Virginia Department of
Health Professions
Board of Counseling

Agenda

Full Board Meeting
January 24, 2025
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 proposed art therapy regulations……………………………………………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 20

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 32
- Report: Virginia Qualified Mental Health Professional Workforce: 2024……………………………………....Page 66

Presentation:
"Overview of Boost 200 Program"
Trinette Randolph, Boost 200 Program Manager, Virginia Health Care Foundation

Legislative and Regulatory Report – Erin Barrett, JD, Department of Health Professions, Director of Legislative and Regulatory Affairs
- Consideration of Petition for Rulemaking to establish a licensure pathway for LSATPs to become LPCs*…... Page 94
- Consideration of Petition for Rulemaking to allow previous clinical experience to become supervisor*……... Page 101

- Consideration of Petition for Rulemaking to accept passage of National MFT exam*…………………………..Page 122
- Consideration of Petition for Rulemaking to establish a licensure pathway for LMFTs to become LPCs*……Page 132
- Consideration of Petition for Rulemaking to require supervisors complete ethics training*…………………….Page 143
- Consideration of fast-track regulatory amendments for the reduction or residency requirements*……………Page 156
- Adoption of proposed regulatory language to implement the Counseling Compact……………………………..Page 188

Committee Reports

- Regulatory Committee – Maria Stransky, LPC, CSAC, CSOTP, Regulatory Committee Chair

Unfinished Business

- Consideration of Policy Document regarding approved trainings for BHTAs, BHTs, and QMHPs* – Jennifer Lang, Deputy Director, Boards of Counseling, Psychology, and Social Work (BSU)…………………………………...Page 203

- Required Supervisor Training – Jaime Hoyle, JD, Executive Director, BSU

New Business

- Appointment of Alternate Commissioner to the Counseling Compact*-- Ms. Hoyle

Staff Reports

- **Executive Director's Report** – Ms. Hoyle

- **Discipline Report** – Ms. Lang...……………………………………………………...Page 207
- **Licensing Report** – Charlotte Lenart, Deputy Director, BSU…………………………………………………...Page 231

Consideration of Consent Order*

Next Meeting:

- Board Meeting: April 25, 2025

Meeting Adjournment

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

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

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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.

Project 6583 - Proposed

Board of Counseling

New chapter for licensure

Chapter 90

Regulations Governing the Practice of Art Therapy

18VAC115-90-10. Definitions.

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

"Art therapist"

“Art therapy”

"Art Therapy Associate"

“Board"

"Counseling"

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

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

“ATCB” means the Art Therapy Credentials Board, Inc.

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

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

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

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

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

Initial licensure as an art therapist: Application processing and initial licensure	$175
Initial licensure as an art therapy associate: Application processing and initial licensure	$65
Active annual license renewal as an art therapist	$130
Inactive annual license renewal as an art therapist	$65
Late renewal	$45
Duplicate license	$10
Verification of licensure to another jurisdiction	$30
Reinstatement of a lapsed license	$200
Replacement of or additional wall certificate	$25
Returned check or dishonored credit card or debit card	$50
Reinstatement following revocation or suspension	$600

B. All fees are nonrefundable.

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

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

1. A completed application;

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

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

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

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

18VAC115-90-40. Requirements for licensure.

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

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

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

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

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

a. Current ATR-BC certification from the ATCB, or

b. Documentation of passage of the examination of the ATCB and evidence of autonomous, clinical practice in art therapy, as defined in §54.1-3500 of the Code of Virginia, for 24 of the last 60 months immediately preceding his licensure application

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in Virginia. Clinical practice shall mean the rendering of direct clinical art therapy services, clinical supervision of clinical art therapy services, or teaching graduate-level courses in art therapy.

C. Every applicant for licensure as an art therapy associate shall submit to the board evidence of a current registration as an ATR or an ATR-P from the ATCB.

18VAC115-90-50. Requirements for Practice as an Art Therapy Associate.

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

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

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

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

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

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

1. A plan for completing the requirement to obtain licensure as an art therapist;

2. Documentation of compliance with the continuing education requirements;

3. Documentation of compliance with requirements related to supervision; and

4. A letter of recommendation from the clinical supervisor of record.

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

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

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

1. A completed form for renewal of the license on which the art therapist attests to compliance with the continuing competency requirements prescribed in this chapter; and

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

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

C. The license of an art therapy associate shall expire after five years from initial licensure unless an extension is granted as indicated in subsection C of 18VAC115-90-60.

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

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

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

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

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

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

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

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

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

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

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

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

1. The International Association of Marriage and Family Counselors and its state affiliates;

2. The American Association for Marriage and Family Therapy and its state affiliates;

3. The American Association of State Counseling Boards;

4. The American Counseling Association and its state and local affiliates;

5. The American Psychological Association and its state affiliates;

6. The Commission on Rehabilitation Counselor Certification;

7. NAADAC, The Association for Addiction Professionals and its state and local affiliates;

8. National Association of Social Workers;

9. National Board for Certified Counselors;

10. A national behavioral health organization or certification body;

11. Individuals or organizations that have been approved as continuing competency sponsors by the American Association of State Counseling Boards or a counseling board in another state;

12. The American Association of Pastoral Counselors;

13. The American Art Therapy Association and its state affiliates;

14. The Art Therapy Credentials Board; or

15. The International Expressive Arts Therapy Association.

18VAC115-90-100. Documenting compliance with continuing competency requirements.

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

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

C. Upon request, an art therapist shall provide documentation as follows:

1. Official transcripts showing credit hours earned; or

2. Certificates of participation.

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

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

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

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

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reinstatement to submit evidence regarding the continued ability to perform the functions within the scope of practice of the license.

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

18VAC115-90-120. Standards of practice.

A. The protection of the public health, safety, and welfare and the best interest of the public shall be the primary guide in determining the appropriate professional conduct of all persons whose activities are regulated by the board. Regardless of the delivery method, whether in person, by phone or electronically, these standards shall apply to the practice of art therapy.

B. Persons licensed by the board shall:

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

2. Practice only within the boundaries of their competence, based on their education, training, supervised experience, and appropriate professional experience and represent their education training and experience accurately to clients;

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

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

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

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

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

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

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

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

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

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12. Use only in connection with one's practice as a mental health professional those educational and professional degrees or titles that have been earned at a college or university accredited by an accrediting agency recognized by the U. S. Department of Education, or credentials granted by a national certifying agency, and that are art therapy in nature; and

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

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

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

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

3. Disclose or release records to others only with the client's expressed written consent or that of the client's legally authorized representative or as otherwise permitted or required by law;

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

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

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

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

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

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

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

2. Not engage in any type of romantic relationships or sexual intimacies with clients or those included in a collateral relationship with the client and not provide therapy to persons with whom they have had a romantic relationship or sexual intimacy. Art therapists shall not engage in romantic relationships or sexual intimacies with former clients within a minimum of five years after terminating the art therapy relationship. Art therapists who engage in such relationship or intimacy after five years following termination shall have the responsibility to examine and document thoroughly that such relations do not have an exploitive nature, based on factors such as duration of art

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therapy, amount of time since art therapy, termination circumstances, client's personal history and mental status, or adverse impact on the client. A client's consent to, initiation of or participation in sexual behavior or involvement with an art therapist does not change the nature of the conduct nor lift the regulatory prohibition;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Any person whose license has been suspended or who has been denied reinstatement by board order, having met the terms of the order, may submit a new application and fee for reinstatement of licensure.

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

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DRAFT
Virginia Board of Counseling
Public Hearing & Quarterly Board Meeting Minutes
Friday, October 4, 2024, at 10:00 a.m.
9960 Mayland Drive, Henrico, VA 23233
Board Room 2

PRESIDING OFFICER:	Terry R. Tinsley, PhD, LPC, LMFT, CSOTP, Board Chairperson
BOARD MEMBERS PRESENT:	Benjamin Allison, Citizen Member Maria Anastasiou, LMFT Lester Paul Bernard, PhD, LPC Marlo Burdge, Citizen Member Nakeisha Gordon, LPC Luanne Griffin, LPC Matthew Scott, LMFT Maria Stransky, LPC, CSAC, CSOTP, Board Vice-Chairperson Tiffinee Yancey, PhD, LPC
BOARD MEMBERS ABSENT:	Natalie Franklin, LPC, LMFT
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 Dalyce Logan, Licensing Specialist
DHP STAFF PRESENT:	Erin Barrett, JD, Director of Legislative and Regulatory Affairs, Department of Health Professions Matthew Novak, Policy Analyst, Department of Health Professions Arnie Owens, Agency Director, Department of Health Professions
BOARD COUNSEL PRESENT:	James Rutkowski, Assistant Attorney General
PUBLIC ATTENDEES:	Kesia Gwaltney, Department of Behavioral Health & Developmental Services Kevin Headly, Germanna Community College Denise Konrad, Virginia Health Care Foundation Mark Smith Crystal Stokes, Virginia Department of Education Ruth Ann Walker, Department of Behavioral Health & Developmental Services Brandie Williams, Rappahannock Community Services Board
CALL TO ORDER:	Dr. Tinsley called the meeting to order at 10:01 a.m.
MOMENT OF SILENCE:	Moment of silence was observed.
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:	Dr. Tinsley read the mission statement of the Department of Health Professions, which was also the mission statement of the Board. Dr. Tinsley also read the emergency egress instructions.

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ADOPTION OF AGENDA: The agenda was adopted as presented.

PUBLIC HEARING: A Public Hearing was held for the Board to hear public comment regarding proposed amendments to 18VAC115-80 regarding Qualified Mental Health Professionals (QMHPs) and proposed amendments to 18VAC115-90 regarding the new professions for Behavioral Health Technicians and Behavioral Health Technician Assistants. These changes are mandated by Senate Bill 403 of the 2024 General Assembly Session.

PUBLIC COMMENT: Public comment was provided by Brandie Williams on behalf of the Virginia Association of Community Services Boards, Inc (VACSB). VACSB recommended setting the didactic hours for Behavioral Health Technician Assistants at 20 hours, Behavioral Health Technicians to 40 hours, QMHP Trainees at 60 hours and QMHPs at 80 hours. In addition, the VACSB recommended the number of hours of experience for a QMHP be set at 1000 hours. ***(Attachment 1)***

The full board would discuss the requirement hours for didactic training during the full board meeting at the conclusion of the public hearing.

The Public Hearing concluded at 10:11a.m.

APPROVAL OF MINUTES: The Board reviewed the minutes from the last quarterly board meeting held on August 2, 2024.

Motion: Ms. Stransky made a motion, which Dr. Yancey properly seconded to approve the minutes from the August 2, 2024 meeting as presented. The motion passed unanimously.

AGENCY REPORT: Mr. Owens welcomed Ms. Anastasiou as a new Board Member. He thanked all the Board Members for their service to the Board.

Mr. Owens reported on the new protocols for enhanced security in the Perimeter Center known as "Expect the Check," a standard security precaution for many government agencies in the Commonwealth of Virginia.

Mr. Owens spoke about legislative proposals for the upcoming 2025 General Assembly in January 2025, which had been submitted for consideration.

Mr. Owens reported on the salary study under way by Gallagher to ensure all employees of DHP are properly being compensated.

BOARD CHAIR REPORT: Dr. Tinsley provided a re-cap of the Association of Marital and Family Therapy Regulatory Boards (AMFTRB) Annual State Delegate Meeting he attended held in Baltimore, Maryland September 15-16, 2024.

Dr. Tinsley informed the board about a presentation on coaching held at the meeting and about discussions surrounding the use of ChatGPT and artificial intelligence. Dr. Tinsley indicated that he thinks the board should discuss guidelines and guidance for the use of ChatGPT and artificial intelligence in the profession. In the meantime, he indicated that he feels staff should look into having a disclaimer on the board's website about the board not supporting the use of ChatGPT and artificial intelligence until more information about its use has been provided.

Action Item: The use of ChatGPT and artificial intelligence was sent to the Regulatory Committee to discuss at its next meeting on October 18, 2024.

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PRESENTATION: The presentation scheduled on the agenda by the DHP Healthcare Workforce Data Center was moved to the January 2025 board meeting to be presented.

LEGISLATION & REGULATORY REPORT:

- **Chart of Regulatory Actions**
  Ms. Barrett reviewed with the Board the current regulatory actions for the Board of Counseling as of September 18, 2024. A copy of the chart was included in the agenda packet.

- **Petition for Rulemaking #1**
  Ms. Barrett reviewed and discussed a petition for rulemaking received to amend 18VAC115-20-52(B)(10) of the Regulations Governing the Practice of Professional Counseling and 18VAC115-50-60(B)(8) of the Regulations Governing the Practice of Marriage and Family Therapy to allow residents to bill directly for services and receive payments directly from clients.

  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.

  Motion: Ms. Gordon made a motion, which Mr. Bernard properly seconded, to take no action on the petition. The motion passed unanimously.

  The Board believes there are additional factors to consider, such as new liability for supervisors and public knowledge of supervision, prior to taking such a regulatory action. **Action Item:** To that end, the Board has referred this issue to its Regulatory Committee to further consider the petitioner's request. The motion passed unanimously.

- **Petition for Rulemaking #2**
  Ms. Barrett reviewed and discussed a petition for rulemaking received to amend 18VAC115-20-52(D) of the Regulations Governing the Practice of Professional Counseling to require supervisors to report the total hours of residency and evaluate an applicant's competency within a set timeframe.

  No public comment was received on the petition.

  Motion: Dr. Yancey made a motion, which Ms. Gordon properly seconded, to accept the petition and initiate rulemaking to implement the request to require supervisors to report total hours of residency and evaluate an applicant's competency within a set timeframe. The motion passed unanimously.

- **Adoption of exempt regulatory changes to QMHP regulations and regulations governing BHT/BHTA registration**

  Ms. Barrett reviewed and discussed with the Board 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; and SB403.

  The Board reviewed and discussed didactic hour recommendations provided by staff, the Virginia Association of Community Services Boards, Inc (VACSB) recommendations provided during the public comment period, and the Department of Behavioral Health & Developmental Services (DBHBS) recommendations that were included in the agenda packet.

DRAFT

Motion: Dr. Tinsley made a motion, which Ms. Stransky properly second to accept VACSB's recommendation to set the didactic hours for Behavioral Health Technician Assistants at 20 hours, Behavioral Health Technicians to 40 hours, QMHP Trainees at 60 hours and QMHPs at 80 hours but excluding the recommendation to change the experience hours for QMHPs to 1,000. The supervision hours for QMHPs would remain at 1,500. The motion passed, with two opposed.

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

Ms. Barrett recommend that this be delayed so the Board and staff could relook at training programs that would meet the approved 20, 40, 60, and 80 didactic hours passed in the previous above motion.

Motion: Ms. Stransky made a motion, which Dr. Yancey properly seconded, to delay the consideration of approved training programs recognized or approved by the Board until the January 2025 Board Meeting. The motion passed unanimously.

EXECUTIVE DIRECTOR'S REPORT:

Ms. Hoyle welcomed Ms. Anastasiou as a new Board Member and thanked staff for their hard work and dedication.

Ms. Hoyle reported on board member appointments and vacancies, the financials of the board, the increase in applications by fiscal year and the number of licenses issued for the quarter. ***(Attachment 2)***

Ms. Hoyle informed the board that she would be attending the Counseling Compact Full Commission Meeting next week and would report back at the next Board meeting scheduled for January 2025.

DISCIPLINE REPORT:

Ms. Lang referenced the discipline report included in the agenda packet that reported on the discipline stats for the Board of Counseling from July 13, 2024-September 20, 2024.

Ms. Lang informed the Board that in November, she would give a presentation on ethics and an overview of the board to students in the counseling program at William & Mary.

Ms. Lang reported that the recruitment process for a new discipline and compliance case specialist has been completed and the chosen candidate is scheduled to start on October 10, 2024.

LICENSING REPORT:

Ms. Lenart reported on the licensure stats for the Board of Counseling as of September 25, 2024. A copy of the report was included in the agenda packet.

Ms. Lenart also thanked Ms. Stransky for her review of numerous QMHP coursework descriptions and Dr. Tinsley for reviewing the education and conviction information for applicants.

Ms. Lenart informed the Board that after 12 years, the credential reviewer who is a former board member and educator who provided guidance to staff by reviewing individual coursework for applicants applying for licensure, will be retiring in December.

Ms. Lenart also recognized and thanked staff for their hard work. She informed the

DRAFT

Board that she would be doing outreach at Mary Balwin next week. She also informed the Board that interviews were recently conducted for a new full-time licensing specialist position for QMHP and a part-time administrative assistant. The chosen candidate for the part-time position is scheduled to start on October 25, 2024 and she hopes the candidate chosen for the full-time position will be able to start later this month as well.

Lastly, Ms. Lenart informed the Board that the Business Process Engineering efforts for the Board of Counseling started today. The engineering will include updating and developing license handbooks for each license, certification and registration type, developing new website pages, updates to all forms, applications and checklist to make the items more reader and user friendly.

Mr. Owens, Ms. Barrett, Mr. Novak, Mr. Boatwright, Ms. Brogan, Ms. Cotman, Ms. Logan, and all public attendees left the meeting at 11:41a.m. for the Board of Counseling to move into a closed session.

DRAFT

Consideration of a Consent Order and Recommended Decisions of the Agency Subordinate

Closed Meetings:

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

Cases Considered:

- Recommended Decisions
  - Krystal Loving, QMHP-A Reinstatement Applicant
    Case No. 231194
    - Krystal Loving did not appear before the board and did not submit a written response. The board considered the agency subordinate's recommendation to deny Ms. Loving's application for reinstatement of the QMHP-A registration.
  - Parnia Samimi Darzikolaie, Resident in Counseling
    Case No. 232482
    - Parnia Samimi Darzikolaie did not appear before the board but did submit a written response. The board considered the agency subordinate's recommendation to place certain terms and conditions on Parnia Samimi Darzokolaie's license to practice as a resident in counseling
- Consent Order
  - Roy Branklin, LPC Reinstatement Applicant
    License No. 0701011528
    Case No. 241346

Reconvene: *(11:53a.m.)*

Dr. Yancey certified that, pursuant to § 2.2-3712 of the *Code of Virginia*, the Board of Counseling heard, discussed, and 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.

Decisions:

Ms. Stransky made a motion to accept the recommendations of the agency subordinate as presented. The motion was seconded and passed unanimously.

Dr. Tinsley made a motion to accept the consent order to approve the application of Roy Branklin for reinstatement of his license to practice as a professional counselor. The motion was seconded and passed unanimously.

NEXT MEETING DATES: The next meeting is scheduled for Friday, January 24, 2025.

ADJOURNMENT: Dr. Tinsley adjourned the October 4, 2024, meeting at 11:54 a.m.

____

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

____

Jaime Hoyle, JD, Executive Director

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Virginia Association Of Community Services Boards, Inc.
Making a Difference Together

Attachment 1

Premier Behavioral Health and Developmental Disability Services in Virginia's Communities

6641 West Broad Street, Suite 102 ▪ Richmond, Virginia 23230 ▪ www.vacsb.org ▪ (804) 330-3141

04 OCT 2024

To: Members, DHP Board of Counseling

From: Jennifer Faison, Executive Director, VACSB

Re: Comments for Regulatory Action Regarding 18VAC115-90-10 et seq.

The Virginia Association of Community Services Boards, Inc. (VACSB) appreciates the opportunity to provide comments on draft regulations concerning the establishment of two new professions, Behavioral Health Technicians (BHTs) and Behavioral Health Technician-Assistants (BHT-As), and revisions to regulations regarding Qualified Mental Health Professionals (QMHPs) and Qualified Mental Health Professional-Trainees (QMHP-Ts).

We have gathered feedback from Community Services Boards (CSBs) that will be affected by these draft regulations. These groups have provided valuable insights, both in terms of the potential benefits the regulations will offer and constructive feedback on areas where further refinement may be beneficial.

VACSB recommends setting the didactic hours for BHT-As at 20 hours, BHTs to 40 hours, QMHP trainees at 60 hours and QMHPs at 80 hours. In addition, the VACSB recommends the number of hours of experience for a QMHP be set at 1000.

The stated goal of the legislation driving these regulatory changes is to create a career ladder in the behavioral health field that allows for earlier entry without replacing existing certifications such as peer recovery specialists (PRS) and certified substance abuse counselors (CSAC). To effectively expand the workforce, the required didactic hours should be concomitant with the level of educational attainment as well as recognize that there are existing positions within our system, such as psychiatric technicians, who are working directly with individuals with complex needs in our state hospitals and who do so with a high school diploma and no additional coursework.

Thank you for your time and consideration of these recommendations. These perspectives are shared with the intent of fostering continued dialogue and ensuring that the final implementation of the regulations have the intended effect.

If you have any questions regarding the above comments, please contact Jennifer Faison at jfaison@vacsb.org, (804) 330-3141.

VACSB Officers
Chair: Patrick Sowers
1st Vice Chair: Gib Sloan, Chesterfield CSB
2nd Vice Chair: Ingrid Barber, Alleghany Highlands Community Services
Secretary: Stephanie Clark, Alleghany Highlands Community Services
Treasurer: Bernetta Watkins, Crossroads CSB
Past Chair: Angelo Wider
Executive Director: Jennifer Faison

Attachment 2

Virginia Department of
Health Professions

Board of Counseling

Executive Director's Report

October 4, 2024

Virginia Department of Health Professions

Board Members/Appointments

Lester Paul Bernard, Ph.D., LPC Lynchburg, VA 1st Term Ends 6/30/2027 LPC Member	**Nakeisha Gordon, LPC** Richmond, VA 1st Term Ends 6/30/2027 LPC Member
Luanne Griffin, LPC Alexandria, VA 1st Term Ends 6/30/2027 LPC Member	**Vacant** **LSATP Member**
Marlo Burdge, Citizen Member Richmond, VA 1st Term Ends 6/30/2028	**Natalie Franklin, LPC, LMFT** Newport News, VA 2nd Term Ends 6/30/2024 LPC Member
Benjamin Allison, Citizen Member Forest, VA 1st Term Ends 6/30/2026	**Tiffinee Yancey, Ph.D., LPC** Suffolk, VA 2nd Term Ends 6/30/2025 LPC Member
Maria Anastasiou, LMFT Woodbridge, VA 1st Term Ends 6/30/2025 LMFT Member	**Matthew Scott, LMFT** Lynchburg, VA 1st Term Ends 6/30/2026 LMFT Member
Maria Stransky, LPC, CSAC, CSOTP **Vice-Chairperson** Richmond, VA 2nd Term Ends 6/30/2025 LPC Member	**Terry R. Tinsley, PhD, LPC, LMFT, CSOTP** **Chairperson** Gainesville, VA 1st Term Ends 6/30/2026 LMFT Member

Virginia Department of Health Professions

Financials

FY 2024 Budget / Actual through June Final 2024

Virginia Department of Health Professions

Cash Balance

Period Ending:	**6/30/2024**
% of the Year Completed:	**100%**
Department Name:	**Board of Counseling**

Cash Balance as of June 30, 2023	3,618,387
YTD FY 2024 Revenue	2,541,665
Less: YTD FY 2024 Direct & Allocated Expenditures	2,160,025
Cash Balance as of June 30, 2024	**$4,000,027**

Virginia Department of Health Professions

Board of Counseling Applications by Fiscal Year

	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
CSAC												
Initial	71	93	89	98	143	220	191	129	114	111	125	155
Add/change	26	20	10	19	1							
Total	**97**	**113**	**99**	**117**	**144**	**220**	**191**	**129**	**114**	**111**	**125**	**155**
CSAC Supervisee												
Initial	75	119	110	136	184	192	172	209	224	239	322	468
Add/change	6	3	8	30	27	45	36	54	78	68	94	123
Total	**81**	**122**	**118**	**166**	**211**	**237**	**208**	**263**	**302**	**307**	**416**	**591**
LMFT	**41**	**33**	**44**	**51**	**63**	**62**	**68**	**65**	**108**	**136**	**103**	**131**
LPC	**348**	**410**	**490**	**486**	**567**	**708**	**753**	**734**	**1002**	**1200**	**1094**	**1254**
Pre Rev LPC								**21**	**74**	**65**	**84**	**92**
Pre Rev MFT								**1**	**3**	**5**	**1**	**5**
Pre Rev SATP								**1**			**2**	**3**
QMHP-A						**3489**	**5709**	**1315**	**1179**	**1073**	**1046**	**995**
QMHP-C						**2980**	**5457**	**1034**	**847**	**731**	**718**	**667**
RPRS						**145**	**186**	**100**	**115**	**192**	**256**	**283**
CRP	**11**	**6**	**1**	**7**	**5**	**4**	**2**	**4**	**5**	**7**	**1**	**5**
ROS												
Initial	455	534	649	689	713	715	818	798	884	**1060**	**1031**	1127
Add/change	424	581	711	808	902	960	981	517				
Total	**879**	**1115**	**1360**	**1497**	**1615**	**1675**	**1799**	**1315**	**884**	**1060**	**1031**	1127
RMF												
Initial	38	40	33	35	54	55	54	50	45	54	56	65
Add/change	22	51	46	57	37	35	47	23				
Total	**60**	**91**	**79**	**92**	**91**	**90**	**101**	**73**	**45**	**54**	**56**	**65**
RSAT												
Initial	1		1	4	3	2	4	11	12	13	11	19
Add/change				2			**2**	**1**				
Total	**1**	**0**	**1**	**6**	**3**	**2**	**6**	**12**	**12**	**13**	**11**	19
CSAC-A	**36**	**41**	**44**	**37**	**64**	**59**	**55**	**60**	**42**	**49**	**57**	**78**
LSATP	**9**	**9**	**6**	**9**	**23**	**41**	**61**	**77**	**72**	**76**	**84**	**78**
QMHP-Trainee						**348**	**2297**	**1827**	**2053**	**2455**	**2231**	**2375**
Total	**1562**	**1940**	**2241**	**2462**	**2783**	**10058**	**16887**	**7019**	**6845**	**7521**	**7309**	**7923**

License Issued* (unofficial numbers)

	Endorsement	Examination	Reinstatement
CSAC	11	78	5
LMFT	78	17	5
LPC	416	682	23
LSATP	66	2	0

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

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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%

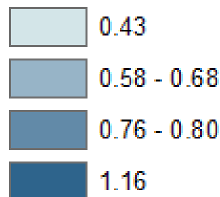
Time Allocation	
Patient Care:	70%-79%
Administration:	10%-19%
Patient Care Role:	64%

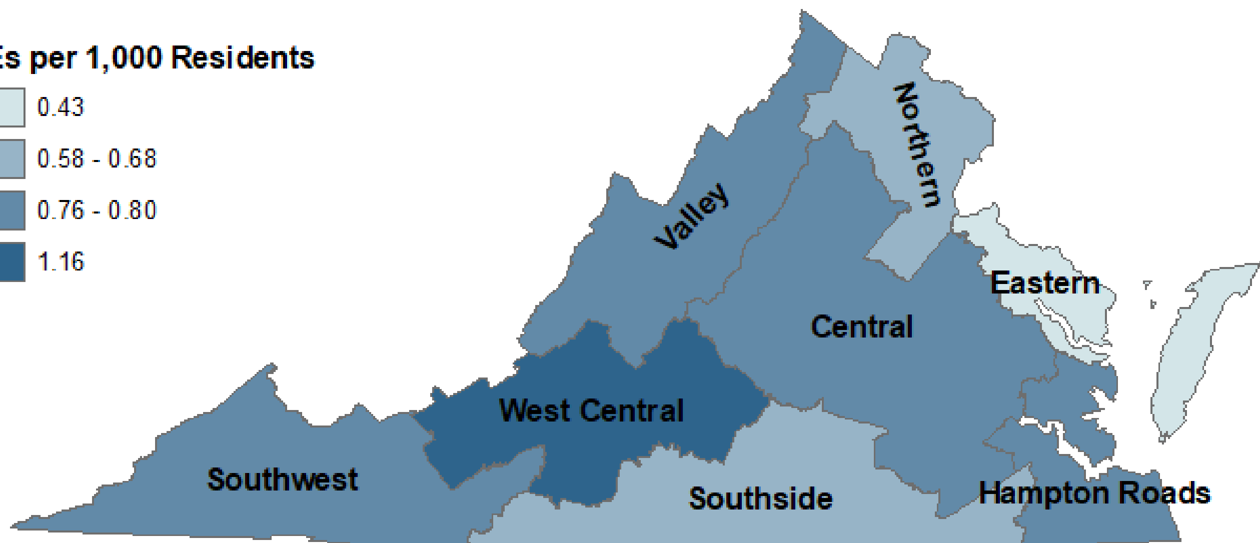
Source: Va. Healthcare Workforce Data Center

Full-Time Equivalency Units Provided by Licensed Professional Counselors per 1,000 Residents by Virginia Performs Region

Source: Va Healthcare Workforce Data Center

FTEs per 1,000 Residents





Annual Estimates of the Resident Population: July 1, 2022
Source: U.S. Census Bureau, Population Division

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.

