cumberland Plateau
New River Valley
Mount Rogers
West Piedmont
Lenowisco
South side
Hampton Roads
Annual Estimates of the Resident Population: July 1, 2022
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S

Appendices

Appendix A: Weights

Rural Status	Location Weight			Total Weight	
	#	Rate	Weight	Min.	Max.
Metro, 1 Million+	5,272	89.59%	1.116	1.075	1.280
Metro, 250,000 to 1 Million	915	90.60%	1.104	1.063	1.266
Metro, 250,000 or Less	1,003	91.43%	1.094	1.053	1.255
Urban, Pop. 20,000+, Metro Adj.	104	91.35%	1.095	1.054	1.256
Urban, Pop. 20,000+, Non-Adj.	0	NA	NA	NA	NA
Urban, Pop. 2,500-19,999, Metro Adj.	266	91.73%	1.090	1.050	1.250
Urban, Pop. 2,500-19,999, Non-Adj.	190	91.05%	1.098	1.057	1.260
Rural, Metro Adj.	127	87.40%	1.144	1.102	1.312
Rural, Non-Adj.	46	91.30%	1.095	1.054	1.256
Virginia Border State/D.C.	1,080	87.78%	1.139	1.097	1.307
Other U.S. State	983	77.72%	1.287	1.239	1.476

Source: Va. Healthcare Workforce Data Center

Age	Age Weight			Total Weight	
	#	Rate	Weight	Min.	Max.
Under 35	1,331	77.24%	1.295	1.250	1.476
35 to 39	1,659	88.25%	1.133	1.094	1.292
40 to 44	1,584	90.66%	1.103	1.065	1.257
45 to 49	1,289	92.01%	1.087	1.050	1.239
50 to 54	1,089	91.64%	1.091	1.054	1.244
55 to 59	923	91.44%	1.094	1.056	1.246
60 to 64	723	91.56%	1.092	1.055	1.245
65 and Over	1,389	88.48%	1.130	1.091	1.288

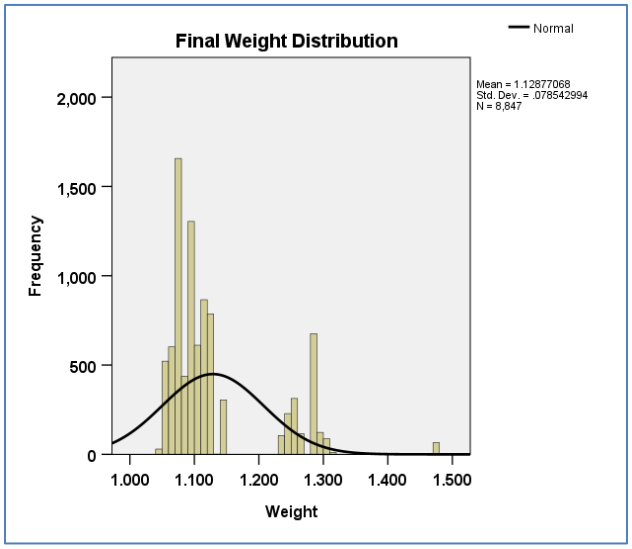
Source: Va. Healthcare Workforce Data Center

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

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

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

Overall Response Rate: **0.885852**



Source: Va. Healthcare Workforce Data Center

Virginia's Qualified Mental Health Professional Workforce: 2024

Healthcare Workforce Data Center

August 2024

Virginia Department of Health Professions
Healthcare Workforce Data Center
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, VA 23233
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More than 8,500 Qualified Mental Health Professionals voluntarily participated in this survey. *Without their efforts, the work of the center would not be possible. The Department of Health Professions, the Healthcare Workforce Data Center, and the Board of Counseling express our sincerest appreciation for their ongoing cooperation.*

Thank You!

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Virginia's Workforce:	11,246
FTEs:	9,544

Work Location	
Central VA:	29%
Hampton Roads:	28%
Northern VA:	12%

Current Employment	
Employed in Prof.:	92%
Hold 1 Full-Time Job:	64%
Satisfied?:	96%

Survey Response Rate	
All Registrants:	73%
Renewing Practitioners:	94%

Education	
Baccalaureate:	51%
Masters:	43%

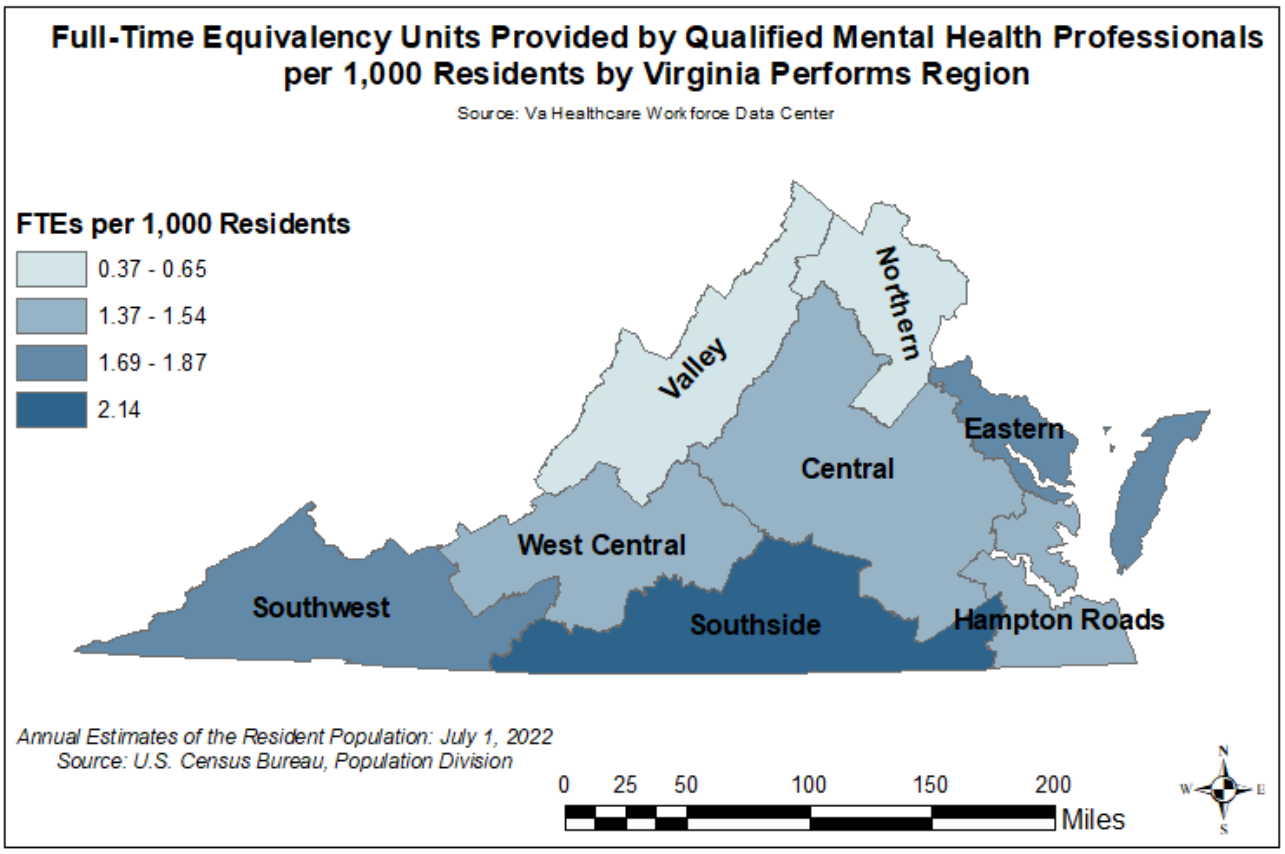
Job Turnover	
Switched Jobs:	7%
Employed Over 2 Yrs.:	63%

Demographics	
Female:	78%
Diversity Index:	55%
Median Age:	44

Prof. Degree	
Psychology:	29%
Counseling:	19%
Social Work:	15%

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

Source: Va. Healthcare Workforce Data Center



Results in Brief

This report contains the results of the 2024 Qualified Mental Health Professional (QMHP) Workforce Survey. Among all QMHPs, 8,588 voluntarily participated in this survey. The Virginia Department of Health Professions' Healthcare Workforce Data Center (HWDC) administers the survey during the registration renewal process, which takes place every June for QMHPs. These survey respondents represent 73% of the 11,788 QMHPs registered in the state and 94% of renewing practitioners.

The HWDC estimates that 11,246 QMHPs participated in Virginia's workforce during the survey period, which is defined as those QMHPs who worked at least a portion of the year in the state, but it does not include QMHPs who live in the state and intend to work as a QMHP at some point in the future. Over the past year, Virginia's QMHP workforce provided 9,544 "full-time equivalency units," which the HWDC defines simply as working 2,000 hours per year.

Nearly four out of every five QMHPs are female, including 81% of those QMHPs who are under the age of 40. In a random encounter between two QMHPs, there is a 55% chance that they would be of different races or ethnicities, a measure known as the diversity index. This diversity index increases to 57% for those QMHPs who are under the age of 40. For the state's population as a whole, the comparable diversity index is 60%.

Just over half of all QMHPs hold a bachelor's degree as their highest level of educational attainment, while another 43% of QMHPs hold a master's degree. With respect to professional degrees, 29% of QMHPs have a degree in psychology, 19% have a degree in counseling, and 15% have a degree in social work. More than four out of every five QMHPs are registered as a Qualified Mental Health Professional-Adult (QMHPs-A), while 59% are registered as a Qualified Mental Health Professional-Child (QMHPs-C). In addition, one-quarter of all QMHPs hold a license from the Board of Counseling/Psychology/Social Work. Nearly two out of every three QMHPs have been registered for more than five years.

Among all QMHPs, 92% are currently employed in the profession, 64% hold one full-time job, and 55% work between 40 and 49 hours per week. Over the past year, 8% of QMHPs have experienced underemployment, while 1% of QMHPs have experienced involuntary unemployment. Meanwhile, 63% of all QMHPs have worked at their primary work location for more than two years, and 34% of all QMHPs have been employed at multiple work locations over the past year.

Nearly seven out of every ten QMHPs are employed in Central Virginia, Hampton Roads, or Northern Virginia. One-half of all QMHPs receive a salary at their primary work location, while another 43% receive their income as an hourly wage. Among all QMHPs, 96% indicated that they are satisfied with their current work situation, including 65% of QMHPs who indicated that they are "very satisfied."

QMHPs typically spend approximately three-quarters of their time in patient care activities. In fact, 61% of all QMHPs fill a patient care role, which means that they spend at least 60% of their time in patient care activities. The median patient workload for QMHPs at their primary work location is between 5 and 9 patients per week. In addition, QMHPs who also have a secondary work location typically treat an additional 1 to 4 patients per week. Nearly three out of every five QMHPs provided clinical services at their place of employment. Among those QMHPs who provide clinical services, 25% provide mental health skill building services, 15% provide intensive in-home services, and another 13% provide crisis stabilization services.

Nearly half of all QMHPs plan on continuing their education or registering as a resident in counseling or as a supervisee in social work in the future, and more than two-thirds of these QMHPs plan to apply to be under supervision within the next three years. Among QMHPs not planning to pursue licensure, 11% are eligible for licensure, and 53% of these QMHPs who are eligible for licensure do not intend to pursue it because they have no desire to become licensed. Among all QMHPs, 13% are registered in order to work while awaiting an application for registration as a resident in counseling or as a supervisee in social work. Furthermore, 11% of QMHPs are registered temporarily in order to bill for services while pursing full licensure as an LPC, LCSW, or LCP. Nearly one out of every four QMHPs are eligible to become licensed as an LPC, LCSW, or LCP, and 68% of these QMHPs plan to get licensed within the next three years.

A Closer Look:

Registrants		
Status	**#**	**%**
Renewing Practitioners	8,724	74%
New Registrants	1,093	9%
Non-Renewals	1,971	17%
All Registrants	**11,788**	**100%**

Source: Va. Healthcare Workforce Data Center

HWDC surveys tend to achieve very high response rates. Among all renewing QMHPs, 94% submitted a survey. These represent 73% of the 11,788 QMHPs who were registered at some point during the survey period.

Definitions

1. **The Survey Period:** The survey was conducted in June 2024.
2. **Target Population:** All QMHPs who held a Virginia registration at some point between July 2023 and June 2024.
3. **Survey Population:** The survey was available to QMHPs who renewed their registration online. It was not available to those who did not renew, including QMHPs newly registered in 2024.

Response Rates			
Statistic	**Non Respondents**	**Respondents**	**Response Rate**
By Age			
Under 30	440	553	56%
30 to 34	531	946	64%
35 to 39	506	1,209	71%
40 to 44	473	1,384	75%
45 to 49	358	1,197	77%
50 to 54	324	1,129	78%
55 to 59	237	970	80%
60 and Over	331	1,200	78%
Total	**3,200**	**8,588**	**73%**
New Registrations			
Issued in Past Year	721	372	34%
Metro Status			
Non-Metro	463	1,487	76%
Metro	2,467	6,495	73%
Not in Virginia	270	606	69%

Source: Va. Healthcare Workforce Data Center

Response Rates	
Completed Surveys	**8,588**
Response Rate, All Registrants	**73%**
Response Rate, Renewals	**94%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Registered QMHPs

Number:	11,788
New:	9%
Not Renewed:	17%

Response Rates

All Registrants:	73%
Renewing Practitioners:	94%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Workforce

Virginia's QMHP Workforce:	11,246
FTEs:	9,544

Utilization Ratios

QMHPs in VA Workforce:	95%
QMHPs per FTE:	1.24
Workers per FTE:	1.18

Source: Va. Healthcare Workforce Data Center

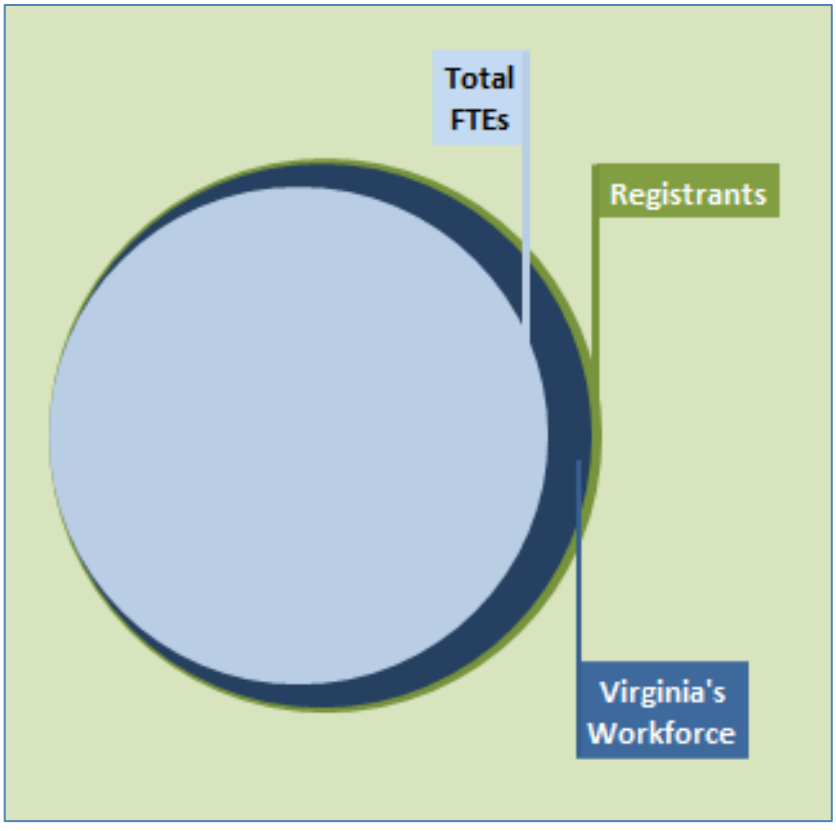
Definitions

1. **Virginia's Workforce:** A practitioner with a primary or secondary work site in Virginia at any time in the past year. It does not include those who intend to return to Virginia's workforce at any point in the future.
2. **Full-Time Equivalency Unit (FTE):** The HWDC uses 2,000 (40 hours for 50 weeks) as its baseline measure for FTEs.
3. **QMHPs in VA Workforce:** The proportion of registrants in Virginia's workforce.
4. **QMHPs per FTE:** An indication of the number of registrants needed to create 1 FTE. Higher numbers indicate lower registrant participation.
5. **Workers per FTE:** An indication of the number of workers in Virginia's workforce needed to create 1 FTE. Higher numbers indicate lower utilization of available workers.

Virginia's QMHP Workforce	
Status	**#**
Virginia's Workforce	**11,246**
Total FTEs	**9,544**
Registered QMHPs	**11,788**

Source: Va. Healthcare Workforce Data Center

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



Source: Va. Healthcare Workforce Data Center

Registrants Not in Virginia's Workforce

Only 5% of Virginia's registrants did not participate in the state's QMHP workforce during the past year. Among these QMHPs, 64% worked at some point in the past year, including 45% who currently work as a QMHP.

At a Glance:

Not in VA Workforce

Total:	542
% of Registrants:	5%
Va. Border State/DC:	30%
Median Age:	46

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Highest Professional Degree				
	Not in Workforce		In Workforce	
Degree	#	%	#	%
Psychology	130	28%	2877	29%
Counseling	84	18%	1928	19%
Social Work	79	17%	1496	15%
Sociology	20	4%	653	6%
Criminal Justice	16	3%	376	4%
Other	129	28%	2734	27%
Total	459	100%	10063	100%

Source: Va. Healthcare Workforce Data Center

Psychology, counseling, and social work degrees are the most commonly held degrees among QMHPs in and not in the workforce.

QMHPs not in Virginia's workforce are slightly less likely to hold another license, certification, or registration from the Boards Counseling, Psychology, or Social Work.

Another License, Certification, or Registration				
	Not in Workforce		In Workforce	
	#	%	#	%
No	216	77%	6,426	71%
Yes	65	23%	2,144	25%
Total	**281**	**100%**	**8,570**	**100%**

Source: Va. Healthcare Workforce Data Center

Registration				
	Not in Workforce		In Workforce	
Registration	#	%	#	%
QMHP-A Only	177	38%	4,087	41%
QMHP-C Only	92	20%	1,874	19%
QMHP-A & QMHP-C	192	42%	4,100	41%
Total	**461**	**100%**	**10,061**	**100%**

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Age & Gender						
Age	Male		Female		Total	
	#	% Male	#	% Female	#	% in Age Group
Under 30	125	14%	767	86%	892	9%
30 to 34	250	19%	1,049	81%	1,299	13%
35 to 39	319	22%	1,139	78%	1,457	14%
40 to 44	323	20%	1,283	80%	1,605	16%
45 to 49	311	23%	1,034	77%	1,344	13%
50 to 54	347	28%	899	72%	1,246	12%
55 to 59	234	23%	790	77%	1,024	10%
60 and Over	323	26%	929	74%	1,252	12%
Total	**2,230**	**22%**	**7,890**	**78%**	**10,120**	**100%**

Source: Va. Healthcare Workforce Data Center

Race & Ethnicity					
Race/ Ethnicity	Virginia*	QMHPs		QMHPs Under 40	
	%	#	%	#	%
White	59%	3,293	33%	1,201	34%
Black	18%	5,737	58%	2,010	56%
Asian	7%	107	1%	42	1%
Other Race	1%	55	1%	13	0%
Two or More Races	5%	260	3%	118	3%
Hispanic	10%	388	4%	184	5%
Total	**100%**	**9,840**	**100%**	**3,568**	**100%**

*Population data in this chart is from the U.S. Census, Annual Estimates of the Resident Population by Sex, Race, and Hispanic Origin for the United States, States, and Counties: July 1, 2022.

Source: Va. Healthcare Workforce Data Center

At a Glance:

Gender

% Female:	78%
% Under 40 Female:	81%

Age

Median Age:	44
% Under 40:	36%
% 55 and Over:	22%

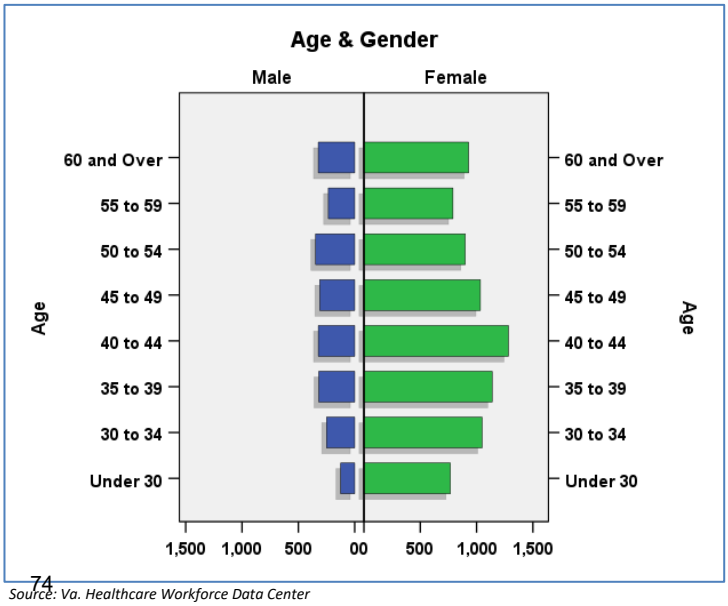
Diversity

Diversity Index:	55%
Under 40 Div. Index:	57%

Source: Va. Healthcare Workforce Data Center

In a chance encounter between two QMHPs, there is a 55% chance that they would be of different races or ethnicities, a measure known as the diversity index. For Virginia's population as a whole, the comparable diversity index is 60%.

More than one-third of all QMHPs are under the age of 40, and 81% of QMHPs who are under the age of 40 are female. In addition, the diversity index among QMHPs who are under the age of 40 is 57%.



Source: Va. Healthcare Workforce Data Center

A Closer Look:

Highest Education Level		
Degree	**#**	**%**
Some High School	0	0%
High School/GED	58	1%
Some College	190	2%
Associate	167	2%
Bachelor's Degree	5,130	51%
Master's Degree	4,359	43%
Doctor of Psychology	47	0%
Other Doctorate/PhD	190	2%
Total	**10,140**	**100%**

Source: Va. Healthcare Workforce Data Center

More than half of all QMHPs have a baccalaureate degree as their highest degree. Another 43% of QMHPs have a master's degree as their highest degree.

At a Glance:

Education

Baccalaureate:	51%
Masters:	43%

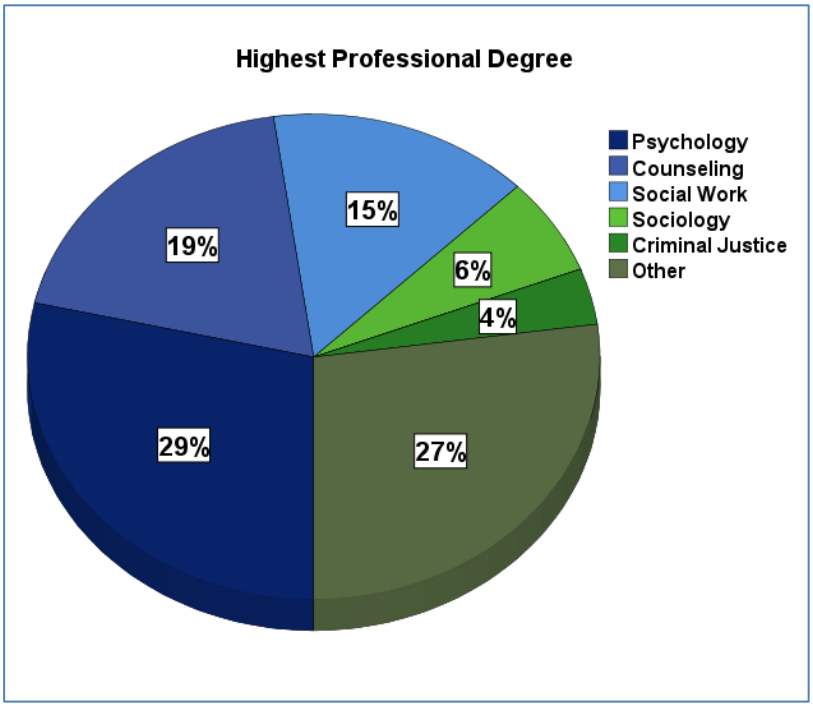
Professional Degree

Psychology:	29%
Counseling:	19%
Social Work:	15%

Source: Va. Healthcare Workforce Data Center

Highest Professional Degree		
Degree	**#**	**%**
Psychology	2,877	29%
Counseling	1,928	19%
Social Work	1,496	15%
Sociology	653	6%
Criminal Justice	376	4%
Other	2,734	27%
Total	**10,063**	**100%**

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

Nearly three out of every ten QMHPs hold their highest professional degree in psychology. Another 19% of QMHPs hold their highest professional degree in counseling.

At a Glance:

Registration

QMHP-A:	81%
QMHP-C:	59%

Registration Duration

Less than 1 Year:	5%
More than 5 Years:	65%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

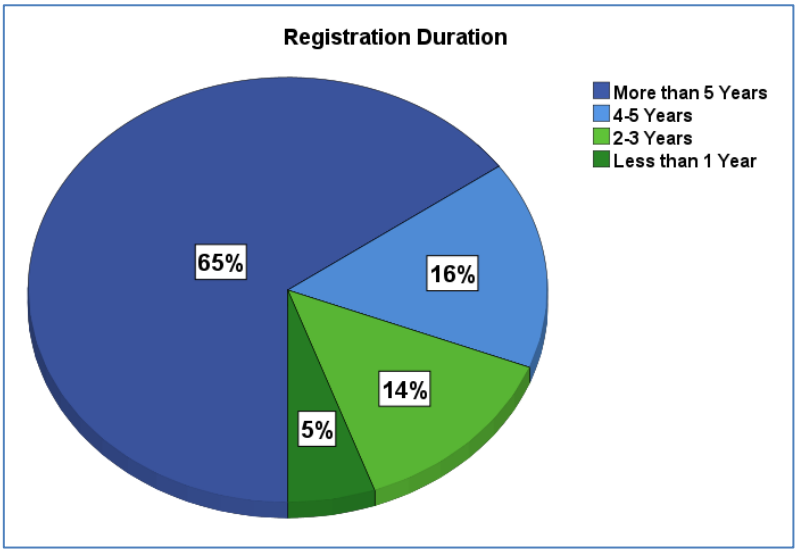
Registration		
Registration	**#**	**%**
QMHP-A Only	4,087	41%
QMHP-C Only	1,874	19%
QMHP-A & QMHP-C	4,100	41%
Total	**10,061**	**100%**

Source: Va. Healthcare Workforce Data Center

More than four out of every five registrants are QMHPs-A, while 59% of registrants are QMHPs-C. In addition, one-quarter of all QMHPs hold a registration, certification, or license from the Board of Counseling, Psychology, or Social Work.

Additional Registration or License		
Response	**#**	**%**
Yes	2,144	25%
No	6,426	75%
Total	**8,570**	**100%**

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

QMHP Registration Duration		
Time Period	**#**	**%**
Less than 1 Year	546	5%
2-3 Years	1,370	14%
4-5 Years	1,588	16%
More than 5 Years	6,541	65%
Total	**10,045**	**100%**

Source: Va. Healthcare Workforce Data Center

Among all QMHPs, 11% are registered as a QMHP in order to work while awaiting their application for registration as a Resident in Counseling or as a Supervisee in Social Work.

Awaiting Registration Application		
Response	**#**	**%**
Yes	1,103	11%
No	7,244	87%
Total	**8,347**	**100%**

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Licensure Eligibility as LPC, LCSW, or LCP		
Response	**#**	**%**
Yes	2,379	24%
No	7,568	76%
Total	**9,947**	**100%**

Source: Va. Healthcare Workforce Data Center

Nearly one-quarter of QMHPs are eligible for licensure as an LPC, LCSW, or LCP. Among these eligible QMHPs, the median number of years to licensure is between 1 and 3.

At a Glance:

Licensure
Eligible for Licensure: 24%
Temporary Registration: 11%

Licensure Timeframe
Median Yrs. to Licensure: 1-3

Source: Va. Healthcare Workforce Data Center

Years to Licensure		
Years	**#**	**%**
Less than 1 Year	456	21%
1-3 Years	1,050	47%
3-6 Years	527	24%
6-10 Years	95	4%
More than 10 Years	88	4%
Total	**2,216**	**100%**

Source: Va. Healthcare Workforce Data Center

Among QMHPs who are not eligible, 25% reported additional education needed as the reason for not being eligible for licensure.

Reason for Not Being Eligible for Licensure		
Reason	**#**	**%**
Additional Education Required	1,029	25%
Degree is not License Eligible	891	22%
Not Pursing Licensure	582	14%
Additional Coursework Needed	370	9%
Currently Pursing Education	278	7%
Additional Supervision Required	212	5%
Not Pursuing Education Required for Licensure	203	5%
Other Career Path	166	4%
Not Eligible (Unspecified)	78	2%
Don't Know	69	2%
Other	224	5%
Total	**4,102**	**100%**

Source: Va. Healthcare Workforce Data Center

Temporary Registration		
Response	**#**	**%**
Yes	1,116	11%
No	8,920	89%
Total	**10,036**	**100%**

Source: Va. Healthcare Workforce Data Center

More than one out of every ten QMHPs are registered temporarily in order to bill for services while they pursue licensure.

At a Glance:

Employment

Employed in Profession: 92%
Involuntarily Unemployed: < 1%

Positions Held

1 Full-Time: 64%
2 or More Positions: 25%

Weekly Hours:

40 to 49: 55%
60 or More: 6%
Less than 30: 11%

Source: Va. Healthcare Workforce Data Center

Among all QMHPs, 92% are currently employed in the profession, 64% hold one full-time job, and 55% work between 40 and 49 hours per week.

A Closer Look:

Current Work Status		
Status	**#**	**%**
Employed, Capacity Unknown	61	1%
Employee of a Provider Licensed by the Department of Behavioral Health and Developmental Services (DBHDS)	5,038	50%
Employee of the DBHDS	1,005	10%
Employee of the Department of Corrections (DOC)	224	2%
Independent Contractor for Provider Licensed by DBHDS	672	7%
Independent Contractor of DBHDS	192	2%
Independent Contractor for DOC	27	< 1%
Employed in a Behavioral Sciences Related Capacity, Specific Designation Unknown	2,057	21%
Employed, NOT in a Behavioral Sciences Related Capacity	568	6%
Not Working, Reason Unknown	1	< 1%
Involuntarily Unemployed	25	< 1%
Voluntarily Unemployed	46	1%
Retired	20	< 1%
Other	80	1%
Total	**10,015**	**100%**

Source: Va. Healthcare Workforce Data Center

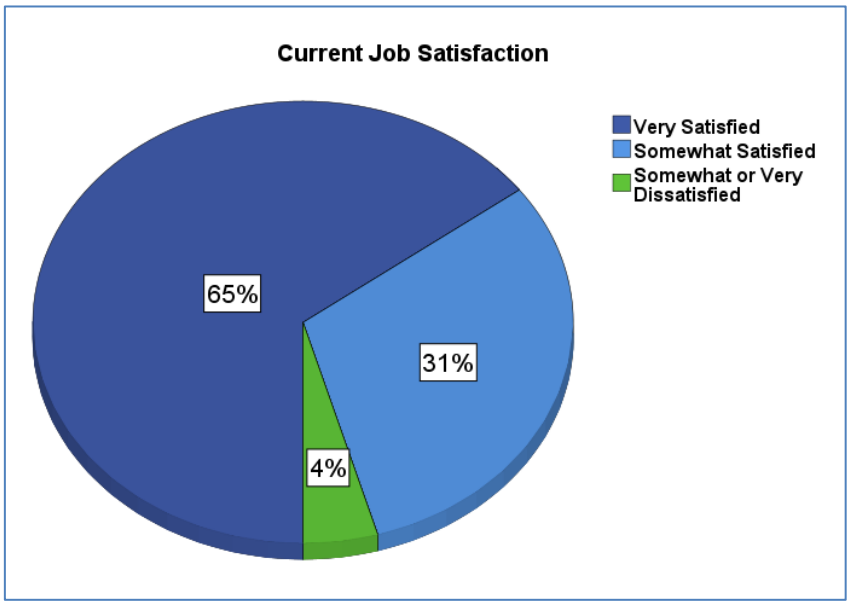
Current Positions		
Positions	**#**	**%**
No Positions	92	1%
One Part-Time Position	1,051	11%
Two Part-Time Positions	352	4%
One Full-Time Position	6,223	64%
One Full-Time Position & One Part-Time Position	1,794	18%
Two Full-Time Positions	136	1%
More than Two Positions	152	2%
Total	**9,800**	**100%**

Source: Va. Healthcare Workforce Data Center

Current Weekly Hours		
Hours	**#**	**%**
0 Hours	92	1%
1 to 9 Hours	184	2%
10 to 19 Hours	385	4%
20 to 29 Hours	537	6%
30 to 39 Hours	1,558	16%
40 to 49 Hours	5,409	55%
50 to 59 Hours	977	10%
60 to 69 Hours	407	4%
70 to 79 Hours	100	1%
80 or More Hours	104	1%
Total	**9,753**	**100%**

Source: Va. Healthcare Workforce Data Center

A Closer Look:



Source: Va. Healthcare Workforce Data Center

At a Glance:

Satisfaction

Satisfied:	96%
Very Satisfied:	65%

Source: Va. Healthcare Workforce Data Center

Among all QMHPs, 96% are satisfied with their current employment situation, including 65% who indicated that they are "very satisfied."

Job Satisfaction		
Level	**#**	**%**
Very Satisfied	6,372	65%
Somewhat Satisfied	3,025	31%
Somewhat Dissatisfied	303	3%
Very Dissatisfied	136	1%
Total	**9,836**	**100%**

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Employment Instability in the Past Year		
In the Past Year, Did You . . .?	**#**	**%**
Experience Involuntary Unemployment?	166	1%
Experience Voluntary Unemployment?	324	3%
Work Part-Time or Temporary Positions, but Would Have Preferred a Full-Time/Permanent Position?	928	8%
Work Two or More Positions at the Same Time?	3,124	28%
Switch Employers or Practices?	791	7%
Experience at Least One?	**4,278**	**38%**

Source: Va. Healthcare Workforce Data Center

Only 1% of Virginia's QMHPs experienced involuntary unemployment at some point during the past year. By comparison, Virginia's average monthly unemployment rate was 2.8% during the same time period.[1]

Location Tenure				
Tenure	**Primary**		**Secondary**	
	#	**%**	**#**	**%**
Not Currently Working at This Location	224	2%	124	4%
Less than 6 Months	545	6%	347	11%
6 Months to 1 Year	887	9%	466	15%
1 to 2 Years	1,975	20%	655	21%
3 to 5 Years	2,688	28%	778	25%
6 to 10 Years	1,553	16%	342	11%
More than 10 Years	1,874	19%	367	12%
Subtotal	**9,746**	**100%**	**3,079**	**100%**
Did Not Have Location	42		7,936	
Item Missing	1,458		231	
Total	**11,246**		**11,246**	

Source: Va. Healthcare Workforce Data Center

One-half of all QMHPs are salaried employees, while 43% receive an hourly wage.

At a Glance:

Unemployment Experience

Involuntarily Unemployed: 1%
Underemployed: 8%

Turnover & Tenure

Switched Jobs: 7%
New Location: 23%
Over 2 Years: 63%
Over 2 Yrs., 2nd Location: 48%

Employment Type

Salary/Commission: 50%
Hourly Wage: 43%

Source: Va. Healthcare Workforce Data Center

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

Employment Type		
Primary Work Site	**#**	**%**
Salary/Commission	3,694	50%
Hourly Wage	3,158	43%
By Contract	422	6%
Business/Practice Income	44	1%
Unpaid	65	1%
Subtotal	**7,383**	**100%**
Did Not Have Location	42	
Item Missing	3,821	

Source: Va. Healthcare Workforce Data Center

[1] As reported by the U.S. Bureau of Labor Statistics. Over the past year, the non-seasonally adjusted monthly unemployment rate has fluctuated between a low of 2.3% and a high of 3.2%. At the time of publication, the unemployment rate for June 2024 was still preliminary.

At a Glance:

Concentration

Top Region:	29%
Top 3 Regions:	69%
Lowest Region:	2%

Locations

2 or More (Past Year):	34%
2 or More (Now*):	31%

Source: Va. Healthcare Workforce Data Center

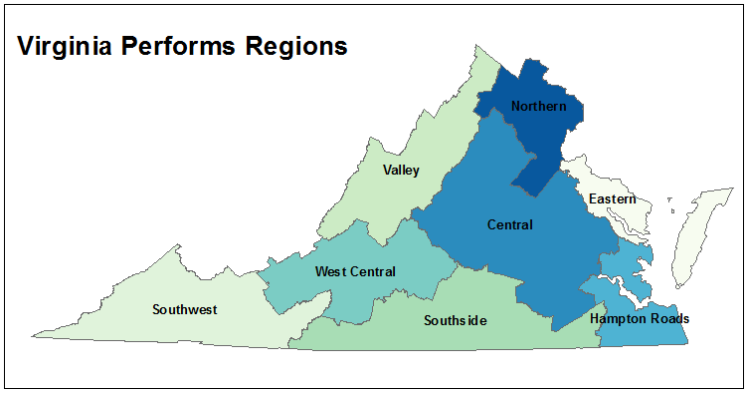
Nearly seven out of every ten QMHPs in the state work in Central Virginia, Hampton Roads, or Northern Virginia.

A Closer Look:

Regional Distribution of Work Locations

Virginia Performs Region	Primary Location		Secondary Location	
	#	%	#	%
Central	2,829	29%	1,047	32%
Eastern	242	2%	101	3%
Hampton Roads	2,720	28%	967	30%
Northern	1,137	12%	336	10%
Southside	739	8%	244	8%
Southwest	662	7%	150	5%
Valley	338	3%	61	2%
West Central	1,002	10%	272	8%
Virginia Border State/D.C.	20	0%	22	1%
Other U.S. State	11	0%	27	1%
Outside of the U.S.	0	0%	0	0%
Total	**9,700**	**100%**	**3,227**	**100%**
Item Missing	1,504		84	

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

Number of Work Locations

Locations	Work Locations in Past Year		Work Locations Now*	
	#	%	#	%
0	0	0%	163	2%
1	6,439	66%	6,550	67%
2	1,277	13%	1,362	14%
3	1,695	17%	1,474	15%
4	123	1%	83	1%
5	50	1%	36	0%
6 or More	146	2%	63	1%
Total	**9,731**	**100%**	**9,731**	**100%**

*At the time of survey completion, June 2024.

Source: Va. Healthcare Workforce Data Center

More than three out of every ten QMHPs currently have multiple work locations, while 34% have had multiple work locations over the past year.

At a Glance:
(Primary Locations)

Typical Time Allocation

Patient Care:	70%-79%
Administration:	10%-19%
Supervisory:	1%-9%

Roles

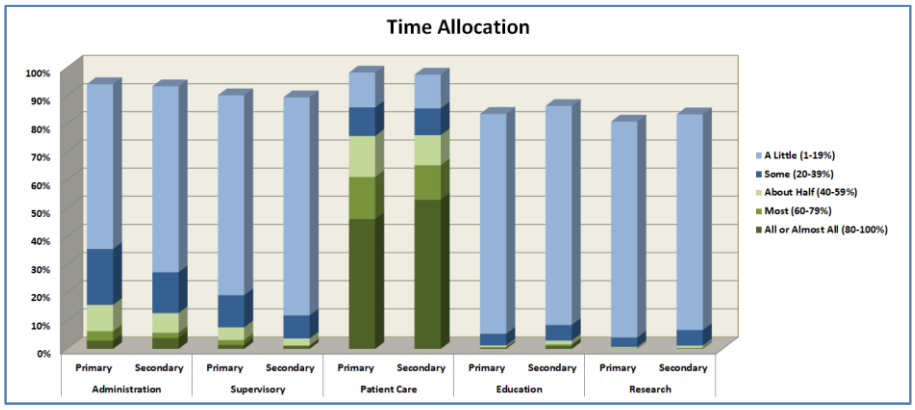
Patient Care:	61%
Administration:	6%
Supervisory:	3%

Patient Care QMHPs

Median Admin. Time:	1%-9%
Avg. Admin. Time:	10%-19%

Source: Va. Healthcare Workforce Data Center

A Closer Look:



Source: Va. Healthcare Workforce Data Center

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

Time Allocation										
Time Spent	Admin.		Supervisory		Patient Care		Education		Research	
	Pri. Site	Sec. Site	Pri. Site	Sec. Site	Pri. Site	Sec. Site	Pri. Site	Sec. Site	Pri. Site	Sec. Site
All or Almost All (80-100%)	3%	4%	1%	1%	46%	53%	0%	1%	0%	0%
Most (60-79%)	3%	2%	2%	0%	15%	12%	0%	1%	0%	0%
About Half (40-59%)	9%	7%	5%	2%	15%	11%	1%	1%	1%	1%
Some (20-39%)	20%	15%	11%	8%	10%	10%	4%	6%	3%	6%
A Little (1-19%)	59%	66%	71%	77%	12%	12%	78%	78%	77%	77%
None (0%)	6%	7%	10%	11%	2%	3%	17%	14%	19%	17%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Patients Per Week				
# of Patients	Primary Location		Secondary Location	
	#	%	#	%
None	869	10%	266	9%
1-4	2,874	32%	1,446	51%
5-9	2,139	24%	548	19%
10-14	1,194	13%	247	9%
15-29	1,128	13%	181	6%
30-44	442	5%	90	3%
45-60	183	2%	40	1%
60 or More	183	2%	40	1%
Total	**9,012**	**100%**	**2,858**	**100%**

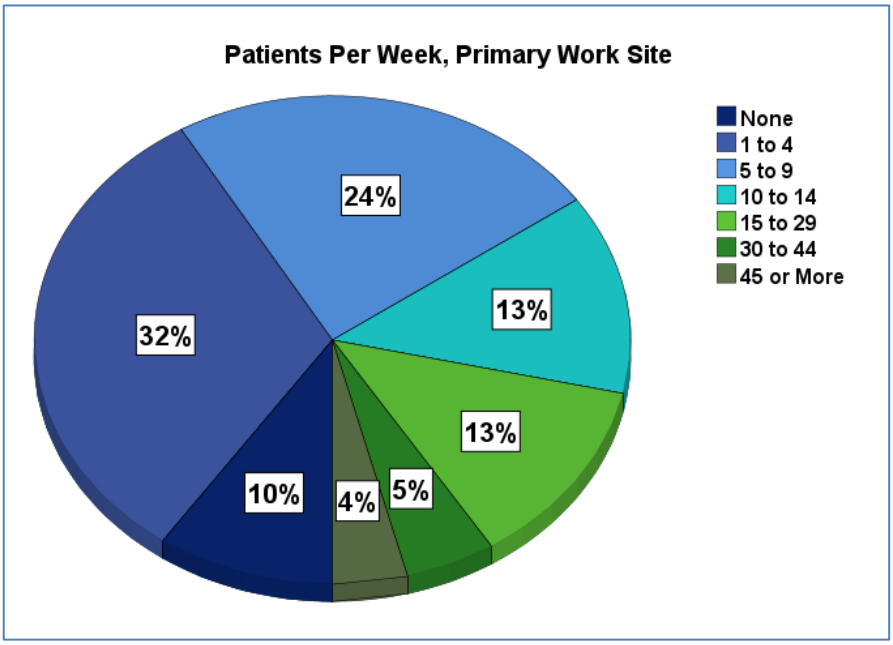
Source: Va. Healthcare Workforce Data Center

At a Glance:

Weekly Patients Totals
(Median)
Primary Location: 5-9
Secondary Location: 1-4

Source: Va. Healthcare Workforce Data Center

The median patient workload for QMHPs at their primary work location is between 5 and 9 patients per week. For QMHPs who also have a secondary work location, their median patient workload is between 1 and 4 patients per week.



Source: Va. Healthcare Workforce Data Center

At a Glance:

Clinical Services

Treatment:	42%
Case Management:	24%
Assessment:	16%

Provision of Clinical Services

% Providing Services:	57%

Services Provided

Mental Health Skill Building:	25%
Intensive In-Home Services:	15%
Crisis Stabilization:	13%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

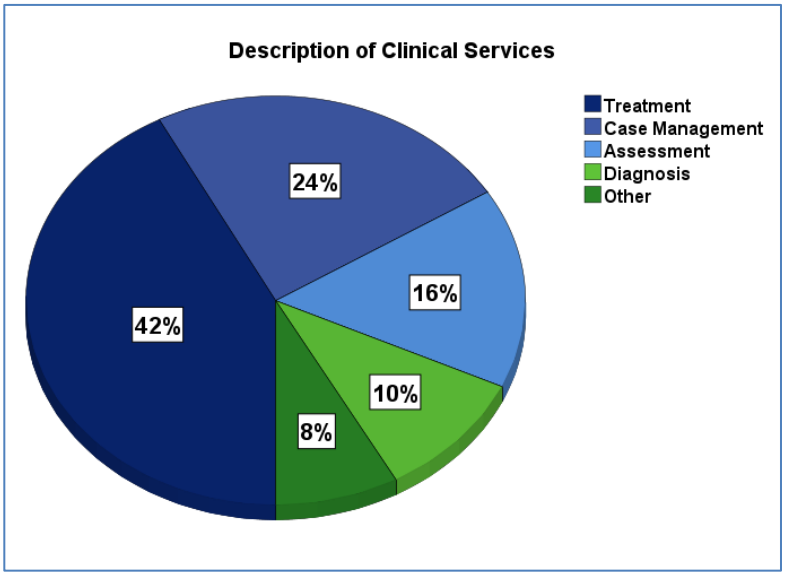
Definition of Clinical Services		
Service	**#**	**%**
Treatment	3,599	42%
Case Management	2,027	24%
Assessment	1,346	16%
Diagnosis	858	10%
Other	682	8%
Total	**8,512**	**100%**

Source: Va. Healthcare Workforce Data Center

Among all QMHPs, 42% define clinical services as treatment, and 57% of QMHPs provide clinical services. Among QMHPs who provide clinical services, one-quarter provide mental health skill building services.

Provision of Services		
Response	**#**	**%**
Yes	4,932	57%
No	3,686	43%
Total	**8,618**	**100%**

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

Clinical Services Provided		
Service	**#**	**%**
Mental Health Skill Building Services	1,225	25%
Intensive In-Home Services	744	15%
Crisis Stabilization	635	13%
Psychosocial Rehabilitation	266	5%
Therapeutic Day Treatment - Children and Adolescents (TDT)	211	4%
Other	1,812	37%
Total	**4,893**	**100%**

Source: Va. Healthcare Workforce Data Center

Supervisor Credential		
Credential	**#**	**%**
Licensed Professional Counselor	3,116	36%
Licensed Clinical Social Worker	2,661	31%
Licensed Clinical Psychologist	281	3%
Other	2,492	29%
Total	**8,550**	**100%**

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Continuing Education		
Response	**#**	**%**
Yes	4,037	46%
No	4,798	54%
Total	**8,835**	**100%**

Source: Va. Healthcare Workforce Data Center

Nearly half of all QMHPs plan on continuing their education or registering as a resident in counseling or as a supervisee in social work in the future. Additionally, the median number of years to supervision is between 1 and 3.

At a Glance:

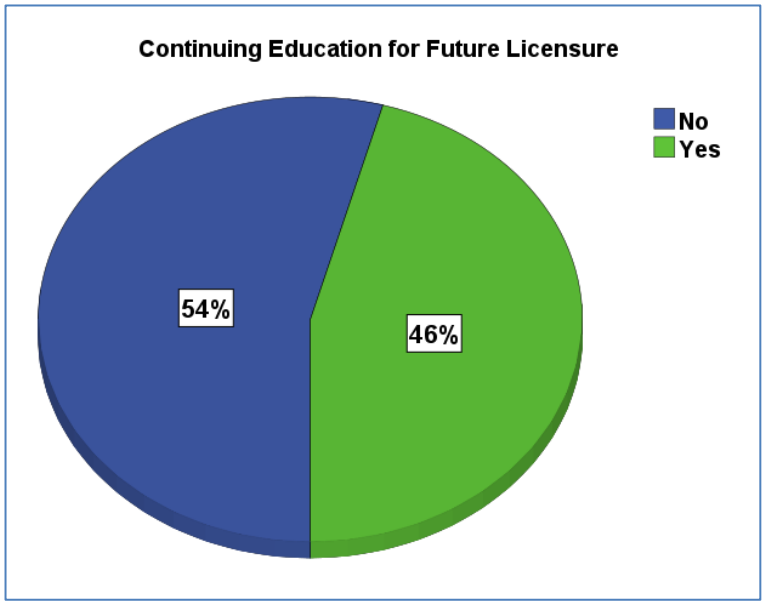
Counseling/Social Work

% Continuing Education: 46%
Median Yrs. to Supervision: 1-3

Licensure Eligibility

% Not Pursuing Licensure but Eligible: 11%
% with No Desire for Licensure: 53%

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

Years to Application for Supervision		
Years	**#**	**%**
Less than 1 Year	889	23%
1-3 Years	1,696	44%
3-6 Years	1,048	27%
6-10 Years	142	4%
More than 10 Years	49	1%
Total	**3,824**	**100%**

Source: Va. Healthcare Workforce Data Center

Among the 11% of QMHPs who are eligible for licensure but are not planning to continue their education or register as a resident in counseling or as a supervisee in social work, 53% are not pursuing licensure because they have no desire to become licensed.

Licensure Eligibility for QMHPs Not Seeking Licensure		
Response	**#**	**%**
Yes	440	11%
No	3,638	89%
Total	**4,078**	**100%**

Source: Va. Healthcare Workforce Data Center

Reason for Not Pursuing Licensure		
Reason	**#**	**%**
No Desire to Become Licensed	208	53%
Incomplete Supervision Hours (Other Reasons)	32	8%
Ineligible Degree	24	6%
Incomplete Supervision Hours (Lack of Staff)	12	3%
Other	117	30%
Total	**393**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

FTEs

Total:	9,544
FTEs/1,000 Residents[2]:	1.099
Average:	0.85

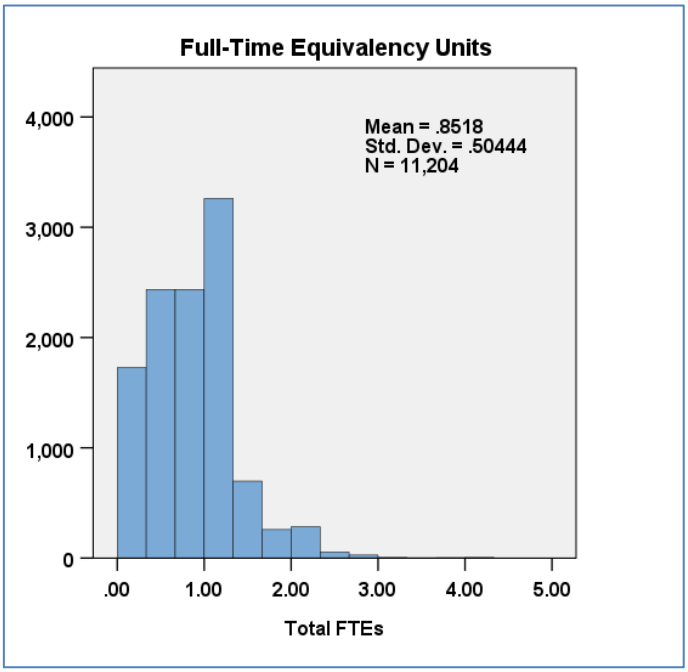
Age & Gender Effect

Age, *Partial Eta*^{2}:	Small
Gender, *Partial Eta*^{2}:	None

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

Source: Va. Healthcare Workforce Data Center

A Closer Look:

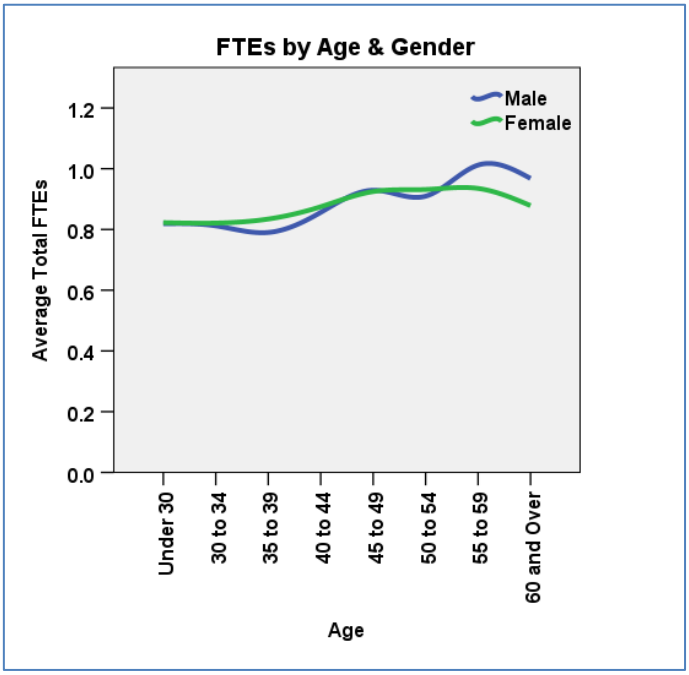


Source: Va. Healthcare Workforce Data Center

The typical (median) QMHP provided 0.89 FTEs over the past year, or approximately 36 hours per week for 50 weeks. Although FTEs appear to vary by age, statistical tests did not verify that a difference exists.[3]

Full-Time Equivalency Units		
Age	**Average Age**	**Median Age**
Under 30	0.80	0.87
30 to 34	0.80	0.82
35 to 39	0.80	0.82
40 to 44	0.83	0.90
45 to 49	0.92	0.93
50 to 54	0.90	0.93
55 to 59	0.92	0.96
60 and Over	0.85	0.88
Gender		
Male	0.89	0.93
Female	0.88	0.95

Source: Va. Healthcare Workforce Data Center



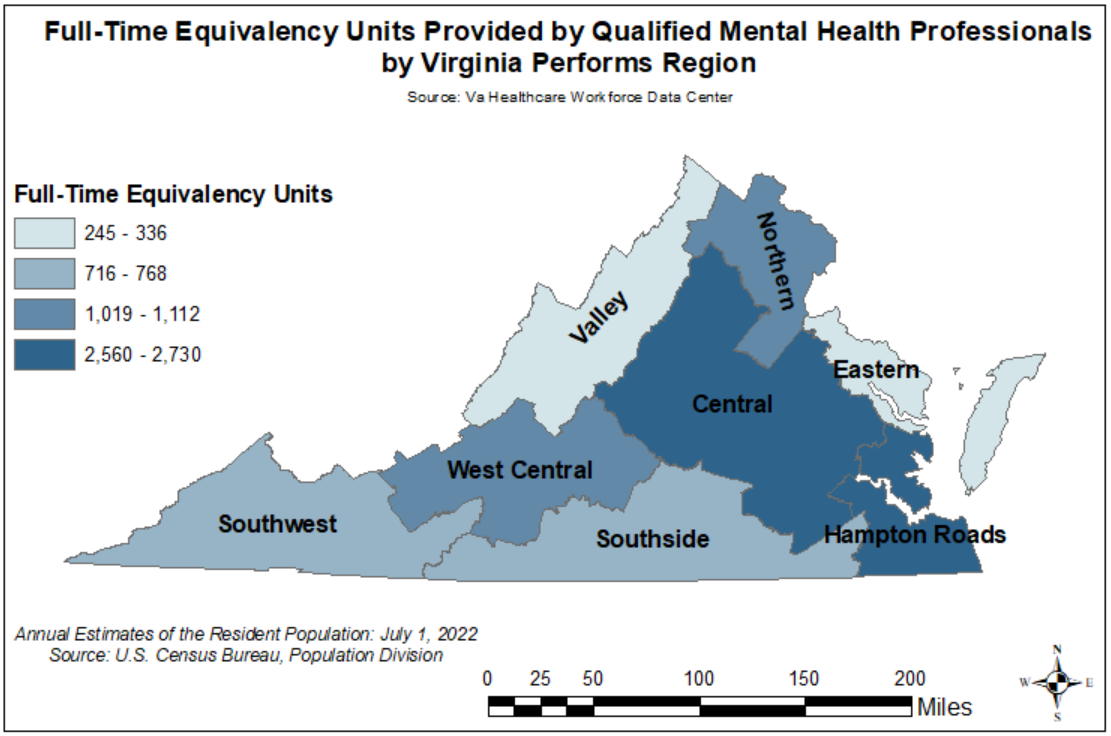
Source: Va. Healthcare Workforce Data Center

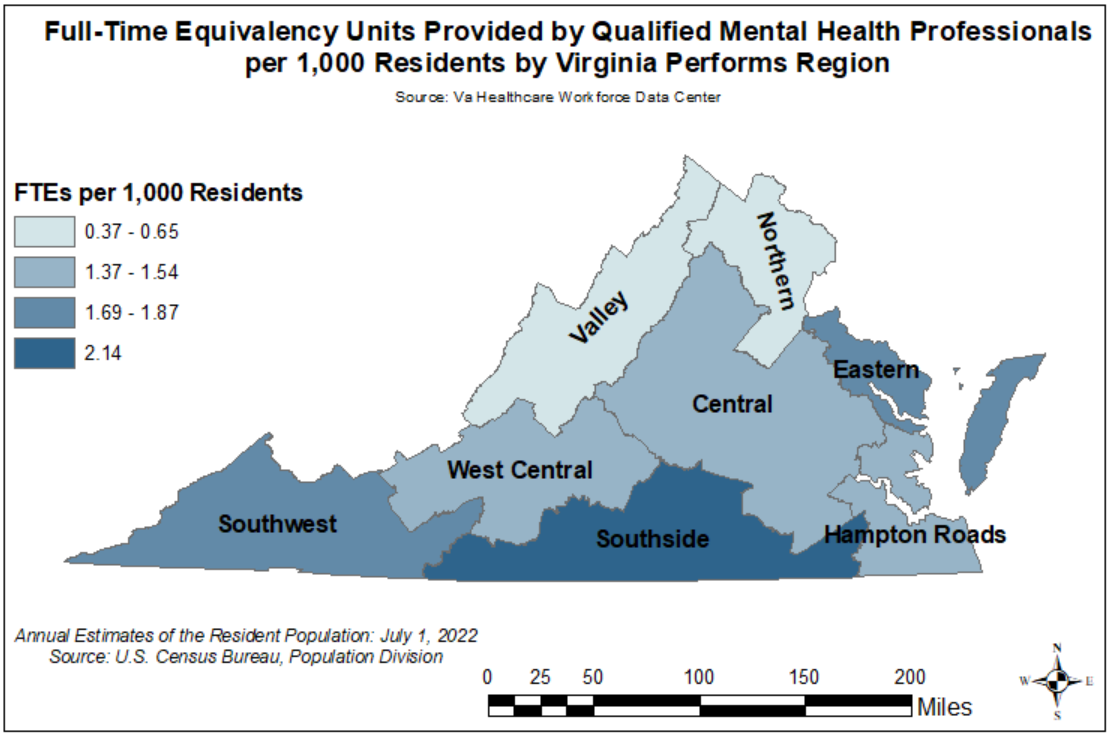
[2] Number of residents in 2022 was used as the denominator.