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

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	
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

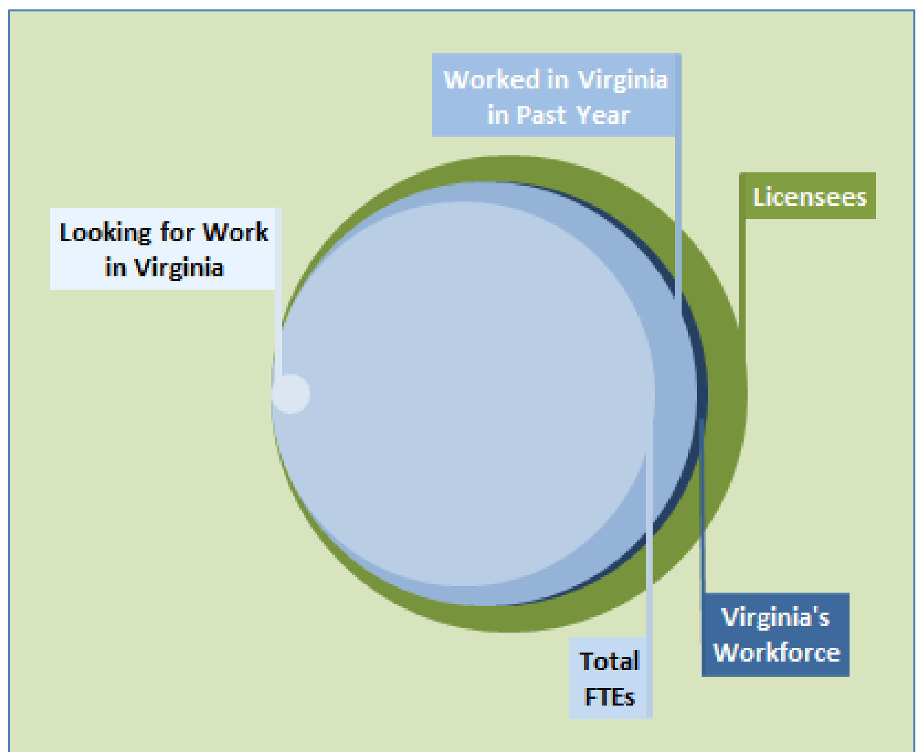
Source: Va. Healthcare Workforce Data Center

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%

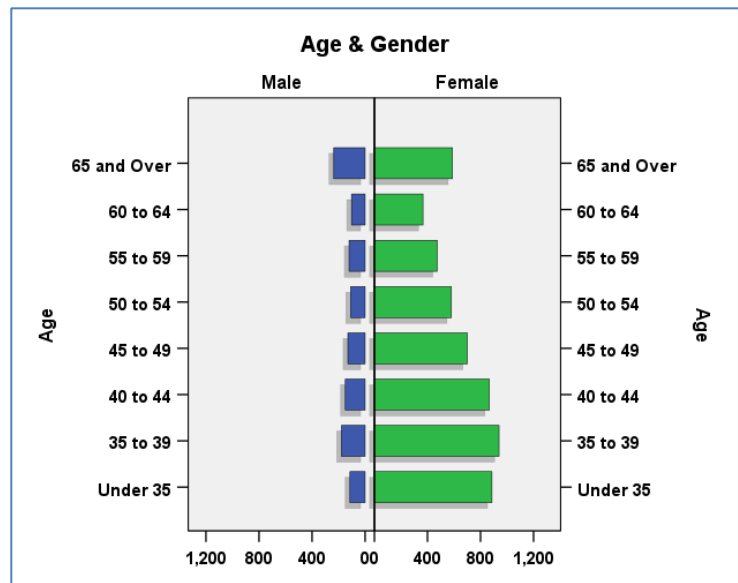
Age
Median Age: 46
% Under 40: 32%
% 55 and Over: 29%

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

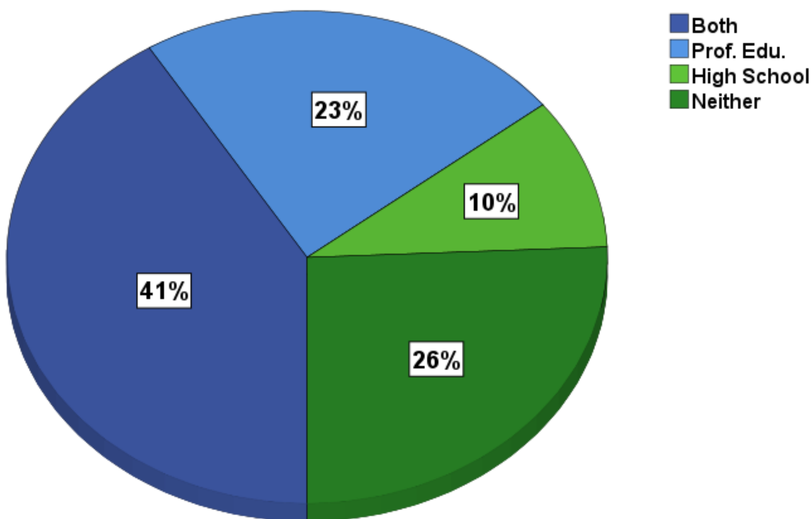
% Rural to Non-Metro: 22%
% Urban/Suburban to Non-Metro: 4%

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.

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 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.

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%

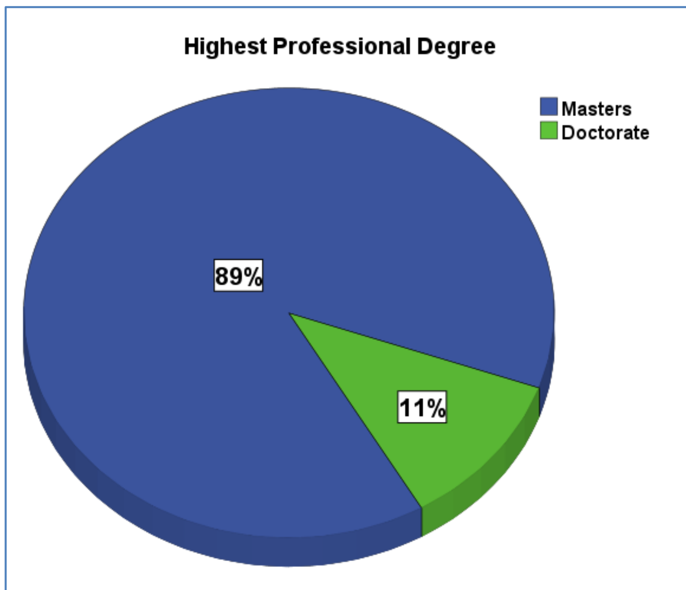
Source: Va. Healthcare Workforce Data Center

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]

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

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

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

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

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

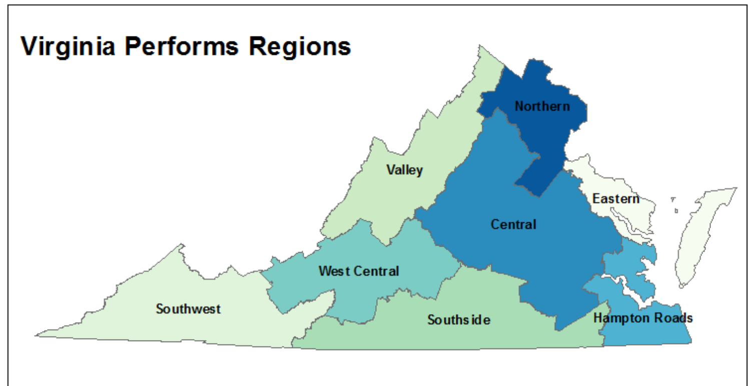
Seven out of every ten LPCs in the state work in Northern Virginia, Central Virginia, and Hampton Roads.

A Closer Look:

Regional Distribution of Work Locations

Virginia Performs Region	Primary Location #	Primary Location %	Secondary 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 in Past Year %	Work Locations Now* #	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)

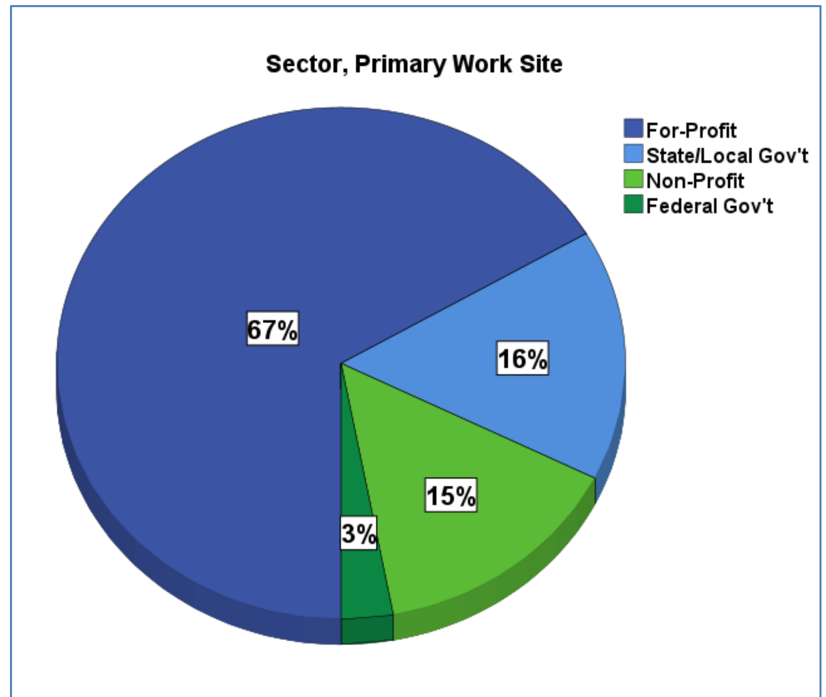
Sector
For-Profit: 67%
Federal: 3%

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)

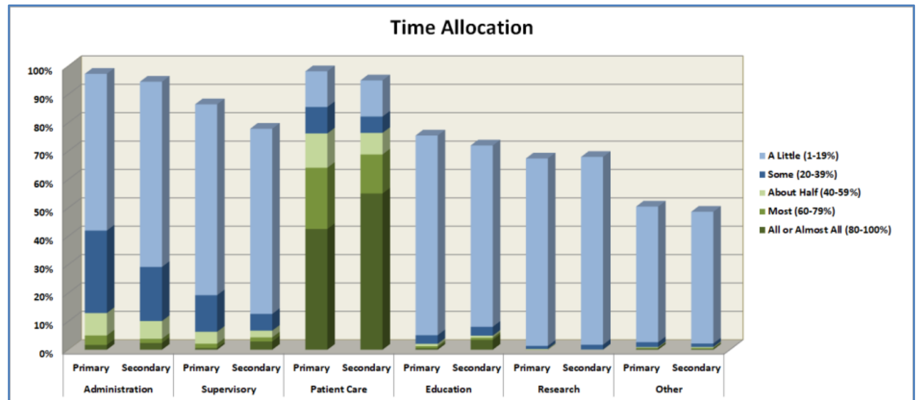
Typical Time Allocation
Patient Care: 70%-79%
Administration: 10%-19%
Supervisory: 1%-9%

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 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%**

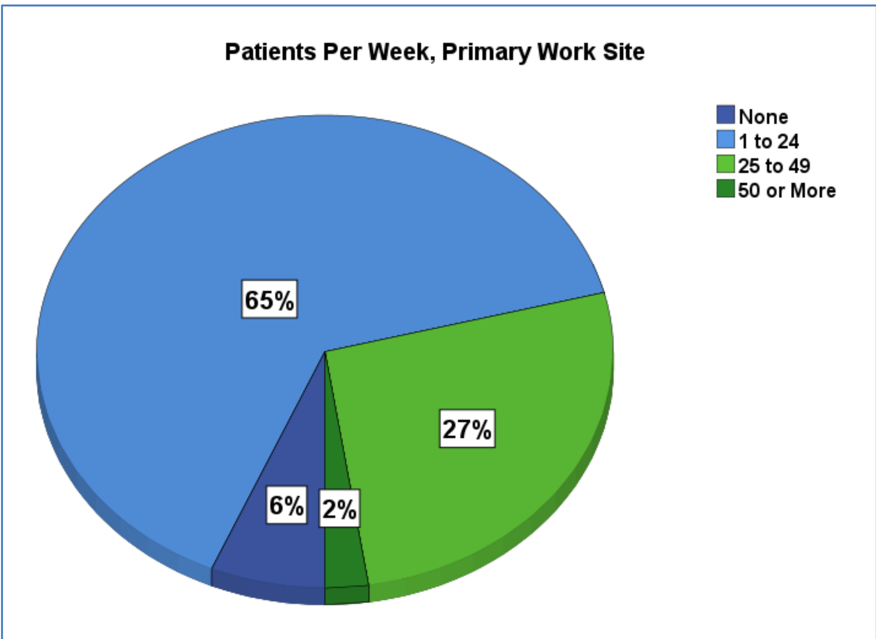
Source: Va. Healthcare Workforce Data Center

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

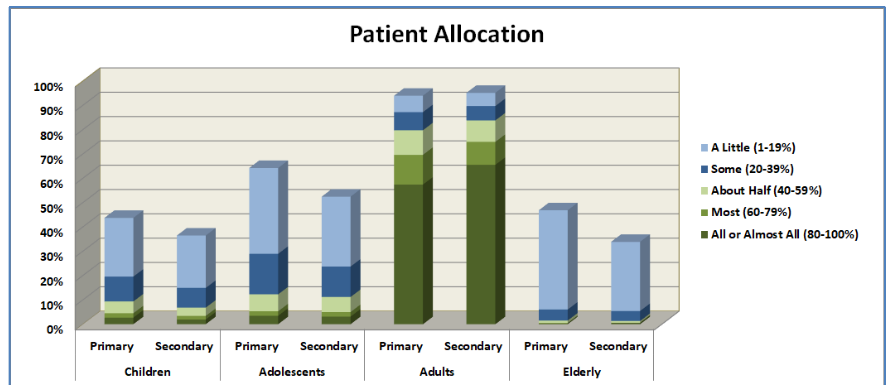
Children:	None
Adolescents:	1%-9%
Adults:	80%-89%
Elderly:	None

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%**

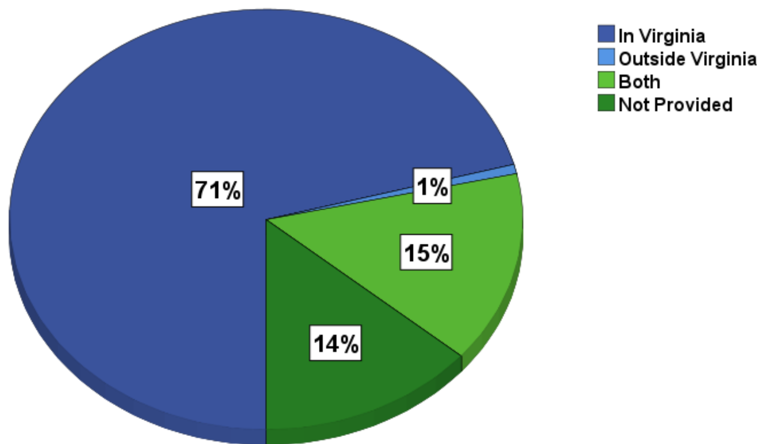
Source: Va. Healthcare Workforce Data Center

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%

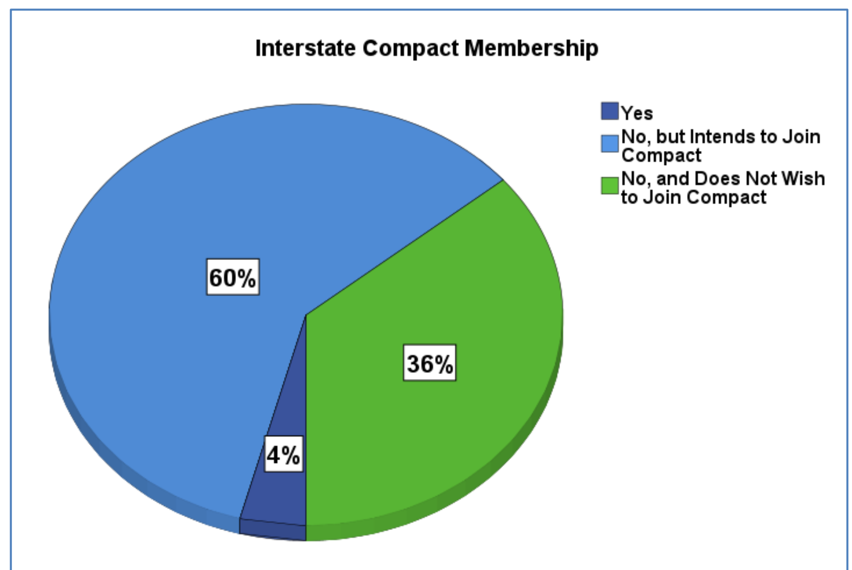
Source: Va. Healthcare Workforce Data Center

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.

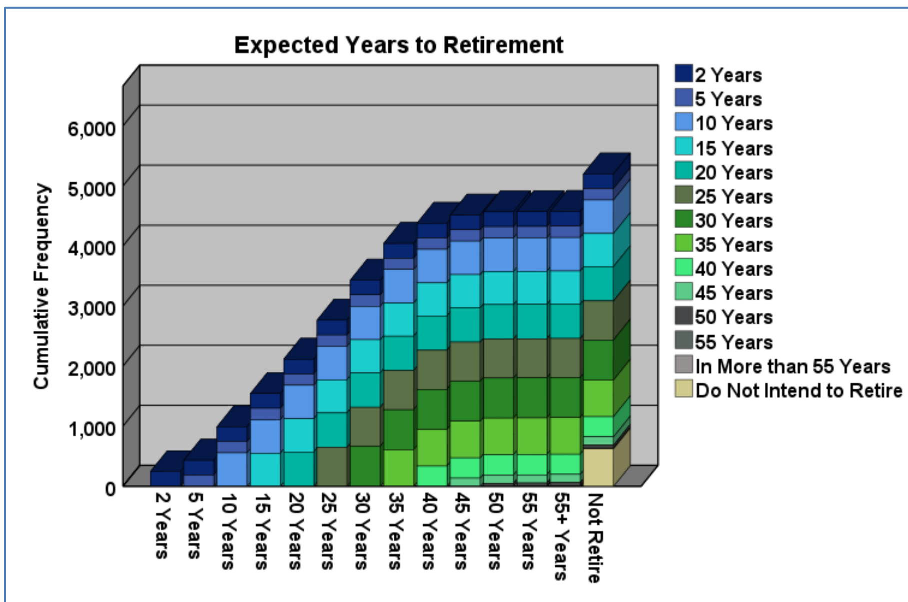
Future Plans		
Two-Year Plans:	#	%
Decrease Participation		
Leave Profession	76	1%
Leave Virginia	211	3%
Decrease Patient Care Hours	699	9%
Decrease Teaching Hours	25	0%
Increase Participation		
Increase Patient Care Hours	1,130	14%
Increase Teaching Hours	581	7%
Pursue Additional Education	917	12%
Return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

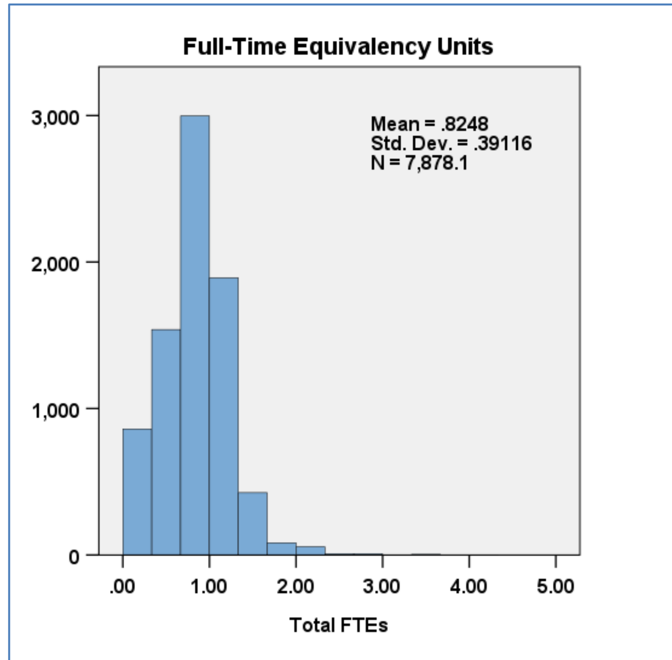
FTEs
Total: 6,498
FTEs/1,000 Residents[2]: 0.748
Average: 0.82

Age & Gender Effect
Age, *Partial Eta²*: Medium
Gender, *Partial Eta²*: Small

Partial Eta² Explained:
Partial Eta² is a statistical measure of effect size.