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

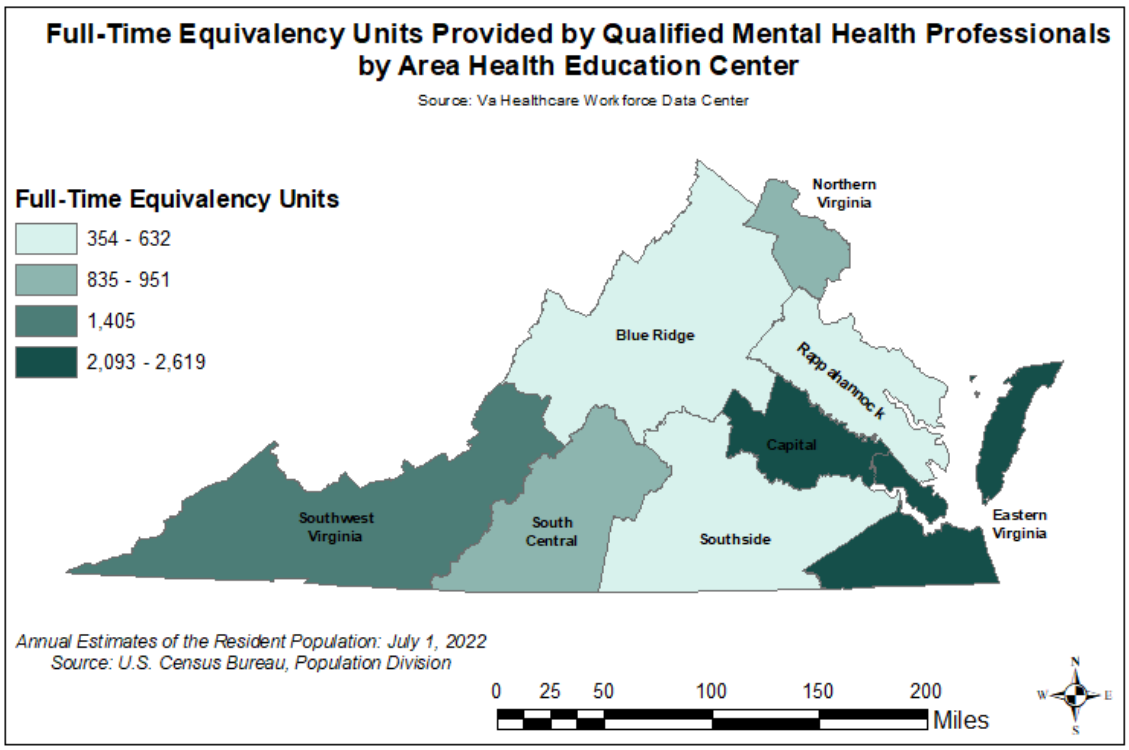
Maps

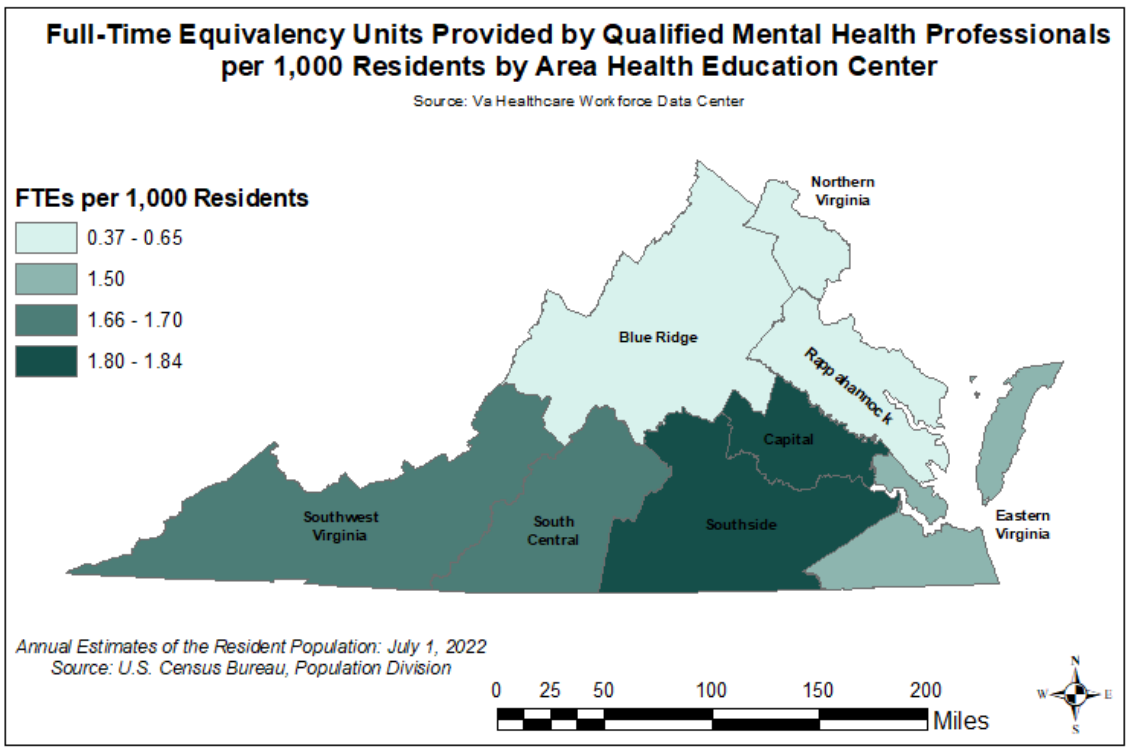
Virginia Performs Regions



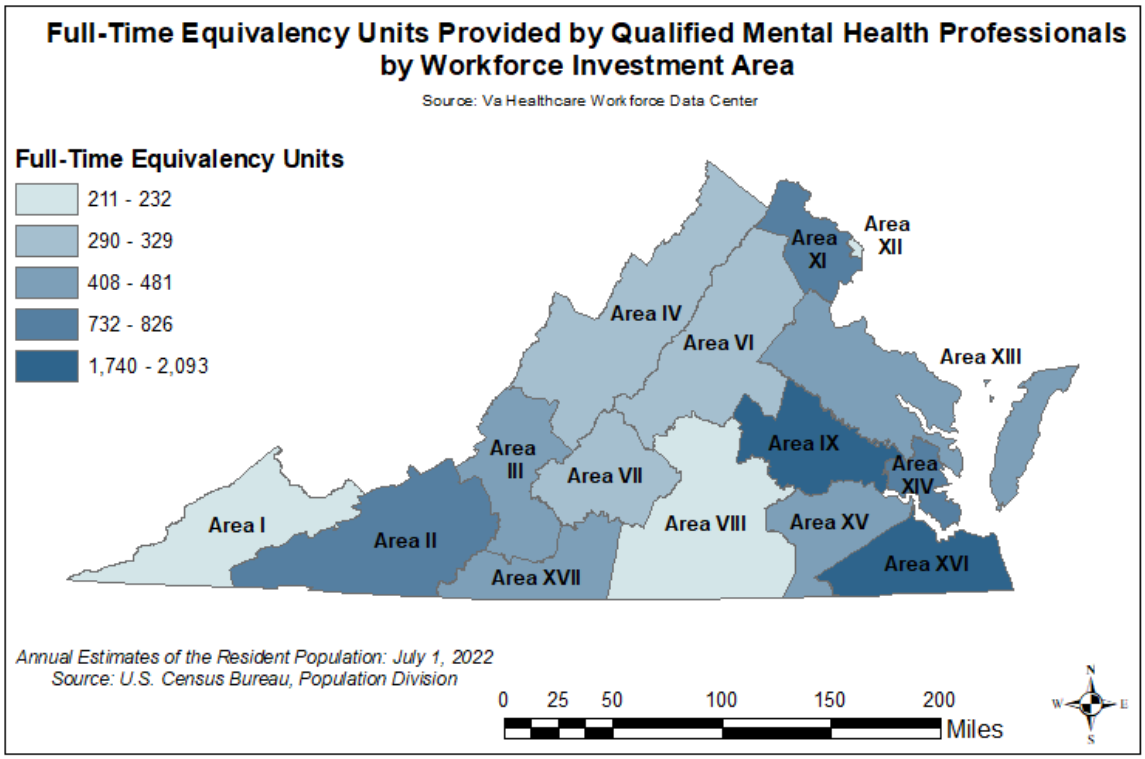


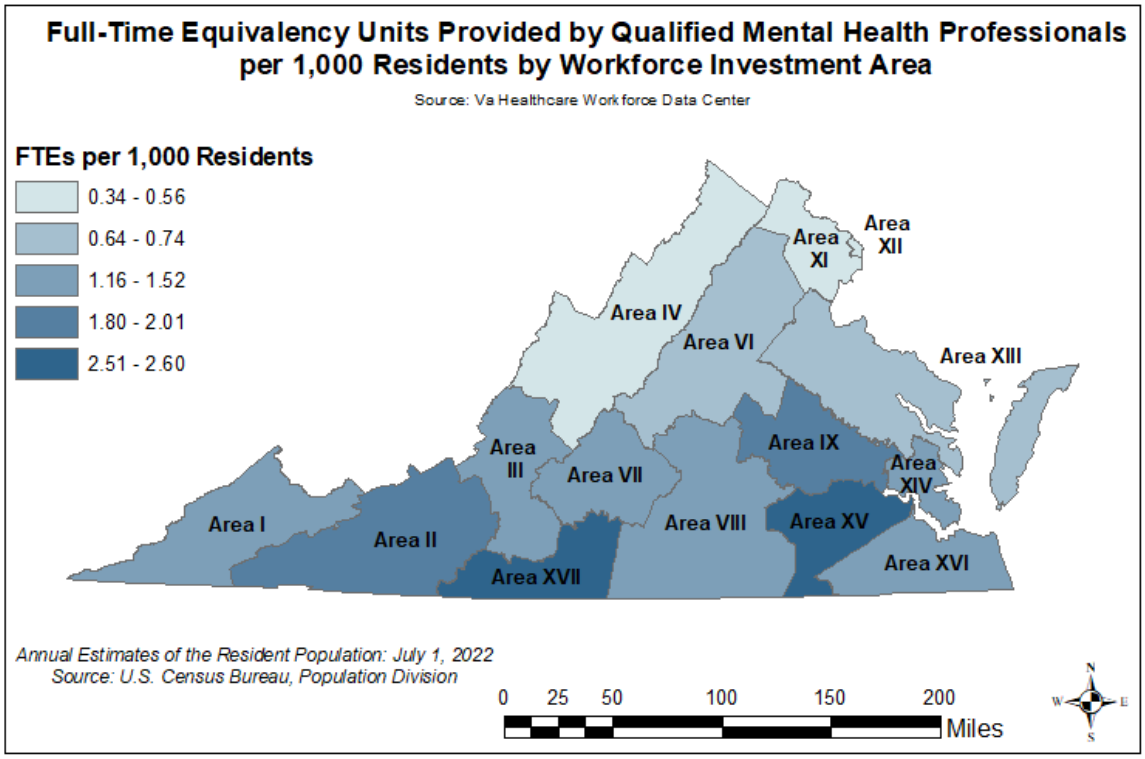
Area Health Education Center Regions

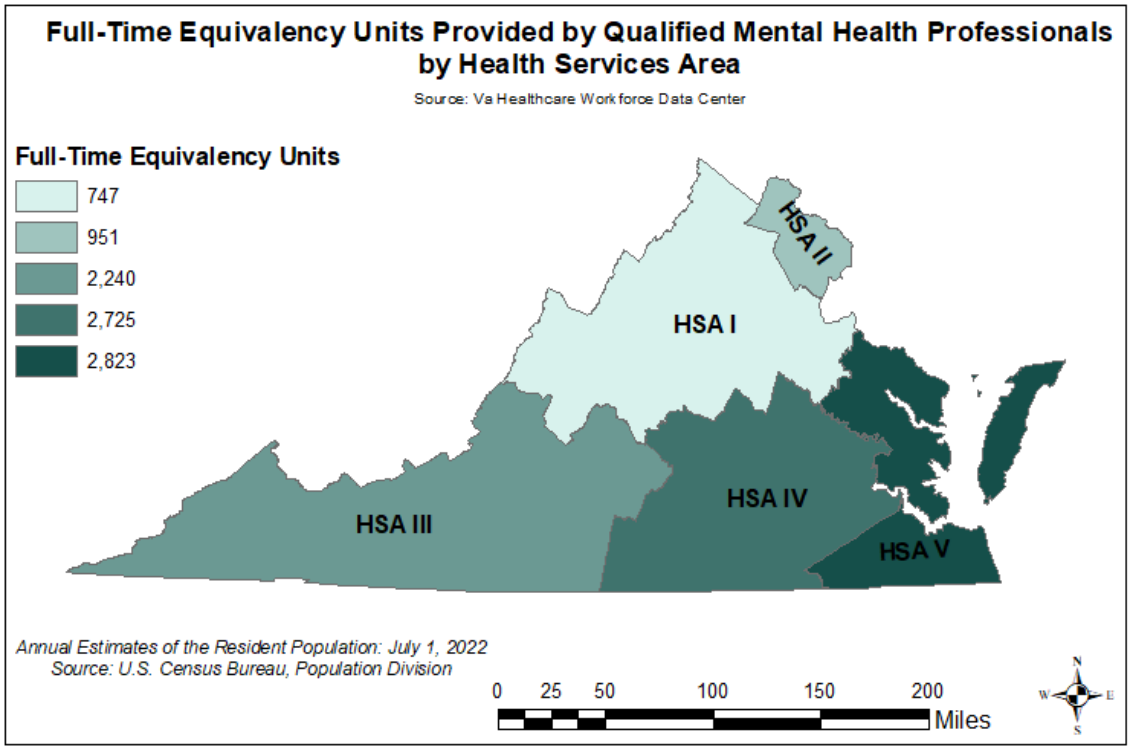


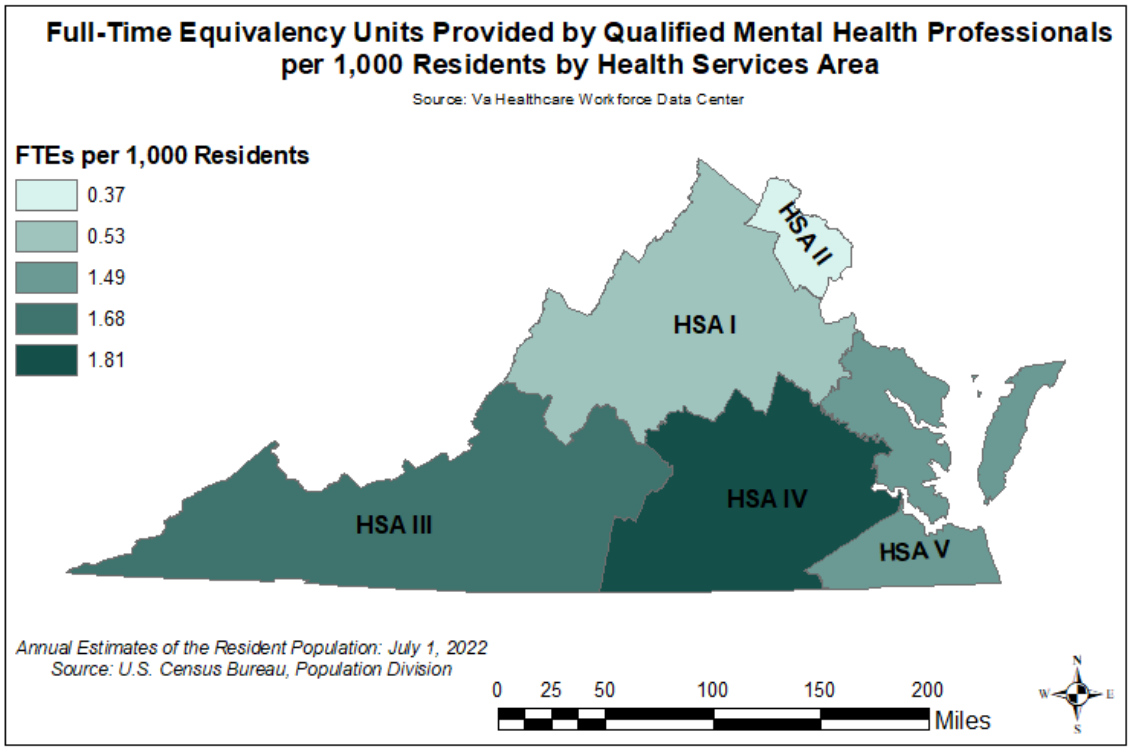


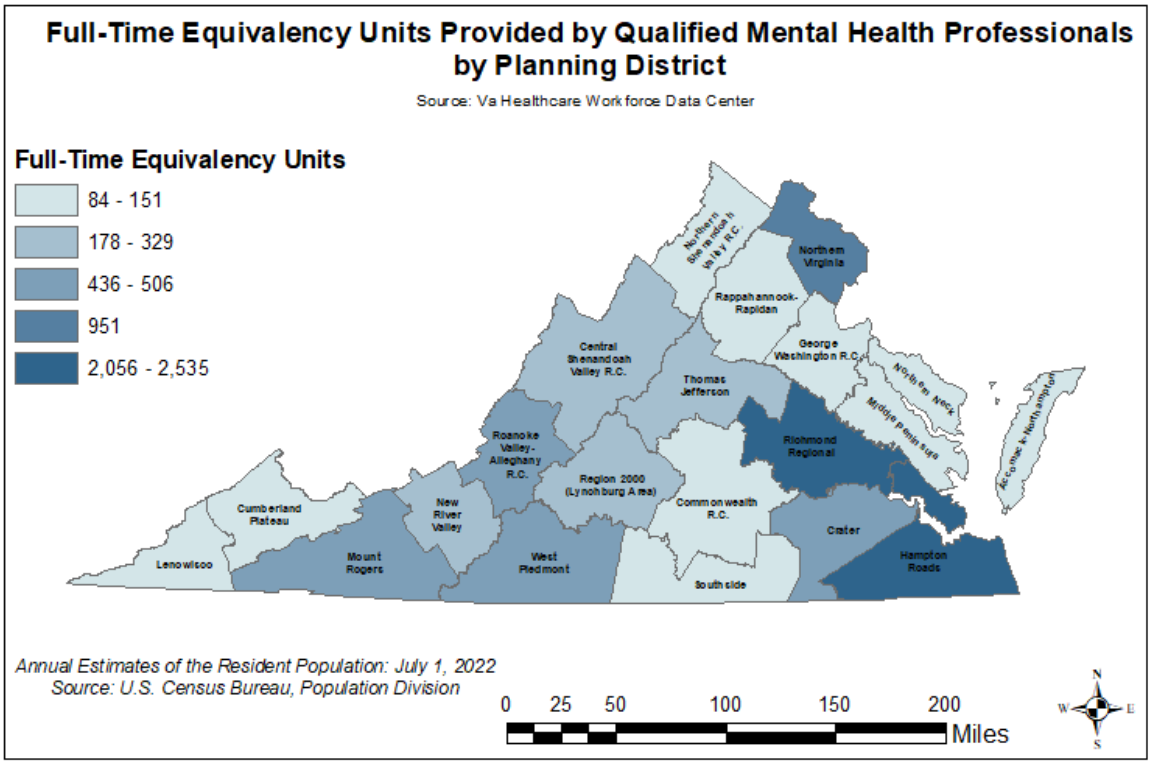
Workforce Investment Areas

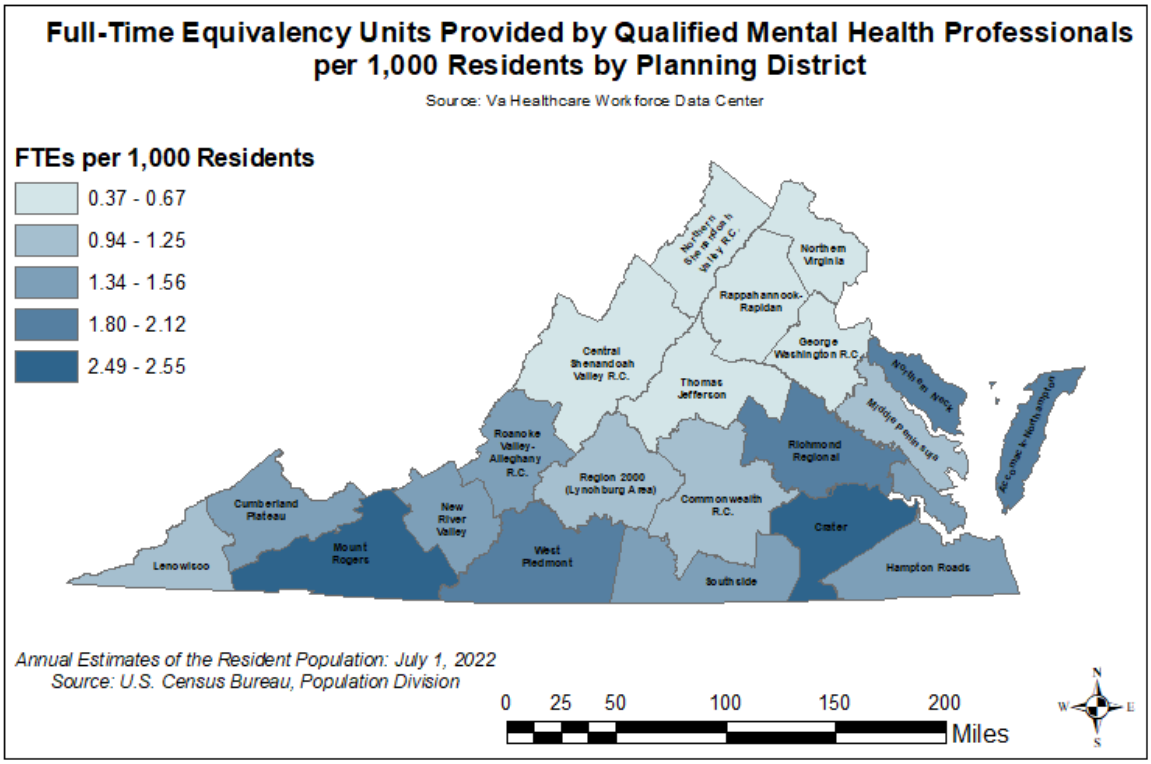





Full-Time Equivalency Units Provided by Qualified Mental Health Professionals by Health Services Area
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
747
951
2,240
2,725
2,823
HSA I
HSA II
HSA III
HSA IV
HSA V
Annual Estimates of the Resident Population: July 1, 2022
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full-Time Equivalency Units Provided by Qualified Mental Health Professionals per 1,000 Residents by Health Services Area
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.37
0.53
1.49
1.68
1.81
HSA I
HSA II
HSA III
HSA IV
HSA V
Annual Estimates of the Resident Population: July 1, 2022
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full-Time Equivalency Units Provided by Qualified Mental Health Professionals by Planning District
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
84 - 151
178 - 329
436 - 506
951
2,056 - 2,535
Northern Shenandoah Valley R.C.
Northern Virginia
Rappahannock-Rapidan
Central Shenandoah Valley R.C.
George Washington R.C.
Northern Neck
Middle Peninsula
Accomack-Northampton
Thomas Jefferson
Richmond Regional
Roanoke Valley-Alleghany R.C.
Region 2000 (Lynchburg Area)
Commonwealth R.C.
Crater
Hampton Roads
Cumberland Plateau
New River Valley
Mount Rogers
West Piedmont
Lenowisco
South side
Annual Estimates of the Resident Population: July 1, 2022
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full-Time Equivalency Units Provided by Qualified Mental Health Professionals per 1,000 Residents by Planning District
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.37 - 0.67
0.94 - 1.25
1.34 - 1.56
1.80 - 2.12
2.49 - 2.55
Northern Shenandoah Valley R.C.
Northern Virginia
Rappahannock-Rapidan
Central Shenandoah Valley R.C.
George Washington R.C.
Northern Neck
Middle Peninsula
Accomack-Northampton
Thomas Jefferson
Richmond Regional
Roanoke Valley-Alleghany R.C.
Region 2000 (Lynchburg Area)
Commonwealth R.C.
Crater
Hampton Roads
Cumberland Plateau
New River Valley
Mount Rogers
West Piedmont
Lenowisco
South side
Annual Estimates of the Resident Population: July 1, 2022
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S

Appendices

Appendix A: Weights

Rural Status	Location Weight			Total Weight	
	#	Rate	Weight	Min.	Max.
Metro, 1 Million+	7,284	72.36%	1.382	1.253	1.808
Metro, 250,000 to 1 Million	939	73.80%	1.355	1.228	1.773
Metro, 250,000 or Less	739	71.85%	1.392	1.262	1.821
Urban, Pop. 20,000+, Metro Adj.	442	73.76%	1.356	1.229	1.774
Urban, Pop. 20,000+, Non-Adj.	0	NA	NA	NA	NA
Urban, Pop. 2,500-19,999, Metro Adj.	672	75.45%	1.325	1.202	1.734
Urban, Pop. 2,500-19,999, Non-Adj.	457	79.21%	1.262	1.144	1.652
Rural, Metro Adj.	257	75.88%	1.318	1.195	1.724
Rural, Non-Adj.	122	79.51%	1.258	1.140	1.645
Virginia Border State/D.C.	666	70.57%	1.417	1.285	1.854
Other U.S. State	210	64.76%	1.544	1.400	2.020

Source: Va. Healthcare Workforce Data Center

Age	Age Weight			Total Weight	
	#	Rate	Weight	Min.	Max.
Under 30	993	55.69%	1.796	1.645	2.020
30 to 34	1,477	64.05%	1.561	1.431	1.756
35 to 39	1,715	70.50%	1.419	1.300	1.596
40 to 44	1,857	74.53%	1.342	1.229	1.509
45 to 49	1,555	76.98%	1.299	1.190	1.461
50 to 54	1,453	77.70%	1.287	1.179	1.448
55 to 59	1,207	80.36%	1.244	1.140	1.400
60 and Over	1,531	78.38%	1.276	1.169	1.435

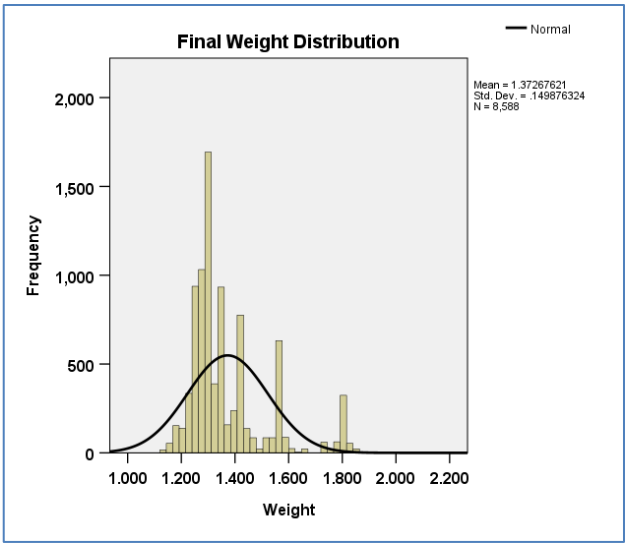
Source: Va. Healthcare Workforce Data Center

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

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

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

Overall Response Rate: **0.728537**



Source: Va. Healthcare Workforce Data Center

Board of Counseling
Current Regulatory Actions
As of September 18, 2024

In the Governor's Office

None.

In the Secretary's Office

VAC	Stage	Subject matter	Submitted from agency	Time in current location	Notes
18VAC115-90	Proposed	New chapter for licensure of art therapists	12/2/2021	Secretary 909 days	Licenses art therapists pursuant to General Assembly legislation.
18VAC115-20	NOIRA	Removal of redundant provisions related to conversion therapy	9/21/2022	Secretary 715 days	Removes language regarding conversion therapy which has been replaced by statutory language.

At the Department of Planning and Budget

None.

At the Office of the Attorney General

None.

Recently effective or awaiting publication

VAC	Stage	Subject Matter	Publication date	Effective date/ next steps
18VAC115-20	Emergency/ NOIRA	Implementation of the Counseling Compact	10/7/2024	Effective 9/9/2024; Board will vote on proposed changes following close of comment period on 11/6/2024
18VAC115-20	Exempt/ Final	Amendments to LMFT licensure by endorsement pursuant to 2024 legislation	9/9/2024	Effective 10/9/2024

Agenda Item: Consideration of petition for rulemaking

Included in your agenda package:

- Petition for rulemaking filed to request the Board amend LPC and LMFT regulations to allow residents to bill directly for services and receive payments directly from clients;

- Public comments received via Regulatory Town Hall;

- 18VAC115-20-52; and

- 18VAC115-50-60.

Staff note: The Board received 126 comments on Town Hall. 91 were in support of the petition; 28 were in opposition to the petition; and 7 did not state a discernible position or merely responded to arguments made in other comments.

Action needed:

- Motion to either:
    - Accept the petition and initiate rulemaking; or
    - Deny the petition, clearly stating why.

Virginia Department of
Health Professions
Board of Counseling

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

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

Petition for Rule-making

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

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

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

Watson, Sharon H.

Street Address	Area Code and Telephone Number	
4931 Portalis Way	703-350-5002	
City	State	Zip Code:
Anacortes	Washington	9 8 2 2 1

Email Address (optional)

sharonhazwatson@hotmail.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.

Petition: To allow Residents in Counseling to directly bill for services and to directly receive payment from clients. LPC Regulations (8-18-2021) 18VAC115-20-52, B 10 & LMFT Regulations (8-18-2021) 18.VAC115-50-60 B 8.

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

The purpose of this petition is to remove the words "directly bill for services rendered" in the LPC and LMFT regulations so a Resident in their own private practice under supervision can directly bill clients and directly receive client payments without their income passing through their supervisor. The regulations do not specify that a Resident cannot "collect" payment, however this has been interpreted as the intent of this wording (verified by the Board of Counseling). However, this is a significant handicap for any Resident who wishes to have their own private practice but cannot find a supervisor willing to take them on because of the lack of clarity on the process of client payments. Supervisors are concerned their Residents' incomes will be considered their own and the financial machinations needed to prove the income is not theirs is burdensome. When a Resident is not an employee or a contractor working for a practice (i.e. paid on an hourly basis) it's difficult to justify this regulation when the entire amount of client payments collected by the supervisor must be returned to the Resident in its entirety, as there are not supposed to be any split payments. This same petition was submitted in 2019 and denied for 2 reasons: 1. insurance reimbursement concerns and 2. that it would incentivize residents to work independently. This decision can be questioned because: 1. the Board has no purview over insurances (insurance companies make their own decisions regarding which providers they accept) and 2. Residents are required to notify their clients they are unlicensed, are under supervision, and are not allowed to practice independently, so clients are already aware they are not independently practicing providers. Residents who follow the regulations should not be penalized when acting ethically by the possibility another Resident goes rogue and unethically practices independently. In that case the Resident can be reported to DHP and sanctioned. An additional support for this petition request is that there are many states who either don't require that client payments be collected by the supervisor (and therefore supervisees/residents can directly bill and receive payment from their clients) or don't even discuss the issue of client payments in their regulations.

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

Signature: Sharon Watson **Date:** 06/26/2024

Commenter	Title	Comment	Date/ID
Sharon Watson	Strongly support this petition	The purpose of my submitting this petition is to remove the phrase "directly bill for services rendered" in the LPC and LMFT regulations so a Resident in their own private practice under supervision can directly bill clients and directly receive client payments without their income passing through their Supervisor. Although the regulations do not specifically say that a Resident cannot "collect" payment, this phrase has been interpreted that Residents are not allowed to take payments from clients (as verified by the Board of Counseling). This is the third attempt to submit this petition. This same regulation change request was previously submitted in 2005 and 2019 by two other individuals and was denied both times. My hope is that it will be reconsidered by the Board of Counseling and this time, accepted. The 2019 petition “Ability for residents in counseling to directly bill for services” resulted in 70 comments with more in favor than not. Regardless of that, the Board of Counseling “after consideration” stated: “The Board decided to take no action based on its concern that [1.] direct billing by residents is contrary to the reimbursement policy of DMAS and other third party payors, and [2.] that it might incentivize residents to engage in independent practice without appropriate supervision.” It’s unclear how #1 applies because the Board of Counseling has said they have no purview over insurance reimbursement for services (insurance companies make their own decisions regarding which providers they accept) and it seems this would include DMAS as Residents are not allowed to bill insurance (including Medicaid). Now, regarding #2. Residents are required, per the regulations to inform their clients “in writing that the resident does not have authority for independent practice and is under supervision” so clients are already aware their counselor is not an independently practicing provider. Residents who follow the regulations should not be penalized when acting ethically by the possibility another individual may act unethically and practice independently. If that does happen, they can be reported to DHP and sanctioned. It’s sometimes difficult for a master’s level graduate to find a job in the field because of a variety of reasons. In Virginia a resident is allowed to have a private practice if they are under Board approved supervision, identify themselves as a Resident in Counseling under supervision and by whom, and inform clients they cannot practice independently. The problem is that not taking payment directly from clients presents an additional significant hardship for a Resident who wishes to have a private practice because of the difficulty in finding a supervisor willing to take them on because of the lack of clarity on how to manage the process of the “pass through” of client payments. Supervisors are concerned their Residents' incomes will be considered their own and the financial machinations needed to prove the income is not theirs is burdensome. Potential supervisors are thinking: “what if I’m audited by the IRS?…why take the risk? Actually, payment is more of a mechanical issue especially since the client’s payment in its entirety must go right back to the Resident (as there are to be no “split payments”; for example, a supervisor is not to keep any portion of the funds as payment for supervision). Cash and paper checks (signed back over to the Resident) are a thing of the past now with instantaneous payments, credit card billing, and cash transfers. The gyrations of having the payment go through the supervisor is unnecessary and puts a tremendous strain on both Residents and Supervisors, specifically those Residents in private practice. And why shouldn't the payment go directly to the Resident who is the one who provided the service? It’s more likely confusing to clients to be told they must pay a supervisor and not the counselor, the one with whom they have made a therapeutic connection and received the service. For those who may suggest that Residents should not be encouraged to have their own practice because of a lack of experience and who would like to keep this regulation unchanged, please take into consideration the following example. In exempt settings, graduates are practicing as counselors in many cases without Board approved supervision, may have a supervisor who isn’t even licensed, and who are required to see the next client on the waiting list regardless of whether or not they have the skills to work with those clients who are often in very intense and difficult situations and may be diagnosed as seriously mentally ill, because it’s the job. There’s no reason then, for an individual coming out of graduate school to not be able to see clients in their own private practice when they are as qualified as those going into exempt settings but must have the required Board approved supervision. Also, this doesn’t necessarily apply only to someone new in the field. There are many Residents who, with experience, may want to leave their current employment and build their own practice but have the same challenges in finding a Supervisor because of the client billing issue.	8/3/24 11:41 pm CommentID:227239

		In fact, this requirement serves to penalize Residents who do not work in exempt locations or who are employees or contractors in a private practice where client payments are billed to the client or the client's insurance and are collected by the employer. An additional support for this petition is that there are some states who either don't require that client payments be collected by the supervisor or don't even discuss the issue of client payments in their regulations (and therefore the supervisee can directly bill and receive payment from their clients). With the upcoming implementation of the Counseling Compact and the agreement that each participating state accepts the regulations required for licensure of other states in the Compact, this is an opportunity for the Virginia Board of Counseling to be in the forefront of making this change in the regulations to be more in line with our increasingly technologically based world and with the opportunities this brings for Residents. Dictating that a resident not take direct client payment does not make our licensure process better, it just keeps us from adapting to the present and keeps some graduates entering the field without employment and income if they are unable to find a job and also unable to have their own practice, as well as for those Residents needing or wanting to move from employment to private practice, if they can't find a Supervisor willing to take them on.	
Linda DuToit, LPC	I fully support this petition	I strongly support this petition.	8/4/24 1:09 pm CommentID:227240
Anonymous	I do not support this	For the reason other's have stated we should allow this, I believe we should not.	8/4/24 1:25 pm CommentID:227241
Linda Ritchie, PH.D.,, LMFT, LPC	Fully Support This Petition	I fully support this petition for all the reasons that were stated in detail by Sharon Watson. It will in no way adversely affect the fact that residents are required and must be supervised.	8/4/24 2:12 pm CommentID:227242
Lindsey N Fors	I fully support this	I fully support this	8/4/24 2:12 pm CommentID:227243
Anonymous	As a Virginia supervisor, I support this	I support this	8/4/24 2:19 pm CommentID:227244
Anonymous	I do not support	They are residents for a reason. There is no substitute for experience and knowledge - we need to stop rushing the PROCESS and lowering standards to meet what may or may not be a need. The risk is much greater than the reward. Think of the damage that has been propagated by those that are licensed.	8/4/24 2:20 pm CommentID:227245
Mary Wiggins	I fully support this petition	This petition will help therapists to provide more needed services without insurance burdens.	8/4/24 2:36 pm CommentID:227246
Anonymous	I support this	I strongly support thisl	8/4/24 2:45 pm CommentID:227247
Anonymous	Wholehearted Yes	I absolutely support this. As it stands, many residents in private practices pay outside clinical supervisors separately upwards of $100 to $180 a week for outside supervision. Then, within the confines of the practice, the residents are expected to pay anywhere from $600 to $1000 plus a month, cover the costs (time and expenses) of my own electronic health record system, marketing, trainings, etc, and then pay a percentage of their profits (usually 20 to 40 percent of collections). Essentially, the laws and codes as written allow many LPC private practice owners to choose to serve only as money launderers for residents. I understand this was not likely the intent of the code, but this is how it is being manipulated as of now and it is unfair and predatory to residents at the expense of clients. As it stands clients keep a card on file with an EHR, the fee gets deposited to an LPC practice owner account, and then filtered back to the resident. That is the only service required by practice owners. Clients are still paying full fee and largely or entirely ignorant (thankfully) to the ways their clinicians are being raked over, taken advantage of and burned out. We as a field should be better than this. We should expect that those serving as LPC practice owners taking on residents are their to mentor and mold and shape the next generation, helping to multiply impact on the mental health outcomes for many more than just 1:1 client work would allow. But oh how quickly greed and easy money can get in the way… and boy is it easy to create essentially a multi-level marketing approach to having interns and residents make quick money with minimal work on the part of a practice owner whose main job becomes simply filtering hard-earned Resident money through their LPC account because residents are prohibited from direct billing.	8/4/24 2:46 pm CommentID:227248
Anonymous	Absolutely, yes!	I feel that residents have a supervisor and should be allowed to take clients and bill directly	8/4/24 2:59 pm CommentID:227249
Anonymous	Support	Yes. Let's get rid of this. Nothing more than codified theft of client fees under the false flag of what exactly? Continue to require the stringent requirements of clinical supervision but let's call a spade a spade and not enrich LPC practice owners at the expense of resident mental health and draining client wallets.	8/4/24 3:00 pm CommentID:227250

Anonymous	I do not support this	If this is passed, it essentially renders the independent licensure unnecessary or said differently, it makes the supervision process impossible.. Consumers cannot be expected to understand the difference in nomenclature, so residents can easily operate their own practices.. Additionally it seems incongruous with wage/hour laws — if a supervisor is still being held responsible for services provided by residents, they need to be able to exercise a certain amount of control over their work. If residents can accept payment independently, they are essentially acting as 1099 independent contractors. To be in compliance with the IRS definition of a 1099, the supervisor cannot exert control over the work of their resident. This puts supervisors in an impossible position. If the Board thinks residents can operate independently, it needs to eliminate the supervision requirement altogether and award independent licensure to graduates of Masters programs. Moreover if residents are able to accept payment, the workforce available to serve in community mental health and agencies will be even farther reduced. I understand the push for this likely revolves around inadequate pay for residents. Let's get to the root of that problem - insurance rates are too low and have not increased with inflation and cost of living. Rather than reducing the quality of the profession by reducing the supervision and oversight of new clinicians, let's focus on raising the quality of services provided and demonstrate the ways in which counselors promote the health of the community thus reducing the overall cost of untreated mental health issues.	8/4/24 3:06 pm CommentID:227251
Suzan Thompson, Ph.D.,LPC	I DO NOT support this	This petition runs against the requirements that supervisors are responsible for Residents. It impacts only those in Private practice and could send a mixed message to clients.	8/4/24 3:22 pm CommentID:227252
Anonymous	I fully support this!	The journey to become a counselor is long are arduous and the current policy adds to the challenges to support oneself with livable means. Allowing residents to bill directly will help residents to fully dedicate themselves to the hours needed to obtain full licensure without the added stressor of worrying how to making ends meet.	8/4/24 3:36 pm CommentID:227253
Anonymous	I strongly do not support this	I strongly do not support this	8/4/24 3:55 pm CommentID:227254
Brett Welch, LPC-Richmond Child and Parent Counseling	Strongly support	I strongly support this petition which will create more equity and access for Residents, which in turn creates better access for patients in a field that desperately needs more practitioners who take insurance. Residents would still be required to be under supervision for the entirety of their residency, but this would allow for insurance payments to go directly to the provider and not through a third-party (supervisor). Allowing residents to successfully begin their own solo or group private practice prior to full licensure creates a necessary pipeline to allow for more professionals to earn a living wage, which will remove unnecessary barriers currently keeping potential practitioners from joining the field.	8/4/24 4:54 pm CommentID:227255
Anonymous	I do not support this	Residents in Counseling need to receive supervision before the Commonwealth certifies that they are eligible to practice independently. Allowing Residents to collect payment directly for services, and to operate their own independent counseling practices, does not contribute to the safety and welfare of citizens in the Commonwealth who rely on Residents for professional services.	8/4/24 5:36 pm CommentID:227256
Anonymous	I support this decision	I support this petition as it addresses an important aspect of professional development for Residents in Counseling. Allowing Residents to directly bill and receive payments for their services under supervision will not only align Virginia with practices in several other states, but it also reduces unnecessary administrative burdens on both Residents and Supervisors. Importantly, this change does not alter the required supervision hours or the standards for supervision itself. Instead, it creates an environment where Residents can establish their practices under clear guidance and oversight during their formative years. By streamlining the billing process, Supervisors can focus more on providing quality guidance, which enhances the overall supervision experience. Additionally, Residents in Counseling often face low wages in the Commonwealth, making it difficult to sustain themselves while gaining necessary experience. This adjustment would provide an opportunity for Residents to improve their financial stability, making the profession more accessible and sustainable for emerging counselors. This adjustment fosters a clearer and more professional relationship between counselor and client while ensuring that the integrity and rigor of the supervisory process remain intact. It also provides a vital pathway for Residents to establish and grow their own practices, ultimately benefiting both the counseling profession and the clients served.	8/4/24 5:36 pm CommentID:227257
Anonymous	Support!	I strongly support the petition to amend 18VAC115-20-52(B)(10) and 18VAC115-50-60(B)(8) to allow residents in counseling to directly bill for services and receive payments from clients. This change is crucial for promoting professional development and financial stability for new practitioners in the field. The current regulation creates unnecessary hurdles for residents who are already under strict supervision requirements. By allowing residents to directly bill clients, we empower them to take ownership of their practice while still under the mentorship and guidance of experienced supervisors. This fosters a learning environment where residents can develop their business acumen alongside their clinical skills, better preparing them for independent practice.	8/4/24 5:43 pm CommentID:227258

		Moreover, this amendment would reduce the administrative burden on supervisors, who currently have to manage the complex process of passing through client payments. The existing system not only complicates the financial aspects of supervision but also potentially dissuades qualified professionals from taking on supervisory roles due to the perceived risks and inconveniences. It is also important to recognize that the cost of living continues to rise, and residents in counseling often face low wages and limited employment opportunities in the Commonwealth. Allowing residents to directly bill clients could alleviate some of the financial stress they experience, making the profession more sustainable and attractive to future practitioners. This change would not incentivize unethical practice but rather support residents in adhering to ethical guidelines while gaining the experience they need to become licensed professionals. In exempt settings, graduates practice without the same level of oversight, often dealing with complex cases without adequate support. By contrast, allowing residents in private practice to bill directly while still under supervision ensures they receive the guidance they need to develop into competent, ethical practitioners. In conclusion, this amendment is not only a step toward modernizing our regulatory framework to match current technology and payment systems but also a move to support the next generation of counselors. It acknowledges the reality of the field and offers a practical solution that benefits both residents and their supervisors, ultimately leading to better outcomes for clients. I urge the Board to reconsider this petition and allow residents to directly bill for their services.	
Anonymous	This doesn't change the licensure and supervisory requirements - I support.	I support the petition to amend 18VAC115-20-52(B)(10) and 18VAC115-50-60(B)(8) to allow residents in counseling to directly bill for services and receive payments from clients. It's important to emphasize that this proposed change is not about reducing or altering the supervision requirements for residents. Instead, it's about providing clarity and modernizing the process to better reflect the current professional landscape. The current regulation's wording has led to confusion and unnecessary complications around the billing process for residents in counseling. This amendment seeks to address that confusion without altering the essential requirements for supervision or the pathway to licensure. Residents will still be under the same rigorous supervision and will still be required to complete all necessary hours and meet all other criteria set by the Board. This amendment is not about changing the certification of licensure; it's about clarifying an administrative aspect that impacts the day-to-day functioning of residents in counseling. The ability to directly bill clients simplifies the process for all parties involved. It allows residents to manage their practice more effectively while under supervision, ensuring that their focus remains on providing quality care to clients rather than navigating cumbersome billing procedures. This clarification also aligns with practices in other states and reflects the shift towards a more streamlined and efficient healthcare environment. By removing the unnecessary complexity of billing through a supervisor, we are not compromising the integrity of the supervision process. Instead, we are allowing residents to operate more independently within the boundaries of their training, supervision, and ethical obligations. In summary, this change is about clarity and practicality, not about altering the foundational requirements for becoming a licensed counselor. It is a necessary step to ensure that residents can focus on their professional growth and client care without unnecessary administrative burdens.	8/4/24 5:51 pm CommentID:227259
Anonymous	Absolutely support this	I absolutely support this	8/4/24 6:11 pm CommentID:227260
Anonymous	Full support	I am in full support of the petition to amend the regulations to allow residents in counseling to directly bill for services and receive payments from clients. This change is essential for aligning the profession with modern practices and the realities of today's technology-driven world. The current regulations were established in a time when payment methods were more manual and required greater oversight. However, in today's world, we have access to digital payment systems that offer transparency, efficiency, and security. The requirement for payments to pass through supervisors is outdated and no longer necessary given these advancements. Direct billing by residents does not undermine the supervision process; instead, it modernizes it. Supervisors will still provide essential oversight to ensure that residents are practicing ethically and within the bounds of their competence. What changes is the administrative burden on supervisors and the financial clarity for residents, who will now have the ability to manage their own income without unnecessary complications. Furthermore, this amendment would benefit clients by simplifying the payment process. Clients often prefer to handle payments directly with the counselor they are working with, as this	8/4/24 6:12 pm CommentID:227261

		maintains the integrity of the therapeutic relationship. By allowing residents to bill directly, we respect the client-counselor relationship and make the process more straightforward for everyone involved. Finally, the current regulation places Virginia out of step with many other states that allow direct billing by residents. As we move toward greater interstate cooperation in counseling licensure through initiatives like the Counseling Compact, it is important that Virginia aligns its regulations with those of other states to ensure consistency and mobility for professionals. This amendment is not about reducing oversight or compromising ethical standards; it is about bringing our profession in line with current practices and technology. I urge the Board to approve this petition and take a necessary step forward in modernizing our regulations.	
Anonymous	Absolutely not	I do not support this measure. Why should LPC's be the only profession allowed to do this? No!	8/4/24 7:09 pm CommentID:227262
Anonymous	Petition to allow residents in counseling to directly bill for services and directly receive payment	I do not support this.	8/4/24 7:58 pm CommentID:227263
Anonymous	I fully support this - other states allow supervisees to bill clients directly!	I fully support this proposal for a multitude of reasons. First, it's time that we all understand what "operate independently" really means. "Operating independently" means practicing without supervision, not that "Residents can't own and operate their own practice." There's a clear difference between "operating independently" and being self-employed (with supervision) and many other states recognize this and allow their supervisees to have their own private practices - as does Virginia! Fact: Virginia Residents CAN legally (and DO) own and operate private practices. This provision alone, has no bearing on the issue at hand (Residents not being able to bill clients directly). Second, others' have commented that if this bill is passed, then the "experience" that Residents are supposed to be receiving will be compromised. Billing clients directly should not equate to professional "experience." Such claims completely demean and disparage the the work and dedication that Residents give in order to maximize all of the benefits surrounding said experience. If a Resident is able to bill their clients directly, the quality of their experience won't change - because they'll still be under supervision. It's supervision that perpetuates the quality of the Residents "experience," not the money. Some people who are opposed to this proposal think that if LPC's aren't monitoring (aka controlling) the money, then Residents can do whatever they want. I find this this frame of thought to be extremely concerning for multiple reasons. One is because it conveys that Residents are ONLY being monitored in one way. If this is the case, then supervisors need to be held accountable for their lack of supervision. Perhaps Supervisors also need be monitored more closely - and maybe revoking their ability to bill Residents directly will achieve this? Furthermore, Residents being in charge of their own billing/money should not be threatening to LPCS/Supervisors. The simple fact that many people in higher positions than Residents are threatened by this should be of great concern to those in charge of regulating the profession. It's no secret that there are numerous "puppy mill" style practices in Virginia wherein LPCs/Supervisors hire Residents (some of them ONLY hiring Residents) because they can make more of a profit this way. I personal know of at least one practice in Virginia that has made over $1 million per year because of this "business model." So, if this proposal goes through, these places fear losing their "golden goose" (i.e., Residents). Personally, I think that this is the real reason why many people oppose this proposal. Other states (such as Texas, Oregon, Colorado, and Ohio) allow their counseling supervisees to bill clients directly. This proposal is not an unprecedented concept in our profession. It is happening in other states and it's happening successfully. These supervisees are still getting the experience they need and they aren't operating independently - because they're still being supervised. Furthermore, the fully-licensed counselors in these states are not of lesser quality or have less competence because their supervision experience is different than ours. So, it's clear that the problem many people have with this proposal just comes down to money. Lastly, many people opposing this proposal also state that prohibiting Residents from billing their clients directly actually helps clients because it shows that Residents are not LPCs and are under supervision. They still seem to say this despite the multiple regulations in place that	8/4/24 8:23 pm CommentID:227264

		require Residents to show/explain/document/discuss/brandish (to the point of extreme overkill) that they are not licensed professional counselors and are indeed under supervision. Changing how the client is billed does not change this requirement. As a matter of fact, I have personally witnessed clients being even more confused and essentially turned off from starting therapy due to the Resident not being able to bill them directly. We're constantly being told that there is a severe therapist shortage in Virginia; so, why are we refusing to make changes that could actually make the process easier for Virginians to get help? At the end of the day, Residents in Counseling should be supported, encouraged, and nurtured - not held back by archaic ideals that only benefit those wishing to profit off of Residents. Rules and regulations should evolve along with an evolving profession, as ours does. Other states recognize the importance of what is being proposed here and have updated their rules and regulations. Virginia should too!	
Anonymous	Absolutely Yes	Approving this change will strengthen the mental health services the State of Virginia can provide to its citizens and bring Virginia to the forefront of tackling the challenges of the mental health crisis in America in this generation. The burnout rate of counselors is unsustainable and one preventable cause of that loss is addressed here, fair and equitable compensation for services provided. Allowing residents to bill directly if they choose does not weaken the requirements for supervision and professional development. Instead, it will likely strengthen the resident/supervisor relationship. The resident who chooses to have their own practice will feel less taken advantage of and more autonomous, which is in line with the code of ethics and the supervisor can focus more on their responsibility to provide oversight and mentoring. As a resident, it is disheartening under the current regulations to see the workload I have to take on in order to make ends meet and provide for my family, when all that separates me from being more fairly compensated is an outdated, unnecessarily oppressive regulation.	8/4/24 8:38 pm CommentID:227265
Anonymous	A welcomed improvment	I support the petition to amend the regulations to allow residents in counseling to directly bill clients. The current system, which requires payments to go through supervisors, disrupts the natural client-counselor relationship and creates unnecessary confusion for clients. When clients seek therapy, they establish a trusting relationship with their counselor. This trust is the foundation of effective therapy, and clients naturally expect to handle all aspects of their service, including payment, directly with the person providing their care. The current regulation, which requires clients to pay the supervisor rather than the resident counselor, can erode this trust and create unnecessary administrative hurdles. Allowing residents to bill clients directly also reflects the modern landscape of payment systems. With digital payments becoming the norm, the process of transferring payments through supervisors is outdated and cumbersome. It is far more efficient and transparent for clients to pay their counselor directly, ensuring a smoother process for all involved. Furthermore, this change would alleviate the administrative burden on supervisors, allowing them to focus more on providing quality supervision rather than managing financial transactions. Supervisors should be there to guide and mentor, not act as intermediaries for payments. This amendment would not compromise the quality of supervision or the ethical standards of the profession. Residents would still be under the oversight of their supervisors, ensuring they adhere to all regulations and continue their professional development. I urge the Board to support this change for the benefit of residents, supervisors, and clients alike.	8/4/24 8:58 pm CommentID:227266
Anonymous	Support	I am writing to express my strong support for the petition to amend 18VAC115-20-52(B)(10) and 18VAC115-50-60(B)(8) to allow residents in counseling to directly bill for services and receive payments from clients. This change is necessary to alleviate the financial strain on residents and to modernize the regulations in line with current payment practices. Residents in counseling are often recent graduates who are still building their professional foundation. The financial burden of entering the field can be significant, especially given the low wages that many residents receive in their early years. The current requirement that residents must pass their earnings through their supervisors adds an unnecessary layer of complexity and financial strain. Supervisors, understandably, may be hesitant to take on residents due to concerns about the implications for their own tax liabilities and the administrative burden of managing these payments. Allowing residents to directly bill clients simplifies this process and provides a clearer financial path for both residents and supervisors. Residents can more easily manage their own income, which is essential for their financial stability and professional growth. Supervisors, in turn, can focus on what they do best—providing guidance and support to the next generation of counselors—without the added stress of handling payments. The argument that direct billing could incentivize unsupervised practice does not hold when we consider the robust supervision requirements already in place. Residents are required to inform	8/4/24 9:00 pm CommentID:227267

		clients in writing that they are under supervision, ensuring transparency and adherence to ethical standards. This amendment would not change the rigorous supervision requirements; it would merely streamline the financial aspect of the supervisory relationship. Furthermore, in many other states, residents are permitted to bill clients directly, and these states have not reported issues with residents practicing independently without appropriate oversight. This demonstrates that direct billing can be implemented without compromising the integrity of the supervision process. The current regulation also creates an artificial barrier for residents who wish to start their own private practice under supervision. In a time when employment opportunities may be limited, especially in certain geographic areas, being able to establish a private practice under supervision can be a critical opportunity for residents to gain experience and build their client base. By allowing residents to bill clients directly, we support their entrepreneurial efforts and help ensure that they can sustain themselves financially while continuing their professional development. In conclusion, the proposed amendment to allow residents in counseling to directly bill clients is a necessary and logical step forward. It supports the financial well-being of residents, reduces administrative burdens on supervisors, and aligns Virginia's regulations with modern payment practices and the standards of other states. I strongly urge the Board to approve this petition for the benefit of all involved in the counseling profession.	
Anonymous	I support this.	I support this.	8/4/24 9:16 pm CommentID:227268
Anonymous	I support this	I support this	8/4/24 9:27 pm CommentID:227269
Anonymous	I support this	I fully support the petition to amend the current regulations and allow residents in counseling to directly bill clients and receive payments for their services. The existing rules create an unfair disadvantage for residents, limiting their ability to build a successful practice and placing unnecessary financial and administrative burdens on both residents and supervisors. The current system, which requires payments to be routed through supervisors, is both cumbersome and outdated. In an era where digital payments are the norm, requiring a middleman for financial transactions only serves to complicate what should be a straightforward process. This outdated requirement places Virginia's residents at a disadvantage compared to their peers in other states where direct billing is allowed. Residents are often in the early stages of their careers, working hard to establish themselves in the field. They face the dual challenge of gaining clinical experience while managing the financial realities of life after graduate school. The inability to directly bill clients adds an unnecessary layer of financial stress. It forces residents to rely on supervisors to manage their income, which can be problematic if the supervisor is not well-versed in these financial processes or is simply unwilling to take on the extra administrative load. Moreover, the requirement for payments to go through supervisors can deter qualified professionals from becoming supervisors. The administrative burden and potential tax implications are significant deterrents, which ultimately limits the availability of quality supervision for residents. By allowing residents to handle their own billing, we can remove this barrier and potentially increase the pool of willing and qualified supervisors. Additionally, clients who choose to work with a resident counselor should not be burdened with a complicated payment process. Clients prefer transparency and simplicity, and being required to pay someone other than the person providing the service can create confusion and disrupt the therapeutic relationship. Direct billing respects the client's choice and maintains the integrity of the counselor-client relationship	8/4/24 10:41 pm CommentID:227270
Anonymous	I 100% Support!	I think this is an excellent idea! The supervision requirements will remain the same and it cuts out the middle man when it comes to billing. It also helps residents have a better understanding of the operational/administrative side of working with clients. School teaches us how to provide care but we aren't given many opportunities to learn the side related to running a business. This move will set clinicians up for success.	8/4/24 10:55 pm CommentID:227271
Anonymous	Yes!	This change is crucial for the economic viability of residents in counseling and for fostering a more equitable entry into the profession. Currently, residents are often caught in a difficult financial situation. They are required to undergo extensive training and supervision, which is essential for ensuring quality care. However, the inability to directly bill clients creates a financial bottleneck that can discourage talented individuals from continuing in the profession. Many residents face low wages and struggle to meet their basic living expenses, let alone pay for the supervision required to advance in their careers. By allowing residents to bill clients directly, we are acknowledging their role as professionals who are capable of managing their own practices under supervision. This change does not	8/5/24 12:13 am CommentID:227272

		reduce the amount or quality of supervision required; instead, it allows residents to focus on providing excellent care without the additional stress of financial uncertainty. This amendment would also bring Virginia in line with other states that have modernized their regulations to reflect the realities of today's healthcare environment. In a world where digital payments are standard and the administrative burden on professionals is increasing, streamlining the billing process is not just a convenience—it's a necessity. This change would simplify the payment process for clients, reduce administrative burdens on supervisors, and make it more feasible for residents to establish their own practices. Moreover, the current regulations may inadvertently penalize those who choose to work in private practice settings under supervision, as opposed to exempt settings where billing and payment practices are less restricted. This creates an uneven playing field that limits opportunities for many qualified professionals. In summary, allowing residents to bill clients directly is a common-sense change that supports the financial and professional growth of new counselors while maintaining the necessary safeguards of supervision. It's a step towards a more sustainable and equitable path into the counseling profession.	
Anonymous	This is a step forward	I strongly support the petition. This amendment is essential not only for promoting ethical practice but also for ensuring the financial independence of residents. The current regulations place residents in a difficult position by requiring their income to be funneled through their supervisors. This setup creates unnecessary complications and opens the door to potential ethical concerns. For example, there could be misunderstandings about the division of payments or delays in residents receiving their rightful earnings. These issues can strain the supervisory relationship and create unnecessary tension between supervisors and residents. Allowing residents to bill clients directly removes these potential conflicts and promotes transparency. Residents can clearly document the services they provide and the payments they receive, fostering an ethical practice where all parties have a clear understanding of the financial arrangements. This clarity is essential for maintaining the trust and integrity of the supervisory relationship. Moreover, the current system can discourage talented individuals from pursuing supervision roles. The added responsibility of managing another professional's income, with all its associated administrative and tax complexities, is a deterrent for many would-be supervisors. By allowing residents to handle their own billing, we remove this barrier, potentially expanding the pool of qualified supervisors and improving the overall quality of supervision available to residents. Financial independence is a critical component of professional development. Residents are emerging professionals who are working to establish their careers and build their reputations in the field. Allowing them to manage their own income is an important step in this process. It teaches them how to handle the business side of private practice, an essential skill for any successful practitioner. Additionally, the current regulation is out of step with modern payment practices. In today's world, digital payments are standard, and the requirement for payments to go through a third party is outdated and unnecessary. Clients expect a streamlined process where they can pay the individual providing the service directly. This not only makes the payment process more efficient but also reinforces the therapeutic relationship between the counselor and the client. Finally, the concern that allowing residents to bill directly might incentivize unsupervised practice is unfounded. The regulations already require residents to inform clients in writing that they are under supervision and not practicing independently. This amendment would not change the supervision requirements; it would simply make the financial aspect of their practice more transparent and manageable. In conclusion, the proposed amendment to allow residents to bill clients directly is a necessary step forward for the counseling profession in Virginia. It promotes ethical practice, financial independence, and aligns our regulations with modern payment systems. By supporting this change, the Board will be fostering a healthier, more sustainable environment for residents, supervisors, and clients alike. I urge the Board to approve this petition.	8/5/24 12:14 am CommentID:227273
Anonymous	I support this	I don't believe this will cause harm or damage the learning process to become fully licensed. I fully support this.	8/5/24 3:10 am CommentID:227274
Anna Rosemond	Yes!	I do support this	8/5/24 5:16 am CommentID:227275
D. Fein	Support	Strongly support for all the reasons state in Sharon Watson's original posting. With the Counseling Compact coming into effect, it is more timely than ever.	8/5/24 7:18 am CommentID:227276