Source: Va. Healthcare Workforce Data Center

A Closer Look:

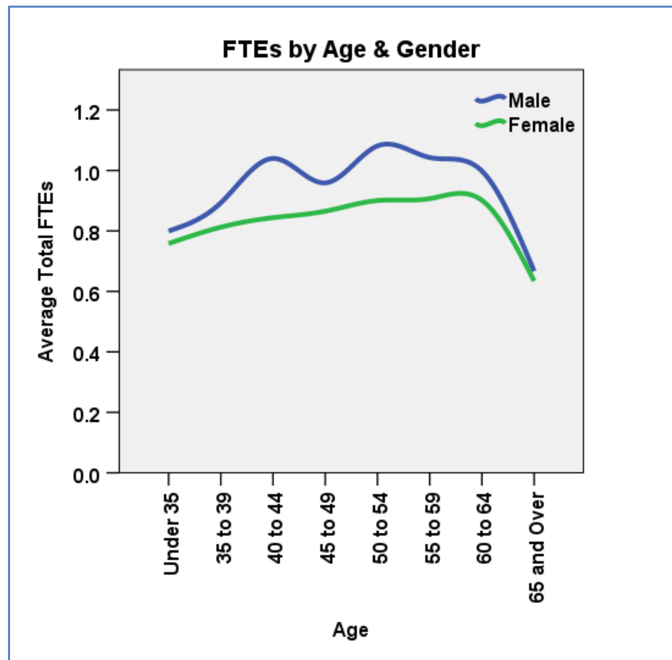


Source: Va. Healthcare Workforce Data Center

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**	**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

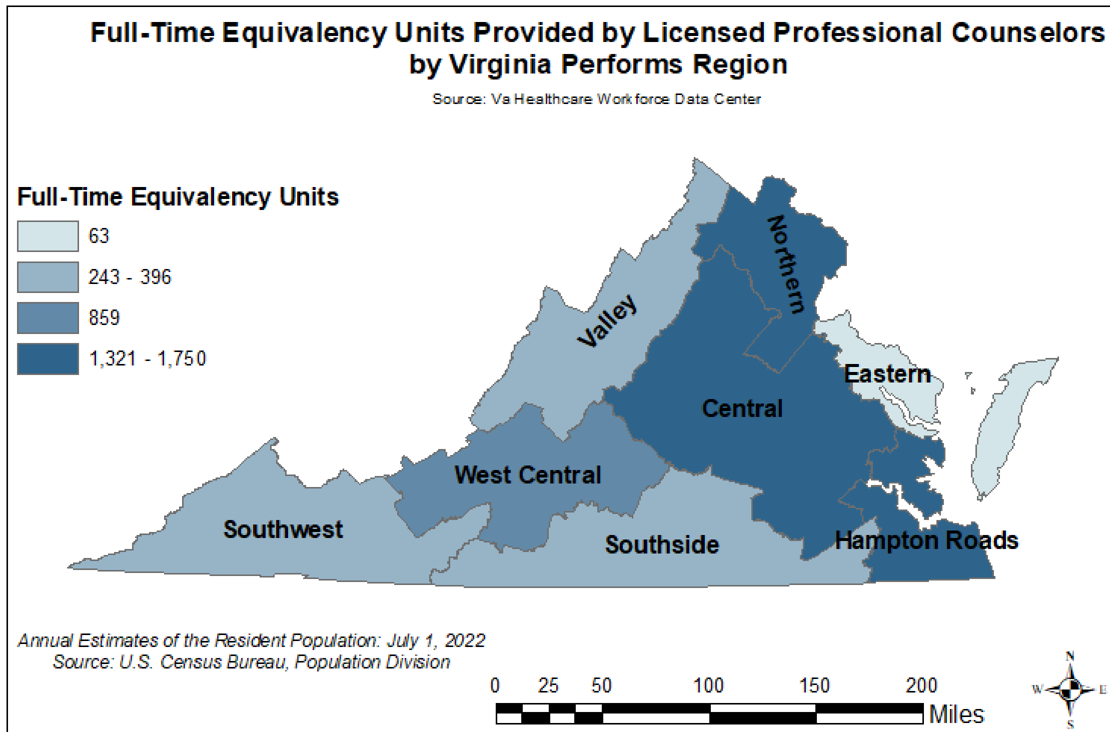


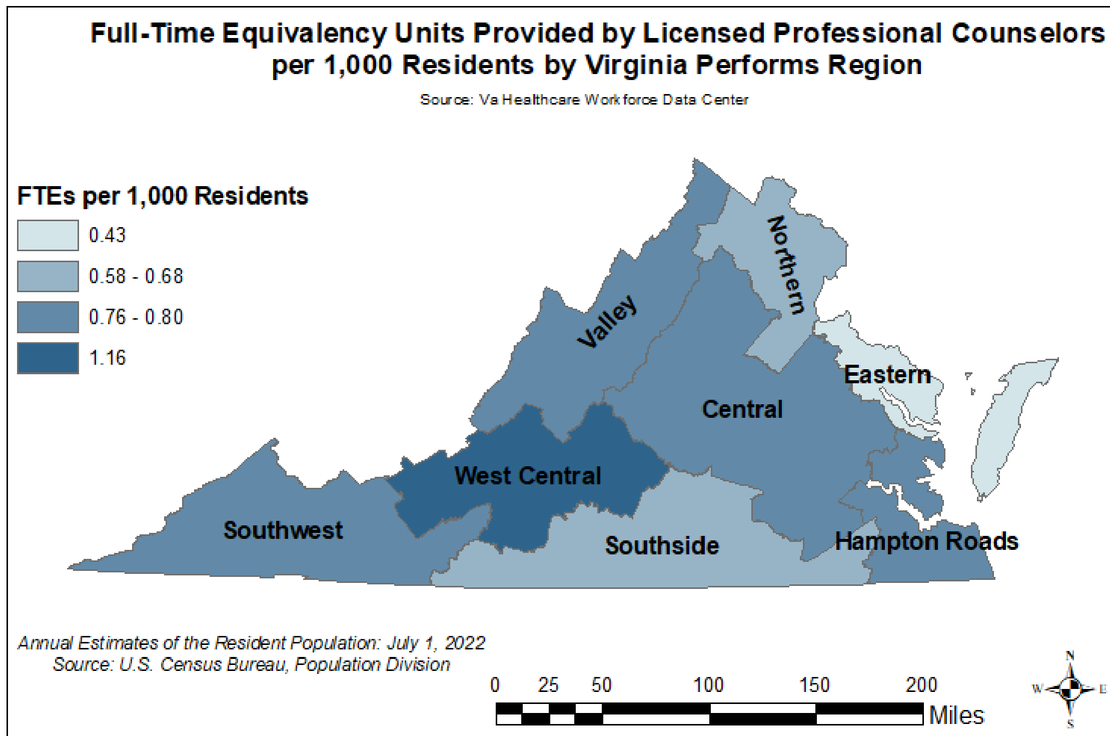
Source: Va. Healthcare Workforce Data Center

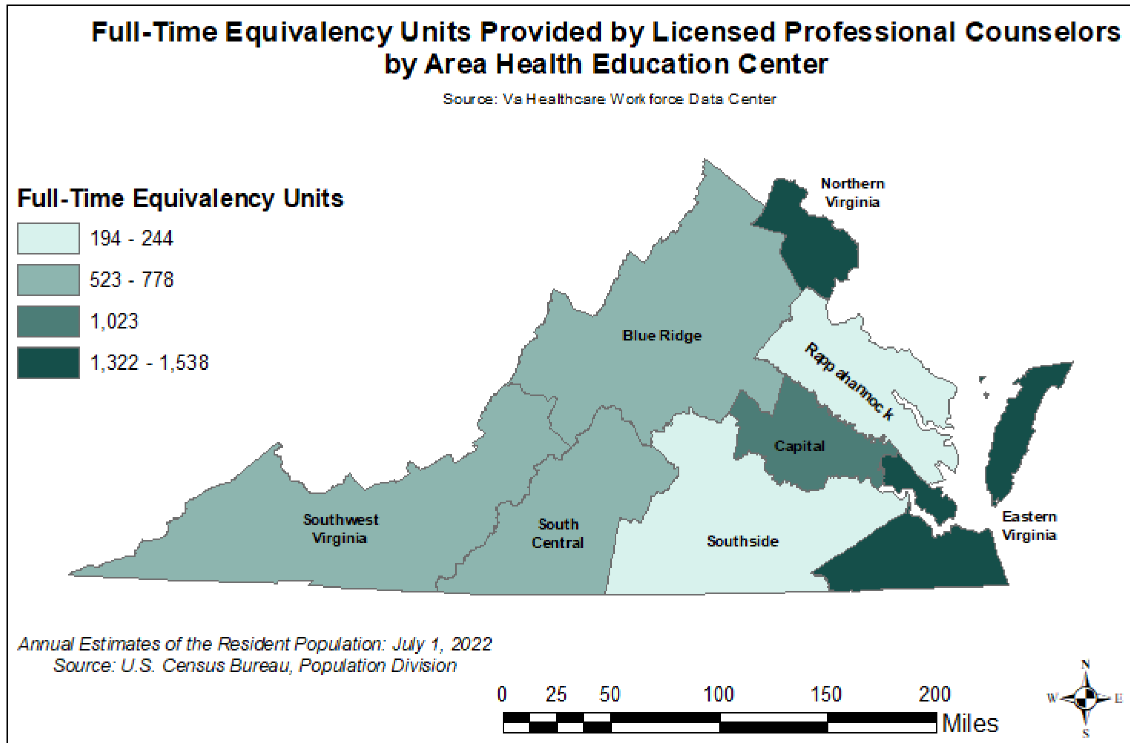
[2] Number of residents in 2022 was used as the denominator.
[3] Due to assumption violations in Mixed between-within ANOVA (Levene's Test and Interaction effect were significant).

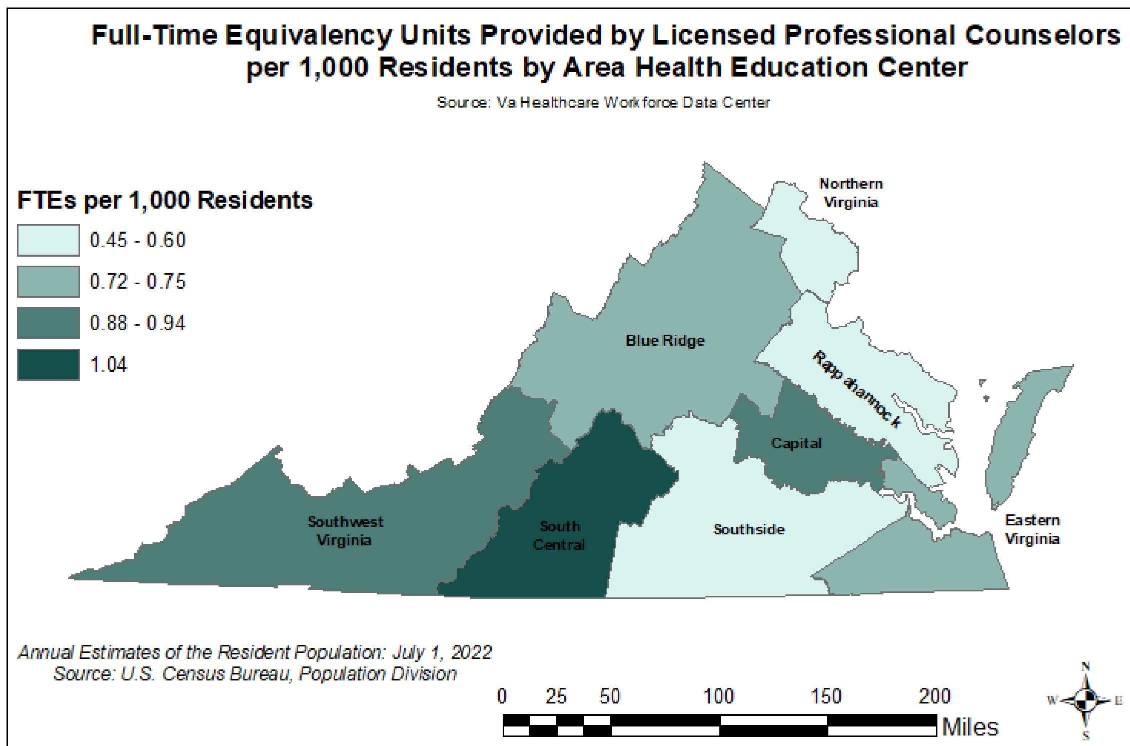
Maps

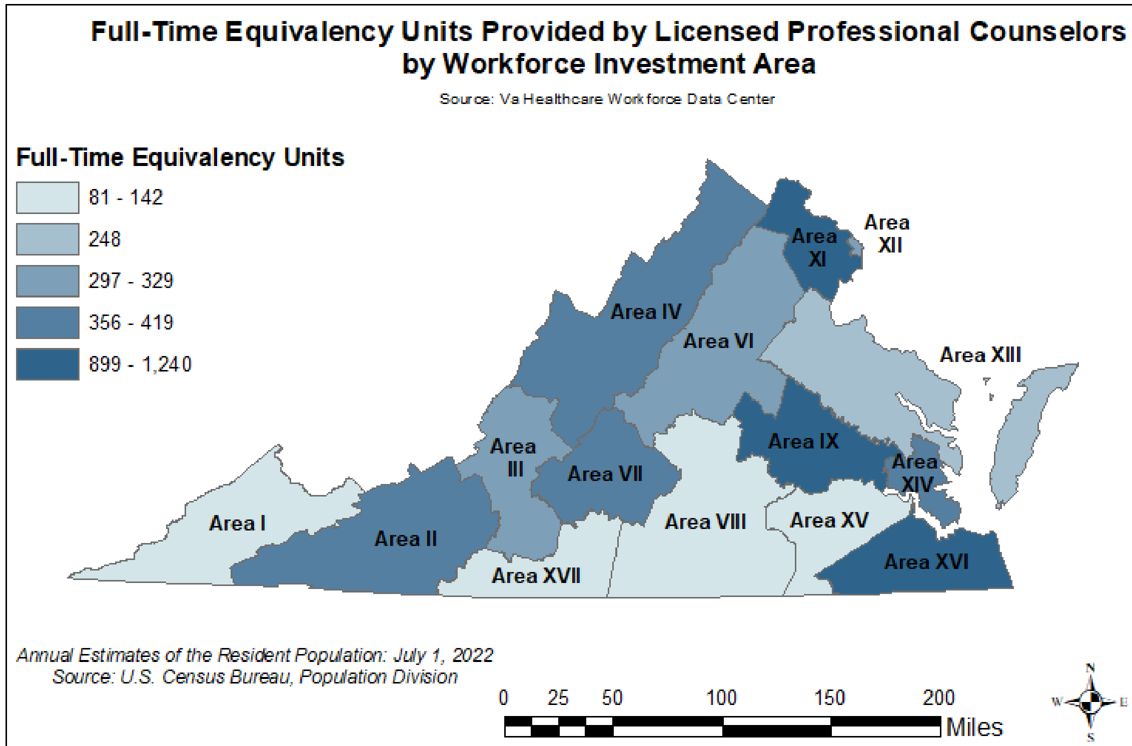
Virginia Performs Regions

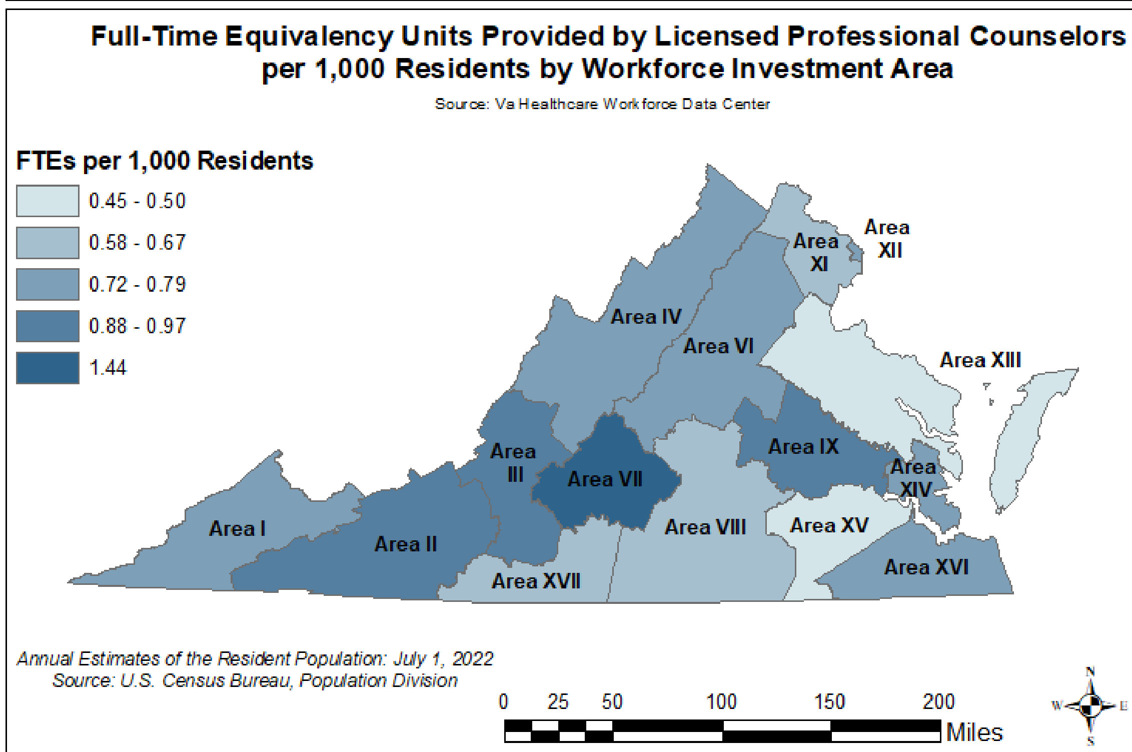


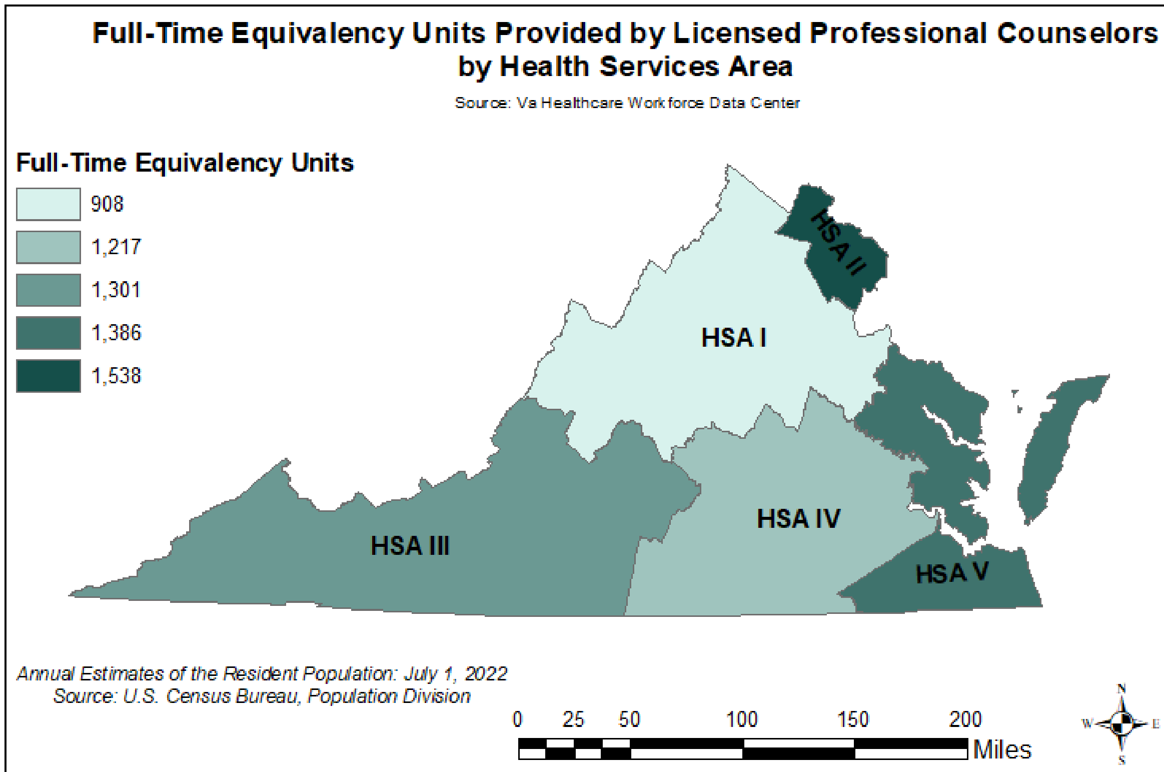


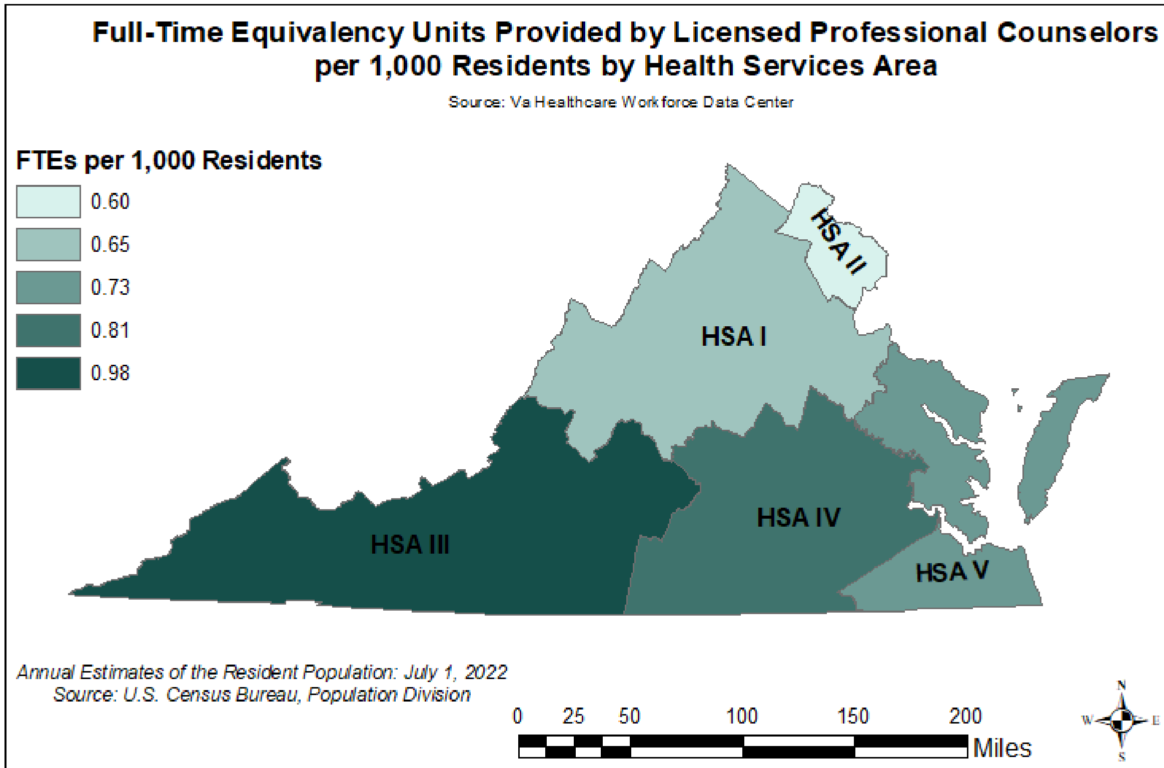

Full-Time Equivalency Units Provided by Licensed Professional Counselors
by Area Health Education Center
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
194 - 244
523 - 778
1,023
1,322 - 1,538
Northern Virginia
Blue Ridge
Rappahannock
Capital
Eastern Virginia
Southwest Virginia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

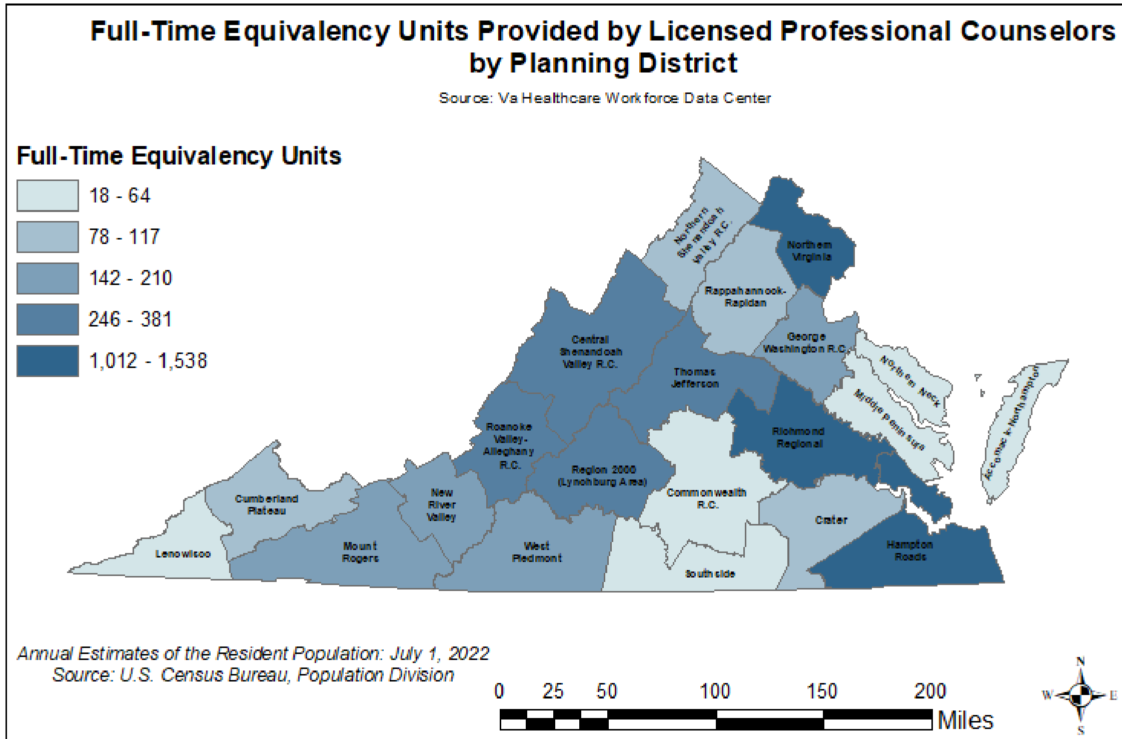

Full-Time Equivalency Units Provided by Licensed Professional Counselors
per 1,000 Residents by Area Health Education Center
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.45 - 0.60
0.72 - 0.75
0.88 - 0.94
1.04
Northern Virginia
Blue Ridge
Rappahannock
Capital
Eastern Virginia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