Anonymous	Ethically Essential	Ethically, it is essential to allow Virginia Residents in Counseling to bill directly for services rendered as the exchange of money (and open dialogue about the same) between client and counselor is an integral aspect of healthy, effective psychotherapy. Residents should be given the opportunity to engage in all aspects of professional counseling practice while under supervision, working with their supervisor to resolve any problematic aspects of client care. Singling out the exchange of money as the only integral part of psychotherapy that Residents cannot take the lead on inhibits their professional growth as Residents and is at worst detrimental to clients (creating confusion regarding payment) and at best completely irrelevant to client welfare (having a supervisor accept a client's money does not improve client wellbeing). This limit on Residents is arbitrary and does not enhance their professional development nor safeguard clients. As Virginia supervision and other Residency requirements (e.g. clearly indicating their status as Resident in Counseling to clients and on all written documentation) are still in place for Residents regardless of whether they accept direct payment, client wellbeing is still at the forefront of the spirit of Residency guidelines; this proposed update to Residency guidelines will afford Residents the right to practice as the ethical and competent masters level clinicians they are.	8/5/24 7:27 am CommentID:227277
Anonymous	Support the petition	Absolutely support this	8/5/24 8:32 am CommentID:227278
Leigh Gathings, Lewisgale Medical Center	Residents in Counseling	As the mental health crisis intensifies across our state, it is increasingly crucial that all professionals in the healthcare sector operate at the highest level of their licensure capabilities. Currently, Virginia residents are facing extensive waitlists for essential services, which impedes their access to timely mental health care. This situation also places an undue burden on Licensed Professional Counselors (LPCs), who are responsible for managing a broad array of services and associated billing. The delay in advancing the proposed legislation exacerbates the challenges faced by an already overwhelmed behavioral health services system. Without this critical reform, the constraints on LPCs will persist, further impeding the delivery of necessary services to those in need. We propose that immediate action be taken to push this law through, as it will alleviate the current pressures on LPCs and enhance the efficiency of mental health service delivery. By doing so, we can ensure that Virginia residents receive timely and effective care, and that LPCs are better supported in their vital roles.	8/5/24 9:20 am CommentID:227279
Shante Williams, LPC, LSATP	Support	I support this petition.	8/5/24 9:27 am CommentID:227280
Anonymous	In Full Support / The Ethical Thing to Do	I am in full support of this. My time was taken advantage of as a free intern in grad school, but I was willing to overlook this, as the experience was necessary for my growth and education. My supervisor even boasted about pocketing more than 100k for my services back then. The cycle of reliance for payment should be broken at the resident level. If providers can see patients alone and at a different site from their supervisors, they should be allowed to directly bill for their services. Other states have provided a great example of this. This would be the best ethical thing to do!	8/5/24 9:50 am CommentID:227281
Chelsea Muth	I support	I support this petition as a step towards financial independence of residents.	8/5/24 11:12 am CommentID:227282
Anonymous	In favor	I strongly support this.	8/5/24 11:20 am CommentID:227283
Neal Whitson	In favor	I support this, and believe it is fair and necessary.	8/5/24 11:33 am CommentID:227284
Anonymous	I absolutely support this petition	Residents in counseling should be allowed to directly bill for services and directly receive payments from clients because, after rigorous training, internship, and supervision, they are capable professionals and deserve to have access to directly bill clients so they don't get paid a portion of what they work for and through a third party. After years of rigorous counselor training, practicum, and internships, the residents are resilient and need encouragement to boost their morale. What better way than receiving direct payment for what they have worked hard for?	8/5/24 11:39 am CommentID:227285
NM	Direct Billing for Residents	I support Residents in Counseling having the ability to directly bill for counseling services. I recently moved from out of state, where Residents had this right. In VA, residents can currently bill indirectly under their supervisors. This results in drastic pay differences between provisionally licensed clinicians in VA vs other states, as companies take advantage of the fact that residents need them to bill. The only benefit offered is illusion of added client care. Residents will be consulting with supervisors about clients whether or not they can bill directly, and this supervision includes session documentation. With supervision of client care occurring in either scenario (and in greater amounts when compared to others states), limiting Residents ability to directly bill for client services serves only to gatekeep Residents and encourage licensure/business development in outside states. With the counseling compact nearing completion, it would be easy, and financially, it would make more sense to be licensed and running a business in an outside state where Residents can bill directly (I know people already doing this)! This only hurts the many clients needing services in VA. Help prospective clients in VA maintain access to skilled clinicians who want to receive deserved reimbursement and	8/5/24 12:09 pm CommentID:227286

		personal freedom in their practice.	
Susanne N	I support this!	It is time to practice the social justice our profession preaches, by adequately compensating counseling residents. There is no downside to changing this law, as it will attract more people into the profession, in VA (other states do not have this barrier). Our graduate internships are unpaid (which is in itself a big issue), so the extra 2+ years of residency should be an opportunity to serve our clients/patients without continuing the financial burden. This will increase the quality of VA counselors.	8/5/24 12:36 pm CommentID:227287
Anonymous	Why Not?	Allowing Residents to take their payments directly would not necessarily require Supervisors to allow that in their practice. But for Supervisors who *do* prefer to allow Residents to directly bill and take payments, this could take a real headache off their plate. If there is a legal reason to not let Residents deal with billing and money, explain the concern. Otherwise, letting Residents learn to deal with money is a serious aspect of training! The emotional issues around billing and getting paid are significant, and it ought to be Supervisors who decide when a Resident is ready to start learning how to do that, not just an arbitrary law that says they may not until they are fully licensed. Let Residents learn all aspects of being a Counselor, including the money part.	8/5/24 12:40 pm CommentID:227288
Anonymous	Full support	Without diminishing the required supervision hours or standards, I support this! It aligns with other states who have seen success in allowing residents to bill directly while increasing access to mental health support in the community.	8/5/24 1:20 pm CommentID:227289
Anonymous	I strongly oppose this petition	The mission of the Board is to protect the public. Part of the way the public is protected is by being fully informed of the status of those counseling them. When Residents start their own private practices (which they can do if if they are able to bill and receive direct payment) there is very little oversight save miniscule supervision. 1 hour to 40 work experience hours leaves quite a bit of time of unsupervised work. Private practice is the most dangerous place for ethical violations and harm to clients. Add in new clinicians and potentially much less oversight we are putting the public at greater risk than necessary or acceptable. Without the clause regarding payment the public will believe that a Resident can practice independently and is on their own. The structure of counseling levels is already confusing enough. Payment through an agency or supervisor is another layer of protection, supervision and clarity for the public.	8/5/24 2:00 pm CommentID:227290
Jessica Cosgriff	In Support of This Petition	**Petition to Amend LPC and LMFT Regulations Regarding Direct Billing by Residents** I am formally requesting the removal of the phrase "directly bill for services rendered" from the LPC and LMFT regulations. This change would allow Residents in private practice under supervision to directly bill clients and receive payment without involving their supervisors. While the regulations do not explicitly prohibit Residents from collecting payment, the Board of Counseling has interpreted this phrase to restrict direct payment to clients. This interpretation has been upheld in previous petition denials in 2005 and 2019. The Board's 2019 decision cited concerns about: 1. **Reimbursement policy conflicts:** This concern is unfounded as Residents cannot bill insurance, including DMAS, and the Board has no authority over insurance reimbursement. 2. **Incentivizing independent practice:** This concern is mitigated by the requirement for Residents to inform clients of their supervised status. Penalizing all Residents for potential misconduct by a few is unfair. The current regulation creates significant hardship for Residents seeking private practice. Finding supervisors willing to manage client payments is challenging due to financial, administrative, and legal concerns. This process is inefficient, confusing for clients, and disproportionately impacts Residents compared to those in exempt settings or employed positions. Allowing direct billing would: • Streamline the payment process for Residents and supervisors. • Reduce administrative burdens and financial risks for supervisors. • Improve client satisfaction by simplifying the payment process. • Create a more equitable environment for Residents seeking private practice. This change aligns with modern business practices and supports the professional development of Residents. It is essential to adapt regulations to the evolving landscape of mental health care. By removing this outdated restriction, the Board can foster a more supportive environment for Residents while maintaining ethical standards. I urge the Board of Counseling to reconsider this matter and approve this petition.	8/5/24 2:20 pm CommentID:227291

Anonymous	In Favor!	Denying this petition on the basis "*that it might incentivize residents to engage in independent practice without appropriate supervision*" is completely illogical. 1) Stating that this proposal "might" incentivize Residents to engage in independent practice without appropriate supervision is not a valid reason to deny it. Otherwise, it could also be **approved** based on a "might." "Might" should not be the stance that we hang our hats on - everything in life is a "might." Instead, let's think logically about the issue at hand. ▪ Residents are not children, and they're not criminals. They've successfully completed the grueling educational requirements to get to this point in their careers (many of them while also working full-time jobs), they're required to abide by numerous rules, laws, codes, and regulations, and every aspect of their work is, not only monitored by Board-approved Supervisors, but also by other counseling professionals and clients. Residents are fully capable of managing their own money and billing clients directly; as well as being fully capable of doing so within the legal regulations of the profession - as they do with *all* of the regulations. ▪ Numerous states allow "pre-licensed" counselors to bill clients directly - I found 4 within a 10-minute search of various state counseling board websites. There is obviously a need for this change across the country and other states are changing their regulations for a reason. Furthermore, there is no indication *anywhere* that this change has been disastrous for these states or that it has caused *any* harm to clients or the counseling profession. So, denying this proposal on a "might," when fact shows the opposite, is absurd and renders the process of petitioning for change pointless. 2) "Residents" as per Virginia law "*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.*" Therefore, saying that a "Resident" might engage in independent practice without appropriate supervision is impossible. To be considered a "Resident," one must have a supervisory contract with an approved supervisor. Thus, if you don't have a supervisory contract with an approved supervisor, you're not a Resident. A supervisory contract with an approved supervisor is required to obtain, and to renew, a temporary Resident in Counseling license. This requirement alone specifically exists to prevent "*independent practice without appropriate supervision*" - allowing Residents to bill their clients directly **does not** change the integrity of this requirement. 3) Providing clinical services without a license **or** an approved supervisor is illegal. People who engage in this criminal activity are not Residents - **NOR** are they Licensed Professional Counselors. Yet, Residents are the ones being punished. If someone can illegally claim to be a Resident, they can also illegally claim to be an LPC (and **do**). Prohibiting Residents from billing clients directly	8/5/24 2:57 pm CommentID:227292

		does nothing to prevent BOTH Residents and LPCs from being professionally impersonated. Life coaches in Virginia, who are not as vigorously educated or trained as those in the counseling profession, and whose field is 100% ***unregulated***, are able to directly bill their clients for services and are charging literally hundreds, and even thousands, of dollars PER session (seriously, look it up)! No, they can't call themselves counselors, but many people have abandoned the long, time-consuming treacherous journey of becoming a fully licensed counselor for the instant benefits that come with helping people as a life coach. So, for the simple fact alone that the counseling profession needs to be more forward-thinking in order to survive, let's not give those who actually want to join and add to this profession more reasons to go elsewhere.	
Heather Clark	Strongly support this!	I strongly support this!	8/5/24 5:58 pm CommentID:227293
Tina Curran-Taylor	Absolutely in favor	In short, I absolutely support the residency process and have been a clinical supervisor since 2016. Residents often have to pay for clinical supervision services and function as independent contractors. The process is long for them extending several months with minimal income and professional expenses including liability insurance, rent, supervision, advertising, etc. Many residents must be employed in other organizations to earn income while completing their residency which slows the timeline for completion. We are in a high demand time and for residents to take three- five years to complete their residency because of remaining in a part time status due to income seems like a rectifiable problem.	8/6/24 7:50 am CommentID:227294
Anonymous	100% In Favor - Reduce Risk - Protect Residents - Help Supervisors - Help Lower Income Clients	Rules are often placed into a guideline or law because the governing body is trying to resolve a problem that they have faced in the past. Unfortunately, this solution is no longer resolving harm, its causing it. Currently Residents are being put in a very difficult situation financially and are not making enough to survive. There are numerous situations where they are being taken advantage of by their supervisors through the control of money (power), and thus have limited power or control to resolve their situation. The control the board is levying to the Supervisor is also unfortunately preventing many likely supervisors from becoming supervisors themselves as they don't want to manage money. Its my belief that "IF" the board is trying to avoid fraud and reduce risk to Residents, while providing the board greater control over Resident Counselors.... then the wording of the rule should be stronger but the act of controlling money needs to be removed from the rule immediately as its doing far more harm than good. We need a rule that fosters the ability to do good, while reducing harm to residents and by placing power and control in a supervisor's role does the opposite. A supervisors focus should be on the clinical abilities of their students while ensuring fiscal intelligence but the power and control provided to a supervisor is doing harm. This change will also reduce the overall cost of residency which will allow our field reach the lower income community that is currently in dire need of care. In summary, a properly worded ruling saying what the board wants will allow supervisors to become teachers and for Resident Counselors to thrive. Unfortunately, they are barely surviving and in far too many cases they are being taken advantage of and even leaving the field all together.	8/6/24 8:07 am CommentID:227295
Anonymous	Protect our Residents	Absolutely	8/6/24 8:18 am CommentID:227296
Anonymous	Support this!	This seems much more reasonable for private pay situations than the current way things are set up.	8/7/24 6:59 am CommentID:227302
Anonymous	Strongly oppose	We have been a residency site for over 15 years offering a wide range of supervision, consultation, training, and support systems to pre-licensed clinicians across multiple therapeutic disciplines. They are incredibly well-trained and supervised and we have a lot of oversight in their work. We have had multiple incidents of supervisees engaging in legally and ethically unsound practices. The origins of these behaviors typically lie in inexperience/competency issues, poor judgment or lack of critical thinking skills, failing to disclose to a supervisor or take	8/7/24 11:55 am CommentID:227306

		ownership of their mistakes/growth edges, failure to regulate anxiety, and inability to manage transference and countertransference issues. The ability to practice therapy/counseling independently is a process that should be respected and earned over time and through exposure to a wide variety of clinical experiences. I am most concerned that there are so many clinicians, some of which appear to be supervisors, who are failing to recognize the risk that this practice would present to clients. I hope the Board does not move in this direction.	
Anonymous	In favor - too many uninformed or biased supervisors	As many others (including the petitioner) have *repeatedly* stated, residents **can** already own a private practice in Virginia. Yet, many LPCs/supervisors are saying (*in the comments and in professional practice*) that if residents can bill clients directly, it would allow them to own a private practice. So, what we have here are supervisors, in particular, who are uninformed and aren't being responsible enough (*as mentors guiding new counselors into the profession*) to simply read what's in front of them or take the time to be informed of the rules and regulations they're supposed to be teaching residents - OR we have supervisors who *are* informed of the current regulations, realizing that residents can own a private practice, but their bias on that issue won't allow them to be open-minded, critical thinkers on the ***separate*** issue that is this petition - "allowing residents to bill clients directly." What it shows, however, is that it's (*mostly*) these supervisors that are for the continuation of supervisor control over the income of residents (*by being against residents directly billing their clients*), citing "*harm to the public*." What's harmful to the public is uninformed, biased, and inattentive "*stewards of the profession*" AND supervisors who want to profit off of residents. Some say that not allowing residents to directly bill clients protects the public because it forces the resident to inform the client of their residency status (*even though there are currently numerous regulations in place that require residents to do this in various ways*). Preventing residents from directly billing clients isn't adding protection for the public, it's allowing supervisors to be able to rely on their control over the resident's income so that they can be more "*hands-off*" supervisors. Saying that this regulation is in place to oversee resident misrepresentation also means that this regulation is clearly in place to relieve **supervisor** oversight of resident misrepresentation. Meaning that if this regulation wasn't in place and residents didn't have to funnel their income through their supervisors, then supervisors would *have* to be more attentive to their residents and make sure that clients are being informed properly. But shouldn't this be happening anyway? Regardless of how the money exchanges hands, supervisors should be involved enough to teach residents how to use the proper titles/credentials and cite the name of their supervisor in all public and client materials (i.e., business cards, websites, informed consent forms, etc.), as well as actively reviewing their materials to make sure that misrepresentation isn't occurring. If the supervisor isn't doing this, then they're just as responsible as the resident, if not **more** so. Yet, *only* the resident is punished (including all other residents) via supervisor control over their money - and for this privilege, mind you, many residents **pay** their supervisors. Some also claim that there are currently too many residents who are not informing their clients of their residency status (*thus Residents should not be allowed to bill their clients directly*). If this is true, then it just goes to show that this regulation is not effective in it's supposed purpose of forcing residents to inform their clients. So, what's the point of having it? The only real purpose it serves is to increase profits for supervisors who are taking advantage of a system that is supposed to *help* residents. There's an overwhelming amount of research that shows that: 1) "Failure to adequately attend to issues of power in supervision can result in ineffective or even harmful supervision." 2) "The supervisory alliance [between supervisor and supervisee] has come to be increasingly regarded as the crucial and pivotal component in the successful prosecution of the supervision relationship." Approving this petition would help to rectify a clearly imbalanced power dynamic and help restore supervisory alliance throughout Virginia. Furthermore, it has to be noted that weak supervision is not the resident's fault and residents should not be punished because of uninformed, biased, or inattentive supervisors. "*There's no such thing as bad students, only bad teachers*" - if supervisors do their jobs well, then residents will most likely do theirs well - and this happens quite often actually! There are fantastic supervisors who mentor fantastic residents! In my experience, supervisors choose to become supervisors either 1) to teach/mentor the next	8/7/24 5:32 pm CommentID:227311

		generation of counselors because they genuinely care about and love this profession, or 2) to make money - (*sometimes both*). Regardless of the reason, supervisors choose to become supervisors knowing that they are responsible for the residents they take on - that's the job. So, why then is the issue at hand *solely* on the shoulders of residents? At the end of the day, if the Board denies this petition, they should, at the very least, seriously investigate the current state of the supervision experience in Virginia - including all of the claims being made in the comments from both sides. No matter where you stand on this particular issue, it's clear that some very serious and potentially harmful problems exist within the supervisory experience in this state. 1) Cook, R. M., McKibben, W. B., & Wind, S. A. (2018). Supervisee perception of power in clinical supervision: The Power Dynamics in Supervision Scale. *Training and Education in Professional Psychology, 12*(3), 188–195. 2) Watkins, C. E. (2014). The Supervisory Alliance: A Half Century of theory, practice, and research in Critical Perspective. *American Journal of Psychotherapy, 68*(1), 19–55.	
Anonymous	I strongly support this petition.	This is long overdue! Prohibiting Residents in Counseling from directly billing their own clients is causing an unnecessary complication to the supervisory process for Residents seeking to start their residency in private practice. Many Residents in Counseling are being supervised successfully without their supervisors considering how the Resident's clients are paying for their services in Exempt and Employed settings. The supervisors in these settings manage to monitor and support the Resident well. There is no reason that a supervisor needs to be involved in the process of a client paying for the services of the Resident in a non-Exempt setting, outside of ensuring the Resident understands the ethical codes. I strongly support this petition.	8/7/24 8:20 pm CommentID:227312
Connected Resilience, LLC	Yes, I support direct billing for Residents	This would not alter the supervision requirements that Residents undergo, but allowing direct billing promotes transparency by accurately reflecting who provided the services. This would not change any of the care that a client receives, since Residents are still doing the direct counseling services and also getting regular supervision.	8/7/24 9:00 pm CommentID:227313
Megan MacCutcheon, LPC, PMH-C	In favor - This does NOT change residency requirements	I am in favor of removing the phrase restricting residents from directly billing for services. This restriction creates an unnecessary burden on residents and supervisors. Further, it leads to discrepancies in how residents in private practice are handling billing, which creates inconsistencies and confusion in the field. There is no guidance on a standard as to what IS acceptable, thus I have heard several methods of how Residents/Supervisors handle this issue over the years - and it ultimately comes down to individual risk aversions and creative work-arounds that ultimately don't serve much purpose. The "money pass through" seems to be superfluous, especially when the focus of supervision ought to be on client care rather than on the details of how money is collected and redistributed. Residents are not to represent themselves as sole practitioners in that they cannot see clients without being under the supervision of a Licensed Professional Counselor. They must inform clients of their status as a resident, use the title "Resident in Counseling" on all correspondence/platforms, etc., and provide contact and licensure information for their Supervisor. Further, they need supervision and notarized documentation of hours in order to apply for licensure. These regulations seem adequate in ensuring Residents are not practicing independently without guidance. Not allowing Residents to directly bill for services may have been an additional layer of indication that a Resident was not fully licensed/independent several decades ago when clients were typically paying for services via checks (written out to a Supervisor versus the Resident, for example). However, in today's world of electronic health records and credit card payments, whose bank account is tied to the payment processor seems irrelevant and not something clients are even privy to. A Supervisor's role is in supporting Residents in case conceptualization and ethical practice, not in bookkeeping. In response to opinions that Residents not be allowed to even have private practices: I believe Residency is the ideal time for clinicians to start a private practice if that is their ultimate goal, as Supervisors can be fundamental in mentoring Residents as they embark on this journey, helping them to ensure they have the proper policies, procedures, and documentation in place to protect both themselves and their clients' rights. While this is not the focus of this petition, the idea of directly billing for services and collecting fees is typically specific to private practice settings, thus it's worth noting the regulations do not prevent Residents from starting their own practice.	8/8/24 11:21 am CommentID:227316

		The idea of not directly billing for services does not seem to serve a purpose and does not equate to Residents practicing independently, given the requirements of full disclosure of Residency status.	
Anonymous	Strongly Support	Residents can already form a private practice here in VA. Micromanaging client payments (now done 99% online via EHR) only takes up admin time for resident and supervisor. Supervision time (which is a paid service) should be focused on developing clinical practice, ethics, workflow, and good business practices. If this is done effectively, the concern about the name on a bank account is asinine. I trust residents as they have passed through many gatekeepers to get to that point in their careers. Let's teach them how to handle fees ethically and legally instead of handholding. Last point -- clients do not care who they hand their money to. They want to feel better and receive high-quality care from clinicians not bogged down by admin tasks. Residents already disclose their licensure status in their credentials as well as should have that conversation during intakes and throughout treatment. Thank you for your time.	8/8/24 1:59 pm CommentID:227318
Anonymous	In Strong Support	I strongly support allowing residents in counseling to bill directly for their services. This change would simplify the payment process for multiple parties and make therapy more accessible. It's confusing and potentially off-putting to pay someone other than the professional providing my care. Residents are already required to disclose their status and supervision details, so I don't see how direct billing would compromise my safety or the quality of care. In fact, it might allow more qualified individuals to enter the field and increase the availability of mental health services in our community. We desperately need more mental health providers, and removing unnecessary barriers for new professionals seems like a step in the right direction. Ultimately, this change could lead to more people getting the help they need, which benefits everyone.	8/9/24 11:05 am CommentID:227323
Kaylie Groenhout, MEd, NCC, Resident in Counseling	Strong Support for Petition	I strongly support removing the restriction that prohibits residents from directly billing for services. Changing the policy would support a more streamlined, transparent administrative process, removing an unnecessary burden on both residents and supervisors. This hurdle appears to have little, if any, benefit. It does not protect clients or ensure quality of care. Requiring the supervisor to bill/manage payments may be confusing to clients. It may also impede therapeutic conversations between clinicians (residents) and clients about finances/financial arrangements, as well as remove practical opportunities for residents to grow as competent, future fully independent, professionals in the field. Because residents in Virginia are allowed to operate within their own private practices, largely because they are under supervision, it’s especially important for them to clearly understand their income, expenses, and financial responsibilities. The purpose of residency is for pre-licensed counselors to gain experience working with different populations, theoretical approaches, and clinical issues, as well as develop their professional identity and functioning. Residents are responsible for telling their clients, in writing, that they aren’t flying solo and are under supervision. Residents are required to use their designated credentials every time they sign their name. They’re also required to be evaluated every three months by their supervisor, which serves as a competency and quantitative (hours) checkpoint. This all seems sufficient in making sure residents are not practicing independently and without oversight. *TL;DR*: Residency is the zone where residents are empowered with growing independence. Handling their own payments gives them an appropriate level of ownership and responsibility that corresponds to their professional competency level. The other gatekeeping checks in place, which are numerous, are sound and sufficient. Supervisors should be able to focus on nurturing clinical competency - not collecting payments and handing them back to residents, suggesting residents don’t have the power to manage themselves in the name of client welfare.	8/9/24 12:19 pm CommentID:227324
Melanie Adkins, NRVCS	Strongly oppose- not good for the public or the profession	Allowing residents to bill independently sends a message that supervision requirements are not important. The current regulations protect the public by ensuring supervision is in place and that the supervisor has significant involvement before billing can occur. Supervision is an essential part of the development of the skills and knowledge necessary for independent practice. The counseling profession struggles already with the respect of the public and a perception that "anyone" can provide counseling. This change does nothing to support recognition of the substantial education and training that is (and should be) required for independent practice as a Professional Counselor	8/9/24 12:48 pm CommentID:227325
Anonymous	I strongly support	I strongly support this	8/12/24 12:29 pm CommentID:227327
Melanie Adkins,	Strongly oppose- not	Allowing residents to bill independently sends a message that supervision requirements are not important. The current regulations protect the public by ensuring supervision is in place and that	8/12/24 1:28 pm CommentID:227328

NRVCS	good for the public or the profession	the supervisor has significant involvement before billing can occur. Supervision is an essential part of the development of the skills and knowledge necessary for independent practice. The counseling profession struggles already with the respect of the public and a perception that "anyone" can provide counseling. This change does nothing to support recognition of the substantial education and training that is (and should be) required for independent practice as a Professional Counselor	
Anonymous	Residents allowed to bill	In strong support	8/13/24 1:12 pm CommentID:227353
Anonymous	LPC supervisor strongly disagree	They are residents for a reason and need further experience prior to billing freely. This could send mixed messages to our clients. This will defer new residents from working with the underserved and more will go to private practice for increased pay. There is no substitute for experience and knowledge. We need to stop rushing the process and focus on growth of residents. If they will bill independently they should have an independent license which is in no way related to their clinical supervisor. The risk to this is too high. I believe clients will not understand the difference in services which can be highly misleading.	8/13/24 1:52 pm CommentID:227356
Anonymous	I do NOT support this	There is a reason that individuals become licensed and that there is a formal process to achieve such. Residents are still learning under the guidance of a Licensed Supervisor. Let's protect the public by making a distinction between a Resident in Counseling and a Licensed Professional Counselor. This is beneficial more for Private providers and for the Residents themselves.	8/13/24 4:21 pm CommentID:227358
Cynthia Miller, Ph.D., LPC	I see the point and I see the problems	I can certainly see how allowing residents to bill clients directly for their services and receive payments directly could simplify some things. However, I think that if that leads to residents opening up their own practice independent of their supervisor and operating the practice with only clinical (but not operational) oversight from the supervisor things start to get legally sticky quickly. Supervisors are currently liable, through the concept of respondeat superior, for EVERY action or inaction their supervisees take. That responsibility means that the supervisor needs broad access to a supervisee's sessions, notes, reports, and correspondence to determine if the supervisee is engaging in sound practice. If allowing residents to bill clients directly opens the door for residents to open their own practice independent of their supervisor and then see clients separately from the supervisor's office, then a great deal of oversight could get lost. For example, the supervisee would presumably utilize their own record system - could the supervisor legally have access to those records? The supervisor is responsible for every case the supervisee is seeing. Could a supervisee operating their own practice individually end up underreporting or omitting certain cases from their supervision sessions, leaving the supervisor in the dark about the full extent of the caseload? If the supervisee intentionally or unintentionally engages in fraudulent billing is the supervisor also responsible? How can a supervisor observe the full scope of the supervisee's skills if the supervisee is operating independently at their own business? Simply relying on the supervisee's self-report of everything is not enough to be able to adequately assess the supervisee's clinical skills, ethics, professional demeanor, etc. The amount of liability involved when a supervisee is operating their own practice independently seems to increase dramatically. I fear that IF adopting this change will open the door for new residents to immediately establish their own businesses then the number of people willing to supervise residents under those conditions and take on the added liability will decrease and exacerbate the shortage of supervisors thereby exacerbating the overall shortage of providers in the training pipeline. I would urge the Board to think very carefully about both the potential benefits and the potential drawbacks before adopting this change.	8/13/24 11:15 pm CommentID:227365
Grad Student-already 10 years of experience in MH field	Fully Support	I support the petition to give residents the ability to directly bill clients. As many have pointed out, residents are already able to run an private practice-it is just a matter of billing through a supervisor. So, when people try and say that it is putting the public at risk-has there been any evidence to support this? Others have also pointed out that graduate students would still be required to participate in supervision-which is oversight-as they continue to earn the hours towards licensure. Again, allowing direct billing does not change any of the other requirements needed and I feel that by trying to make some connection that direct billing and the quality of services being provided to consumers is a weak basis for not allowing residents an opportunity to begin their own practice. Other states, like Texas, have been doing this for years at this point due to the realization that mental health professionals are needed and that many do not want to waste time working for agencies where they are being paid pennies and being subjected to burn out. Virginia is facing a shortage and people are not wanting to go into this field because of the low pay, lack of incentives, and the literal years it takes to get licensed. For those who are saying that one doesn't get into this field for money, please stop drinking the Kool Aid that you were given back in the day when you started. We put in the hours and sacrifice, take on the burden of student loans, and sometimes have to work two jobs coming out of graduate school because we are looked at as cash cows and rarely paid what we are worth. Someone else in private practice is making money off of us. Some	8/16/24 7:39 am CommentID:227385

		agency is using us to meet their quota and keep their funding. I've been working in the field for years (In home counseling, Case Management, QMHP A/C) and I know that when I begin looking for employment, no one is going to pay me what I am worth in terms of experience and expertise because I will be "just a Resident". Being able to dictate our pay, being able to operate our own practice (with oversight from a qualified supervisor) will serve as incentive to keep those of us who still want to help people in this field while still being able maybe a salary we can live off of. It makes no sense as to why a resident would have to supplement their income via Uber or Instacart while trying to earn hours towards licensure. The Board needs to do a better job of supporting us now or deal with the consequences later.	
Anonymous	Do NOT Support This!	How much further can you lower the bar in the name of access to care? The disproportionate number of counselors who are disciplined by the Board should be a clear indication that this profession requires stringent supervision! Duty to protect the public should be paramount!	8/16/24 6:29 pm CommentID:227391
Anonymous	Strongly Support- Supervisors Opposing Should Be Required to State Their Name	I find those in opposition to this unwilling to state their name publicly to be quite curious. There is a financial interest in supervisors requiring residents to continue to direct bill. Perhaps the requirement then should be changed for oversight purposes to: residents may not direct bill, but supervisors must return residents full fee to residents. Supervisors may only charge for supervision services and cannot profit off money laundering fees for residents. This whole system is broken and does not benefit clients or residents, only supervisors.	8/17/24 8:15 am CommentID:227393
Anonymous	Support- Tax Issue Cumbersome	The tax issues are very burdensome in this rule and I think were an unanticipated biproduct. It is my hope that a new rule would make it clear that supervisors are paid directly for supervision services at an hourly rate, and that residents receive adequate supervision clinically under those services. Compensation for resident services is between their employer— and outside the scope of supervision. There are too many emotions caught up in these posts and a lot of projection and animosity over folks who got a raw bargain back when they were in residency. We all need to be better than that and fix the broke. System, and not have people starting off burned out. I suggest we consult with employment lawyers and accountants moving forward so we don’t make these mistakes again. And I suggest we consult with our hearts and consciences and internal compasses because honestly— this feels like a lot of scarcity mindset and financial greed at the expense of vulnerable residents and clients. Clinical supervision has and always will be in place, and has zero to do with direct billing in today’s day and age of Simple Practice and Therapy notes— which are just a matter of a click of a button and switching an account number, and you all know that as supervisors.	8/17/24 8:30 am CommentID:227394
Anonymous	No difference between this and outside clinical supervision	In response to Cynthia millers lengthy commentary about this opening up issues between clinical supervisor not having access to records, etc because a resident could would now, under direct billing, be allowed to open up their own independent practice— the rules as they stand allow residents to have a contract filed with the Board for supervision with their residency supervisor and work at an agency or private practice elsewhere. This would be no difference. So that argument is mute. Respondant Superior is a legal concept that would be applicable to one’s clinical supervisor from a legal perspective, but quite frankly would likely come into play in an agency setting as well even if a resident was being supervised from outside because some day to day supervision in an agency setting is expected. In the case of an independent private practice owned solely by a resident, then respondant superior would only relate to the outside clinical supervisor. Please don’t throw around fancy legal terms of art to intimidate. It isn’t necessary or helpful.	8/18/24 6:18 am CommentID:227396
Anonymous	In favor	I am in favor of this amendment.	8/18/24 6:51 am CommentID:227397
Fabian Kuttner	Opposed, blind empowerment is not the way to develop equity or ethical practices amongst supervisors	I am a resident in Counseling. I've considerable experience before seeking licensure in Virginia. I have a lot of respect for the tradition. I believe we need to develop excellence in our residency and EARN the independence of such a private, powerful relationship; competency over power seems more useful to someone learning the "practice" of psychotherapy. I appreciate that. My supervisor is benevolent, and ethical. I have experienced many abusive supervisors. But blind empowerment of us residents is not the way to develop equity, or ethical practices amongst supervisors. It's amazing to me that we aren't all required to tape sessions and review them with colleagues throughout our entire careers. We know it is the number one way for us to be accountable to the work we do. Supervisors should also videotape their sessions with supervisors and have them reviewed with a trusted colleague occasionally.	8/19/24 8:44 am CommentID:227398
Dr. T Bushkoff	In support	IN support with supervisory review during supervision a necessity.	8/19/24 10:41 am CommentID:227400
Anonymous	I fully support this petition & rebut Fabian Kuttner's points	First and foremost: People need to accept that Residents are dedicated professionals in their own right and deserve the same dignity and respect that's afforded to Licensed Professional Counselors - and I think that this is a reality that has been completely lost to most people! Second: The notion being circulated - that allowing Residents to bill clients directly will cause harm - is absolutely ridiculous and completely demeans the dedication, professionalism, and competency that residents already possess. If residents are trusted enough to provide complex and extensive mental health treatment to adults, children, families, and couples (under supervision), then why is there such a lack of trust when it comes to simply billing a client	8/19/24 5:20 pm CommentID:227403

		(while under supervision)? This is a completely upside-down bonkers ideology that has yet to be logically and factually explained and defended successfully. Rebuttal to Fabian's statements: It sounds like you have a great relationship with your supervisor and that's a wonderful thing! It also sounds like you're happy with where you've landed (including the manner in which your employer has structured their business - employing almost entirely residents and students). You, of course, have a right to choose what's best for you and it sounds like you have done just that. On the other hand, not everyone is as lucky as you. You may be content and satisfied with your supervisor and the business model you're employed under, but that doesn't mean that ALL residents should be forced to take the same path that you have - especially if it's not what's right for THEM. Why prevent others from being able to choose what's best for them, just as you have? You stated: "*I have a lot of respect for the tradition*" = As someone who supports this petition, I also have a lot of respect for the "tradition" of the supervisory experience. However, I also have a lot of respect for progression, growth, and change - tradition doesn't automatically mean that it's the best option for everything and everyone forever and always. Things change, people change, professions change, technology changes, economies change, business changes, and yes, laws and regulations change. Which is why, those in support of this petition, are requesting this change. You stated: "*I believe we need to develop excellence in our residency and EARN the independence of such a private, powerful relationship*" = If by "*private, powerful relationship*" you mean "*billing clients directly*," please define how you feel that billing clients directly is "earned" and why you feel that residents - dedicated professionals holding advanced degrees - have not "earned" this already. Also, consider the fact that U.S. consumers pay for an astonishing amount of different services in this country every day wherein no "relationship" exists - thus, why is an "earned relationship" required to bill someone directly? Is the simple act of providing a service to someone for which you should be compensated not sufficient enough? What relationship are you referring to, then, that needs to be earned in order for a resident to bill their clients directly for the very services that they have provided? Additionally, under this "earned relationship" concept, what relationship has a supervisor earned with the resident's client wherein the supervisor can directly bill the client? Please clarify what you mean and explain how it justifies the continued prohibition of residents directly billing their clients. If, however, by "*private, powerful relationship*" you mean "*owning and operating a private practice*," then this point is irrelevant given the fact that residents can already own and operate a private practice - which has nothing to do with this petition. You stated: "*competency over power seems more useful to someone learning the practice of psychotherapy*" = Why does this have to be one or the other? Residents can be quite competent **AND** have power over their own salaries simultaneously - one does not have to exist without the other. The points being made in support of this petition are not "*give us more power so we can be less competent*" - that wouldn't make sense. It's about counseling professionals and those in charge of regulating the profession as a whole understanding that residents ARE competent, and that being a "Resident" doesn't automatically mean that they are incompetent, irresponsible, untrustworthy, negligent, naive, unprofessional people who can't or shouldn't bill their own clients directly. It's also about residents being taken advantage of by supervisors wishing to profit off of them - which is allowed to happen *because* of this outdated regulation that serves zero purpose (especially considering the multitude of other rules, regulations, and codes that make this regulation obsolete). Regardless, improving one's competency and skillset doesn't automatically go out the window because they have power over their own salary. Otherwise, how are LPC's (who should also continue to improve their competency level and skillset) able to have power over their own salaries? You stated: "*But blind empowerment of us residents is not the way to develop equity, or ethical practices amongst supervisors*" = "Blind empowerment" is a **bold** statement, in my opinion. You're essentially saying that the points being made in support of this petition "lack perception, awareness, and/or discernment" - hence "blind empowerment." I would advise anyone feeling this way or making a statement such as this to carefully read all of the comments listed for this petition and to actually speak with those who are currently suffering as a result of this regulation - then, you can determine whether these points truly "lack perception, awareness, and/or discernment."	
Anonymous	Allow residents in counseling to directly bill for services	In Support	8/22/24 4:35 pm CommentID:227406
Graduate Student	Fully support-look to other states for guidence	As mentioned in previous posts, other states are already allowing Residents to directly bill clients. If the Board has any questions or concerns, then they should be reaching out to those entities and gaining information on how they addressed issues that came up and look at hard data and factual information instead of trying to pass or decline the petition based upon misinformation and "strong feelings" from supervisors who are opposed citing concern for our population and ethics as a reason to deny the petition. Keep in mind, some of those very same	8/24/24 5:54 am CommentID:227409

		supervisors would have their income affected due to residents being able to directly bill and cutting them out of that process. If supervisors are so worried about things from an ethical and professional view, then they need to advocate for Residents to get proper pay or don't charge a fee for their services but I don't see anyone making either one of those suggestions. Supervisors want to be paid for their time-so do Residents.	
Anonymous	Support	Some supervisors have stated that passing the petition will defer new residents from working with underserved populations. To that I ask: So Residents are supposed/expected to work with those populations for minimal pay? Why? Because they are new? What about those Residents who have worked in the field for a number of years in a different capacity and decided to get licensed? Should someone with 10 years of mental health experience come out of school and get paid the same as someone with little to no experience? Some have also stated that clients may not understand the difference in services or be mislead. To this I ask: How? Clients are required to sign a contract for services and Residents have to disclose that information to them. And if a client is not satisfied with services, they have every right to stop. Just like they would if the Resident was with an agency or working under the umbrella of a private practice. I think these "concerns" are just ways for supervisors to gatekeep and continue in the old mindset of "well that's how it's been."	8/24/24 6:07 am CommentID:227410
Anonymous	I support	I see significant benefits for lowering the challenges for Residents to locate supervision opportunities. This change would only allow for Residents to receive payments and be responsible for their own taxes. Many organizations use an EHR to process payments and this distinction is not very clear to the consumer. As a Supervisor in Private Practice, I don't currently accept Residents in my Private Practice to work because I'm not interested financial burden of passing through the money to them. Yes, Residents should clearly inform the public of their title and explain to clients what the difference is between residency and being full licensed. I don't see how the collection of payments cause any confusion of the client, if the Resident is abiding by the requirements of informed consent of the public and not misrepresenting themselves as licensed professionals.	8/24/24 6:51 am CommentID:227411
Anonymous	Resident in counseling	I support this.	8/24/24 7:22 am CommentID:227412
Anonymous	I support this.	Support	8/24/24 7:23 am CommentID:227413
Anonymous	Not in support.	I'm appalled at the lack of training and basic skills residents have in VA. Coming from a state that requires two separate licensure levels before hanging a shingle, the quality of clinicians in VA are already subpar. You have clinicians who have only taken a 30 credit online program at Liberty trying to present as a resident. No clinical training, no idea how to even spell psych medications, no skill in documentation, can't diagnose…I can go on and on. THIS. This right here is why our profession is a joke in VA. Way to go random clinical supervisor who also sits on the board?!?!?! Terrible. Terrible proposal by a colleague who is the opposite of a gatekeeper. I've been fully licensed for 20 years. Next this individual will say, "oh let's allow residents to practice and bill BEFORE THEY GET THEIR MASTERS". When will it end.? We had another clinician advocating for cutting supervision hours for residents. WHEN WILL THIS END?? Why even have a license? Why have a profession? A board? VA puts unlicensed people into supervisory positions anyway so why not do away with the whole damn system?! This proposal is ridiculous. And damn scary that a board member is advocating for less oversight, you gotta be kidding me!	8/24/24 9:00 am CommentID:227414
Anonymous	Fully support	I fully support. See other states guidance	8/24/24 10:01 am CommentID:227415
CHRISTINE Galli, LPC, LSATP, NCC	Opposed	As many before me have stated, this opens up more liability of the supervisors. Additionally, it is placing more onus on supervisee's that may be setting them up for failure. The way the field is going with practicum and internship is at a faster pace. Schools are wanting the students to immediately start seeing their own clients without solid observation IRL. Many of these students are not prepared for the severity of the addiction, mental health and/or co-occurring disorders	8/24/24 10:13 am CommentID:227416

		and with complications of medical issues. This process is overwhelming enough for them. Beginning as a resident is still a learning curve period of time. Further, I have recently seen a proposal to lesson the hours for supervision. This is all looking to dilute the process of providing a solid experience for ethical and professional growth for the resident, assisting them through the stages of counselor development.	
Anonymous	Support	Not allowing residents to bill directly is exploitive of residents. Group private practices hiring mostly residents and interns are, most of the time, a sign of someone/s making a decision to exploit people (residents) and make profit. Many practices offering this model are known to offer sub-par supervision. In fact, I believe the required training to become a supervisor is what needs to much more rigorous. Limiting how residents make their income is not correlated with what makes a good clinician.	8/24/24 10:43 am CommentID:227417
Anonymous	Strongly Oppose	I strongly oppose this petition for the simple reason that in my experience Virginia Counseling Residents are simply not ready to be on their own. A two-year residency, under close supervision, is an absolute must to maintain the integrity of the field. Some respondents on this petition describe “bad” supervisors. I agree, a bad supervisor is a problem, and we should do everything to ensure that Residents are getting high quality clinical supervision. A bad supervisor is not a reason to give Resident Counselors permission to open their own practices! The problem I see today is that new residents want to start out making $70K and that’s financially near impossible for a small practice clinical supervisor to make happen. Where does that leave us? Big companies come in, hire lots of “supervisors”, offer minimal oversight and you get a bunch of unhappy residents who aren’t getting good clinical supervision. Rather than making it easier for new clinicians to be on their own before they are clinically ready, the board should secure state funds to offset the costs for Clinical Supervisors to take on new Residents. This would make it possible for more small-practice clinical supervisors to accept Resident Clinicians and offer them great supervision and better financial compensation.	8/24/24 1:57 pm CommentID:227418
Anonymous	Resident Direct Payments	Strongly Do Not Support	8/24/24 4:25 pm CommentID:227419
Anonymous	Support - This regulation doesn't prevent harm, it causes it.	Multiple commenters have stated that this regulation shouldn't be changed because it provides resident oversight by forcing residents to inform clients of their residency status in order to obtain payment/wages. So, let's explore why this regulation no longer serves this purpose. At most therapy sites, the primary method of collecting payments from clients is electronic/online payment processing platforms (i.e., Square, SimplePractice, Stripe, etc.). Typically, when a client begins therapy, at these sites in particular, their credit/debit card information is electronically stored and payment is processed following each session. At this stage in the process, this is pretty much all the client is aware of when it comes to paying for therapy. Behind the scenes, however, there's more to the process. Once the client's card is charged, the payment is transferred to the bank account that has been linked to the online payment processing platform by the clinician or practice. This is the most important step when it comes to residents *not* billing clients directly. In order to be in compliance with this regulation, the bank account that is linked to the online payment processor cannot belong to the resident. Therefore, the bank account must belong to the resident's supervisor (or the resident's employer depending on the site) even though **nothing** is different on the client's end. The client would have no idea that their payments are going to the supervisor/employer's bank account if the resident doesn't inform them of this process - this is especially true when it comes to residents who own a private practice. So, as it stands, the consensus essentially boils down to this: Residents **can't be trusted to inform clients of their residency status**, therefore, as a measure of enforcement, we must remove their ability to receive payments directly from clients and **trust them to inform their clients of the payment process** even though the resident will receive the payment whether the client knows the process or not. It's clear to see that this regulation no longer serves its purpose, and, based on this fact alone, should be removed. It is an unnecessary cog in the machine that doesn't prevent harm as others have stated - it actually creates it. The implementation of this middleman-style payment process has made clients, residents, and supervisors more vulnerable to a multitude of modern-day risks and problems. For instance, the frequency of cybercriminals exploiting vulnerabilities in digital payment systems leading to financial crimes and exposure of personal data is now more common than ever. As such, having to move client payments through a series of electronic transactions from person to person to person (each transaction having its own risks) exponentially increases the security risks for everyone involved. Furthermore, as income, tax, and financial laws, codes, and policies change at the city, state, and federal levels, having an unnecessary, multi-step financial process increases the potential for unintentional ethical and legal violations for both residents and supervisors. Lastly, this regulation has systemically obstructed the financial growth of residents while fostering a professional culture wherein residents are seen as financial commodities. As others have commented, many licensed professionals are hiring "cheap labor" practitioners (residents) and charging the client a rate that is highly incongruent with what the resident is being paid. Since residents can't bill clients directly, what kind of voice do they have in this arrangement? If you're really paying attention, you'll see that there are countless "supervision horror stories"	8/24/24 4:56 pm CommentID:227420

		proving that residents have no voice at all. This regulation does not promote fruitful, effective supervision experiences, nor does it prevent harm. Give residents a voice, help protect residents, supervisors, and clients from unnecessary harm, and let's create a more rewarding supervision experience in Virginia by removing this outdated, ineffective regulation.	
Anonymous	Fully support	The focus for Residents in Counseling and Supervisors should be primarily on case conceptualization, clinical and professional issues, clinical approaches, assessing the process, and many other areas. Addressing bookkeeping issues distracts from the importance of the supervision time.	8/24/24 5:59 pm CommentID:227421
Anonymous	I support this petition	The amount of emotional, nonfactual comments from those who are opposed to this petition is truly astonishing. Regarding the anonymous commenter (CommentID: 227414): I hope that the Board sees the absurdity surrounding this person's comment and realizes that *this* is part of the problem - this is the kind of mindset that residents are up against. If this person is so concerned with the way residency is structured in Virginia, then I call on them to stop anonymously ranting about it in the comments of a petition that has nothing to do with misspelling psych medications and put forth some *real* effort (just as the petitioner has) to create the change that they want. This is the problem with some of these commenters - they want to claim that residents are too inexperienced/unprofessional/irresponsible (for which no evidence or factual data has been supplied to corroborate these claims), yet what have they done to change whatever they feel is wrong with the system? If there have been so many problems regarding residents, then why haven't these "protectors of the profession" done anything about it other than commenting on this petition? It seems to me that they must feel like these problems are harmful enough to warrant a comment on this petition, but not harmful enough for them to actually advocate for change. You can't have it both ways - either the problems are harmful or they're not, either you want to protect the profession or you don't. This petition is about allowing residents to bill clients directly - nothing else. There has been zero evidence showing that allowing residents to bill clients directly will negatively affect the supervision experience, degrade resident professionalism, or reduce resident compliance with ethical and legal codes - nor is there any evidence to suggest that it will cause harm to clients. In fact, there are numerous comments in support of this petition that provide actual evidence to the contrary. I support this petition and I truly thank the petitioner for taking the time to actually advocate for change the proper way on behalf of residents.	8/24/24 7:05 pm CommentID:227422
Denielle Rigoglioso	Fully support this!	This should be available to all residents who are under supervision.	8/24/24 7:28 pm CommentID:227423
Amber Chamberlain	Petition for Residents in Counseling to Bill	I fully support this.	8/25/24 9:55 am CommentID:227424
Anonymous	Virginia citizen	Oppose this Petition I question the training and integrity these days. I witnessed "concerning" counseling in the public school where the parents were not contacted.	8/25/24 12:54 pm CommentID:227426
Anne Miniter McKay LPC NCC CCMHC LPC-S	Fully Support!	Here's an expanded version of your message: --- I fully support Sharon's perspective on this critical issue. As a Supervisor, I firmly believe that Residents must be exposed to the full scope of what it takes to become a competent counselor. Competence goes beyond just clinical skills—it also includes understanding and managing the business aspects of a counseling practice. This includes learning how to run a business, manage financials, handle client billing, and navigate the various administrative tasks that are integral to a successful practice. These skills are essential for any counselor who intends to work independently or manage a private practice in the future. **Learning these business skills should not be an afterthought or something left to chance; it needs to be an integral part of the training process, conducted under the supervision of a knowledgeable and experienced trainer. Supervisors have a responsibility to ensure that Residents are well-prepared for all aspects of their future roles, including the business side of counseling.** Furthermore, placing the entire responsibility for the business management of a Resident's practice solely on the Supervisor is not only an unnecessary burden but also a significant deterrent for many qualified and caring LPCs who might otherwise contribute to the field of	8/25/24 3:59 pm CommentID:227431

		supervision. The added liability, time commitment, and complexities involved—such as managing tax structures and other financial responsibilities—can discourage potential Supervisors from stepping into these roles, which ultimately limits the number of new entrants into the profession. Given these considerations, I strongly support the idea of allowing Residents to manage their own client billing and other business aspects of their practice. This approach not only fosters independence and practical experience for the Residents but also alleviates some of the burdens on Supervisors, making the supervision process more sustainable and attractive for experienced LPCs.	
Anonymous	100% in favor of this petition!	People are claiming that when residents don't inform clients that they are under supervision it causes harm to the client and that if residents are allowed to bill clients directly, it will increase this harm. Aside from these claims being completely offensive to a resident's integrity and completely dismissive of the fact that residents, generally, aren't irresponsible, unprofessional children, there's just no evidence to support these claims. I reviewed ALL of the DHP case decisions for the past 5 years (feel free to review them yourself - they are available to the public on DHP's website) and found **zero** cases involving residents who caused harm as a result of not informing their clients of their residency status. I did, however, find several cases that are far more appalling which has caused **ACTUAL** harm to clients. Here are my findings: *Finalized Case Decisions From The Past 5 years (08/16/2018 to 08/16/2024) (with duplicate records removed):* Total Cases = 66 | LPC/LMFT = 51 | Residents = 15 1. Inappropriate dual sexual relationship with client(s) - 15 LPC/LMFT | 7 Residents ◦ LPC/LMFT met his client (who was inebriated) in his office after hours, took her out to dinner, gave her prescription drugs, paid for alcoholic beverages, and took her to his home. The client woke up the next day, observed him walking around in his underwear, and was unaware as to whether intercourse had occurred or not. ◦ LPC/LMFT told his client that he had a sex dream about her. ◦ LPC/LMFT transferred her client to another therapist and continued a sexual relationship with him. ◦ LPC/LMFT had a sexual relationship with his client as well as a personal relationship with the client's children. ◦ LPC/LMFT had a sexual relationship with her client and sold his prescription drugs to help pay for his criminal lawyers. ◦ Resident had a sexual relationship with the mother of a minor client. ◦ Resident became pregnant after starting a sexual relationship with her client, thought that he was the father so he accompanied her to her doctors' appointments, she found out (after some tests) that her husband was the father, and cut off contact with the client. 2. Falsely claimed to have completed required CE hours at license renewal - 11 LPC/LMFT | 0 Residents 3. Inappropriate dual social relationship with client(s) - 4 LPC/LMFT | 3 Residents ◦ LPC/LMFT client was also a family member. ◦ LPC/LMFT interacted with her client multiple times outside the office and referred to her as being "like a daughter." This therapist had multiple, similar social relationships with clients. ◦ Resident treated a client with whom there was a pre-existing friendship. ◦ Resident purchased plane tickets for her client's daughter so she could visit the client. After being terminated, the therapist continued to maintain a social relationship with the client. ◦ Resident battled addiction in the past, relapsed, and asked his client where he could acquire opioids. 4. Convicted of separate crime causing surrender of license - 5 LPC/LMFT | 2 Residents ◦ LPC/LMFT assaulted a family member. ◦ LPC/LMFT possessed child pornography. ◦ LPC/LMFT sexually abused a child. ◦ LPC/LMFT was driving under the influence. ◦ LPC/LMFT was driving under the influence. ◦ Resident sexually abused a minor family member. ◦ Resident possessed child pornography. 5. Fraudulent billing practices - 4 LPC/LMFT | 1 Resident ◦ LPC/LMFT was convicted of a felony and ordered to pay $925,461 in restitution. ◦ LPC/LMFT was convicted of a felony (including identity theft) and ordered to pay	8/25/24 4:53 pm CommentID:227432

		\$2,266,209.77 in restitution. ◦ Resident created a false psychotherapy note for a date wherein he was absent, leading to the client being fraudulently billed for that date. 6. Payment failure to renew license - 1 LPC/LMFT | 2 Residents 7. Inability to support a given disability diagnosis - 2 LPC/LMFT | 0 Residents 8. Shared confidential information without client consent - 2 LPC/LMFT | 0 Residents 9. Refused to release client mental health records - 2 LPC/LMFT | 0 Residents 10. Absences/lateness causing harm to clients - 1 LPC/LMFT | 0 Residents 11. Physical abuse of a minor client - 1 LPC/LMFT | 0 Residents 12. Therapist had neurocognitive issues - 1 LPC/LMFT | 0 Residents 13. Accidentally sent an offensive message to a client about the client - 1 LPC/LMFT | 0 Residents 14. Failure to report sexual abuse of a minor client - 1 LPC/LMFT | 0 Residents Again, there have been zero cases in the past 5 years involving residents causing harm because they didn't inform clients of their residency status. Considering the nature of the client harm that has actually occurred over the past 5 years, why are we focusing on some kind of illusional harm to clients simply because they weren't properly informed about a clinician's residency status? What's the *real* harm that's being caused by this? As someone else stated, at the end of the day, "If a client is not satisfied with services, they have every right to stop." The approval/denial of this petition should not depend on a hollow concept that 1) makes no sense, and 2) has no evidence to support it. Allowing residents to bill their clients directly has numerous benefits (which have been thoroughly outlined in the comments) and only ONE drawback - practices profiting off of residents will lose money.	
Anonymous	Fully Support This Bill	Residents in counseling already are required to have a supervisor. Technically, supervisees are licensed residents to independently practice by the state as long as they are working under a licensed supervisor, they just are not able to bill independently usually—this would create a lot of growth in the field both in independent practices and the ability to help residents have more job security and more opportunity for unbiased supervision. I fully support this bill!	8/26/24 9:47 am CommentID:227433
Anonymous	Fully Support!	We should let residents bill directly for services. Not only are they getting the experience of what it's like to run a private practice, but patients can receive care quicker and with fewer barriers in the way. We are in the midst of a mental health crisis and it's time we start acting like it!	8/26/24 11:14 am CommentID:227434
Rhonda Ladd	Oppose this Petition	I strongly oppose residents/provisionally licensed clinicians from being able to bill for themselves and receive direct payment for services. For me this implies they can own their own business and work for themselves. In my experience as both a internship and residency supervisor, the provisionally licensed clinician simply is not ready for all of these responsibilities developmentally. My experience of supervisees show the residency as necessary to further establish independent clinical skills and perhaps begin to observe other professional and business practices. Perhaps there needs to be better knowledge, awareness, and application of the counselor developmental models in our supervision processes to help clinicians understand the purposes of the residency.	8/26/24 12:54 pm CommentID:227437
Rhonda Ladd	Reject this Petition: LPC-A billing	I strongly oppose residents/provisionally licensed clinicians from being able to bill for themselves and receive direct payment for services. For me this implies they can own their own business and work for themselves. In my experience as both a internship and residency supervisor, the provisionally licensed clinician simply is not ready for all of these responsibilities developmentally. My experience of supervisees show the residency as necessary to further establish independent clinical skills and perhaps begin to observe other professional and business practices. Perhaps there needs to be better knowledge, awareness, and application of the counselor developmental models in our supervision processes to help clinicians understand the purposes of the residency and their potential limitations in the process (i.e., you don't know yet, what you don't know). However, I would suggest that LPC-As would be served well through legislation that enables practices to direct insurance bill for LPC-A services similar to other states. This would help both LPC-A, the clients, and the practices they work with.	8/26/24 1:01 pm CommentID:227438
Willard Vaughn	Neutral	I have some reservations about allowing provisionally licensed clinician to bill for services, but overall my position is neutral for the reason's below. First, just because the board makes it okay for this to happen does not meant that insurance companies will comply. There would have to be a change in legislation, which may make this	8/26/24 2:01 pm CommentID:227440

		decision beyond the scope of the board. Secondly, I do echo my other peer's comments that state that this would allow provisionally licensed counselors to open their own practice. The alternative to this would be to have every private practice licensed by the board or DBHDS to ensure that someone qualified is in charge. Having gone through the licensure process, I do not think this is something that a private provider would want, nor do I think that DBHDS or the Board would understand or want such a workload. Without agency licensure, then the resident's actions would put tremenduous liability on a supervisor, which would lead to fewer supervisory relationships, and do nothing to ease the shortage of counselors we are currently experiencing. Alternatively, it would also allow residents to be exploited, particularly by larger companies such as BetterHelp who would pay them very little and offer no oversight. So, while I am all for systemic change and modernization, I think that there would have to be other things to follow such a change that could be problematic for private practices and supervisors.	
Anonymous	I Support This Petition	I see no reason why a resident shouldn't be able to bill themselves. They are doing the work seeing the clients and therefore are entitled to be FULLY compensated for their time and service. Just because a resident is billing does not mean they are exempt from supervision nor does it mean the standards are being lowered. Personally, I find that those who do not support this are the clinicians that are benefitting financially from residents doing the leg work for their practices aka making 160 dollars a client but only paying the resident 30 dollars. So if you do not support this petition, be honest about why you don't.	8/26/24 2:44 pm CommentID:227442
Anonymous	Legal Ramifications to Consider	[previously emailed to the Board] Good Afternoon! I hope the Board members are enjoying their summer. I wish to bring to your attention a current active legal scenario for case study/consideration. I understand the Board cannot interpret law. I have advised my attorney of the following: A resident in counseling I supervise was requested to be an expert witness for a VA citizen/client who is in active litigation with an international entity. Records were properly released to the attorney's office Fall 2023. I advised the attorney's office that based on interpretation of the Virginia Administrative Code concerning counseling and supervisees, I am responsible for all clinical actions of the supervisee and would need to attend any future trial or deposition activities [*The supervisor shall provide supervision as defined in 18VAC115-50-10 and shall assume full responsibility for the clinical activities of residents as specified within the supervisory contract for the duration of the residency*]. They have since remained in contact with both me and the resident in counseling. I wish to advocate for the Board's continued follow up with clinical supervisors, residents in counseling, and the ability to own private practices and practice counseling in said business/practice without a collocated supervisor. In previous correspondence with this Board and Maryland's Board where I am also licensed, both jurisdictions/licensing coordinators have advised via email correspondence, graduate level therapists/supervisees are able to own their own practice *and* practice counseling without their clinical supervisor being collocated at their location (whether physical or virtual). I find this to be a vague and potentially harmful gray area should a legal scenario like the current one transpire. Because this resident in counseling and I have a long-standing professional relationship and they operate via contract under my practice's umbrella, I own the clinical records, can review with ease, sign off, and release records in a timely manner vs. being contracted as a clinical supervisor and solely meet with the supervisee/resident in counseling, yet have no access or ownership to records; thus, be expected to show up for legal and ethical reasons if called upon. I invite the Board to consider and create verbiage around the legal/ethical ramifications of supervisees/residents in counseling owning a practice and practicing counseling out of said practice without a collocated clinical supervisor. I am not against an RIC/supervisee owning a practice and hiring persons to conduct supervision and other team members to provide counseling and being paid for such services. I do believe their supervisor must be on payroll/contractor, have ownership or equity in their company in order to maintain full access/ownership of records for unseen legal reasons. Respectfully,	8/26/24 4:52 pm CommentID:227445
Anonymous	In favor	I support. I work for a company that charges $210 a session. As a resident, I don't see half of that on my paycheck. I'm also doing the same work as my fully licensed coworkers. It's unfair to be held at the same standard but can't be compensated the same.	8/26/24 6:56 pm CommentID:227446
Anonymous	I do not support this	While I agree that the Residency process can be long and difficult due to heavy caseloads and low wages, I do not believe this as proposed is the solution.	8/27/24 1:27 am CommentID:227448