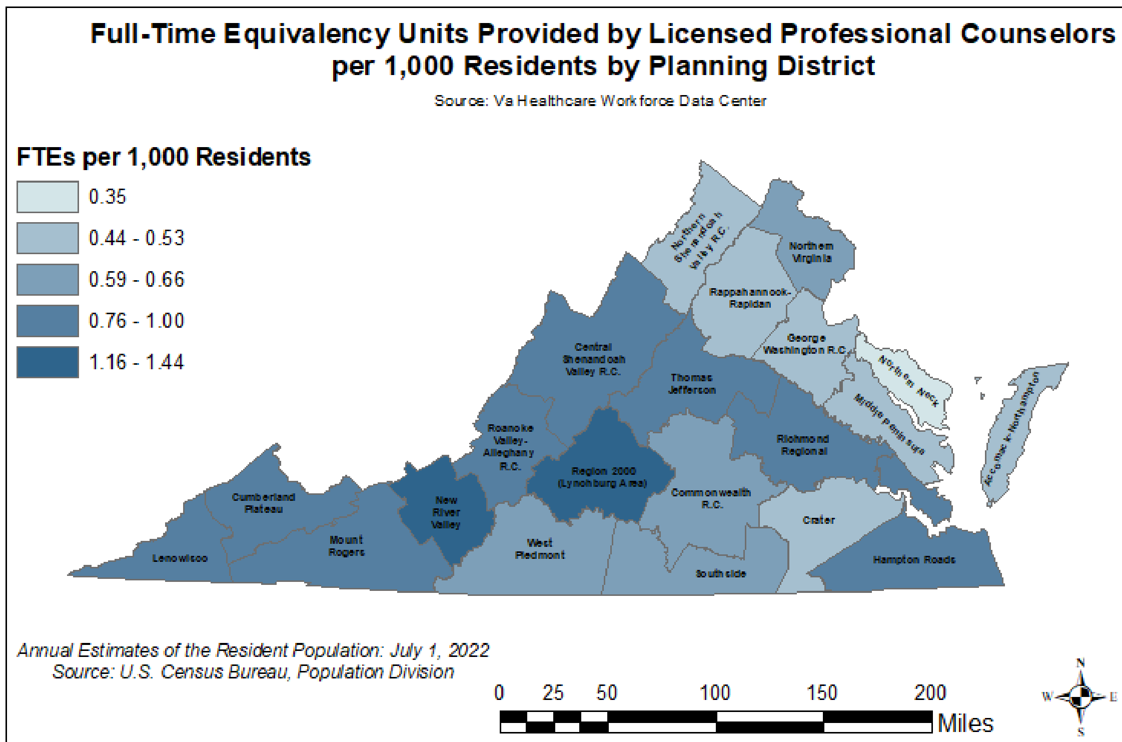

Full-Time Equivalency Units Provided by Licensed Professional Counselors by Workforce Investment Area
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
81 - 142
248
297 - 329
356 - 419
899 - 1,240
Area I
Area II
Area III
Area IV
Area VI
Area VII
Area VIII
Area IX
Area XI
Area XII
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


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


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


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


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
Accomac-Northampton
Roanoke Valley-Alleghany R.C.
Richmond Regional
Region 2000 (Lynchburg Area)
Cumberland Plateau
New River Valley
Commonwealth R.C.
Crater
Lenowisco
Mount Rogers
West Piedmont
Southside
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


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
Accomac-Northampton
Roanoke Valley-Alleghany R.C.
Richmond Regional
Region 2000 (Lynchburg Area)
Cumberland Plateau
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Crater
Lenowisco
Mount Rogers
West Piedmont
Southside
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

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

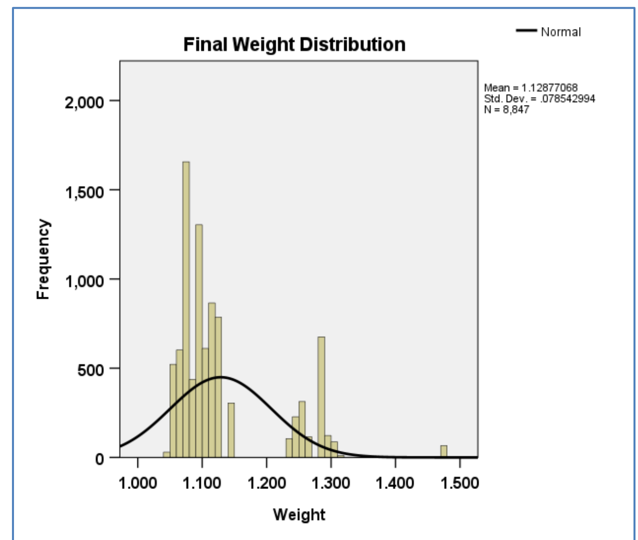
Source: Va. Healthcare Workforce Data Center

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
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 8,500 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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The Qualified Mental Health Professional Workforce At a Glance:

The Workforce	
Registrants:	11,788
Virginia's Workforce:	11,246
FTEs:	9,544

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

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

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

Education	
Baccalaureate:	51%
Masters:	43%

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

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

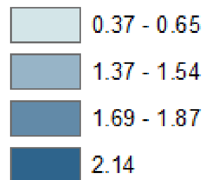
Job Turnover	
Switched Jobs:	7%
Employed Over 2 Yrs.:	63%

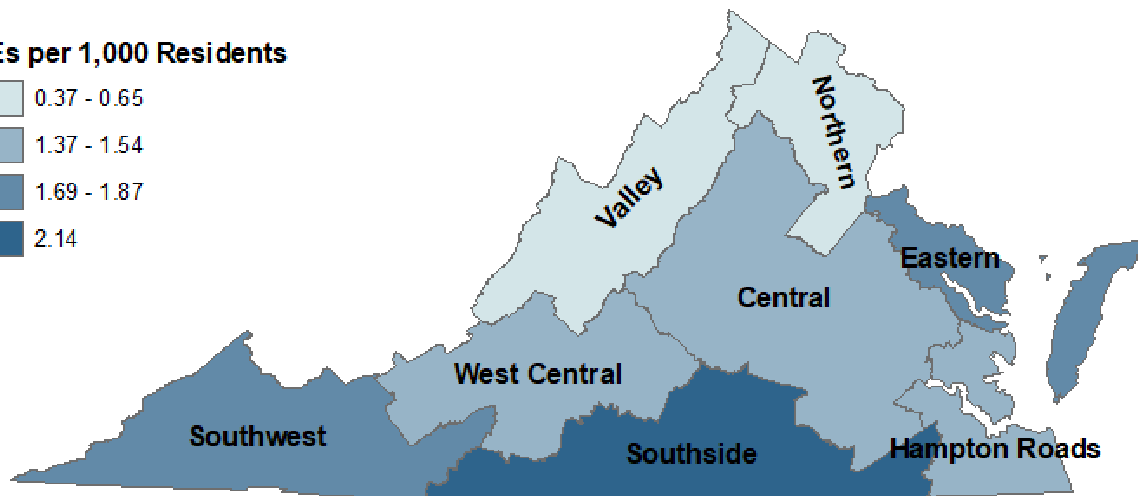
Time Allocation	
Patient Care:	70%-79%
Administration:	10%-19%
Patient Care Role:	61%

Source: Va. Healthcare Workforce Data Center

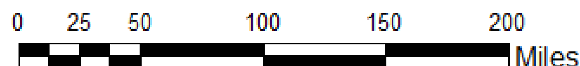
Full-Time Equivalency Units Provided by Qualified Mental Health Professionals per 1,000 Residents by Virginia Performs Region

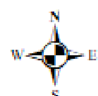
Source: Va Healthcare Workforce Data Center





Annual Estimates of the Resident Population: July 1, 2022
Source: U.S. Census Bureau, Population Division





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

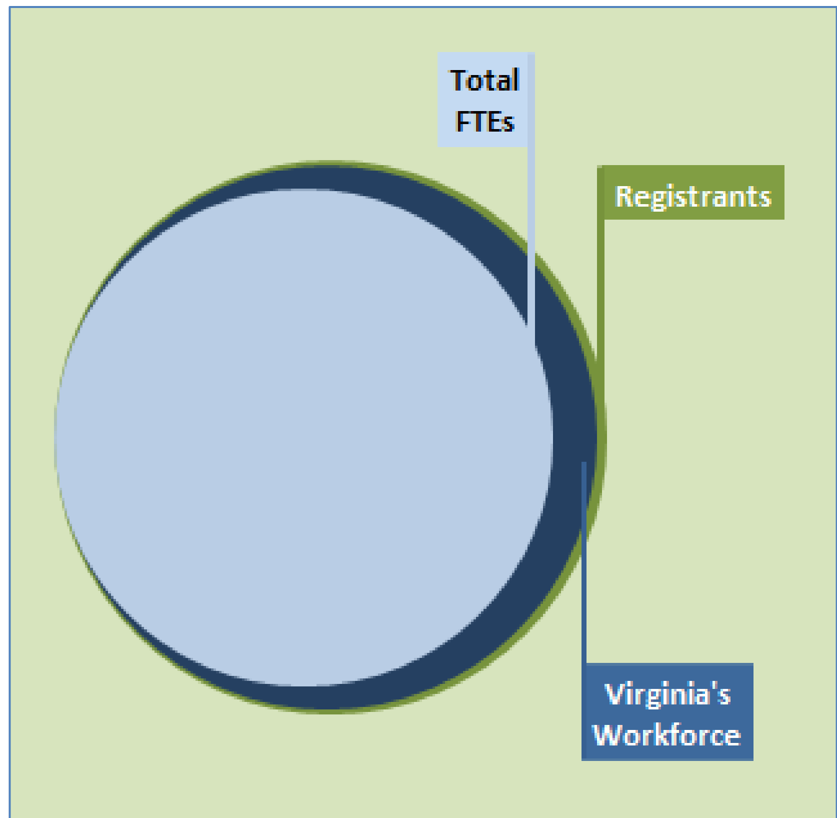
Definitions

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

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%

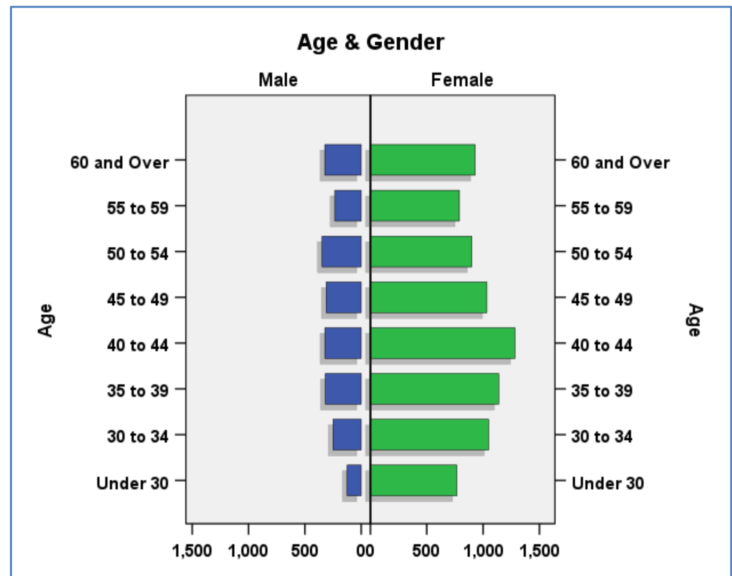
Age
Median Age: 44
% Under 40: 36%
% 55 and Over: 22%

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

At a Glance:

Education
Baccalaureate: 51%
Masters: 43%

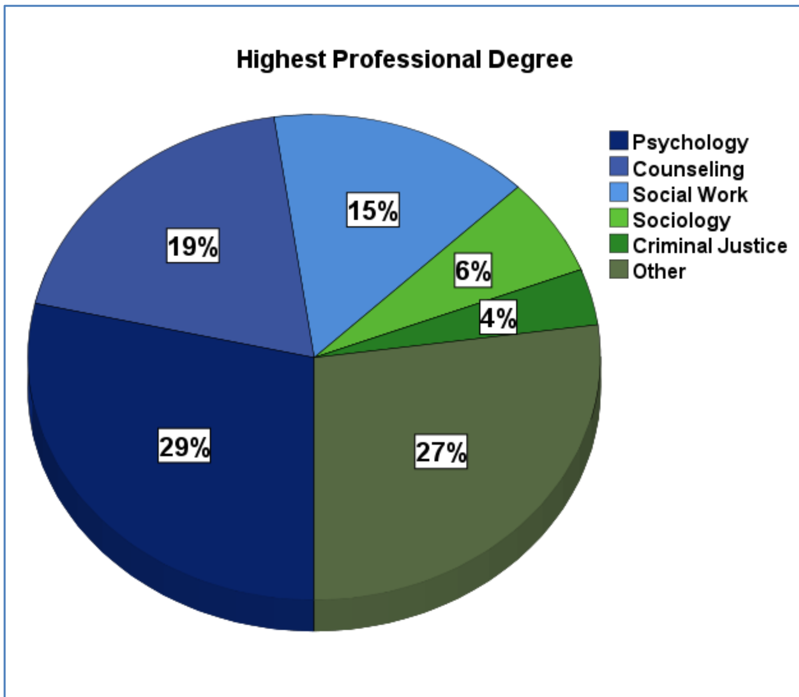
Professional Degree
Psychology: 29%
Counseling: 19%
Social Work: 15%

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.

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:

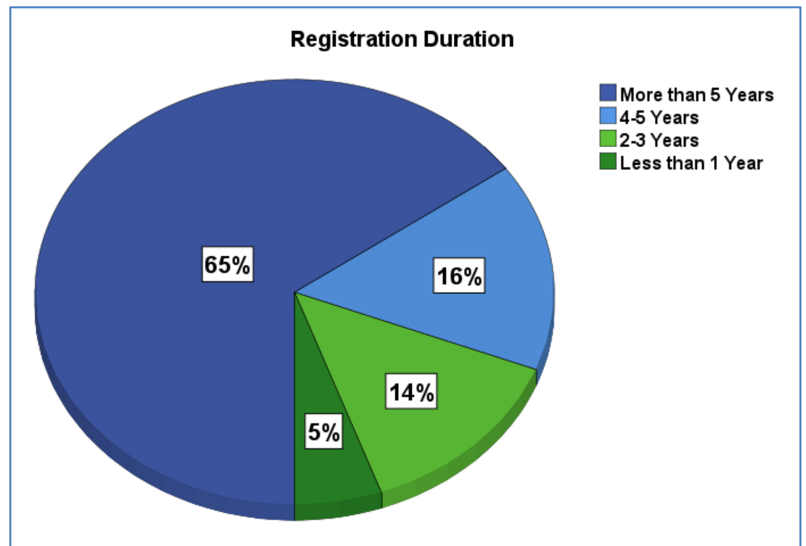
Registration		
Registration	#	%
QMHP-A Only	4,087	41%
QMHP-C Only	1,874	19%
QMHP-A & QMHP-C	4,100	41%
Total	**10,061**	**100%**

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

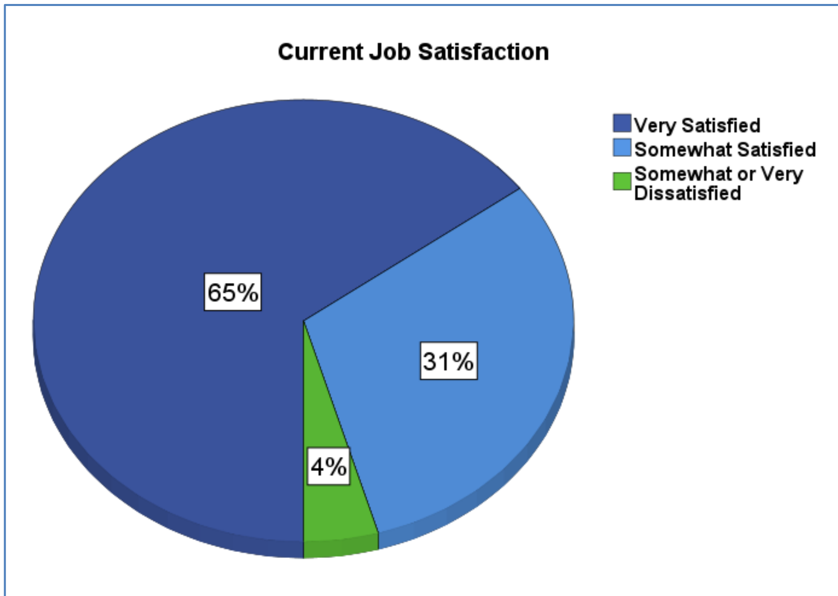
Current Positions		
Positions	**#**	**%**
No Positions	92	1%
One Part-Time Position	1,051	11%
Two Part-Time Positions	352	4%
One Full-Time Position	6,223	64%
One Full-Time Position & One Part-Time Position	1,794	18%
Two Full-Time Positions	136	1%
More than Two Positions	152	2%
Total	**9,800**	**100%**

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]

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

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

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

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

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%

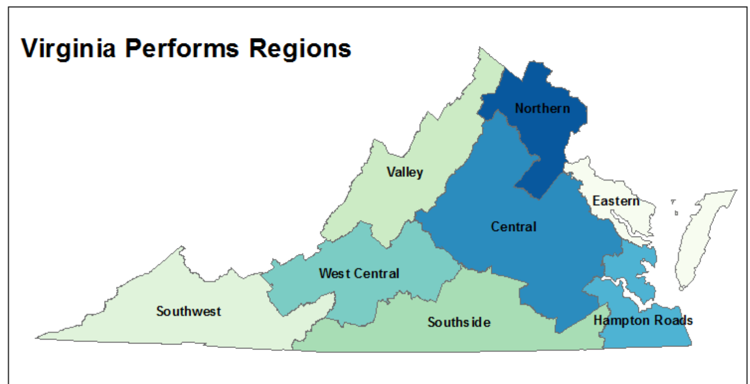
Source: Va. Healthcare Workforce Data Center

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)

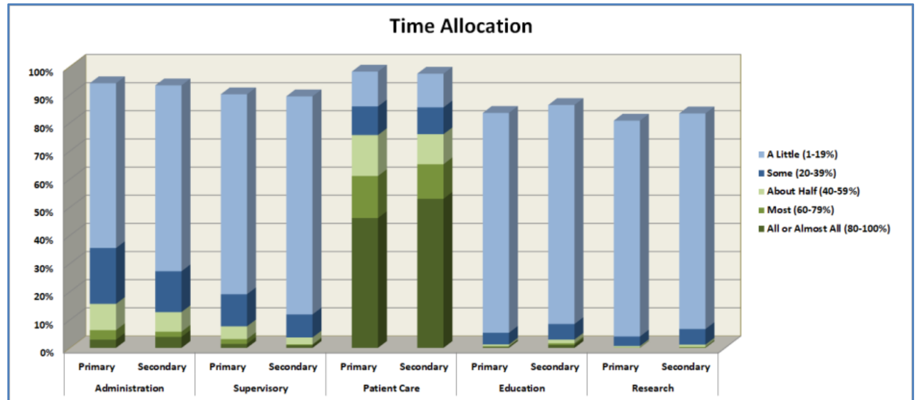
Typical Time Allocation
Patient Care: 70%-79%
Administration: 10%-19%
Supervisory: 1%-9%

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%**

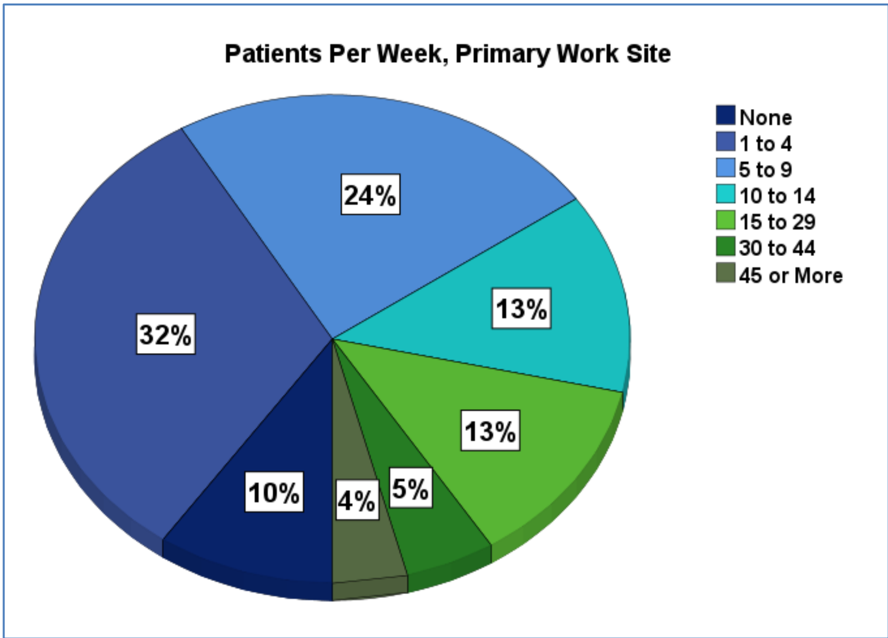
Source: Va. Healthcare Workforce Data Center

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:

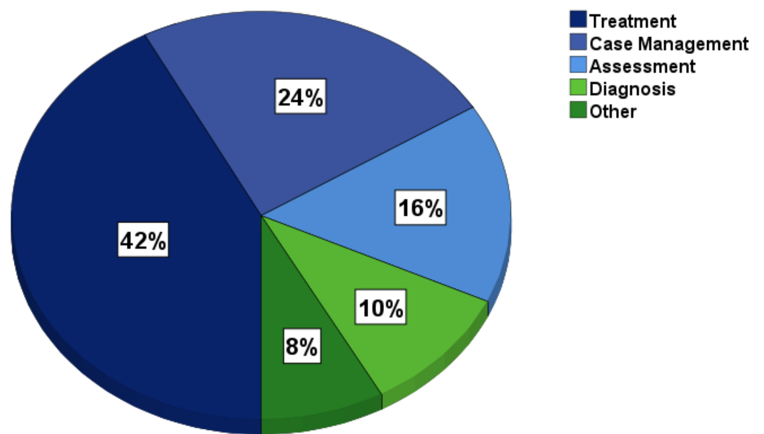
Definition of Clinical Services		
Service	**#**	**%**
Treatment	3,599	42%
Case Management	2,027	24%
Assessment	1,346	16%
Diagnosis	858	10%
Other	682	8%
Total	**8,512**	**100%**

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:

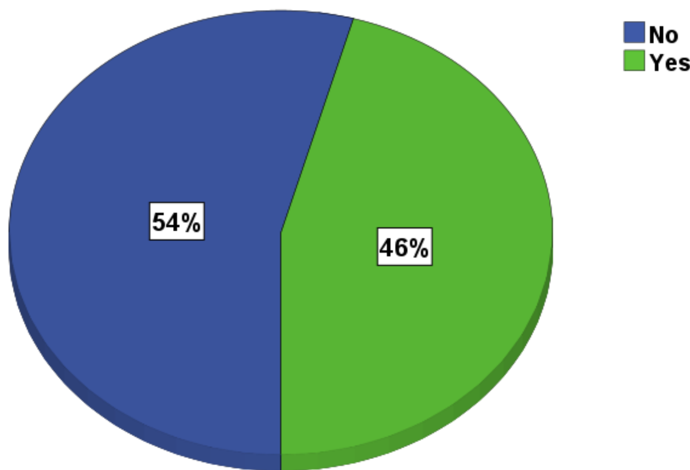
Counseling/Social Work
% Continuing Education: 46%
Median Yrs. to Supervision: 1-3

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

Source: Va. Healthcare Workforce Data Center

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



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:

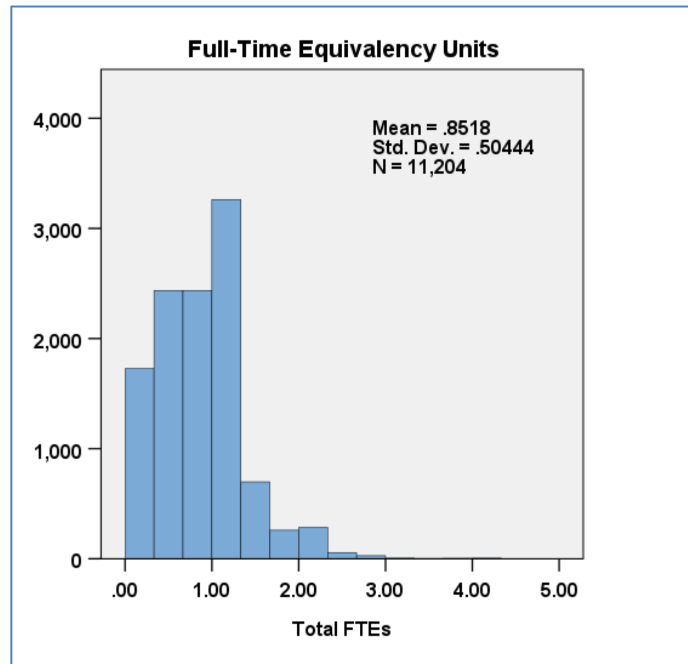
FTEs
Total: 9,544
FTEs/1,000 Residents[2]: 1.099
Average: 0.85

Age & Gender Effect
Age, *Partial Eta²*: Small
Gender, *Partial Eta²*: None

Partial Eta² Explained:
Partial Eta² is a statistical measure of effect size.

Source: Va. Healthcare Workforce Data Center

A Closer Look:

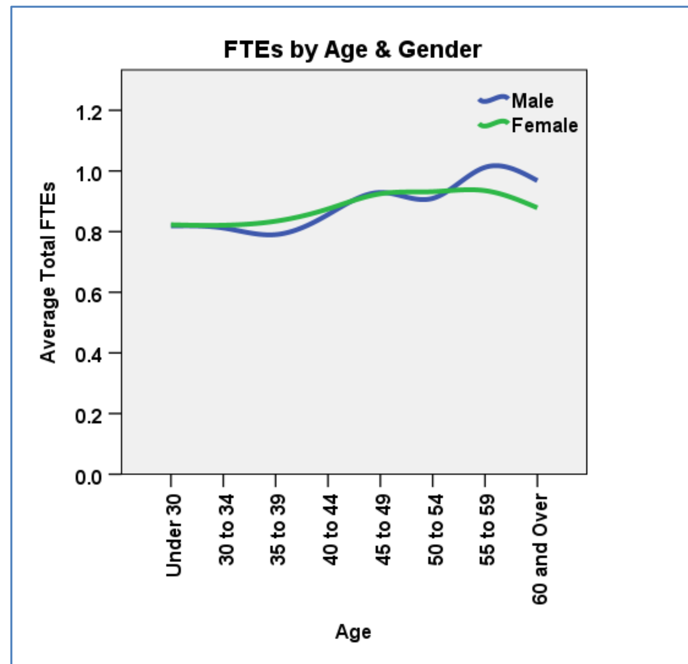


Source: Va. Healthcare Workforce Data Center

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**	**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

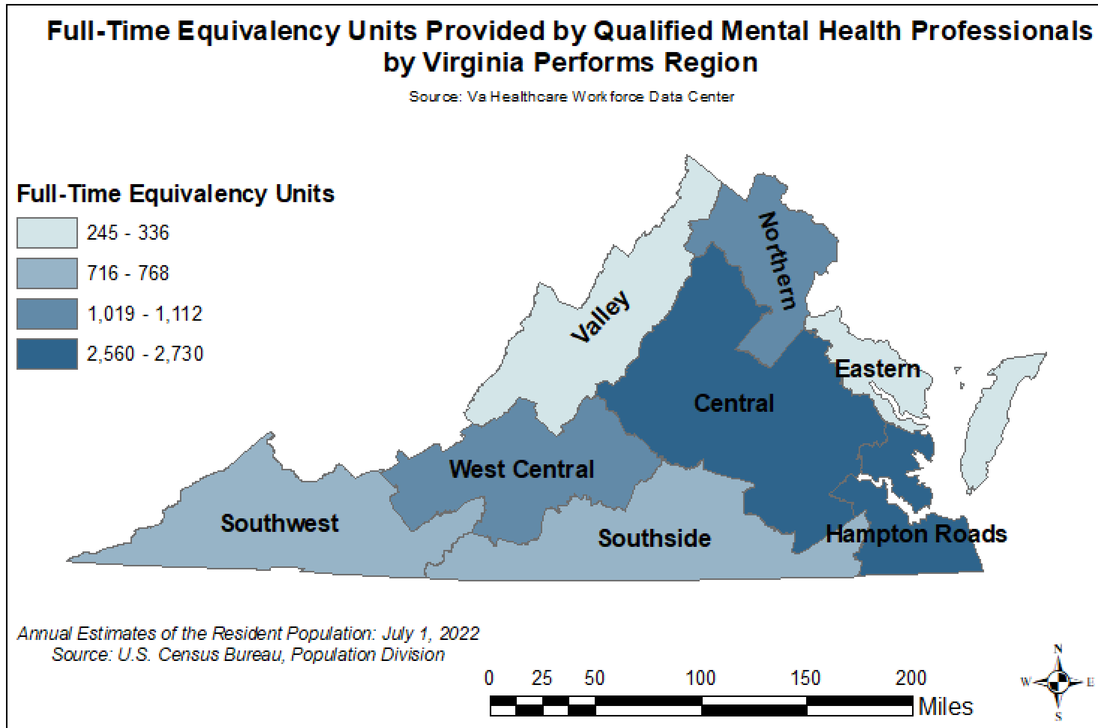


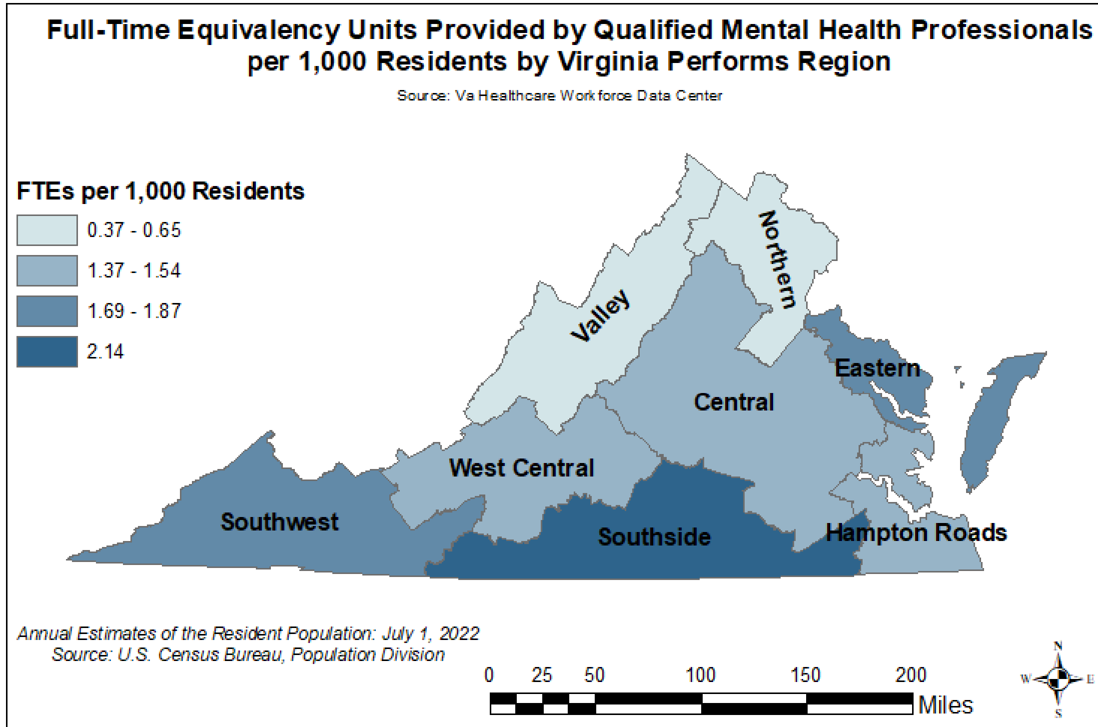
Source: Va. Healthcare Workforce Data Center

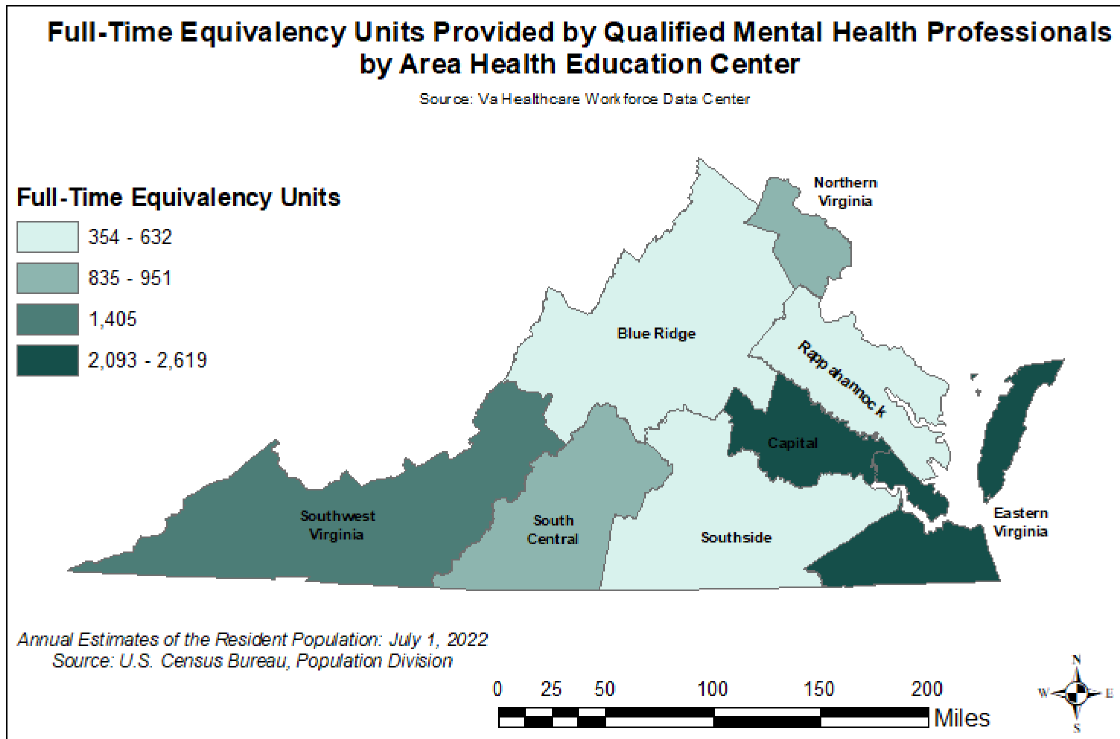
[2] Number of residents in 2022 was used as the denominator.
[3] Due to assumption violations in Mixed between-within ANOVA (Levene's effect was significant).

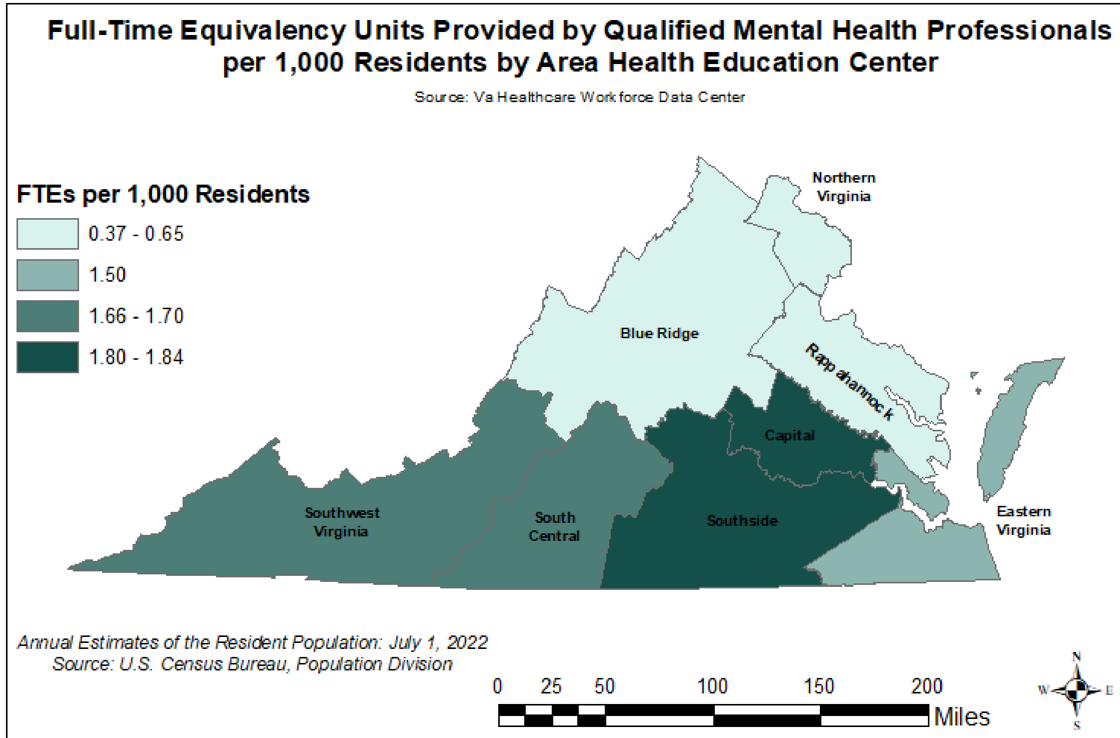
Maps

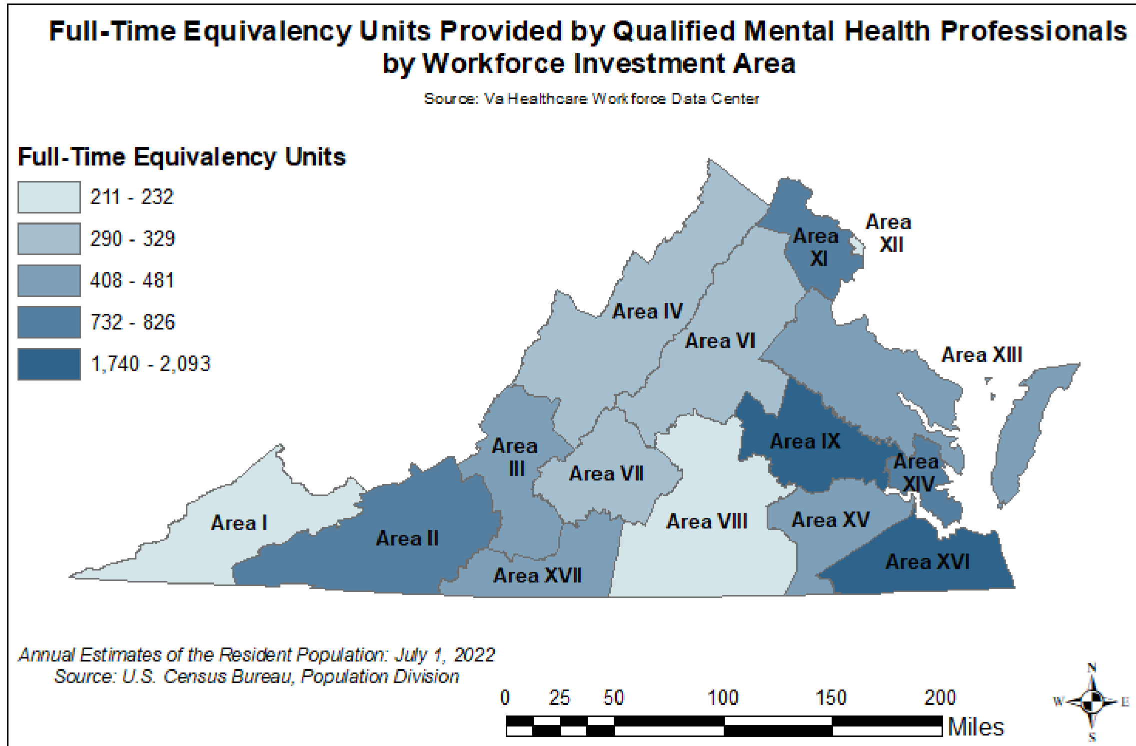
Virginia Performs Regions

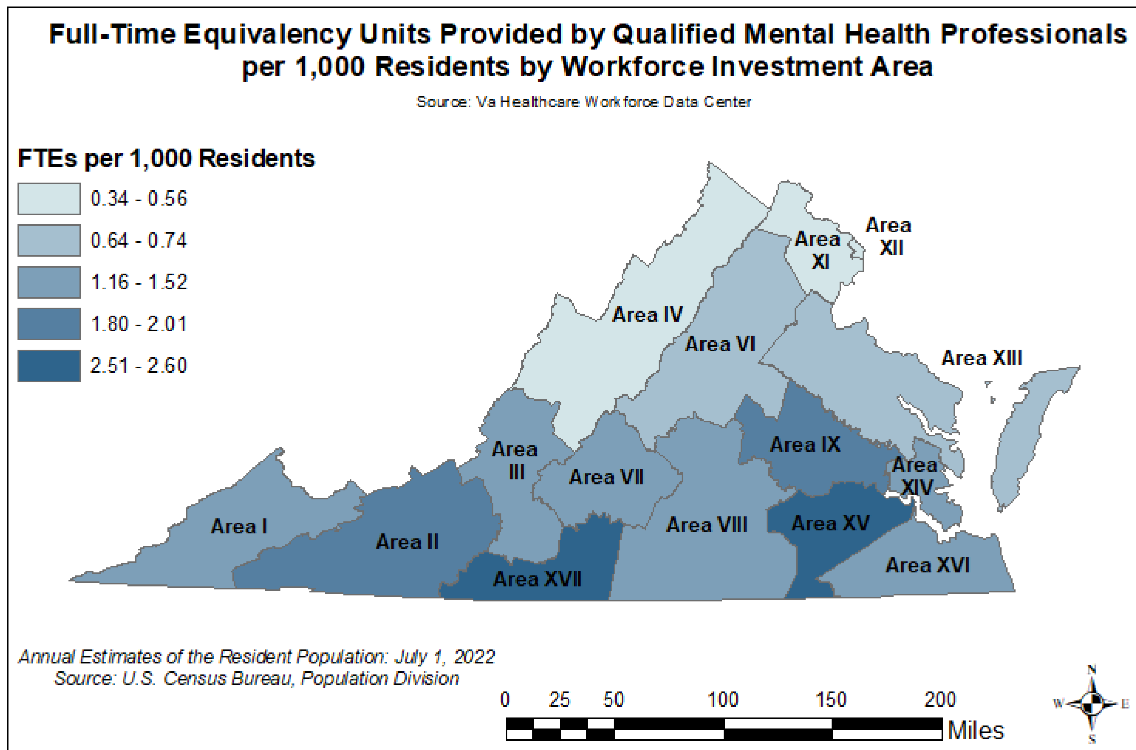


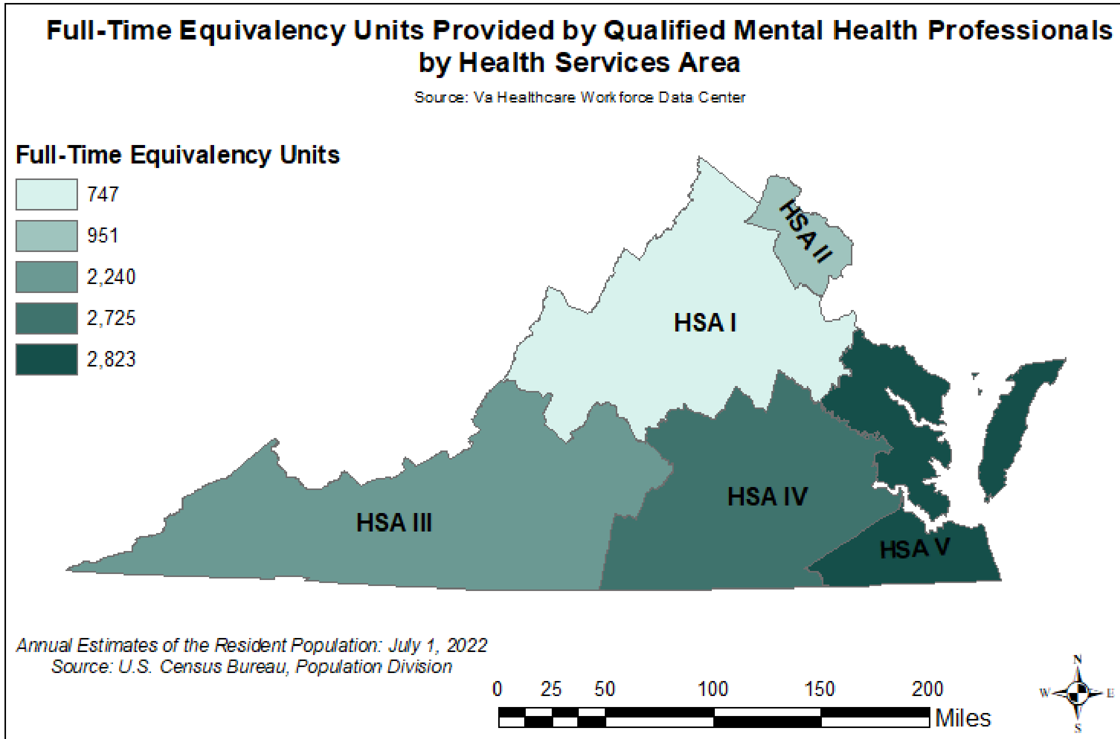


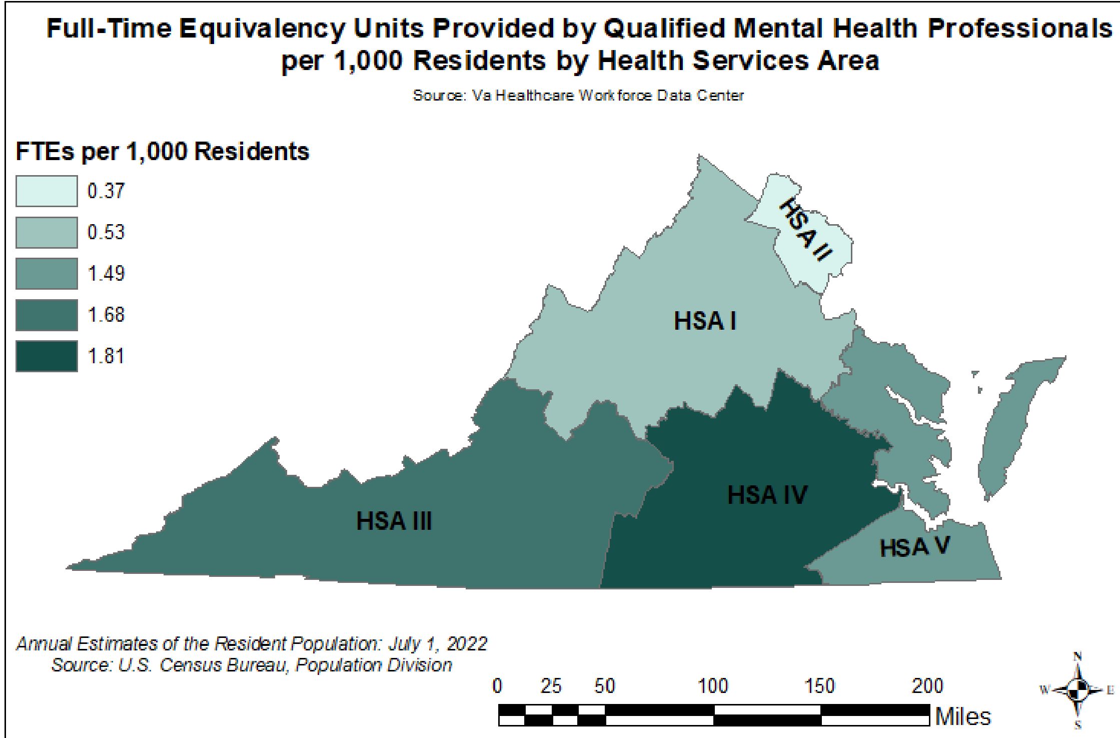

Full-Time Equivalency Units Provided by Qualified Mental Health Professionals
by Area Health Education Center
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
354 - 632
835 - 951
1,405
2,093 - 2,619
Northern Virginia
Blue Ridge
Rappahannock
Capital
Eastern Virginia
Southwest Virginia
South Central
Southside
Annual Estimates of the Resident Population: July 1, 2022
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles

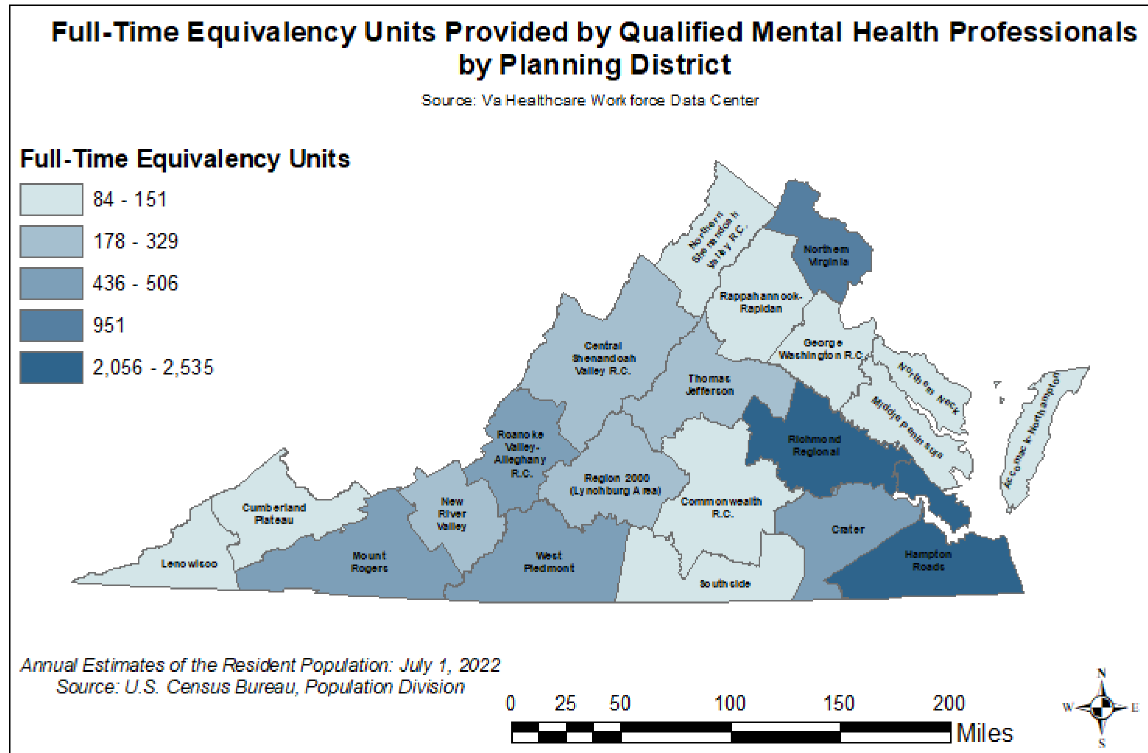

Full-Time Equivalency Units Provided by Qualified Mental Health Professionals
per 1,000 Residents by Area Health Education Center
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.37 - 0.65
1.50
1.66 - 1.70
1.80 - 1.84
Northern Virginia
Blue Ridge
Rappahannock
Capital
Eastern Virginia
Southwest Virginia
South Central
Southside
Annual Estimates of the Resident Population: July 1, 2022
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles

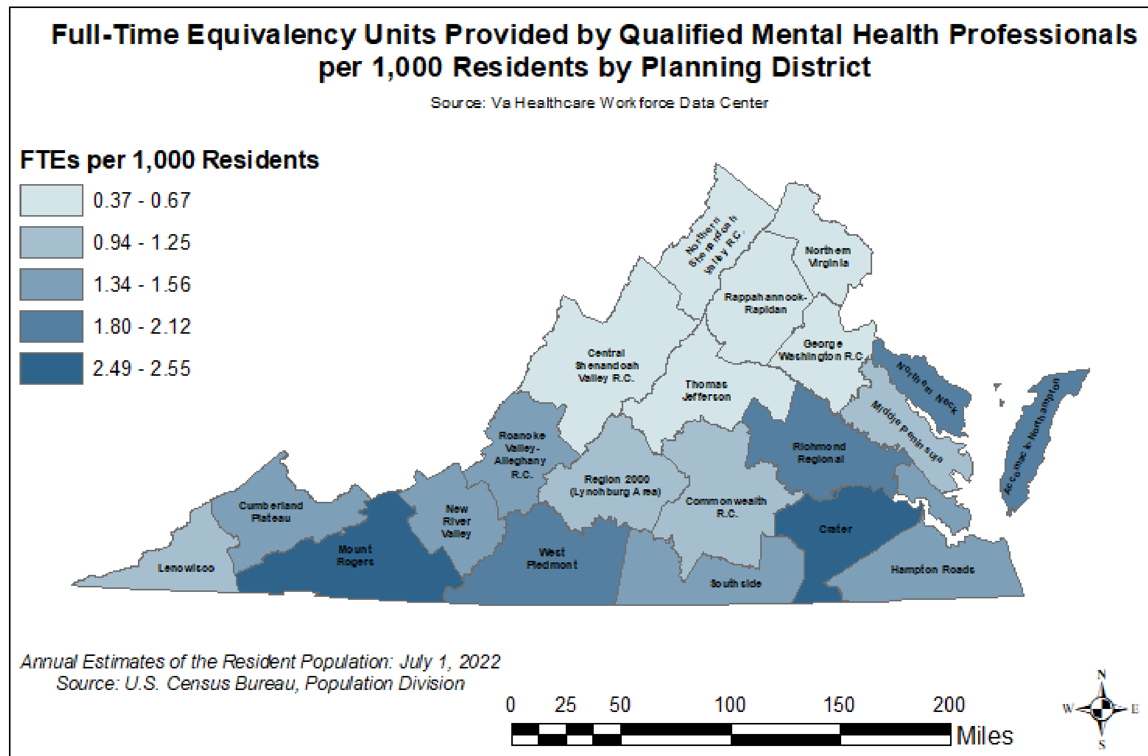

Full-Time Equivalency Units Provided by Qualified Mental Health Professionals by Workforce Investment Area
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
211 - 232
290 - 329
408 - 481
732 - 826
1,740 - 2,093
Area I
Area II
Area III
Area IV
Area VI
Area VII
Area VIII
Area IX
Area 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


Full-Time Equivalency Units Provided by Qualified Mental Health Professionals per 1,000 Residents by Workforce Investment Area
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.34 - 0.56
0.64 - 0.74
1.16 - 1.52
1.80 - 2.01
2.51 - 2.60
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


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


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


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
George Washington R.C.
Northern Neck
Middle Peninsula
Accomac-Northampton
Central Shenandoah Valley R.C.
Thomas Jefferson
Richmond Regional
Roanoke Valley-Alleghany R.C.
Region 2000 (Lynchburg Area)
Commonwealth R.C.
Cumberland Plateau
New River Valley
Crater
Hampton Roads
Lenowisco
Mount Rogers
West Piedmont
Southside
Annual Estimates of the Resident Population: July 1, 2022
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles


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
George Washington R.C.
Northern Neck
Middle Peninsula
Accomac-Northampton
Central Shenandoah Valley R.C.
Thomas Jefferson
Richmond Regional
Roanoke Valley-Alleghany R.C.
Region 2000 (Lynchburg Area)
Commonwealth R.C.
Cumberland Plateau
New River Valley
Crater
Hampton Roads
Lenowisco
Mount Rogers
West Piedmont
Southside
Annual Estimates of the Resident Population: July 1, 2022
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles

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

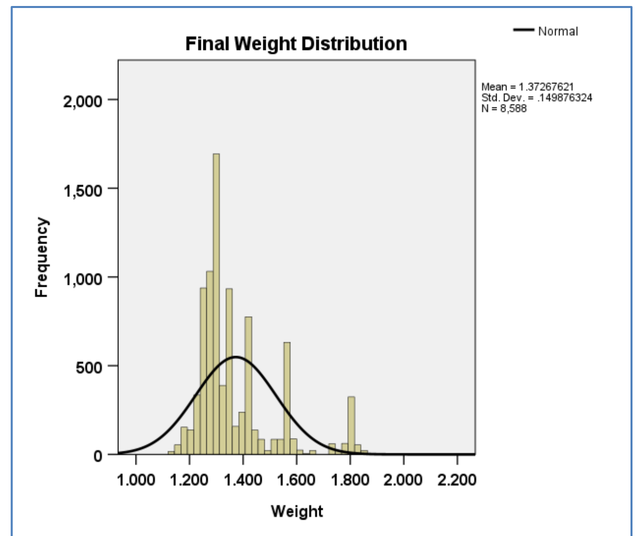
Source: Va. Healthcare Workforce Data Center

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

Agenda Item: Consideration of petition for rulemaking

Included in your agenda package:

- Petition for rulemaking received by the Board;
- Comments received via Town Hall; and
- 18VAC115-20-40 and 18VAC115-60-90, referenced by the petition.