		The Residency experience is a time for pre-licensed clinicians to learn, grow, polish skills, and develop their professional Counselor identity. Running a private practice, even a solo practice not easy, and I just don't believe new therapists are ready for that yet. Spend the time during Residency doing what it was designed for: learning and sharpening clinical skills while providing an invaluable service to clients. What we should be fighting for is for more insurance companies to allow our residents to see their members, but I digress.	
Anonymous	Opposed	I do no support this petition to allow residents to bill clients directly for services. I do agree that low compensation and finding work is a challenge for Residents, but this does not seem to be the safest (for supervisors, residents, and clients) solution to that problem. Many others have stated reasons that I also agree with, therefore I will not restate what's already been said.	8/27/24 9:35 am CommentID:227450
Crystal Hamling, LPC	Strongly in favor	I am strongly in favor of this regulation change. Residents in counseling being able to bill and accept payment directly is a mechanical issue. Residents still require supervision wherever they practice, and allowing residents to bill/accept payment directly is merely a logistical matter that will make things more simplified for residents and supervisors alike, leaving more time for resident and supervisor to focus on the more important matter of clinical supervision.	8/27/24 11:10 am CommentID:227452
Susan Klemmer, MEd, NCC, Resident in Counseling	Strongly in Favor	I strongly support this petition, as my personal experience in receiving compensation for the work I do as a Resident in Counseling has been varied and often unpredictable. This petition does not remove the requirement for Supervision, it merely removes the requirement that clients and Residents engage in a payment relationship with a Supervisor that is outside the boundaries of Supervision. Supervision compensation should be, and legally is, totally separate from Resident compensation. As stated in several previous comments, asking a client to pay a Supervisor for the therapeutic relationship established solely with the Resident is confusing to clients and mechanically cumbersome to Supervisor. It also delays payment to Residents, often for weeks or months at a time, depending on the Supervisor's ethics. I am aware of Residents whose Supervisors "pay them out" quarterly - for compensation the Supervisor took no part in earning, and should not retain for anything more than a minimum period of time. When I was unexpectedly required to open a private practice while still a Resident in Counseling in order to guarantee continuity of care for my clients, the most challenging obstacle to overcome was finding a Supervisor who was willing to process payments on my behalf and return compensation to me in a timely manner. Make no mistake, finding a payment processor to run payments through was still entirely my responsibility, with the added challenge of finding a processor willing to deposit funds into an account that does not have my name on it. As an example, my EHR categorically refused to allow me to use their built-in credit card processing feature if the funds were not deposited into my own (named) business bank account. Many Supervisors I approached were unclear on the legality of processing payments for Residents, or were flat out unwilling to engage in the practice out of concerns for the impact on their own tax reporting. ***This change would not impact Residents who have engaged their services as an independent contractor or employee with a counseling practice, or as an employee of a non-profit or community organization. This change would not impact Supervisors who are already declining to consider the unique arrangement required by Residents trying to earn income through private practice.*** This change would impact only those Residents who are working in private practice before licensure; those who are entrepreneurial; those who are limited in their employability by outside companies due to personal reasons (family obligations/needs, personal disability, physical location, etc.); or those who want to start a private practice toward the end of their Residency (potentially while being fully employed elsewhere in or out of the counseling field) in order to get a "head start" on building their client base before going out fully on their own. Finally, as stated by others, removing this barrier will help align Virginia's licensing requirements more closely with other states as we move forward with the Counseling Compact. Certainly, Virginia should be proud of our stringent licensing requirements, as it provides the citizens of Virginia with an assurance that any licensed Counselor has been Supervised as a Resident for at least 21 months in addition to the hours required during internship (600 hours, usually over the span of 6-12 months) in a CACREP accredited Master's program. **The added burden of "not accepting payment directly from clients" is unnecessary and provides no additional benefit to clients, the Resident, or the Supervisor.**	8/27/24 3:16 pm CommentID:227456
Anonymous	Response to Opposition Assumptions	I am seeing a lot of opposition comments referring to residents in a way that implies they are untrustworthy, unseasoned, and generally unable to manage the difficulty of handling their own compensation. (waves scented hankie to revive herself from the horrors of managing her own finances) In response to these assumptions/implications, I urge you all to please recall that residents have only reached that stage in their journey by completing their undergraduate degree; being	8/27/24 3:50 pm CommentID:227458

		accepted to graduate school; completing their graduate school curriculum, including 600 hours of internship; passing a background check; responding to a long list of ethical questions; finding a Supervisor and submitting their Supervision contract to the Board, etc, etc. (If you need to refamiliarize yourself with the long list of requirements to **apply** for Residency, the link is here: https://www.dhp.virginia.gov/media/dhpweb/docs/counseling/forms/LPC/LPCHandbook2024.pdf Residents are not babes in the woods who took a few counseling courses on a whim and decided to hang out shingle. Nor are Residents unethical scoundrels who will abscond with their clients' payments without providing services. Many Residents are in their second or third career, and many are experienced entrepreneurs. To imply that we are untrustworthy or too stupid to manage our own businesses is a grave insult. To that point, in what capacity is the Board assisting our professional/clinical growth as Counselors by forcing us to process payments through our supervisors? I am disappointed and angered to read comments from licensed professional Counselors denigrating the intelligence and ethics of residents. Removing this burdensome language from the regulations simply reduces a logistical roadblock to residents eager to serve the growing number of Virginians desperate for mental health support, it does not encourage fraud or unethical behavior among residents.	
Anonymous	Strongly Support	I find it absolutely ridiculous payments to residents must pass through their supervisor. Especially if that supervisor is not part of the same organization (business/practice, or public health system). This process puts supervisors in an uncomfortable position financially and could have potentially detrimental effects on their taxes, or open them up to fraud. I have a close friend who is a therapist and a supervisor. She told me she has to collect her residents' income, meaning the income that is earned by her residents, not her. She said that the income has to pass through her account based on the rules and that she has to return the entire amount of earnings back to the resident, with the resident paying her separately for supervision. I've been concerned for her because of what could be IRS/tax implications of this, meaning that that income could easily be misconstrued as her own income and that she would have to pay taxes on that money which she didn't earn. She also felt the understandable need to set up a separate account at a different bank in order to collect and disperse these payments for her residents, so that it was separate from her own accounts. She said she has done her best to keep records to prove it's not her income, but who would want to try to explain this convoluted process to the IRS? She mentioned that she saw this petition and that anyone, even those not in the field can post a comment, which has led me to comment on something I've thought for years is a totally unnecessary burden on her and her residents. From what I understand, clients are required to be informed the resident who is providing care is, in fact, under supervision, so having the payments go directly to the resident shouldn't change anything there. It would merely remove the burden from the supervisor to have to process payments. I am submitting this comment anonymously because I don't want to potentially negatively impact my friend's business.	8/27/24 4:56 pm CommentID:227460
Anonymous	Support - It's about having more OPTIONS, not forcing ALL residents to bill clients directly.	This is a much-needed change! No one has given a real, non-vague reason to deny this petition. The most reasonable point that someone has made is that if this petition is approved, there's no guarantee that insurance companies will allow pre-licensed counselors to bill directly. This may or may not be true, and I think that more research needs to be conducted before one can really make this claim. Not all clients use insurance to pay for therapy and residents in private practice can only accept self-pay clients - but they can't bill them directly. Therefore, IF there actually is an issue regarding residents billing insurance, that's no reason to deny this petition. If approved, this petition will allow residents to bill self-pay clients directly. The insurance aspect of things is a separate issue that may or may not warrant separate action. This petition is about allowing residents to bill clients directly and people keep trying to make it about residents owning a private practice (which is already allowed) and keep making vague claims about safety, "developmental" capabilities, and disruptions to the overall supervision experience. Yet, no one has explained HOW changing this rule will actually cause these things to happen. These claims are especially baffling given that there are numerous states in the US (and numerous countries globally) that allow their supervisees to bill clients directly. How is it possible that all of these other jurisdictions see no problem with supervisees billing clients directly, yet, in Virginia, there are safety, developmental, and supervision issues? Also, let's not overlook the fact that, if this petition is approved, all it means is that residents will have more options - that's it! Residents will be able to choose to work in an environment where they can bill clients directly or choose to work in an environment where someone else bills clients. If a resident isn't comfortable with billing, they won't HAVE to - nothing changes for them. But for the residents who are comfortable with it, they'll now have that option. What's mind-blowing is that so many people think that residents are too incompetent and/or irresponsible to bill clients directly. I am a supervised, 38-year-old resident in counseling (yep -	8/27/24 6:12 pm CommentID:227461

		because not all residents are inexperienced 20-year-olds) who owns a private practice, and as such, I've been able to obtain a business license from the State of Virginia as an entrepreneur, develop and implement a business model, develop and monitor a business budget and cash flow, hire a Virginia registered agent (as required by the State), file and maintain the appropriate taxes, subscribe to and utilize various business tools, purchase and maintain appropriate liability insurance, create practice policies and procedures, build my own clientele/caseload, and maintain my own client schedule all while keeping a 100% client retention rate. Not to mention that I've achieved all of this while fully maximizing the benefits of the supervision experience. Running my business has had zero negative impact on my supervision experience. In fact, I truly feel like it has enhanced it! Not only have I been able to sharpen my skills, enhance my knowledge, and continue to develop my sense of professional identity, but because of owning my own practice, I feel more competent and responsible than I ever did when I worked at an existing practice. But, according to some people here, somehow I am incapable of billing my clients directly?	
Anonymous	Oppose this position	Though I disagree that allowing residents to directly bill for services would "incentize residents to engage in independent practice without supervision," I do believe removal of this requirement would further contribute to the unintended deception of the general public as to what constitutes "independent practice." Regardless of the disclaimers on a website, in consent forms, etc. regarding someone being a "resident" and "supervised by...", most people do not understand the nuances that exist between graduate and professional licenses. Further, they often make the assumption (which is not unreasonable) that someone who owns a private practice is working independently. Residents directly billing for services would further complicate this matter.	8/27/24 10:10 pm CommentID:227462
Virginia Association of Community Services Boards (VACSB)	VACSB's comments on proposed changes to billing practices for residents in counseling	The Virginia Association of Community Services Boards (VACSB) appreciates the opportunity to comment on these proposed regulatory changes related to billing practices for residents in counseling. The VACSB is generally supportive of efforts to reduce administrative burdens and streamline processes to allow for the efficient and effective delivery of behavioral health services and understands the basic reasoning behind this petition, but please note the below concerns: • While this proposal would certainly save time for the supervisor, CSBs believe it is more important to maintain the integrity of supervision in the clinical environment as well as recognize the value of an individual's "time in residence," which is expressly designed to provide opportunities for growth and guidance from seasoned professionals. • CSBs are concerned about liability issues with direct billing that does not include co-signature supervision because a resident is still learning skills and competency in their profession. Inappropriate billing could create a financial liability in a CSB. • If the proposed changes were to be implemented, it could change the incentive structure for attaining licensure. In other words, if a resident in counseling can directly bill and be directly reimbursed for service delivery without a supervisory review, there may not be the same incentive to move forward with licensure. • If notes do not need to be reviewed for billing purposes, it is possible that they would not be reviewed at all, thus diluting the supervision experience.	8/28/24 2:26 pm CommentID:227470
Anonymous	Disagree/ oppose	In my opinion, residents should be in a practice or group setting until they are licensed. A resident who goes directly to private practice and only works with their supervisor does not gain nearly enough experience. If the resident were working for a company, organization, or group practice payment would not be in question.	8/28/24 3:13 pm CommentID:227471
Anonymous	I oppose this petition	For the reasons stated by others, I oppose this petition.	8/28/24 5:30 pm CommentID:227473
Anonymous	SUPPORT! We are an evidence-based profession - let's act like it!	I can understand why many LPCs feel like this regulation shouldn't be changed. I don't agree, but I can see why. I mean, why would they want this regulation to be changed when you consider that there is a generational ideology in our field that everyone is molded by from the very onset of their careers which encompasses every thought regarding residents (whether accurate or not) - "misrepresentation of credentials (whether intentional or unintentional) is harmful to the client." Take this ideology and combine it with the fact that these LPCs have already completed residency and, therefore, *must* be far more knowledgeable than a resident, on top of the fact that they completed their residencies without being able to directly bill clients themselves - "*what's everyone whining about? Residents shouldn't bill clients directly. I didn't. It's harmful to the client. It's an unnecessary change. It goes against what supervision is all about.*" I can see how having this mindset prevents many LPCs from viewing this petition in an objective, forward-thinking manner. Many, if not all, of these LPCs have been able to practice independently without supervision for quite some time now, and are missing one very important aspect of the conversation: In the realm of residency/supervision, **SO MANY THINGS HAVE CHANGED** since they were residents. Things are not the same as they used to be. Mental health is booming now more than ever - there are more people becoming therapists and more people seeking therapy services, yet there's still a therapist shortage. We are in the throes of a mental health crisis. Insurance companies are overloaded with therapy claims. Many residents have to work 50, 60, or 70 hours a week - sometimes more. So many therapists (residents	8/28/24 5:55 pm CommentID:227474

		included) are experiencing extreme burnout. There's an increasing amount of supervisors implementing business models wherein they only hire residents in order to significantly increase their own profits - which only adds to the problems that residents are facing. We're living in a (semi) post-COVID era, and that alone has changed everything. Tuition/educational costs are higher. The housing market/rent is higher. The cost of living is higher. I'm sure that supervision rates are higher than, let's say, 5-10 years ago. A counseling compact is being implemented soon, which is bound to shake things up in and of itself. Things have clearly changed, so why shouldn't our regulations? Unless you can fully consider ALL of the factors surrounding the **CURRENT** state of the residency experience in its entirety (compared to when you were a resident), you are not being completely fair and impartial when commenting on this petition. After graduation, residents must continue with supervision and continuing education. No one is saying that these are bad things - they build our body of knowledge, increase standards for the field, and lend us even more credibility. But, they also come at a cost of both time and money - *especially* in today's changing professional landscape! Therefore, it's important to recognize that we CAN change our regulations to stay current while also continuing to maintain the overall purity of the supervision experience. Approving this petition will provide residents with the option to govern their own salaries, eliminate supervisor tax risks, reduce cybercrime risks (for everyone involved in the financial transactions that are billed), and help balance an imbalanced power dynamic between residents and supervisors - while still maintaining the integrity of the supervision experience (to include the accurate representation of credentials - as outlined multiple times in previous comments). **We are an evidence-based profession** - let's act like it! Until someone offers a legitimate reason for denying this petition that is not based on "*I believe*," "*I think*," "*I feel*," "*could*," "*might*," or "*may*," but is based on true evidence/research (which has **YET** to happen from those opposing this petition), then there's simply no reason for this petition to be denied, as there have been numerous evidence-based reasons to approve it. And that includes the notion that residents billing clients directly causes harm to the client (for which there is actual evidence that proves otherwise - read previous comments). Anybody can say it - PROVE IT!	
Anonymous	In Favor - We NEED to recognize the professional integrity of Residents!!	In Virginia, the mental health landscape is shifting, yet a troubling stigma persists against Residents in Counseling. Often viewed as inexperienced or unprofessional, these emerging counselors are, in reality, dedicated professionals striving to make a meaningful impact in their communities. It is high time that we challenge the misconceptions that frame Residents as being severely inferior to Licensed Professional Counselors. First and foremost, it is essential to understand the rigorous training that Residents undergo. If we go by what many LPCs are saying, they're making the impression to society that Residents have only completed a couple of psychology classes and are now trying to be expert therapists operating independently with their own practices. LPCs have somehow forgotten that being a Resident means holding advanced degrees in counseling, requiring the completion of extensive coursework that has equipped them with the theoretical knowledge necessary for effective practice. Following graduation, Residents enter a period of supervised practice, where they hone their skills under the guidance of Board-approved Supervisors. **This transition is not merely an extension of their education;** it is a critical phase wherein they apply their knowledge to real-world situations. According to the Board, "Supervision" means the ongoing process performed by a supervisor who monitors the performance of the person supervised and provides regular, documented individual or group consultation, guidance, and instruction that is specific to the clinical counseling services being performed ***with respect to*** *the clinical skills and competencies* of the person supervised." The perception that Residents are less professional stems from a misunderstanding of their role. **They are not trainees; they are professionals in their own right**, who are just as committed to providing quality care as LPCs. Many Residents bring unique perspectives and life experiences that enhance their counseling practice, allowing them to connect with clients in profound ways. Just as LPCs once navigated the same path, Residents are dedicated to their client's well-being and adhere to ethical standards that ensure responsible practice. This should NOT be forgotten. Respecting Residents as professionals not only honors their commitment and hard work but also fosters a culture of collaboration and **mentorship** within the field. When you stop viewing them as irresponsible, incompetent infants and start viewing them as the colleagues that they are, you encourage a more supportive environment where all counselors, regardless of their licensure status, can learn from one another and ultimately provide better care for their clients. Therefore, it is time to dismantle the stereotypes that unfairly characterize Residents in Counseling. They are not unprofessional degenerates, but rather **responsible, dedicated professionals deserving of the same dignity and respect** that's afforded to Licensed Professional Counselors. By acknowledging their contributions, you enhance the counseling profession and, most importantly, the mental health services available to those in need.	8/28/24 6:51 pm CommentID:227477

		The points being made against this petition aside, many of the comments about Residents, in general, are just plain sad and demeaning - and, if I'm being honest, extremely disheartening. It's clear that many people do not view Residents as colleagues or competent professionals but as inferior pseudo-counselors. As someone who is somewhat new to the profession myself, I would love to be able to reach out to other LPCs (besides my supervisor) to collaborate and network. However, in doing so, thinking that I would be welcomed and supported, I have only been met with disrespect, denigration, and actions that truly felt like clique-ish style bullying. I was a new, excited, wide-eyed Resident in Counseling, mind you, who was innocently trying to connect with the more experienced, "veterans" in the profession to expand my knowledge and skills, and it turned out to be a horrible experience. As it turns out, I found some support, not from LPCs, but from LCSWs - which again is sad. Since becoming a Resident in Counseling, in Virginia, my enthusiasm for wanting to be an LPC in Virginia has severely plummeted due nature in which LPCs view Residents (the comments for this petition speak volumes). So, I am seriously considering completing my supervisory experience elsewhere and have started looking at other states. I want to be a part of a community that doesn't look down on new professionals coming into the field and view them as competition, but who are happy that the field is growing and want to provide support and guidance to those eager and ambitious enough to ask for it; wherein there doesn't have to be a huge debate on whether or not a Resident has the integrity, wherewithal, competency, and professionalism to simply bill their own clients. So, I'm slowly starting to see that Virginia is not that community and may need to complete my supervision experience elsewhere.	
Anonymous	As the spouse of a Resident In Counseling and a concerned citizen&#65533;I support!	I wholeheartedly support this petition. However, as I read through the comments, I found myself becoming extremely appalled. When my wife brought this petition to my attention, I was immediately intrigued to learn more about this debate from professionals in the field, through their postings online. I expected a healthy, intelligent, productive discussion. Instead, what I observed was a clear lack of compassion, understanding, intellectual reasoning, and general common sense. I find this to be very troublesome given that this debate is taking place amongst mental health professionals. I found the comments from some of the “supervisors” quite disturbing, in particular. This perception, from the alleged mentors in your field, that residents are immature, irresponsible, inexperienced adults is unbelievably unacceptable. I am a scientist who spent 10 years in undergraduate and graduate education and am now applying those skills as a researcher. I have never witnessed colleagues, in what should be a respectable profession, being treated in such a demeaning manner at so many levels. Residents should be, and are, the colleagues of LPCs and their respective supervisors. There is a very mutual, professional, and business relationship that exists between the resident and supervisor. When I see the amount of energy being focused on attacking the character of residents instead of actually understanding the purpose of the petition, the rules that already exist in the state of Virginia (A RESIDENT IS ALLOWED TO HAVE A PRIVATE PRACTICE), and putting together incoherent rebuttals to the idea of residents directly billing clients, it makes it very clear that this entire debate is about money and competition. THIS is why a stigma remains draped all over, not only, mental health but all STEM fields. Should Virginia citizens (your clients) read these comments, some of which may have already experienced this level of greed from a therapist themselves, will undoubtedly see this as a case where money and profit are more important than building a force of specialized human beings that can create a safe place for them to address their struggles. As a consumer of these therapeutic services myself and one who has relationships with other consumers of these services, I can tell you that the comparison to the medical industry is an issue that is heavily discussed. That is NOT a good thing. It’s one thing for a shoe salesperson to have a debate over potential profit gains and losses BUT it is NOT ok for a system that requires residents to accumulate a certain number of hours under SUPERVISION, which they have to pay for. Nor is it ok to have its supervisors angrily oppose, not only something that is already allowed but to also attempt to restrict the potential financial growth of residents. To the consumer, it looks very distasteful and untrustworthy. How about, as mental health professionals and mentors, there be some level of assumption that everyone is a decent person and that grown, educated adults who share a common passion will most likely, in a professional setting, make the best decisions for the sustainment of their career, as well as for the customer, client, stakeholder, patient, etc., and NOT assume that residents are irresponsible, untrusting, immature people.	8/28/24 9:24 pm CommentID:227480
Sharon Watson, LPC, LMFT, LSATP, NCC, ACS	Corrections to misinformation, questionable assumptions, obvious unfamiliarity with the regulations,	As the petitioner, I would like to address some of the comments: Regarding the Anonymous comment “Not in support” posted at 8/24/24 9:00 am that contained the following: *“THIS. This right here is why our profession is a joke in VA. Way to go random clinical supervisor who also sits on the board?!?!?! Terrible. Terrible proposal by a colleague who is the opposite of a gatekeeper. I’ve been fully licensed for 20 years. Next this individual will say, “oh let’s allow residents to practice and bill BEFORE THEY GET THEIR MASTERS”. When will it end.?* To help clarify “sits on the board,” I sent an email encouraging comment (whether in support or not) for this petition in which I said “I am doing this independently as a Virginia approved supervisor since 1994 and not in my role as a Northern Virginia Licensed Professional Counselors Board member and Chair. This represents my own opinion and not that of NVLPC.” That statement was to make it absolutely clear that I was not submitting this petition as part of my NVLPC roles so as to be sure there is NO confusion since many people know me from my volunteerism with that organization. However, this may have led to the confusion in thinking I am an employee of the Virginia Board of Counseling or that I sit on the Board as a Board member. I am neither. I have been in contact with the Board of Counseling for over 30 years though my own residencies, licensures, supervisory responsibilities, and their	8/28/24 11:40 pm CommentID:227484

answering the many questions I've asked regarding the regulations. I am confident in saying they are careful in being ethical stewards of our regulations. There would be no possibility that anyone employed by the Board or on the Board would submit a petition because it would be a conflict of interest. On a separate note, suggesting that I would support graduate students in practicing independently is unfounded and unwarranted. Although not quoted here, it is disappointing to hear such disparagement of all the clinicians in Virginia and of the Board itself.

Next, why would there be so many anonymous posts? Is it possible that some are from residents caught up in some of these exploitive situations and are afraid of retribution? Or are they from supervisors who are threatened by the financial loss if their residents are more easily able to transition to their own practices? Based on the multiple situations I'm aware of, sadly these may be the reasons.

Regarding the VACSB's comment: is it based on a misunderstanding of this petition because this petition does not apply to residents who are employees of the CSB (or who work for a private practice):

- This petition is NOT about saving a supervisor time, it's about protecting a supervisor's financial liability for funds that pass through their account (specifically for a Resident in their own private practice) because of an antiquated process that has not been updated. Also, how does client payments going into one account vs another account "affect the growth and guidance" from a supervisor?
- What liability issues are you suggesting exist? This petition in no way changes the CSB's continued ability to submit claims for reimbursement because the Resident is an employee, not an independent practitioner. The CSB submits claims for licensed clinicians as well, even though licensed clinicians could submit claims themselves, except they can't, again because they are employees. In any case, insurance reimbursement is not dictated by any Virginia licensure regulations because the Board of Counseling has no purview over insurance issues. It's the insurance companies that determine whose services they will reimburse. But again, how does this petition apply to the CSB?
- How could it possibly change the incentive structure for licensure? In the CSB employees can't bill clients because, again, they are employees. There is already a built-in incentive to become licensed in the CSB, not only because it's strongly encouraged, but because it provides an opportunity to apply for a better job within the CSB. However, if this comment is meant to be in consideration of Residents in private practice, over which the CSB has no authority, this suggestion is still highly unlikely. A Resident cannot practice without supervision even if they have completed all of the hours for total work and supervision because they must remain under supervision until licensed. How many residents would want to postpone licensure and continue to pay for supervision they don't need?
- Again, residents can't bill because they are employees so the process of a supervisor/team leader/manager reviewing notes is not impacted by this petition.

Now to address the misinformation that seems to be coming from posters who identify themselves as supervisors. It's important to regularly monitor the regulations in order to be aware of the many changes that have happened over the years. Using the old terminology only perpetuates the misuse.

- The term pre-licensed is inaccurate because Residents actually have a Resident in Counseling license with a license number and is not a term used by the Board
- LPC-A and LPC-R designations do not exist in Virginia, even if you see these used repeatedly; also, LPC-S to designate a supervisor doesn't exist either
- The term "supervisee" has not been the correct term for years – it's "resident"
- Residents ARE ALREADY ALLOWED in Virginia to have their own private practice; this petition does not change that.
- Practices that employ residents (if the practice is paneled with insurance companies) already submit billing for the Residents' work so this petition does not apply to employees.

If there is any concern that any of these are inaccurate, please email the Board to confirm and if I'm wrong, I'm happy to correct what I've written.

Regarding the supervisor who said that the vicarious liability for their resident includes going to court and depositions based on the regulations they quoted: [*The supervisor shall provide supervision as defined in 18VAC115-50-10 and shall assume full responsibility for the clinical activities of residents as specified within the supervisory contract for the duration of the residency*]. Who interpreted the regulations to you in that way. It would be important to confirm this and to know if that's the experience of any other supervisors. Wouldn't it only be the case if you "specified within the supervisory contract" that you would accompany them, which would then be specific to you. However, how is this related to the petition?

Regarding the poster who said this change would mean "more liability" for a supervisor: it

seems there is more of a liability to have the IRS possibly think the Resident's income that's passing through the supervisor's account would be the supervisor's income and then requiring the supervisor to pay the taxes on that income.

Regarding the posters who said this would encourage "blind empowerment" and that it would "lower the bar" because Residents are "not ready for all the responsibilities" and "sends a message that supervision requirements are not important". The question is: when the client (who is informed that the Resident is under supervision and by whom and that they are NOT practicing independently) gives the Resident their credit card number and agrees to have their credit card billed for each session, do you think the client knows or checks or cares if the account number into which their payment is deposited is that of the Resident or the Supervisor? The only reason the client knows that it's going into the supervisor's account, is because the Resident has explained that in the financial agreement signed by the client. This electronic process can't possibly have anything to do with lowering the standards of residency and supervision in Virginia. Regarding lowering standards, does the fact that MSW supervisees only being required to have 100 hours of supervision before licensure and independent private practice cause anyone concern about their lower bar?

Regarding the comment that this "will defer new residents from working with the underserved and more will go to private practice for increased pay": Are you suggesting that it's right to sacrifice the opportunity for Residents to earn a living wage so that they will be forced to work with the underserved? Instead, an alternative would be to promote better funding to improve the services who are already working with the underserved.

Regarding the many posters who think this will result in a flood of inexperienced Residents to be out in the world without any supervision: What is that based on? Supervision is required. If anyone is practicing without a license and without supervision, they can be reported to the DHP. This also makes the assumption that supervisors aren't vetting the Residents they take on in their role as gatekeepers. Because of the vicarious liability, it's more likely supervisors are much more inclined to NOT take on a Resident they feel is not competent enough to be in a private practice, therefore resulting in Residents being more likely to work in a practice before going out on their own.

One more thought. It's naïve to assume that all LPC's, LMFT's, supervisors, and Residents are all ethical and following the regulations. Like any group of individuals, the bell-shaped curve applies here as well. There are people functioning at both ends of the curve, those who are extremely ethical and those who acting unethically at the other end of the curve. It is true that the majority of people are acting ethically and doing the best they can, and are not taking advantage of Residents, but I am keenly aware that that's not true. Accepting this petition should not be based on the outliers. Residents should not be denied the opportunity to earn a livable wage just because they can't find a supervisor because of supervisors' concern about the possible financial impact of money they did not earn going through their bank account.

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.

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

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

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

3. Pay the registration fee;

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

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

B. Residency requirements.

1. The applicant for licensure as a marriage and family therapist shall have completed no fewer than 3,400 hours of supervised residency in the role of a marriage and family therapist, to include 200 hours of in-person supervision with the supervisor in the consultation and review of marriage and family services provided by the resident. For the purpose of meeting the 200 hours of supervision required for a residency, in-person may also include the use of technology that maintains client confidentiality and provides real-time, visual contact between the supervisor and the resident. At least one-half of the 200 hours of supervision shall be rendered by a licensed marriage and family therapist.

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

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

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

2. The residency shall include documentation of at least 2,000 hours in clinical marriage and family services of which 1,000 hours shall be face-to-face client contact with couples or

families or both. The remaining hours may be spent in the performance of ancillary counseling services. For applicants who hold current, unrestricted licensure as a professional counselor, clinical psychologist, or clinical social worker, the remaining hours may be waived.

3. The residency shall consist of practice in the core areas set forth in 18VAC115-50-55.

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

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

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

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

8. Residents shall not call themselves marriage and family therapists, directly bill for services rendered, or in any way represent themselves as marriage and family therapists. During the residency, residents may use their names, the initials of their degree, and the title "Resident in Marriage and Family Therapy." Clients shall be informed in writing that the resident does not have authority for independent practice and is under supervision, along with the name, address, and telephone number of the resident's supervisor.

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

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

11. Residency hours that are approved by the licensing board in another United States jurisdiction and that meet the requirements of this section shall be accepted.

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

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

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

3. Have received professional training in supervision, consisting of three credit hours or 4.0 quarter hours in graduate-level coursework in supervision or at least 20 hours of continuing education in supervision offered by a provider approved under 18VAC115-50-96. At least one-half of the 200 hours of supervision shall be rendered by a licensed marriage and family therapist. Supervisors who are clinical psychologists, clinical social workers, or psychiatrists and have been approved to provide supervision may continue to do so until August 24, 2017.

D. Supervisory responsibilities.

1. The supervisor shall complete evaluation forms to be given to the resident at the end of each three-month period. The supervisor shall report the total hours of residency and evaluate the applicant's competency to the board.

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

3. The supervisor shall provide supervision as defined in 18VAC115-50-10 and shall assume full responsibility for the clinical activities of residents as specified within the supervisory contract for the duration of the residency.

Statutory Authority

§§54.1-2400 and 54.1-3506 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 13, Issue 19, eff. July 9, 1997; amended, Virginia Register Volume 16, Issue 7, eff. January 19, 2000; Volume 24, Issue 24, eff. September 3, 2008; Volume 25, Issue 24, eff. September 2, 2009; Volume 32, Issue 24, eff. August 24, 2016; Volume 35, Issue 24, eff. September 6, 2019; Volume 37, Issue 20, eff. June 23, 2021.

Agenda Item: Consideration of petition for rulemaking

Included in your agenda package:

- Petition for rulemaking filed to request the Board amend 18VAC115-20-52(D) to require supervisors to report the total hours of residency and evaluate an applicant's competency within a set timeframe;

- Town Hall summary page showing no comments on the published petition;

- 18VAC115-20-52.

Action needed:

- Motion to either:
    - Accept the petition and initiate rulemaking; or
    - Deny the petition, clearly stating why.