Action needed:

- Motion to either:
  - Accept the petition and initiate rulemaking; or
  - Deny the petition, stating reasons for the denial in the motion.

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,)
Baskerville, Marva Michelle

Street Address
8925 Christanna Highway

Area Code and Telephone Number
434-865-5788

City
Gasburg

State
Virginia

Zip Code:
2 3 8 5 7

Email Address (optional)
mjones321@liberty.edu

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.

The petitioner requests that the Board of Counseling amend 18VAC115-20-70 and 18VAC115-60-90 to establish a pathway for Licensed Substance Abuse Treatment Practitioners (LSATPs) to obtain licensure as Licensed Professional Counselors (LPCs), similar to the existing pathway that allows LPCs to obtain licensure as LSATPs.

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

The petitioner requests that the Board of Counseling amend 18VAC115-20-40 and 18VAC115-60-90(C) to establish a pathway for Licensed Substance Abuse Treatment Practitioners (LSATPs) to obtain licensure as Licensed Professional Counselors (LPCs), similar to the current pathway allowing LPCs to obtain licensure as LSATPs.

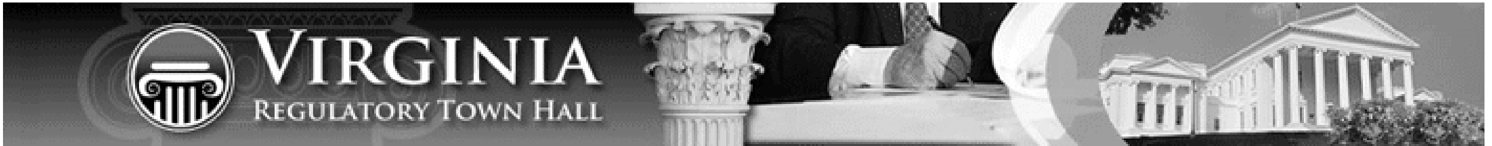
The LPC and LSATP tracks have comparable educational requirements. Section C of 18VAC115-60-90 states: " The examination is waived for an applicant who holds a current and unrestricted license as a professional counselor issued by the board." Both licensure tracks require 600 hours of internship. Currently, LPCs may waive the exam and apply for LSATP licensure. This same opportunity should be extended to LSATPs seeking LPC licensure.

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

The Board of Counseling's legal authority to amend regulations is granted by § 54.1-2400 of the Code of VA. It authorizes the board to regulate licensure and practice for professions under its jurisdiction. Any additional legal authority would come from other relevant sections of the Code specific to LPCs and LSATPs.

Signature: [signature]

Date: 10/11/2024



Agency **Department of Health Professions**

Board **Board of Counseling**

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

3 comments

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

Back to List of Comments

Commenter: Council for Accreditation of Counseling and Related Educational Programa

11/18/24 12:06 pm

Oppose this Petition

November 18, 2024

Re: Opposition to Virginia Petition 423

To Whom It May Concern:

The Council for Accreditation of Counseling and Related Educational Programs (CACREP) **opposes** Virginia Petition 423 which would establish a pathway for Licensed Substance Abuse Treatment Providers (LSATPs) to become Licensed Professional Counselors (LPCs).

CACREP is the leading national accrediting body for Professional Counselor preparation programs. We accredit programs in the specialized practice areas of Addiction Counseling, Career Counseling, Mental Health Counseling, Clinical Rehabilitation Counseling, College Counseling and Student Affairs, Marriage, Couple and Family Counseling, Rehabilitation Counseling, and School Counseling. Additionally, CACREP accredits doctoral programs in Counselor Education and Supervision for the preparation of counselor educators and advanced practitioners.

CACREP **opposes** the proposed pathway allowing LSATPs to qualify as LPCs, as these roles represent distinctly different scopes of practice. The LSATP license is specialized and limited to substance abuse treatment, while LPCs are qualified to diagnose and treat a wide range of mental health issues beyond substance abuse, including career counseling, marriage and family counseling, and specific mental health diagnoses. Unlike LPCs, LSATPs do not receive the same level of educational training or skills development, as defined by the CACREP curriculum requirements that support the broader LPC scope. Graduates of CACREP-accredited Addictions Counseling programs meet degree requirements for LSATP licensure, and regulation 18VAC115-60-90(C) permits LPCs to bypass an examination when transitioning to LSATP licensure, as their competency has already been assessed through the National Counselor Examination (NCE) or the National Clinical Mental Health Counseling Examination (NCMHCE) required for LPCs.

For these reasons, CACREP **opposes** Virginia Petition 423.

For any further questions, please contact CACREP's CEO Sylvia Fernandez at sfernandez@cacrep.org.

CommentID: **228878**

Commenter: Blaire Cholewa

12/10/24 4:16 pm

Strongly Oppose

The proposed policy raises significant concerns as it would equate LSATPs (Licensed Substance Abuse Treatment Providers) with LPCs (Licensed Professional Counselors), despite their fundamentally different professional scopes. While LSATPs focus exclusively on substance abuse treatment (and have solely received training in such), LPCs are trained to address a comprehensive range of mental health needs, including career counseling, substance abuse, family and marriage therapy, and diverse psychological conditions.

The educational differences are critical: LPCs undergo rigorous training aligned with CACREP curriculum standards, which ensure a broader and more comprehensive professional preparation that LSPATs do not receive. Consequently, conflating these two distinct licensure tracks would potentially compromise the quality and depth of mental health services.

CommentID: **228970**

Commenter: Anonymous

12/14/24 8:44 am

Support

I am an associate professor of counselor education at an R1 institution in Virginia. I have carefully reviewed the **requirements** for Licensed Substance Abuse Treatment Practitioners (LSATPs) and they are nearly identical to the standards set forth by CACREP for Licensed Professional Counselors (LPCs). Of all the proposed pathways in mental health that I have seen presented in recent years (some of which are equally insulting and terrifying), this seems straightforward and stringent, particularly given the standards set forth by the Virginia Board of Counseling.

Why would this not be an option for LSATPs? I suspect it is because the CACREP has a monopoly on graduate programs and the counseling profession in general. While I **strongly support** accreditation standards, we are in the midst of a public mental health crisis. I believe the CACREP has outdated standards and is in desperate need diverse and alternative pathways to help those, like LSATPs, earn LPC credentials.

In our CACREP-accredited graduate program, our students take one class on substance use. They graduate able to either work provisionally in a school setting (two years before fully licensed) or provisionally as a resident counselor under the supervision of an LPC-S (3400 hours) and they see students and clients battling addictions. One could easily argue this is not nearly enough, but we don't because CACREP states it is fine and the graduate program checked a box. In fact, all of the areas the the CACREP mentioned in their comment are typically one class in graduate school. While there are specialization tracks, they are not necessary to become an LPC.

The VA Board of Counseling could easily require a simple respecialization pathway, too. We need more licensed counselors in Virginia, not less.

CommentID: **228982**

Part II. Requirements for Licensure as a Professional Counselor

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

Every applicant for licensure examination by the board shall:

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

2. Pass the licensure examination specified by the board;

3. Submit the following to the board:

    a. A completed application;

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

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

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

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

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

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

Statutory Authority

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

Historical Notes

Derived from VR560-01-02 § 2.1, eff. July 6, 1988; amended, Virginia Register Volume 5, Issue 24, eff. September 27, 1989; Volume 7, Issue 14, eff. May 8, 1991; Volume 9, Issue 25, eff. October 6,

1993; Volume 13, Issue 25, eff. August 7, 1997; Volume 16, Issue 13, eff. April 12, 2000; Errata, 16:16 VA.R. 2081 April 24, 2000; amended, Virginia Register Volume 26, Issue 1, eff. October 14, 2009; Volume 30, Issue 19, eff. July 3, 2014; Volume 32, Issue 24, eff. August 24, 2016; Volume 37, Issue 20, eff. June 23, 2021.

Part III. Examinations

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

A. Every applicant for licensure as a substance abuse treatment practitioner by examination shall pass a written examination as prescribed by the board. Such applicant is required to pass the prescribed examination within six years from the date of initial issuance of a resident license by the board.

B. Every applicant for licensure as a substance abuse treatment practitioner by endorsement shall have passed a substance abuse examination deemed by the board to be substantially equivalent to the Virginia examination.

C. The examination is waived for an applicant who holds a current and unrestricted license as a professional counselor issued by the board.

D. The board shall establish a passing score on the written examination.

E. A resident shall remain in a residency practicing under supervision until the resident has passed the licensure examination and been granted a license as a substance abuse treatment practitioner.

Statutory Authority

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

Historical Notes

Derived from Virginia Register Volume 16, Issue 7, eff. January 19, 2000; amended, Volume 26, Issue 1, eff. October 14, 2009; Volume 32, Issue 24, eff. August 24, 2016; Volume 37, Issue 20, eff. June 23, 2021.

Agenda Item: Consideration of petition for rulemaking

Included in your agenda package:

- Petition for rulemaking received by the Board requesting that the Board amend regulations to allow previous clinical experience obtained by an LPC or LMFT who also holds a license as a psychologist, LCSW, or psychiatrist to satisfy requirements for two years of post-licensure clinical experience to become a supervisor;

- Comments received via email;

- Comments received via Town Hall; and

- 18VAC115-20-52 and 18VAC115-50-60.

Staff note: Twenty-four comments were received in response to the petition. Twenty-one were in opposition; three were in support.

Action needed:

- Motion to either:
  - Deny the petition, providing specific reasons for the decision; or
  - Accept the petition and initiate rulemaking (NOIRA).

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,)
Honeycutt, James E.

Street Address
186 Robinson Dr

Area Code and Telephone Number
(434) 944-9222

City
Lynchburg

State
Virginia

Zip Code:
2 4 5 0 2

Email Address (optional)
dr.honeycutt@icloud.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.

18VAC115-50-60 (Sec. C-3) of the Regulations Governing the Practice of Marriage and Family Therapy and 18VAC115-20-52 (Sec. C-3) of the Regulations Governing the Practice of Counseling.

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

The standards for a residency supervisor are to ensure s/he is licensed in the discipline and has the requisite clinical experience to bar a novice from overseeing the process. The Regulations and Supervisor Application both stipulate a supervisor must meet three criteria: License (i.e., LPC, LMFT), at least two years of "post-licensure clinical experience" and/or "post-licensure marriage and family therapy experience," as well as professional training in supervision. Licensed psychologists and clinical social workers who have obtained the LPC or LMFT as an additional license meet all the above criteria according to the letter of the Regulations and Application, and it is appropriate these experienced clinicians be permitted to supervise residents upon receiving the second license. Therefore, I petition the Board to replace the last sentence of Section C-3 in both Regulations with the following: "Licensed psychologists, clinical social workers, and psychiatrists who have also obtained an LPC or LMFT may use previous clinical experience to satisfy 18VAC115-20-52 (C-1) and 18VAC115-50-60 (C-2)."

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

§ 54.1-2400 (Sec. 1) of the Code of Virginia speaks to the importance of establishing "qualifications for licensure" and to "ensure competence." This proposed amendment speaks directly to this legal authority of the Board.

Signature: James Honeycutt

Date: 08/22/2024

September 15, 2024
Jaime Hoyle
Executive Director, Virginia Boards of Counseling, Psychology, and Social Work

Dear Ms. Hoyle

As a Licensed Professional Counselor (LPC), I oppose the proposed amendment to 18VAC115-20-52(C)(3) and 18VAC115-50-60(C)(3), which seeks to allow clinical experience obtained by licensed psychologists, social workers, or psychiatrists to count toward the two-year post-licensure requirement for LPCs and LMFTs. This amendment overlooks critical differences in education, clinical training, and professional competencies between these fields and the counseling profession.

1. Distinct Educational Requirements

LPC and LMFT programs focus heavily on therapeutic techniques and counseling-specific skills, which differ significantly from psychology, social work, and psychiatry programs. Counseling programs emphasize specialized coursework, such as:

- **Counseling Theories and Techniques**: This course covers models like cognitive-behavioral therapy (CBT) and family systems therapy, foundational to LPC practice but less emphasized in psychology or psychiatry programs.
- **Group Counseling**: Focuses on group dynamics and intervention strategies specific to counseling, which are distinct from the more research-oriented training in psychology or the systems-focused approach of social work.
- **Diagnosis and Treatment Planning**: While psychology often emphasizes diagnosis, LPCs concentrate more on long-term therapeutic intervention and client-specific treatment plans.
- **Career Counseling**: Essential for helping clients navigate daily stressors and life transitions, a vital skill not typically covered in depth in psychology or psychiatry training.

Additionally, LPC and LMFT programs require extensive **practicum and internship experiences**, typically involving 600 hours of supervised clinical work, with at least 240 hours of direct client contact. These experiences are essential for honing counseling-specific skills in real-world settings, emphasizing the development of therapeutic relationships and practical interventions.

After graduation, LPCs must complete **supervised residency hours**, where they continue to refine their identity as competent therapists. This residency period helps ensure that

counselors not only understand the medical model but focus on a **holistic, wellness-oriented approach** that distinguishes the counseling profession. This essential training helps counselors develop a professional identity rooted in the therapeutic alliance and wellness, rather than the diagnosis-centric focus of other fields.

2. Maintaining Professional Standards

The current two-year post-licensure clinical experience is crucial for ensuring that LPCs and LMFTs refine their skills under appropriate supervision within their specific fields. Allowing clinical hours from psychology, social work, or psychiatry to count toward this requirement risks diluting the specialized expertise that LPCs develop. These other professions often emphasize different areas of focus—such as **assessment, diagnosis, case management, or medication management**—which, while valuable, do not align with the core competencies required in counseling practice.

LPCs are trained to apply **client-centered, therapeutic techniques** that focus on empowering the individual within a counseling framework. Substituting hours from other professions that emphasize different competencies would compromise the quality of training and care LPCs provide.

3. Licensure Pathways Should Remain Distinct

Each profession—counseling, psychology, social work, and psychiatry—has its own ethical guidelines, competencies, and approaches. LPCs are specifically trained to build **therapeutic relationships** and employ **client-centered techniques**, while psychiatrists often focus on medication management and psychologists prioritize **testing and assessments**. Social workers, on the other hand, focus heavily on **case management** and **social systems**.

Blurring these distinctions by allowing overlapping clinical hours diminishes the unique value each profession brings to mental health care. LPCs have a specific identity as counselors who emphasize therapeutic interventions and holistic care, which should not be conflated with the approaches of other professions.

It is also worth noting that there is no scenario where LPCs or LMFTs can apply their clinical experience to qualify for licensure in psychology, psychiatry, or social work. We respect the distinct training, skills, and perspectives that each of these professions brings to the field. In the same vein, we ask that the uniqueness of the LPC and LMFT pathways be honored and respected, ensuring that clients receive high-quality care from professionals who are fully trained in the counseling profession.

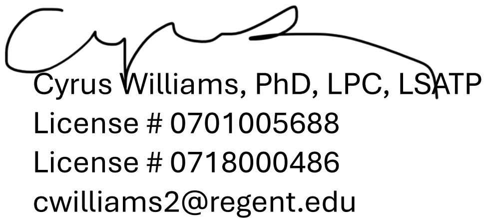
Conclusion

Allowing clinical experience from psychology, social work, or psychiatry to count toward LPC and LMFT licensure undermines the specialized training and competencies that counseling professionals develop. The current two-year post-licensure requirement ensures that LPCs and LMFTs receive targeted supervision and continue to develop the therapeutic skills necessary for effective practice. Diluting this requirement risks compromising the quality of care and undermining the public trust in the counseling profession.

I respectfully urge the Board to maintain the existing standards to uphold the integrity and specialized focus of the LPC and LMFT professions. Thank you for your consideration.

Thank you for your consideration.

Sincerely,



Cyrus Williams, PhD, LPC, LSATP
License # 0701005688
License # 0718000486
cwilliams2@regent.edu

From:	Hoyle, Jaime (DHP)
To:	Barrett, Erin (DHP)
Cc:	Lenart, Charlotte (DHP); Austin, Latasha (DHP)
Subject:	Fw: Oppose Proposed Changes to 18VAC115-20 Petition ID 415
Date:	Thursday, October 24, 2024 12:07:17 PM
Attachments:	attachment.jpeg attachment.jpeg attachment.jpeg attachment.jpeg attachment.jpeg

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Erin,

I reached out to the commenter and let her know that we accepted her public comment, and that you would include it in your report on the petition at the next meeting. Thanks.

Jaime

From: West, Melanie (Virginia) <melanie.west@dpb.virginia.gov>
Sent: Thursday, October 24, 2024 10:20 AM
To: Hoyle, Jaime (DHP) <Jaime.Hoyle@dhp.virginia.gov>
Subject: Fw: Oppose Proposed Changes to 18VAC115-20 Petition ID 415

Hi Jaime! I hope all is well.

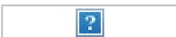
Last night, before the end of the comment on this petition https://townhall.virginia.gov/L/ViewPetition.cfm?petitionid=415, an attempt was made to submit a comment (see below) via Town Hall but it was unsuccessful. We are still trying to determine the technical reasons why. Anyway, this party wishes to have their comment included since they attempted and sent us an email about it before the public comment period closed.

Could you please let them know the status of their comment? Thanks, Melanie

---

From: Holly Hartwig Moorhead <holly.moorhead@csi-net.org>
Sent: Wednesday, October 23, 2024 7:18 PM
To: West, Melanie (Virginia) <melanie.west@dpb.virginia.gov>
Subject: Re: Oppose Proposed Changes to 18VAC115-20

Thank you for your reply. All of our submissions have been just text - no images, links, signature lines, etc. included. Additionally, nothing has been copied and pasted - only text has been typed into the form. I just tried submitting again using the form. Again, nothing happens after the “Human Check” is entered and the submit button is pressed. No error message, no change on the form.



Holly J. Hartwig Moorhead, Ph.D.
Chief Executive Officer
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Thomasville, NC 27360
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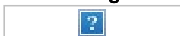
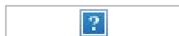
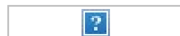
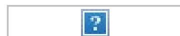
Member, Association of College Honor Societies

Connect with CSI:    

On Oct 23, 2024, at 6:53 PM, West, Melanie (Virginia) <melanie.west@dpb.virginia.gov> wrote:

Could you please try submitting without the chi sigma iota graphic? That may be the problem.

Get [Outlook for iOS](#)

From: Holly Hartwig Moorhead <holly.moorhead@csi-net.org>
Sent: Wednesday, October 23, 2024 6:20:05 PM
To: West, Melanie (Virginia) <Melanie.West@dpb.virginia.gov>; Rose, Jeannine (Virginia) <Jeannine.Rose@dpb.virginia.gov>; Hubbard, Scott (DPB) <Scott.Hubbard@dpb.virginia.gov>; Colvin, Ashley (Virginia) <Ashley.Colvin@dpb.virginia.gov>
Subject: Oppose Proposed Changes to 18VAC115-20

The following is noted on this public comment form (https://townhall.virginia.gov/L/Comments.cfm?petitionid=415):

> ***Trouble posting comments?*** *These pages have been tested with multiple versions of all the major browsers. If you have trouble: (1) try another computer if you have access to one, (2) try another browser if your computer has one installed (3) contact [Town Hall support staff](#) for assistance.*

Consistent with these instructions, Chi Sigma Iota has attempted to submit the following comments related to the proposed changes to 18VAC115-20 within the online form using three different browsers and on different computers - but none of the attempts were successfully accepted/submitted by/within the system. Please accept the following public comment to oppose proposed changes to 18VAC115-20. Thank you for your assistance.

Your Name, Organization Chi Sigma Iota Counseling Academic and Professional Honor Society Intl

Email Address admin@csi-net.org

Comment Subject/Title Oppose Proposed Changes to 18VAC115-20

Location North Carolina

Oppose Proposed Changes to 18VAC115-20
Chi Sigma Iota Counseling Academic and Professional Honor Society International (CSI) **opposes** the proposed amendments to 18VAC115-20 that would allow professionals from other disciplines to count their experience toward counselor licensure.

CSI is an international honor society dedicated to promoting excellence in the counseling profession. Our mission is to promote scholarship, research, professionalism, leadership, and excellence within the profession. More than 170,000 counselors are initiated members of the Society, which is one of the largest single-member organizations of professional counselors in the world.

Our members have expressed concern about the proposed changes because a counselor's post-licensure clinical experience should be in counseling - just as a psychologist's training is in psychology, a licensed clinical social worker's training is in social work, and a psychiatrist's training is in psychiatry. Counselor training and post-clinical experience should be in counseling, as this counseling-specific experience is essential to preserving the profession's unique identity and ethical requirements, including its specialized teachings and theories.

Additionally, the proposed rule seems to contradict existing Virginia regulations for the current two-tier counselor licensure of the restricted Resident-in-Counseling designation and the unrestricted independent practitioner Licensed Professional Counselor (LPC) designation. The intent of 18VAC115-20-52 C 3 is to require Residents-in-Counseling to be supervised only by LPCs or LMFTs. The sunset provision contained in the last sentence of C 3 brings an end on August 24, 2017 to approving professionals from other disciplines as supervisors.

If the proposed petition relates to C 1, it is effectively a request to either:

A) revoke the final sentence of C 3, or

B) restore the previously enacted (and previously changed) rule that allowed supervision by professionals from other disciplines.

In either case, permitting a professional licensed in a different profession to supervise Residents-in-Counseling undermines the purpose of counselors being supervised within and by the counseling profession because the supervisor would not be a counselor.

Moreover, the Virginia Counseling Board does not have jurisdiction over supervisors who are licensed in other professions. Therefore, it is critically important to note that the Virginia Counseling Board does not have authority to regulate or take disciplinary action against supervisors who are licensed in other professions if such action becomes necessary for the Board to fulfill its duty to protect the public. The C 3 requirement that counselors must be supervised by LPCs safeguards both Residents-in-Counseling and the public.

For these reasons, CSI **opposes** the proposed changes to 18VAC115-20.

Questions for CSI may be directed to CSI's CEO, Dr. Holly Moorhead, at admin@csi-net.org.

<attachment.jpeg>
Holly J. Hartwig Moorhead, Ph.D.
Chief Executive Officer
Chi Sigma Iota Counseling Academic and Professional Honor Society International
P.O. Box 1829
Thomasville, NC 27360
www.csi-net.org
(336) 841-8180

Member, Association of College Honor Societies
Connect with CSI: <attachment.jpeg> <attachment.jpeg> <attachment.jpeg> <attachment.jpeg>

Agency Department of Health Professions

Board Board of Counseling

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

22 comments

All good comments for this forum Show Only Flagged

Back to List of Comments

Commenter: Willard Vaughn 9/26/24 6:21 pm

Strongly Support this Change

I strongly support this change being made in the regulations. The board allowed supervision across disciplines for many years without issue, and it never really made sense why the board made this change given the shortage of providers we have in Virginia.

CommentID: **228006**

Commenter: Louis M. Alvey 10/17/24 12:24 pm

Support for Acceptance of clinical hours

Acceptance for this change will increase access to supervisors that have clinical experience, even if in other disciplines, without detracting from the necessity for licensure to be held in the current mental health specialty. I support this update and believe it will benefit the current pool of approved supervisors and attract other experienced practitioners to our clinical specialty.

CommentID: **228136**

Commenter: Council for Accreditation of Counseling and Related Educational Programa 10/22/24 3:09 pm

Oppose this Petition

October 22, 2024

Re: Proposed Changes to 18VAC115-20

To Whom It May Concern:

The Council for Accreditation of Counseling and Related Educational Programs (CACREP) **opposes** the proposed amendments to 18VAC115-20 that would allow professionals from other disciplines to count their experience toward counselor licensure.

CACREP is the leading national accrediting body for Professional Counselor preparation programs. We accredit programs in the specialized practice areas of Addiction Counseling, Career Counseling, Mental Health Counseling, Clinical Rehabilitation Counseling, College Counseling and Student Affairs, Marriage, Couple and Family Counseling, Rehabilitation Counseling, and School Counseling. Additionally, CACREP accredits doctoral programs in Counselor Education and Supervision for the preparation of counselor educators and advanced practitioners.

Firstly, CACREP believes the proposed regulation's language lacks clarity. The rule mentions "requirements for two years of **post-licensure** clinical experience," but it is unclear whether this refers to C 1, which pertains to holding an unrestricted license as an LPC or LMFT. Additionally, the regulation states, "**who is also** a licensed psychologist, licensed clinical social worker, or psychiatrist." If these credentials are held concurrently, there would be no need for an amendment. CACREP suspects that the rule is attempting to recognize these professionals from other disciplines as supervisors under their non-counseling licenses; however, the ambiguity as written raises several concerns.

Secondly, it is crucial that counselors are supervised by counselors, just as professionals in other fields should be supervised by members of their own profession. Virginia has a two-tier licensing system: the Resident-in-Counseling (restricted license) and the LPC (unrestricted independent practitioner). The purpose of 18VAC115-20-52 C 3 is to ensure that Residents-in-Counseling are supervised exclusively by LPCs or LMFTs. The final sentence in C 3 establishes a sunset provision, ending the approval of professionals from other disciplines as supervisors as of August 24, 2017. If the request pertains to C 1, it is effectively asking to either rescind this final sentence or reinstate the previous rule allowing supervision by professionals from other disciplines. However, permitting a licensee from another profession to supervise Residents-in-Counseling undermines the intent of supervision within the counseling profession, as the supervisor would not be part of the counseling profession. Furthermore, the Counseling Board lacks jurisdiction over supervisors licensed in other professions, meaning it cannot regulate or take disciplinary action against those supervisors if necessary. The C 3 requirement safeguards both Residents-in-Counseling and the public.

Thirdly, the purpose of 18VAC115-50-60 C 3 is to ensure that Residents-in-MFT are supervised solely by LPCs or LMFTs. The same arguments above should apply here also for Marriage and Family Therapy.

For these reasons, CACREP definitively **opposes** the proposed changes to 18VAC115-20.

For any further questions, please contact CACREP's CEO Dr. Sylvia Fernandez at sfernandez@cacrep.org.
CommentID: **228170**

Commenter: Patricia Kimball

10/23/24 11:47 am

Lets Keep Counselor Identity Clear

I want to voice my opposition to this change. As a profession, counselors have been battling forming a clear identity where clients, communities and other professionals can distinguish them from Psychologist and Social Workers. This identity is philosophically different than these two other helping professionals and practice of being a Professional Counselor is in practice different than the practice of being a Psychologist and a Clinical Social Worker. Allowing these two helping professionals to gain a Professional Counseling License without going through the supervision process where they learn what it means to be a Professional Counselor will chip away at the identity that Counselors have been working to establish and maintain.

I have a very specific education and time/focus of supervision that has allowed me to become a Licensed Counselor. Allowing others who do not have the clear professional identity that is needed to be a Professional Counselor will have a negative impact on the profession overall.

In addition, as a Licensed Professional Counselor, I would never be allowed to use my counseling experience to gain a License as a Psychologist or Clinical Social Worker. When these two helping professions allow me to gain their license in the same way they are requesting they gain my license, then I will support this idea. Until then, I am strongly opposed to this plan.
CommentID: **228183**

Commenter: Counseling grad student

10/23/24 12:11 pm

no

I oppose the motion. Other professionals should be required to complete the same testing, education, and supervision as Counselors before obtaining the title.

CommentID: **228185**

Commenter: Alex Kempton

10/23/24 12:12 pm

Keep the professions separate

As a future counselor, this bill harms my profession. Do not pass this unless I can become a LCSW or LCP with just years of work as a counselor. This attempt to encroach on the counseling profession shows a lack of respect for the supervision, education, and examination hours that are required to become a counselor. We have a role to fill, keep the professions separate.

CommentID: **228186**

Commenter: Sophia Varrati

10/23/24 12:16 pm

In Opposition

As a counseling student, I believe that the title of a counselor should be given only to those who had to undergo supervision and obtain the proper licensure. To know that there are people who can practice under my title that I aspire to have one day without going through the same education and supervision that I'm working so hard to obtain is personally discouraging and diminishes the specialization of the counseling profession.

CommentID: **228190**

Commenter: Brittany Potts

10/23/24 12:21 pm

Counselor Identity

Hello,

I am currently a student at Liberty University pursuing my master's in clinical mental health counseling and I would like to oppose this change. Licensed counselors are required to go through extensive training, education, supervision, and a licensure exam. If we allow psychologists and social workers to become licensed without going through all the required steps, this could cause these individuals to provide counseling that is not beneficial for those receiving the services. This can be confusing for clients if they are going to a psychologist or social worker and not receiving the care they need.

This also takes away from the individuals going through the training, education, supervision, and licensure exam. Licensed counselors put a lot of time, effort, money, etc., into becoming licensed counselors and are passionate about providing their clients with the best services.

Please consider my request to oppose this change from allowing psychologists and social workers to become licensed counselors without going through the proper education, training, supervision, and licensure exam.

Thanks,

Brittany
CommentID: **228191**

Commenter: D Emmanuel

10/23/24 12:52 pm

Strongly disagree

I strongly disagree! This would imply that counselors do not have a specific identity, training, and skill set. This would negatively affect counselor identity, and potentially clients as well.

Additionally, if psychologists and social workers do the same work as counselors and can get licensed as counselors, counselors should also be able to become licensed psychologists and social workers.

CommentID: **228194**

Commenter: Radford University

10/23/24 1:04 pm

18VAC115-20-52(C)(3) and 18VAC115-50-60(C)(3)

Fully support!

CommentID: **228195**

Commenter: Counseling Grad Student

10/23/24 1:16 pm

Absolutely Not

We are still a young profession and are trying to identify WHO we are. This will only weaken the profession

CommentID: **228196**

Commenter: Justin Jordan

10/23/24 1:29 pm

Opposed, protect counselor professional identity

Learning from other counselors is a key component of internalizing the way of healing our profession has established. This makes us unique compared to LMFT's, LCSW's, and psychologists. This identity is based in a wellness model (anti-medical model), an emphasis on development and prevention, client empowerment, and advocacy. We should protect the process that advances our professional identity, rather than diluting our training. We do collaborate with other professionals, but our training should be based in who we are.

CommentID: **228197**

Commenter: Jordan Knepper

10/23/24 1:57 pm

Very Opposed To The Proposed Idea

As a graduate student preparing to become a LPC in Virginia I have many requirements to get there. Where as, social workers, LMFT’s, psychologists, and others have very different

requirements to become licensed. If this is allowed it would heavily hurt the identity and the integrity of Licensed Professional Counselors. Other programs should not be able to become licensed like me with much different standards and steps. This will only harm the counseling profession and further dilute the differences between each of these fields.
CommentID: **228201**

Commenter: Reagan Manning

10/23/24 2:05 pm

Opposed. Counselors need to be trained.

Counseling is a separate profession. Individuals who have not had a supervised residency lack adequate expertise for counseling work. A counselor cannot get a license as a social worker or psychologist for the same reason, the professions are separate. Allowing untrained individuals to get licensed is not good for the profession or for clients.

CommentID: **228202**

Commenter: Tyler Virgilio, Liberty University Grad Student

10/23/24 3:14 pm

Keep the Counselor Identity Clear

Post-licensure clinical experience is vital to becoming an effective counselor. Replacing that with a substitute would create identity confusion and less competent counselors.

CommentID: **228205**

Commenter: Alayna Prachar, Liberty University student

10/23/24 3:38 pm

Protect Counselors Identity/Licensure Requirements

I am a future counselor and student at Liberty University. This should not be passed, as psychologists and social workers have not had the training and supervision that Licensed Professional Counselors are required to go through for licensure. They would make unequipped counselors, and they should not be doing mental health counseling or marriage and family therapy without undergoing the same education and supervision.

CommentID: **228206**

Commenter: Anonymous

10/23/24 3:44 pm

Specializations Should be Unique

The approaches to care taken by LPCs, LCSWs, psychologists, etc. and so different from one another that I believe that supervision should be given by a licensee in the same field.

CommentID: **228207**

Commenter: Taylor Strutton, Liberty University Graduate Student

10/23/24 3:57 pm

Opposition: Disservice to Future Clients and Counseling Profession

I oppose this motion. Counseling is a specific profession with a unique philosophy and skill set that differs from psychology, social work, and psychiatry. It would be a disservice to future clients and

the counseling profession for any counselor to forgo the specific counseling licensure requirement of supervised hours, replacing it with experience that is not equivalent.
CommentID: **228208**

Commenter: Laurel Cooper, Grad Student

10/23/24 4:04 pm

Opposed to this proposal

Experience cannot fully replace education; there is a reason why the degree requires extensive completion of both. Avoidance of the licensure exam solely based on having a certain amount of experience is bound to produce counselors who lack fundamental knowledge and expertise.

CommentID: **228209**

Commenter: Clay Addison, Liberty University

10/23/24 4:15 pm

In Opposition to this Motion

Professional counselors' work is distinct from that of a psychologist, psychiatrist, or social worker, and it ought to be treated as such. Not treating it as such would be a disservice to clients who expect a well-practiced and experienced professional in the world of counseling, as well as an encroachment on LPCs' and LMFTs' individuality as their own unique discipline within the helping professions.

CommentID: **228210**

Commenter: Olive Bediako

10/23/24 8:37 pm

In Opposition with the Petition

I oppose the petition for previous experience in another helping profession to count towards getting a LPC/LMFT license. Licensed social workers and psychologists have a different focus and background when dealing with clients. Counselors have a more strengths-based and wellness focus when dealing with clients. Therefore, supervision is necessary in order to ensure that counselors are operating in a strengths-based focus. It would also skew the counselor identity, making it difficult to further differentiate between a counselor and other helping professions.

CommentID: **228214**

Commenter: Brittany Szilagyi, Liberty University

10/23/24 9:54 pm

In strong opposition

Professional clinical mental health counseling (CMHC) is a fairly new profession that is still working to establish a strong identity and distinct boundaries. Psychologists and social workers have a much more solidified identity, and scope of practice. CMHC boasts one of the longest masters level programs, and it is because we specialize ONLY in professional counseling. CMHC is preventative, and holistic. It focuses on empowering the individual to make the needed changes to overcome life's difficulties, in congruence with their worldview, convictions, and culture. Although perhaps there is a slight overlap into social work and psychology, and psychological research is used by counselors to promote evidenced based practice in the counseling room; psychology is generally not preventative. Psychologists spend their masters and doctoral career conducting research in a mostly sterile environment with little client interaction. Social workers focus mainly on connecting clients with community resources and intervening for children in unacceptable living

conditions. In contrast, CMHCs spend their ENTIRE masters career training for only one thing: to use evidence based practice techniques and methods to help clients overcome life's difficulties. Psychologists simply conducting research does not qualify them to adequately apply research studies and statistics to counseling practice. In fact, without the client exposure and training in counseling methods and techniques, the results could be extremely detrimental to the client. I do realize that before CMHCs existed, psychologists conducted the counseling. However, now we have professionals being thoroughly trained for counseling, and counseling ONLY. If a CMHC cannot be grandfathered into social work or psychology without any further training, education, or exams (which they would never allow us to do) then this should not even be considered the other way around. This would water down and be detrimental to CMHCs working hard to establish their own individual identity. For a CMHC to become a psychologist they must attend 4 more years of college on top of the 3 they already attend to achieve their masters/counseling license (as well as an additional 2 years of residency). It is simple, if psychologists would like the right to counsel, they need to specialize in CMHC, just like the counselors, so that clients are not harmed by individuals that are not adequately prepared. In my own experience, I was counseled for a short time by a psychologist who committed some of the very mistakes we learned within our first week of classes not to make and she was a PhD psychologist! It is a matter of "bedside manner," as we say in the medical field, and people skills which most psychologists, in my experience, do not possess. The scope of practice for social workers seems too vastly different to even be considered to counsel without formal training, so I will not use any more space to explain why I believe this to be so.
CommentID: **228215**

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 received by the Board requesting that the Board accept passage of the National MFT exam in place of the NCMHCE or NCE for marriage and family counselors applying for licensure as an LPC;

- Comments received via Town Hall; and

- 18VAC115-20-40.

Staff note: Sixteen comments were received on Town Hall in response to the petition. Thirteen were in opposition and two were in support. On comment was "correcting" an assertion on another comment and did not state a position.

Action needed:

- Motion to either:
    - Deny the petition, providing specific reasons for the decision; or
    - Accept the petition and initiate rulemaking (NOIRA).

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,)

Street Address	Area Code and Telephone Number	
City	State	Zip Code: ___ ___ ___ ___ ___

Email Address (optional)

Respond to the following questions:

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

I am petitioning to amend 18VAC115-20-40, the regulation governing examination requirements for those who hold a Virginia LMFT, currently requiring them to pass the NCMHCE and/or NCE exam in order to become licensed as a Virginia LPC. This is in contrast to Virginia LPCs, who are not required to pass the National MFT exam to become licensed as a Virginia LMFT.

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

I am requesting that the board amend 18VAC115-20-40 to provide reciprocal examination exemptions for LMFTs seeking LPC licensure in Virginia, similar to the current waiver for LPCs seeking LMFT licensure. The board's current regulation exempts Virginia LPCs from the National MFT examination when they apply for LMFT licensure, but does not grant the same reciprocity for LMFTs seeking LPC licensure, requiring them to pass the NCMHCE and/or NCE.

This creates a regulatory barrier that places LMFTs at a disadvantage, despite their comprehensive training in diagnosing and treating individuals, couples, and families. LMFT training aligns significantly with the core competencies required for LPCs. Amending this regulation would ensure fairness and remove unnecessary hurdles for LMFTs, enabling greater workforce flexibility while maintaining the high standards of care that both LMFTs and LPCs are trained to provide.

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

The board's authority to adopt and amend regulations is outlined in § 54.1-2400 of the Code of Virginia, which grants the board general powers to establish qualifications for licensure. Specifically, § 54.1-2400(1) and (2) empower the board to define licensure requirements, including examinations. Additionally, 18VAC115-20-40 and 18VAC115-20-70 both state, "shall pass a written examination as prescribed by the board," which provides the board the flexibility to determine which examinations are necessary for licensure. Given this authority, the board has the discretion to waive the examination requirement for LMFTs, just as it does for LPCs seeking LMFT licensure.

Signature: [signature] **Date:** 9-23-24

Agency **Department of Health Professions**

Board **Board of Counseling**

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

16 comments

All good comments for this forum Show Only Flagged

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Commenter: Anonymous 10/24/24 11:12 am

Not in support/agreeement

Disagree as exam content is different

CommentID: **228218**

Commenter: Dr. Michael Moates 10/28/24 2:21 pm

Argument Against Permitting LMFTs to Use National MFT Exam for LPC Licensure

The petition to allow licensed marriage and family therapists (LMFTs) to use the National MFT exam to satisfy the examination requirement for licensure as a licensed professional counselor (LPC) should be rejected. While both LMFTs and LPCs provide mental health services, the scope of practice and educational requirements for these professions differ significantly.

The educational requirements for LMFTs and LPCs are distinct. LPCs are required to complete a master's degree in counseling or a related field, which includes coursework in human growth and development, counseling theories and techniques, and assessment and testing (American Counseling Association, 2021). In contrast, LMFTs must complete a master's degree in marriage and family therapy or a related field, with coursework focusing on family systems, couples therapy, and child development (American Association for Marriage and Family Therapy, 2021). The differences in educational requirements reflect the unique focus of each profession.

The scope of practice for LMFTs and LPCs differs. LPCs provide individual, group, and family counseling, focusing on mental health, substance abuse, and personal growth (National Board for Certified Counselors, 2021). LMFTs, on the other hand, specialize in treating relationship and family issues, with a focus on systemic interventions (American Association for Marriage and Family Therapy, 2021). The National MFT exam is designed to assess knowledge and skills specific to the practice of marriage and family therapy, not the broader scope of professional counseling.

Allowing LMFTs to bypass the NCMHCE or NCE exams for LPC licensure could undermine the integrity of the LPC profession. These exams are designed to ensure that LPCs possess the necessary knowledge and skills to provide competent and ethical counseling services (National Board for Certified Counselors, 2021). Permitting LMFTs to become licensed as LPCs without demonstrating mastery of professional counseling content could potentially put the public at risk.

While LMFTs and LPCs both provide valuable mental health services, the educational requirements, scope of practice, and licensure exams for these professions are distinct. Permitting LMFTs to use the National MFT exam for LPC licensure would fail to ensure that these professionals possess the necessary knowledge and skills to practice as professional counselors, potentially compromising public safety.

References:
American Association for Marriage and Family Therapy. (2021). About marriage and family therapists. https://www.aamft.org/About_AAMFT/About_Marriage_and_Family_Therapists.aspx

American Counseling Association. (2021). Licensure requirements for professional counselors: A state-by-state report. https://www.counseling.org/knowledge-center/licensure-requirements

National Board for Certified Counselors. (2021). About NBCC. https://www.nbcc.org/about
CommentID: **228752**

Commenter: Anonymous 10/31/24 6:12 am

Absolutely Support

The differences in MFT and LPC are theoretical and not necessarily in practical application. California didn't even have an LPC license until a few years ago so the vast majority of LMFTs actually clinically operate more like LPCs. The standards of practice to protect the public are the same. I support any movement in bringing these two designations together vs the confusion and disharmony that exists in holding them as vastly different. It is confusing to the public, isolating to the clinicians and costly to everyone. I find the comments against this argument mean-spirited and disheartening (and even antiquated.)

CommentID: **228778**

Commenter: Anonymous 11/8/24 10:30 pm

Worst Idea Ever

LMFT's are not qualified to be counselors. It would be unsafe to not test them in the theories of counseling.

CommentID: **228838**

Commenter: Anonymous 11/13/24 12:48 pm

Not in favor

LMFT is a specialty training with a focus on relational and family systems. The scope of practice, theoretical orientation, differs from LPC which encompasses and has broader range of practice and training. The exam assesses for technical knowledge, as well as ethical and legal considerations. It should not be permissible for a LMFT to bypass this competency assessment particularly in the absence of training and education specific to the field with whom the exam is designed for. If the theories and training of both fields were deemed equivalent there would be one exam…there is not. I do not support this proposed exemption/petition.

CommentID: **228868**

Commenter: Anonymous 11/15/24 7:24 am

Not supportive of this petition

The process and training for becoming a LMFT and LPC are very different and have unique focuses. Yes, they overlap at times; however, the scope and focus remain different. As a LPC, I choose to refer to LMFTs when working with certain cases that require complex family system work because I feel that is what they train for and is clinically appropriate/ethically sound. I'm operating as a professional that the same consideration is also being paid as we are ethically bound to work within our scope of competency, meaning we have been educated, trained, and tested in certain domains that do not overlap. As much as I know there is a great need for mental health supports currently, I do not support this proposed exemption.

CommentID: **228870**

Commenter: Anonymous

11/17/24 7:42 am

Correction to Supporting Petition Post

California has had licensure 14 years way longer than "a few years."

CommentID: **228873**

Commenter: Council for Accreditation of Counseling and Related Educational Programa

11/18/24 10:17 am

Oppose this Petition

Re: Opposition to Virginia Petition 418

To Whom It May Concern:

The Council for Accreditation of Counseling and Related Educational Programs (CACREP) **opposes** Virginia Petition 418 which would allow licensed marriage and family therapists (LMFTs) to bypass national counselor exams, needing only the LMFT examination for licensure as a Licensed Professional Counselor (LPC).

CACREP is the leading national accrediting body for Professional Counselor preparation programs. We accredit programs in the specialized practice areas of Addiction Counseling, Career Counseling, Mental Health Counseling, Clinical Rehabilitation Counseling, College Counseling and Student Affairs, Marriage, Couple and Family Counseling, Rehabilitation Counseling, and School Counseling. Additionally, CACREP accredits doctoral programs in Counselor Education and Supervision for the preparation of counselor educators and advanced practitioners.

Licensing exams serve as a critical assessment of an individual's competence to enter a profession. For Professional Counselors, the National Counselor Examination (NCE) and the National Clinical Mental Health Counselor Examination (NCMHCE) evaluate both content knowledge, based on CACREP curricular standards, and practical skills, grounded in a job task analysis of practicing counselors. At least one of these exams is required by licensing boards in all 50 states. In contrast, the National Marriage and Family Therapy (MFT) exam assesses a more focused area of practice, specific to the field of marriage and family therapy, which does not encompass the broad scope of competencies required for Professional Counselors.

Allowing LMFTs to become LPCs without passing the relevant counselor exams would create a pathway that fails to fully assess competence for practice in this profession. This approach poses a risk to public safety by permitting individuals trained in a different field to practice as Professional Counselors without the necessary qualifications. Practicing outside one's area of expertise is not only inadequate in addressing client

needs but also unethical, as emphasized by the American Association for Marriage and Family Therapy (AAMFT) Code of Ethics, section 3.11.

For these reasons, CACREP **opposes** Virginia Petition 418.

For any further questions, please contact CACREP's CEO Sylvia Fernandez at sfernandez@cacrep.org.
CommentID: **228875**

Commenter: Laurie Lynne Wilson

11/18/24 11:25 am

Do not support

I do not support removing the exam requirement for one discipline to become licensed in aonther discipline. Marriage and Family Therapists are trained differently than Professional Counselors. Each discipline is valuable.

CommentID: **228877**

Commenter: Anonymous

11/19/24 11:21 am

SUPPORT

LMFT's are counselors. CACREP accredits programs that train family therapists, they receive the same base education with extra coursework in systems work and 600 hours of supervised internship. LMFT counseling trainees often have internships in the same places as other counseling trainees, CSB's, addictions treatment, inpatient, and outpatient therapeutic agencies.

Taking national exams is costly and can be prohibitive on a structural level. As counselors we need to be promoting workforce development, mental health access is at an all time low.

Why not decrease a structural burden for LMFT's by allowing the acceptance of the national exam they already have to take? It seems like decreasing a structural barrier to promote professional counseling access would be an ideal of the counseling profession.

CommentID: **228883**

Commenter: Kathleen McCleskey

11/19/24 2:35 pm

Not in Support of this Petition

I appreciate LMFTs and the work that they do. They have focused training and work that extends beyond other helping professionals' training in working with couples and families. Because of this, their training and their professional identity is not the same as professional counselor training and identity. I am very worried about diluting counselor identity, as we have been fighting for decades for a strong professional counselor identity. The NCE or NCMHCE exams are both grounded in counselor training and are more appropriate exams for the LPC than is the National MFT exam. I do not support this petition and hope that the Board does not pass it.

CommentID: **228885**

Commenter: Anonymous

11/19/24 3:54 pm

Do not Support

The LMFT exam is there to serve a purpose specific to the discipline. It was not intended to assess readiness for LPC.

CommentID: **228887**

Commenter: Trisha Goodall

11/19/24 3:57 pm

Opposed to this petition

As a student in a couples and family counseling program, I can appreciate the specialized training available that LMFT's have had. That said, I also recognize that there are a broader set of skills available to general professional counselors that as a student I am seeking out. I plan to obtain licensure as an LPC, LMFT, and NCC. However, I also recognize that there are distinctions and it would be unethical to practice outside our scope of expertise. Therefore, while it is cumbersome to take multiple exams I am opposed to bypassing that safeguard for the public. I also am in favor of creating a pathway for LMFTs and LPCs to become dual licensed that does not require an additional full degree in a couples and family program.

CommentID: **228888**

Commenter: Arnold Woodruff, LMFT

11/19/24 6:31 pm

Oppose LMFT Becoming LPC without Exam

I am opposed to this proposal. I understand that it is being made, in part, to balance the regulation that allows lpc's to become lmft's without taking the national mft exam. I'm equally opposed to that provision and would suggest that the path to equity is to require applicants to take the exam that is intended to assess skills and knowledge for the professional license being sought! We are two different professions who cover much the same scope of services, but from a research and technique base that relies on quite different base assumptions. Neither profession can claim outcome supremacy, but the client community deserves to know that the license being presented represents a professional trained in that particular speciality with a background of education, supervised experience and skills consistent with the license advertised. This change would cloud that understanding.