Virginia Department of
Health Professions
Board of Counseling

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Petition for Rule-making

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

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

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

Peterson, Tamara, L.

Street Address	Area Code and Telephone Number
9210 Greenford Drive	804-396-1528

City	State	Zip Code:
Henrico	Virginia	2 3 2 9 4

Email Address (optional)
tphen271@gmail.com

Respond to the following questions:

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

18VAC115-20-52 (D) Supervisory Responsibilities
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.

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

The current rule does not indicate a completion timeframe as to when supervisors should report the total hours of residency to the resident. This is detrimental to the forward progression of residents in the licensure process because the Verification of Supervision for Licensure form is critical to the resident's ability to account for the total amount of hours that are completed under the supervisor in which the resident holds or held a contract with during the employment period. The omission of this form in the application process can cause a resident to have to redo hours that have already been completed. Supervisors should be required to complete the form in conjunction with the time that the supervision contract ends. This would prevent a supervisor from retaliating against a resident who decides to work for another agency. This would also prevent undo distress upon the resident if the supervisor does not complete it at the end of the contract and some unfortunate event occurs that prevents the resident from gaining access to the completed form. As the rule stands, if a resident decides to end an agreement with a supervisor, the supervisor can subject the resident to the power differential that the situation causes and evoke unnecessary stress and duress upon the resident. This behavior by any supervisor should be deemed as unethical. This gap in power can be closed by specifying a time, such as stated in Section 3, which indicates when quarterly forms must be completed. Again, as the rule currently stands, a resident can leave a practice with all of his or her quarterly forms but not have access to the Verification of Supervision for Licensure form. Please provide the resident with the right to walk away from a supervisor with all documentation of hours earned in the resident's possession.

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.

18VAC115-20-52 (D) Supervisory Responsibilities
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.

Signature: Tamara L. Peterson, M.A., Resident in Counseling **Date:** 06/12/2024

VIRGINIA REGULATORY TOWN HALL

Secretariat **Health and Human Resources**

Agency **Department of Health Professions**

Board **Board of Counseling**

Edit Petition

Petition 410

Petition Information	
Petition Title	Request to include completion timeframe for supervisors to report residency hours under 18VAC115-20-52(D)
Date Filed	6/18/2024 **[Transmittal Sheet]**
Petitioner	Tamara Peterson
Petitioner's Request	The petitioner requests that the Board amend 18VAC115-20-52(D) to require supervisors to report the total hours of residency and evaluate an applicant's competency within a set timeframe.
Agency's Plan	The petition for rulemaking will be published in the Virginia Register of Regulations on July 15, 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 July 15, 2024 and will close on August 14, 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 October 4, 2024. The petitioner will be notified of the Board's decision after that meeting.
Comment Period	Began 7/15/2024 Ended 8/14/2024 0 comments
Virginia Register Announcement	Submitted on 6/18/2024 **The Virginia Register of Regulations** Published on: 7/15/2024 Volume: 40 Issue: 24
Agency Decision	Pending

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This petition was created by Erin Barrett on 06/18/2024 at 9:54am

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: Adoption of exempt regulatory changes to QMHP regulations and new regulations governing BHT/BHTA registration

Included in your agenda package:

- Draft changes to qualified mental health professional regulations pursuant to SB403;
- Draft regulations governing behavioral health technician and behavioral health technician assistant registrations;
- Public comment received by the Board regarding training hours included in draft regulations;
- SB403.

Staff note: Public hearing was held earlier in the meeting to receive any additional comments to the draft regulatory amendments.

Action needed:

- Motion to adopt exempt regulatory changes to 18VAC115-80 governing QMHP registration; and
- Motion to adopt regulations 18VAC115-90 governing behavioral health technicians and behavioral health technician assistants by exempt action.

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 as a QMHP	$30
Renewal of registration as a QMHP-trainee	$10
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 [40] 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. Requirements for registration as a qualified mental health professional-trainee.

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 [40] 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;

3. Provide a current report from the NPDB, if applicable; and

3. Submit evidence of completion of ~~20~~ eight hours of continuing education ~~consistent with requirements of 18VAC115-80-80~~ for each year in which the license has been inactive or lapsed, not to exceed 32 hours.

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.

Language below is part of a new VAC chapter for BHTs and BHTAs

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 [20] 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 [20] 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;

3. Provide a current report from the NPDB, if applicable; and

4. Submit evidence of completion of two hours of continuing education for each year in which the license has been inactive or lapsed, not to exceed eight hours.

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.

COMMONWEALTH of VIRGINIA

NELSON SMITH
COMMISSIONER

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September 5, 2024

To: Members, DHP Board of Counseling

Cc: Jaime Hoyle, Director, Board of Counseling
Braden Curtis, Chief Deputy Commissioner
Heather Norton, Deputy Commissioner, Community Services

Fr: Dev Nair, Assistant Commissioner, Division of Provider Management
Nicole Gore, Assistant Commissioner, Division of Behavioral Health Services

Re: Considerations for Regulatory Action Implementing SB403 (2024)

Thank you for the proactive collaboration with DBHDS regarding mandated regulatory actions creating a new chapter for behavioral health technicians (BHTs) and behavioral health technician-assistants (BHT-As), and amendments to your regulations regarding qualified mental health professionals (QMHPs) and qualified mental health professional-trainees (QMHP-Ts).

In this period of draft revisions, and prior to your meeting on October 4, 2024, we are writing to communicate DBHDS' thoughts for your consideration in your discussion of final edits to both draft regulatory actions. DBHDS recommends consideration of increases in didactic hours for new professions of BHTs and BHT-As to 72 hours, QMHPs to 240 hours, and QMHP-Ts to 120 hours.

Specifically, regarding the new professions of BHTs and BHT-As:

- Increase didactic hours to 72 hours.
    - It is noted that a peer recovery specialist (PRS) is required to complete a 72-hour didactic training before they are eligible for certification. Setting a significantly lower requirement for BHT and BHT-A registration, may inadvertently create a shift in the workforce to that avenue rather than PRS because of a potentially similar rate of pay for less training.
    - The importance of balancing the creation of a low-barrier pathway into the behavioral health workforce with the need to have staff prepared to provide high-quality services and care to vulnerable individuals with complex needs is a significant consideration in this recommendation.

Specifically, regarding the new professions of QMHPs and QMHP-Ts:

- Increase didactic hours to 240 hours for QMHP and 120 hours for QMHP-T.
    - In an effort to remain consistent with the requirements of these analogous designations, consideration was given to the requirements for certified substance abuse counselor (CSAC) and certified substance abuse counseling assistant (CSAC-A) professional designations, which have similar roles and scope to those of QMHP and QMHP-T within behavioral health services.
        - *18VAC115-30-50. Educational requirements for substance abuse counselors.*
          A. An applicant for examination for certification as a substance abuse counselor shall:
            1. *Have a bachelor's or post-baccalaureate degree; and*
            2. *Have completed 240 clock hours of didactic training in substance abuse education from one of the following programs: …*

        - *18VAC115-30-62. Educational requirements for substance abuse counseling assistants.*
          A. An applicant for certification as a substance abuse counseling assistant shall:
            2. B. Substance abuse education. The education will include 120 hours spent in receiving didactic training in substance abuse counseling. Each applicant shall have received a minimum of eight clock hours in each of the following 13 areas:…
        - This again, recognizes the need to balance a path for access to this workforce with the importance of providing high quality care for some of Virginia's most vulnerable citizens (including complex mental health and co-occurring diagnoses).

Thank you for your consideration of these recommendations. We appreciate your collective expertise with these kinds of regulatory professional structures, and your efforts to implement the mandates for the new BHT pipeline and the updates to the QMHP requirements.

If you have any questions regarding the considerations above, please do not hesitate to contact either of us: Dev Nair at dev.nair@dbhds.virginia.gov (804) 335-4193, or Nicole Gore at nicole.gore@dbhds.virginia.gov or (804) 219-7531.

Chart of Various Position Requirements and Didactic hours (not just credit hours)

CNAs (from DHP staff:) The regulation does not require a certain number of didactic hours. Due to other requirements [140 hours for the program under 18VAC90-26-50 C 1 and 20 hours skills acquisition and 40 hours of clinical under 18VAC90-26-50 C 3] they are typically a minimum of 80 hours. But again, that is not a hard requirement in regulation. 54.1: "Practice of a nurse aide" or "nurse aide practice" means the performance of services requiring the education, training, and skills specified in this chapter for certification as a nurse aide. Such services are performed under the supervision of a dentist, physician, podiatrist, professional nurse, licensed practical nurse, or other licensed health care professional acting within the scope of the requirements of his profession. 18VAC90-25-71. Certification by examination. A. To be placed on the registry and certified by examination, the nurse aide must: 1. Have satisfactorily completed: a. A nurse aide education program approved by the board; b. At least one clinical nursing course that includes at least 40 hours of clinical experience involving direct client care within the past 12 months while enrolled in a nursing education program preparing for registered nurse or practical nurse licensure; or c. A nursing education program preparing for registered nurse licensure or practical nurse licensure; 2. Pass the state examination required by the board; and
Advanced CNA § 54.1-3028.1. Nurse aide education programs. Nurse aide education programs designed to prepare nurse aides for certification shall be a minimum of 120 clock hours in length. The curriculum of such programs shall include communication and interpersonal skills, safety and emergency procedures, personal care skills, observational and reporting techniques, appropriate clinical care of the aged and disabled, skills for basic restorative services, clients' rights, legal aspects of practice as a certified nurse aide, occupational health and safety measures, culturally sensitive care, and appropriate management of conflict. The Board shall promulgate regulations to implement the provisions of this section. 18VAC90-25-110. Requirements for initial certification as an advanced certified nurse aide. A. In order to be certified as and use the title of "Advanced Certified Nurse Aide," an applicant shall meet the following qualifications: 1. Hold current certification as a certified nurse aide in Virginia; 2. Have been certified for at least three years as a certified nurse aide; 3. Have never had a finding of abuse, neglect, or misappropriation of patient property entered on a nurse aide registry in any jurisdiction and have not had any disciplinary actions taken by the board within the five years preceding application for advanced certification; 4. Have a recommendation for advanced certification from a licensed nurse who has supervised the applicant in providing direct patient care for at least six months within the past year; and 5. Have successfully completed a minimum of 120 hours of advanced training in an approved program that includes a competency evaluation acceptable to the board.
Certified Substance Abuse Counselor (CSAC) The scope of practice for a Certified Substance Abuse Counselor is defined in § 54.1-3507.1, which states that: “A certified substance abuse counselor shall be (i) qualified to perform, under appropriate supervision or direction, the substance abuse treatment functions of screening, intake, orientation, the administration of substance abuse assessment instruments, recovery and relapse prevention planning, substance abuse treatment, case management, substance abuse or dependence crisis intervention, client education, referral activities, record keeping, and consultation with other professionals; (ii) qualified to be responsible for client care of persons with a primary diagnosis of substance abuse or dependence; and (iii) qualified to supervise, direct and instruct certified substance abuse counseling assistants. Certified substance abuse counselors shall not engage in independent or autonomous practice. ”

CSAC in supervision: Bachelor's degree and 120 hours of didactic training. CSAC by examination: Bachelor's Degree AND 240 hours of didactic training. Board-approved training can be obtained, and specific training areas. 18VAC115-30-50. Educational requirements for substance abuse counselors. A. An applicant for examination for certification as a substance abuse counselor shall: 1. Have a bachelor's or post-baccalaureate degree; and 2. Have completed 240 clock hours of didactic training in substance abuse education from one of the following programs:
Peer Recovery Specialist: Requirements: Certified Peer Recovery Specialist (CPRS) | Virginia Certification Board (vacertboard.org) 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 employer, 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).
"Qualified paraprofessional in mental health" or "QPPMH" means a person who meets at least one of the following criteria: (i) is registered with the United States Psychiatric Association (USPRA) as an Associate Psychiatric Rehabilitation Provider (APRP); (ii) has an associate degree in a related field (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling) and at least one year of experience providing direct services to individuals with a diagnosis of mental illness; (iii) is licensed as an occupational therapy assistant, and supervised by a licensed occupational therapist, with at least one year of experience providing direct services to individuals with a diagnosis of mental illness; or (iv) has a minimum of 90 hours classroom training and 12 weeks of experience under the direct personal supervision of a QMHP-A providing services to individuals with mental illness and at least one year of experience, including the 12 weeks of supervised experience.

Other States: Chart of Various Position Requirements and Didactic hours (not just credit hours)

State	Credential Type	Education	Experience	Role
MN	Certified MH Rehab Spec	Masters	3 yrs.	May only be employed by a certified agency
MN	MH Behavioral Aide 1	HS	2 yrs.	May only work under supervision of LMHP
MN	MH Behavioral Aide 2	Bachelors		May only work under supervision of LMHP
MN	MHCM	30 credit hours or Bachelors		CM under supervision of LMHP
MN	MH Practitioner	30 credit hours or Bachelors	2000 hrs. and internship	Specific roles under supervision of LMHP or Certified MH Rehab Spec
MO	LBSW	Bachelors in SW	Exam and suicide prevention training	Similar to QMHP, only under LMHP supervision
MO	Community Health Worker	HS and approved training program		Case management
OK	Licensed BH Practitioner	Masters	Exam	BH services
OK	MH Technician	Bachelors or HS+1 year exp	Exam	Highly limited scope, direct care, observation, and recording in outpatient and inpatient clinics
PA	BSW	Bachelors	Exam	
PA	MH Associate	Bachelors		Similar to QMHP, only under LMHP supervision
KY	MH Technician	AA or approved certificate	Exam	Carries out treatment plans created by LMHP or licensed medical provider
GA	MH Technician	HS	1 year	Carries out treatment plan, provides direct care services
GA	Behavior Technician	HS + 40 hrs. training in ABA and ethics	Exam	behavior interventions under treatment plan and supervision of licensed ABA provider

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.

Agenda Item: Consideration of approved training programs "recognized or approved by the Board" for QMHP, QMHP-T, BHT, and BHTA applicants

Included in your agenda package:

- Chart with proposed lists of approved training for QMHP-T and QMHP;
- Chart with proposed lists of approved training for BHTs; and
- Chart with proposed lists of approved training for BHTAs.

Staff note: SB403 requires applicants for these professions to complete training in programs approved or recognized by the Board. The Board can review the proposed lists and amend as necessary. Staff will take Board approval from this meeting and create a policy document that will be posted on the Board website to provide information to potential applicants.

Programs can apply to the Board at any point in the future for inclusion on one or all of these lists.

Action needed:

- Motion to recognize training programs for QMHP-Ts, QMHPs, BHTs, and BHTAs as discussed by the Board.

Documentation for Registration as a **Qualified Mental Health Professional (QMHP)**

Submit proof of completion of a bachelor's degree AND one of the following training programs:

Approved Training Programs

- American Association of Psychiatric Techs (AAPT) Level 4
- Crisis Intervention Team (CIT) Training
- DBHDS Academy
- DBHDS PRS (Peer Recovery) Training
- U.S. Air Force Mental Health Service Specialist
- U.S. Army Behavioral Health Tech 68X
- U.S. Navy Behavioral Health Tech
- VHWDA Community Health Worker Training

Degree or certificate from the following programs:

- Blue Ridge Community College
  Human Services, AAS
  Human Services I, CSC
  Human Service II, CSC
  Substance Abuse Counseling, CSC
- Brightpoint Community College
  Human Services, AAS
  Human Services-Pre-Social Work Spec, AAS
  Psychology, AS
  Bereavement and Grief Counseling, CSC
  Substance Abuse Assistant, CSC
- Germanna Community College
  Paraprofessional Counseling, CSC
  Behavioral Health Technician, Certificate
- Laurel Ridge Community College
  Human Services, AAS
- Northern Virginia Community College
  Substance Abuse Rehab Counselor, Certificate
- Rappahannock Community College
  Psychology/Social Work Specialization, AAS
- Reynolds Community College
  Human Services, AAS
  Behavioral Health Technician, CSC
  Human Services Technician, CSC
  Substance Abuse Counselor Education, CSC
- Southside Community College
  Human Services, AAS
  Human Services, CSC
  Human Services, Certificate
  Substance Abuse Counseling Assistant, Certificate
  Substance Abuse Counseling Aide, CSC
- Virginia Highlands Community College
  Human Services, AAS
  Human Services Advocate, Certificate
  Substance Abuse Counselor Assistant, CSC
- Virginia Peninsula Community College
  Human Services, AAS
  Substance Abuse Counselor Assistant, CSC
- Virginia Western Community College
  Human Services, AAS
  Human Services: Foundations, CSC
- Wytheville Community College
  Human Services, AS
  Human Services Professional, AAS
  Human Services-Mental Health, CSC

Documentation for Registration as a **Behavioral Health Technician (BHT)**

Submit proof of completion of one option from List A OR a transcript showing completion of an associate's degree AND training from List B.

Choose one from the list below:

List A

- American Association of Psychiatric Techs (AAPT) Level 4

Degree from the following programs:

- Blue Ridge Community College
  Human Services, AAS
- Brightpoint Community College
  Human Services, AAS
  Human Services-Pre-Social Work Spec, AAS
  Psychology, AS
- Laurel Ridge Community College
  Human Services, AAS
- Rappahannock Community College
  Psychology/Social Work Specialization, AAS
- Reynolds Community College
  Human Services, AAS
- Southside Community College
  Human Services, AAS
- Virginia Highlands Community College
  Human Services, AAS
- Virginia Peninsula Community College
  Human Services, AAS
- Virginia Western Community College
  Human Services, AAS
- Wytheville Community College
  Human Services, AS
  Human Services Professional, AAS

OR

Associate's Degree AND one from the list below:

List B

- Adult Continuing Education (ACE) for Mental Health Technician
- Crisis Intervention Team (CIT) Training
- DBHDS Academy
- DBHDS PRS (Peer Recovery) Training
- VHWDA Community Health Worker Training
- Youth Mental Health Corps Training
- High school diploma with successful completion of the Career and Technical Education (CTE) program in Mental Health Assistant or equivalent
- U.S. Air Force Mental Health Service Specialist
- U.S. Army Behavioral Health Tech 68X
- U.S. Navy Behavioral Health Tech

Certificate from the following programs:

- Blue Ridge Community College
  Human Services I, CSC
  Human Service II, CSC
  Substance Abuse Counseling, CSC
- Brightpoint Community College
  Bereavement and Grief Counseling, CSC
  Substance Abuse Assistant, CSC
- Germanna Community College
  Paraprofessional Counseling, CSC
  Behavioral Health Technician, Certificate
- Northern Virginia Community College
  Substance Abuse Rehab Counselor, Certificate

Documentation for Registration as a **Behavioral Health Technician (BHT)**

Choose one from the list below:	OR	Associate's Degree AND one from the list below:
List A		List B

- Reynolds Community College
  Behavioral Health Technician, CSC
  Human Services Technician, CSC
  Substance Abuse Counselor Education, CSC

- Southside Community College
  Human Services, CSC
  Human Services, Certificate
  Substance Abuse Counseling Assistant, Certificate
  Substance Abuse Counseling Aide, CSC

- Virginia Highlands Community College
  Human Services Advocate, Certificate
  Substance Abuse Counselor Assistant, CSC

- Virginia Peninsula Community College
  Substance Abuse Counselor Assistant, CSC

- Virginia Western Community College
  Human Services: Foundations, CSC

- Wytheville Community College
  Human Services-Mental Health, CSC

Documentation for Registration as a
Behavioral Health Technician Assistant (BHTA)

Submit proof of completion of one option from List A OR a transcript showing completion of a high school diploma/GED AND training from List B.

Choose one from the list below:

List A

- American Association of Psychiatric Techs (AAPT) Level 2 or higher
- High school diploma with successful completion of the Career and Technical Education (CTE) program in Mental Health Assistant or equivalent
- U.S. Air Force Mental Health Service Specialist
- U.S. Army Behavioral Health Tech 68X
- U.S. Navy Behavioral Health Tech

Degree or Certificate from the following programs:

- Blue Ridge Community College
  Human Services, AAS
  Human Services I, CSC
  Human Service II, CSC
  Substance Abuse Counseling, CSC
- Brightpoint Community College
  Human Services, AAS
  Human Services, Pre-Social Work Specialization, AAS
  Psychology, AS
  Bereavement and Grief Counseling, CSC
  Substance Abuse Assistant, CSC
- Germanna Community College
  Paraprofessional Counseling, CSC
  Behavioral Health Technician, Certificate
- Laurel Ridge Community College
  Human Services, AAS
- Northern Virginia Community College
  Substance Abuse Rehab Counselor, Certificate
- Rappahannock Community College
  Psychology/Social Work Specialization, AAS
- Reynolds Community College
  Human Services, AAS
  Behavioral Health Technician, CSC
  Human Services Technician, CSC
  Substance Abuse Counseling Education, CSC

OR

High School Diploma/GED AND one from the list below:

List B

- Adult Continuing Education (ACE) for Mental Health Technician
- Crisis Intervention Team (CIT) Training
- DBHDS Academy
- DBHDS PRS (Peer Recovery) Training
- VHWDA Community Health Worker Training
- Youth Mental Health Corps Training

Documentation for Registration as a
Behavioral Health Technician Assistant (BHTA)

Choose one from the list below:

List A

- Southside Community College
  Human Services, AAS
  Human Services, CSC
  Human Services, Certificate
  Substance Abuse Coun Asst, Certificate
  Substance Abuse Counseling Aide, CSC

- Virginia Highlands Community College
  Human Services, AAS
  Human Services Advocate, Certificate
  Substance Abuse Counselor Assistant, CSC

- Virginia Peninsula Community College
  Human Services, AAS
  Substance Abuse Counselor Assistant, CSC

- Virginia Western Community College
  Human Services, AAS
  Human Services: Foundations, CSC

- Wytheville Community College
  Human Services, AS
  Human Services Professional, AAS
  Human Services-Mental Health, CSC

OR

High School Diploma/GED AND one from the list below:

List B

Virginia Department of
Health Professions
Board of Counseling

Discipline Reports

Jul 13, 2024 to Sep 20, 2024

NEW CASES RECEIVED BY BOARD Jul 13, 2024 to Sep 20, 2024
108

TOTAL OPEN INVESTIGATIONS (ENFORCEMENT)
76

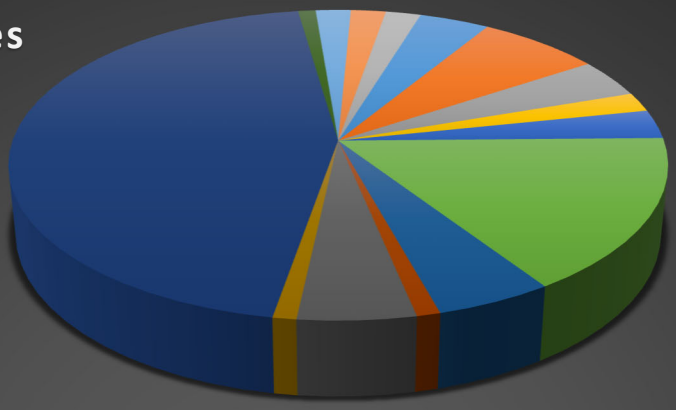
OPEN CASE STAGES as of Sep 20, 2024	
Probable Cause Review	148
Scheduled for Informal Conferences	9
Scheduled for Formal Hearings	6
Other (pending CCA, PHCO, hold, etc.)	21
Cases with APD for processing (IFC, FH, Consent Order)	12
TOTAL ACTIVE CASES AT BOARD LEVEL	**196**

CONFERENCES AND HEARINGS			
Informal Conferences			
Conferences Held:	Jul 26, 2024		
Scheduled Conferences:	Nov 15, 2024	Dec 13, 2024	
	Jan 31, 2025	Mar 7, 2025	Apr 4, 2025
	May 16, 2025	Jun 27, 2025	Jul 18, 2025
Formal Hearings			
Hearings Held:	n/a		
Scheduled Hearings:	Oct 4, 2024		
	Jan 24, 2025	Apr 25, 2025	

CASES CLOSED Jul 13, 2024 to Sep 20, 2024	
No violation 1 Informal Conference (dismissal)	78
Undetermined	7
Violation 3 Informal Conferences 3 mandatory suspensions 1 Consent Order entered 2 Confidential Consent Agreements	9
Application Approved 1 Informal Conference	1
Application Denied 5 Informal Conferences	5
Application Withdrawn	0
TOTAL CASES CLOSED	**100**

Virginia Department of
Health Professions
Board of Counseling

Closed Case Categories



- Abuse/Abandonment/Neglect (4)
- Business Practice Issues (7)
  1 violation (RIC)
- CE Noncompliance (4)
  3 violations (2-LPC, CSAC)
- Confidentiality Breach (2)
- Criminal Activity (3)
  3 violations (LPC, QMHP-T, RPRS)
- Diagnosis/Treatment (16)
- Eligibility (5)
  1 approved (QMHP-T)
  4 denied (3-RIC, QMHP-A)
- Fraud, patient care (1)
- Inability to Safely Practice (5)
- Inappropriate Relationship (1)
  1 violation (LPC)
- No jurisdiction (45)
- Noncompliance with Board Order (1)
  1 violation (QMHP-A)
- Records Release (2)
- Reinstatement (2)
  1 denied (LPC)
- Unlicensed Activity (2)

AVERAGE CASE PROCESSING TIMES (counted on closed cases)	
Average time for case closures	**167**
Avg. time in Enforcement (investigations)	70
Avg. time in APD (IFC/FH preparation)	30
Avg. time in Board (includes hearings, reviews, etc).	98

Virginia Department of
Health Professions
Board of Counseling

Discipline Staff for Behavioral Science Boards

Jennifer Lang, Deputy Executive Director
Christy Evans, Discipline and Compliance Case Manager
Vacant, Discipline and Compliance Case Manager
Discipline Reviewer, Board of Counseling (part-time)
Discipline Reviewer, Board of Psychology (part-time)
Discipline Reviewer, Board of Social Work (part-time)

CASES RECEIVED YEAR-TO-DATE PER BOARD Jan 1, 2024 – Sep 20, 2024	
Board of Counseling	**359**
Board of Psychology	147
Board of Social Work	130
TOTAL CASES RECEIVED	**636**

CURRENT OPEN CASES PER BOARD as of Sep 20, 2024	
Board of Counseling	**196**
Board of Psychology	146
Board of Social Work	197
TOTAL CASES WITH BOARD STAFF	**539**

LICENSING REPORT

Satisfaction Survey Results	
2024 3rd Quarter (January 1 – March 31, 2024)	**95.6%**
2024 4th Quarter (April 1 – June 30, 2024)	**92.9%**

Totals as of September 25, 2024*

Current Active Licenses	
Certified Substance Abuse Counselor	1,698
CSAC Supervisee	2,631
Substance Abuse Counseling Assistant	273
Licensed Marriage and Family Therapist	1,185
Marriage & Family Therapist Resident	195
Licensed Professional Counselor	9,932
Resident in Counseling	3,471
Substance Abuse Treatment Practitioner	495
Substance Abuse Treatment Residents	18
Rehabilitation Provider	140
Qualified Mental Health Prof-Adult	6,356
Qualified Mental Health Prof-Child	4,084
Trainee for Qualified Mental Health Prof	9,480
Registered Peer Recovery Specialist	775
Total	**40, 733***

*Unofficial numbers (for informational purposes only)

Licenses, Certifications and Registrations Issued

License Type	April 2024	May 2024	June 2024	July 2024	August 2024
Certified Substance Abuse Counselor	14	7	12	10	5
CSAC Supervisee	58	51	30	55	39
Certified Substance Abuse Counseling Assistant	4	4	2	9	5
Licensed Marriage and Family Therapist	12	7	7	43	32
Marriage & Family Therapist Resident	5	4	6	9	10
Pre-Education Review for LMFT	0	0	0	0	0
Licensed Professional Counselor	97	91	108	103	113
Resident in Counseling	39	86	142	103	103
Pre-Education Review for LPC	7	7	5	5	6
Substance Abuse Treatment Practitioner	5	8	7	5	1
Substance Abuse Treatment Residents	0	2	0	2	0
Pre-Education Review for LSATP	0	0	0	0	0
Rehabilitation Provider	1	0	0	0	0
Qualified Mental Health Prof-Adult	62	75	63	69	83
Qualified Mental Health Prof-Child	54	47	39	46	51
Trainee for Qualified Mental Health Prof	139	211	211	199	243
Registered Peer Recovery Specialist	17	20	17	30	23
Total	**514**	**620**	**649**	**688**	**714**

*Unofficial numbers (for informational purposes only)

Licenses, Certifications and Registration Applications Received

Applications Received	April 2024*	May 2024*	June 2024*	July 2024*	August 2024*
Certified Substance Abuse Counselor	17	23	12	12	14
CSAC Supervisee	60	56	61	58	52
Certified Substance Abuse Counseling Assistant	7	9	9	12	16
Licensed Marriage and Family Therapist	16	14	17	36	31
Marriage & Family Therapist Resident	11	4	13	5	8
Pre-Education Review for LMFT	0	0	0	0	0
Licensed Professional Counselor	106	133	122	134	130
Resident in Counseling	46	130	131	104	143
Pre-Education Review for LPC	4	11	5	7	12
Substance Abuse Treatment Practitioner	5	7	8	7	9
Substance Abuse Treatment Residents	1	5	1	2	1
Pre-Education Review for LSATP	0	1	0	0	0
Rehabilitation Provider	1	1	0	0	1
Qualified Mental Health Prof-Adult	91	109	119	122	102
Qualified Mental Health Prof-Child	63	78	87	76	67
Trainee for Qualified Mental Health Prof	177	263	240	222	281
Registered Peer Recovery Specialist	21	25	29	27	31
Total	**626**	**869**	**854**	**824**	**898**

*Unofficial numbers (for informational purposes only)

Additional Information:

- **Board of Counseling Staffing Information:**

  - The Board currently has six full-time staff to answer phone calls, emails and to process applications across all license, certification and registration types.
    - Board of Counseling Licensing and Operations Manager
      - Latasha Austin – Licensing and Operations Manager (Full-Time)
    - Licensing Staff:
      - Victoria Cunningham – Licensing Specialist (Full-Time)
      - Dalyce Logan – Licensing Specialist (Full-Time)
      - Trasean Boatwright – Licensing Specialist (Full -Time)
    - QMHP Staff:
      - Sandie Cotman – Licensing Program Manager (Full-Time)
      - Shannon Brogan – Licensing Specialists (Full-Time)
      - Vacant – Licensing Specialists (Full-Time)
      - Vacant - Licensing Administration Assistant (Part-Time)