CommentID: **228890**

Commenter: Julie Sayre

11/19/24 7:32 pm

Opposed to Petition

I oppose this petition. In Virginia, LPC's have been permitted to become LMFT's without taking the MFT licensing exam, a practice I would also oppose. Professional examinations are designed to measure competency in specific areas of study, including theory and practice outcomes. An MFT practitioner has been trained in systemic (relational) theory and practice; the exam measures competency of systemic theoretical approaches and their practice. Similarly, the Counselor exam reflects that discipline's theory and training, focused on individuals. The disciplines overlap but retain areas unique to their professional arenas. Any profession requiring examination should hold their applicants responsible for a passing grade in their discipline. This petition seeks to correct an imbalance in the licensing exam requirements within the purview of the Board of Counseling; however, this exacerbates a blurring of the professional lines that already exist.

CommentID: **228894**

Commenter: Anonymous

11/20/24 3:28 pm

Oppose

Allowing LMFTs to become LPCs without passing the relevant Counselor exams would create a pathway that fails to fully assess competence for practice in this profession. Practicing outside one’s area of expertise is not only inadequate in addressing client needs but also unethical, as emphasized by the American Association for Marriage and Family Therapy (AAMFT)

CommentID: **228899**

Part II. Requirements for Licensure as a Professional Counselor

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

Every applicant for licensure examination by the board shall:

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

2. Pass the licensure examination specified by the board;

3. Submit the following to the board:

    a. A completed application;

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

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

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

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

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

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

Statutory Authority

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

Historical Notes

Derived from VR560-01-02 § 2.1, eff. July 6, 1988; amended, Virginia Register Volume 5, Issue 24, eff. September 27, 1989; Volume 7, Issue 14, eff. May 8, 1991; Volume 9, Issue 25, eff. October 6,

1993; Volume 13, Issue 25, eff. August 7, 1997; Volume 16, Issue 13, eff. April 12, 2000; Errata, 16:16 VA.R. 2081 April 24, 2000; amended, Virginia Register Volume 26, Issue 1, eff. October 14, 2009; Volume 30, Issue 19, eff. July 3, 2014; Volume 32, Issue 24, eff. August 24, 2016; Volume 37, Issue 20, eff. June 23, 2021.

Agenda Item: Consideration of petition for rulemaking

Included in your agenda package:

- Petition for rulemaking received by the Board requesting creation of a regulatory pathway for LMFTs to become LPCs similar to that provided for LPCs to become LMFTs;

- Comments received via Town Hall; and

- 18VAC115-50-55 and 18VAC115-50-60, which contain provisions to allow LPCs to obtain licensure as an LMFT.

Staff note: Nine comments were received on Town Hall in response to the petition. Eight were in opposition and one was in support.

Action needed:

- Motion to either:
    - Deny the petition, providing specific reasons for the decision; or
    - Accept the petition and initiate rulemaking (NOIRA).

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,)

Street Address	Area Code and Telephone Number	
City	State	Zip Code: ___ ___ ___ ___ ___

Email Address (optional)

Respond to the following questions:

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

I am petitioning to amend 18VAC115-20-40 (Examination requirements) and 18VAC115-20-50 (Educational requirements) to create a pathway for Virginia Licensed Marriage and Family Therapists (LMFTs) seeking LPC licensure in Virginia, similar to the pathway that LPCs currently have to obtain LMFT licensure. This amendment would outline an educational equivalency process for LMFTs to obtain LPC licensure.

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

I am requesting that the board establish a clear pathway for LMFTs to become LPCs in Virginia without needing to meet all university-level LPC-specific education requirements, similar to the pathway that allows LPCs to become LMFTs. The current LMFT Handbook allows LPCs to obtain LMFT licensure by completing additional coursework in marriage and family therapy, but no such pathway exists for LMFTs seeking LPC licensure.

LMFTs are already highly trained in psychotherapy, diagnosis, and treatment across the lifespan and are required to complete significant supervised residency hours. The lack of an outlined process for LMFTs to become LPCs places an undue burden on LMFTs to duplicate their education despite substantial overlap in training and competencies.

This amendment would create parity, allowing LMFTs to demonstrate equivalency through additional coursework in individual and group therapy, similar to the 12-credit coursework requirement LPCs face for LMFT licensure.

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

The board's authority to amend licensure regulations is established in § 54.1-2400 of the Code of Virginia, which grants the Board of Counseling the power to define and modify licensure qualifications. Specifically, § 54.1-2400(1) and (2) empower the board to set licensure standards, including educational requirements. Both 18VAC115-20-40 and 18VAC115-20-50 outline the board's authority to determine examination and education standards, giving the board the flexibility to create a pathway for LMFTs to become LPCs through additional coursework without requiring an entirely new degree.

Signature: [signature] **Date:** 9-23-24

Agency **Department of Health Professions**

Board **Board of Counseling**

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

9 comments

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

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Commenter: Dr. Michael Moates 10/28/24 2:34 pm

Argument Against Creating a Pathway for LMFTs to Obtain LPC Licensure

The petition to create a pathway for licensed marriage and family therapists (LMFTs) to obtain licensure as licensed professional counselors (LPCs) should be rejected. While there are some similarities between the two professions, the differences in education, training, and scope of practice are significant enough to warrant maintaining separate licensure requirements.

Differences in Educational Requirements

Although both LMFTs and LPCs complete graduate-level education, the focus of their coursework differs. LMFTs' education emphasizes family systems, couple dynamics, and systemic interventions (American Association for Marriage and Family Therapy, 2021). In contrast, LPCs' education focuses on individual counseling, mental health disorders, and a broader range of counseling theories and techniques (American Counseling Association, 2021). These differences in educational focus highlight the distinct knowledge and skills required for each profession.

Variations in Scope of Practice

While there is some overlap in the scope of practice between LMFTs and LPCs, there are also notable differences. LMFTs specialize in treating relationship and family issues, with a focus on systemic interventions (American Association for Marriage and Family Therapy, 2021). LPCs, on the other hand, provide a wider range of counseling services, including individual, group, and family counseling, as well as addressing mental health disorders and substance abuse issues (National Board for Certified Counselors, 2021). The distinct scopes of practice underscore the need for profession-specific licensure requirements.

Maintaining the Integrity of Each Profession

Creating a pathway for LMFTs to obtain LPC licensure without requiring them to meet the same educational and examination standards as LPCs could undermine the integrity of the LPC profession. LPCs have worked diligently to establish rigorous licensure requirements that ensure practitioners possess the necessary knowledge and skills to provide competent and ethical counseling services (American Counseling Association, 2021). Allowing LMFTs to bypass these requirements could dilute the quality and consistency of care provided by LPCs.

Protecting the Public

Maintaining separate licensure requirements for LMFTs and LPCs is essential for protecting the public. Licensure laws exist to ensure that mental health professionals have the appropriate education, training, and competence to provide safe and effective services (National Board for Certified Counselors, 2021). By requiring LMFTs to meet the same standards as LPCs to obtain LPC licensure, the Board of Counseling can ensure that all licensed professionals have demonstrated the necessary qualifications to practice within their respective scopes.

While there are some similarities between LMFTs and LPCs, the differences in education, training, and scope of practice warrant maintaining separate licensure requirements. Creating a pathway for LMFTs to obtain LPC licensure without meeting the same rigorous standards could undermine the integrity of the LPC profession and potentially put the public at risk. The Board of Counseling should reject this petition to uphold the distinct qualifications of each profession and ensure the provision of safe, competent, and ethical mental health services.

References:

American Association for Marriage and Family Therapy. (2021). About marriage and family therapists. https://www.aamft.org/About_AAMFT/About_Marriage_and_Family_Therapists.aspx

American Counseling Association. (2021). Licensure requirements for professional counselors: A state-by-state report. https://www.counseling.org/knowledge-center/licensure-requirements

National Board for Certified Counselors. (2021). About NBCC. https://www.nbcc.org/about
CommentID: **228753**

Commenter: Anonymous

11/13/24 12:27 pm

Not in support

LMFT is a specialty training with a focus on relational and family systems. The scope of practice, theoretical orientation, differs from LPC which encompasses and has a broader range of practice and training. In the interest of professional integrity and public safety, this petition is not endorsed.

CommentID: **228867**

Commenter: Anonymous

11/15/24 7:28 am

Not supportive

Agreement with the comments already made.

CommentID: **228871**

Commenter: Council for Accreditation of Counseling and Related Educational Programa

11/18/24 10:19 am

Oppose this Petition

Re: Opposition to Virginia Petition 419

To Whom It May Concern:

The Council for Accreditation of Counseling and Related Educational Programs (CACREP) **opposes** Virginia Petition 419 which would create a pathway for Licensed Marriage and Family Therapists (LMFTs) to obtain licensure as a Licensed Professional Counselor (LPC).

CACREP is the leading national accrediting body for Professional Counselor preparation programs. We accredit programs in the specialized practice areas of Addiction Counseling, Career Counseling, Mental Health Counseling, Clinical Rehabilitation Counseling, College Counseling and Student Affairs, Marriage, Couple and Family Counseling, Rehabilitation Counseling, and School Counseling. Additionally, CACREP accredits doctoral programs in Counselor Education and Supervision for the preparation of counselor educators and advanced practitioners.

CACREP **opposes** this petition for a few main reasons. First, Marriage and Family Therapy is a specialized area of practice with a unique focus that differs significantly from the broader scope of Professional Counseling. Unlike LPCs, LMFTs are not trained to provide the wide-ranging services expected of LPCs, nor do they meet the same educational requirements. The competencies required of LMFTs are a subset within the competencies for LPCs, underscoring the distinct scope of each profession. The petition indicates that the proposed change would create a similar pathway, but this is not the case. In the case of counselors having a pathway to the MFT license, this pathway is very narrow, allowing only counselors who have graduated specifically from a marriage and family counseling program to obtain the MFT license. The proposal in this petition would create a pathway for MFTs to significantly **broaden** their scope of practice, enabling them to practice with populations outside marriage and family counseling (such as addictions counseling) without the requisite training.

For these reasons, it is concerning from a public protection standpoint when individuals licensed as LMFTs practice outside their area of expertise or training (such as an LPC without the appropriate training). Permitting LMFTs to operate as LPCs would not only be unethical but also a potential risk to client safety, as it allows practice outside the licensed scope of competency.

For these reasons, CACREP definitively **opposes** Virginia Petition 419.

For any further questions, please contact CACREP's CEO Sylvia Fernandez at sfernandez@cacrep.org.
CommentID: **228876**

Commenter: Laurie Lynne Wilson 11/18/24 12:20 pm

Do not support

LPC and MFT are distinct disciplines and should not be lumped together. Education requirments and scope of work are different. There is much value in maintaining disctinction in the disciplines.

CommentID: **228879**

Commenter: Anonymous 11/19/24 11:15 am

support

In CACREP programs, family counseling trainees obtain the same base educational requirements, with the addition of systems trainings supporting their expertise in systems/family work. They recieve 60 credit hour degrees with 600 hour internships with supervision - often in the same types of agencies that mental health students are placed. COAMFTE programs require between 60-72 credit hours for a degree with supervised internships.

Adding another exam is costly and provides additional barriers to licensure that are unnecessary. We need to promote workforce development as a field - and paying attention to structural barriers prohibiting access to licensure is an important philosophical ideal of the counseling profession.

One qualifying exam should be enough. We are in a position to slightly lessen the financial and systemic burden of master's level professionals who have earned a 60 credit hour degree and practiced years under supervision to earn a license. That feels like an ideal the field would support.

CommentID: **228882**

Commenter: Anonymous

11/19/24 3:53 pm

Do not Support

In agreement with Moates' comments and CACREP comments. These are two distinct disciplines and the specific licenses (LMFT and LPC) represent those distinctions.

CommentID: **228886**

Commenter: Julie Sayre

11/19/24 7:28 pm

Opposed to Petition

I oppose this petition. LPCs are trained to focus on the individual; LMFTs focus on relational systems and the interactive effects between individuals and systems. The current rules of the Board permit LPCs to become LMFTs without relevant examination. Though this petition may seek to address an imbalance, approval would further blur the lines of clinical specialization and eradicate the purpose of creating separate examinations: to assess competency in a specific field of behavioral health.

CommentID: **228893**

Commenter: William "Wally" Scott, President, VAMFT

11/21/24 12:00 am

Opposed to the petition

It may seem odd that the President of the Virginia Association for Marriage and Family Therapy would oppose this petition requesting a pathway for LMFT's to become licensed as LPC's similar to the pathway for LPC's to become licensed as LMFT's. "Two wrongs do not make a right." Both disciplines are unique and distinct. Because LPC's have a pathway to licensure as LMFT's does not mean LMFT's should have a similar pathway to licensure as LPC's. Both are wrong, although this seems to imply that counseling is a "superior" discipline to marriage and family therapy when it is not. Without rewriting the definitions contained in 54.1-3500, it is obvious that there is considerable overlap between the professions of counseling and marriage and family therapy, as well as clear differences between the two professions recognized in the Code of Virginia and by the Virginia Board of Counseling. In reviewing the Regulations for LPC's and LMFT's, I also found considerable differences in the education requirements, with emphases in different areas for each discipline. The Board created separate licenses for each discipline because of these noted differences. LPC's take more of an individual, linear approach to mental health issues, where problems are located within the individual, and A leads to B; while LMFT's take more of a systemic, circular approach to mental health issues where A leads to B leads to A, while considering and focusing on context, relationship, interaction and what happens between rather than within people. The practice of LMFT's and LPC's are different because of these different orientations to mental health issues. This does not mean that LPC's don't consider context and relationship, and LMFT's don't consider individual pathology; but these orientations establish different tendencies in practice. Again, when I examined the Degree Program Requirements for both LPC's and LMFT's in their respective Regulations, I found that the graduate programs in each discipline have to have a distinct sequence of academic study to prepare the Resident for licensure as an LPC or LMFT; and there must be an identifiable training faculty with credentials and specialization in each discipline. The Board created different licenses because of the recognition and sensitivity to professional identity. We are colleagues under the professional umbrella of mental health professionals yet are

uniquely different as counselors and marriage and family therapists. Reviewing graduate catalogs for degrees in counseling and marriage and family therapists, I again find clear differences. Now, the general public may not recognize the differences between the two disciplines when seeking a mental health professional, but their experiences in sessions will be different. It is for these reasons that I oppose the petition.

CommentID: **228907** Late

18VAC115-50-55. Coursework requirements.

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

1. Marriage and family studies (marital and family development; family systems theory);
2. Marriage and family therapy (systemic therapeutic interventions and application of major theoretical approaches);
3. Human growth and development across the lifespan;
4. Abnormal behaviors;
5. Diagnosis and treatment of addictive behaviors;
6. Multicultural counseling;
7. Professional identity and ethics;
8. Research (research methods; quantitative methods; statistics);
9. Assessment and treatment (appraisal, assessment and diagnostic procedures); and
10. Supervised internship of at least 600 hours to include 240 hours of direct client contact, of which 200 hours shall be with couples and families. Only internship hours earned after completion of 30 graduate semester hours may be counted towards residency hours.

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

Statutory Authority

§ 54.1-2400 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 16, Issue 7, eff. January 19, 2000; amended, Virginia Register Volume 24, Issue 24, eff. September 3, 2008; Volume 32, Issue 24, eff. August 24, 2016.

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 received by the Board requesting that the Board amend regulations to require supervisors complete two hours of continuing education in ethics yearly;

- Comments received via Town Hall; and

- 18VAC115-20-52 and 18VAC115-50-60.

Staff note: Fifteen comments were received in response to the petition. Twelve were in support; three were in opposition.

The Board should consider the current de-regulatory climate nationally and the move away from specified continuing education as it discusses this petition.

Action needed:

- Motion to either:
    - o Deny the petition, providing specific reasons for the decision; or
    - o Accept the petition and initiate rulemaking (NOIRA).

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,)

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.

LPC Reg(8-18-2021) 18VAC115-20-52, C 2 & LMFT Reg (8-18-2021) 18VAC115-50-60, C 3;To require LPC & LMFT Supervisors to have 2 hrs of CEs yearly specifically on Virginia supervision/residency requirements/ethics.

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

I am requesting that the Board of Counseling amend the regulations for LPC and LMFT supervisors to require that at least 2 hours of the 20 hours of continuing education required yearly for licensure renewal to be on the current LPC/LMFT regulations specifically on residency and supervision requirements and the related supervisory ethical issues. Over the past few years, I have become aware of multiple instances of supervisors supervising inappropriately (not following the regulations) and unethically. It's not clear that this is volitional or due to ignorance of the regulations. Some examples are: supervision "prep" hours (preparing case studies) in advance of supervision being counted as face-to-face supervision; dyad supervision being counted as individual hours; immediately "firing" a resident as retribution for the resident giving the required 30 or 60 days' notice of leaving their practice (which did not allow for appropriate termination with their clients); supervisors making negative comments to clients about the resident who resigned; supervisors writing negative/inaccurate information on the verification of supervision form as retribution; the supervisor using their resident as a confidant in dealing with their own personal issues; supervisors requiring their resident to have and pay for supervision they're unable to count because of not having enough indirect & direct hours to justify the supervision; supervisors not providing enough supervision to cover their resident's hours (leaving the resident with needing more supervision hours even after completing the work hour requirements).

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:** 08/01/2024

Public Petition for Rulemaking: 414

Commenter	Title	Comment	Date/ID
Michelle Smith	Agreed wholeheartedly	I applaud Petitioner Watson's request for two hours of continuing education specifically related to supervision/supervisory ethics. I believe this is long overdue, a minimal ask to those of us that supervise, and essential as we attempt to guide, gatekeep, and stay abreast to current trends in our field. Change can be hard, even when it is positive change. For anyone reluctant to embrace that which will benefit future professionals and those we serve, an additional consideration: the National Board for Certified Counselors (NBCC)'s Approved Clinical Supervisor credential requires 45 hours of approved training as well as 20 hours of continuing education specifically related to supervision every five year term, meaning approximately four hours each year. This is double what is being proposed in this petition. In sum, I say bring it on!	9/9/24 1:49 pm CommentID:227743
Suzan Thompson, Ph.D., LPC	I support this petition	LPC supervisors are in a position to model to their supervisees how a professional continues to learn and develop. Continuing education for supervisors should be a component of their own professional development. Other specialties require ongoing related education and training. The Board of Counseling should require supervisors to continue their education in supervision. I support this petition!	9/10/24 7:32 pm CommentID:227762
Jerry Mize	Agree	I fully support the petition to amend 18VAC115-20-52(C)(2) and 18VAC115-50-60(C)(3). Supervisors often face challenges in adequately preparing for their role, and without sufficient training, there can be ethical concerns. Further, there can be concern around financial exploitation of residents where supervisors lose sight of their role. Requiring supervisors to complete two hours of continuing education focused on residency, supervision requirements, and ethical issues will help ensure that they are better equipped to supervise ethically and effectively. This change would protect both supervisees and the integrity of the profession.	9/10/24 7:42 pm CommentID:227763
Carmen Greiner, LPC	I disagree	I disagree with this requirement 1. We already have regulations requiring supervision training and yearly ethics CEUs. 2. Adding another regulation is unnecessary, burdensome and paternalistic. At some point, clinicians have to be responsible for their own ongoing education. 3. This is going to be a waste of time. It is already difficult to find engaging yearly ethics trainings (especially for those of us who have been doing this for many years), how are we going to get “useful” supervision information every year. 4. If you must do something like this, what about the following compromise options a. Allow supervisors to substitute ethics CEU requirements for supervision CEUs. b. Require supervision CEUs in a longer period of	9/17/24 7:49 am CommentID:227865

		time – for example, there needs to be 2 supervision CEUs every three years. c. Define "Supervision CEUs" broadly so as to include cultural competence, training in specific therapeutic interventions (a DBT program supervisor can use training in DBT for their supervision CEUs, training in motivational interviewing is clearly applicable to supervision tasks), supervisors who meet for peer supervision with other supervisors can count their hours in supervision (2 ours of peer supervisor supervision = the 2 CEUs requirements), etc. d. Allow supervisors to substitute pro bono supervision for all the CEU requirements. For example, the Virginia Telemental Health organization needs clinical supervisors. So supervisors who provide 6 months of weekly supervision pro bono are allowed to use that supervision in place of their required 20 hours of CEUs per year. In summary, providers are ethically required to have continuing education. Adding undue requirements regarding the type of education (2 hours of ethics AND 2 hours of supervision) CEUs is unreasonable.	
Anonymous Citizen	In Agreement	We are in a time when ethics seems to have been in many cases thrown out the window due to external pressures to perform to meet certain goals and billable hours rather than fully focus on a client and each client's needs as the priority it should, and was intended to be. Ethics must always be top of mind in performance of any profession.	9/19/24 12:45 pm CommentID:227869
Sharon Watson, LPC, LMFT, LSATP, NCC, ACS	My justification for submitting this petition	I am requesting that the Board of Counseling amend the regulations for LPC and LMFT supervisors to require that at least 2 hours of the 20 hours of continuing education required yearly for licensure renewal to be on the current LPC/LMFT regulations specifically on residency and supervision requirements and the related supervisory ethical issues. This would not change the current requirement of having a total of 20 hours of CEs yearly, of which 2 hours currently are to be on any ethics topics. This would only be for supervisors to have 2 hours specifically on supervision regulations and ethics. The reason I submitted this petition is because, over the past few years, I have become aware of multiple instances of supervisors supervising inappropriately (not following the regulations) or unethically. It's not clear that this is volitional or due to ignorance of the regulations. Some examples are: supervision "prep" hours (preparing case studies) in advance of in-person supervision being counted as face-to-face supervision hours; dyad supervision being counted as individual supervision; immediately "firing" a resident as retribution for the	9/24/24 12:51 am CommentID:227891

		resident giving the required 30 or 60 days' notice of leaving their practice (which did not allow for appropriate termination with their clients); supervisors making negative comments to clients about the resident who resigned; supervisors writing negative/inaccurate information on the verification of supervision form as retribution; the supervisor using their resident as a confidant in dealing with their own personal issues; supervisors requiring their resident to have and pay for supervision they're unable to count (i.e. when the resident does not have enough indirect & direct hours to justify the supervision); supervisors not providing enough supervision (or not suggesting outside additional supervision) to cover their resident's hours, leaving the resident with needing more supervision hours even after completing their total (direct + indirect) work hours resulting in unnecessarily prolonging their residency and postponing their licensure. My petition is specifically only for supervisors and is specifically for 2 CEs reviewing the Virginia regulation requirements for supervisors and residents and any specific ethical issues regarding the supervisory process. I understand this would only be for those supervisors who, for whatever reason, have not kept up with the changes in the regulations or who may simply be functioning based on what they “think” are the regulations without checking for any updates. I understand this will not address some of the issues I listed above for supervisors who are acting out of retribution or volitionally ignoring the regulations.	
Anonymous	Agreed	As its true that Supervisors in some instances have taken advantage of residents, something should be done and this is as good of an option as has been proposed in the last many years that I'm aware of. While this won't fix a supervisory issue that's purposefully predatory towards a resident, it will help those supervisors who have forgotten about rules and ethics. A 2 hour, or 10% of a Supervisory credit hours being dedicated to supervision requirements and the related supervisory ethical issues sounds like a small and appropriate ask. Any reminder that supervisors are to operate ethically and correctly would be appreciated.	9/25/24 5:55 am CommentID:227899
Anonymous	Disagree	The issue at hand is subpar clinicians and clinical supervisors. Two CEUs, forced by this petition, is not the way to correct the issues Sharon identified. The standard CEU courses are not 2 credits. One CEU or 6 is the norm. I would be hard pressed to find a course offering “2	9/26/24 6:11 am CommentID:228003

		CEUs". I don't have the time, energy or resources to comb through CEU offerings to figure out how to get 2 hours. We must already take Ethics. Ethics courses typically touch on ethics in supervision. The issue is poor supervision and poor supervisors. The other issue is the lack of highly trained clinicians. When you allow people to work in the field after taking 30 credits, virtually, and say that they now have a Masters degree, you will have poorly trained clinicians. When you allow non clinically trained people to open and operate mental health services in the community, you will have poorly trained clinicians. When the insurance reimbursement is a pittance of what other providers make, you will have poorly trained clinicians. The gatekeeping must be done earlier in the process. Once an individual is a supervisor, all the classes in the world will not prevent the ridiculous shenanigans that Sharon is observing. I have been a fully licensed clinician from a state that requires two levels of licensure for therapists, for 20 years. I have moved back to VA and am embarrassed of my colleagues because it's apparent they have not been trained properly. That level of responsibility must be addressed at the lowest level- at the educational standards, licensing standards, etc before adding on more oversight to those who are already supervisors tasked with cleaning up the mess a terrible state system created.	
Anonymous	I agree	I agree	9/26/24 7:20 am CommentID:228004
Shelby DeBause	Support fully	I think in order to keep one's place on the registry of state supervisor's one should have to complete this 2 hour yearly requirement. I have been supervising for 12 years and see the need in the field.	9/26/24 9:40 am CommentID:228005
Robin Brown	Comment	I support this petition	9/26/24 9:11 pm CommentID:228007
Anonymous	Completely disagree	I believe supervisors are doing a great job considering some of the unprepared residents they are getting. Add to that the entitlement that some residents are bringing with them that they are paying so minimal effort be put forth and threats of complaints to the board. Frankly I am surprised anyone wants to supervise anymore.	9/27/24 11:53 am CommentID:228016
Jack Childers, LPC	In support of the petition	I am a Virginia LPC. I support this petition because I feel that the power imbalance supervisors have over supervisees, especially, as is often the case, when the supervisor has a dual employer-employee relationship with the supervisee, requires a robust ethical framework to protect supervisees. As an ethics investigator for the WV Board of Counseling, I	9/28/24 7:23 pm CommentID:228025

		have direct experience with the importance of protecting supervisees. This modest proposal to target supervisory ethics is well worth it.	
Enid	I support this petition	I support this petition	9/30/24 6:09 pm CommentID:228029
Madeline Vann LPC CSAC	100% Support this reg	Clinical supervision is a necessary and critical part of developing the workforce. It is there for imperative that all board approved clinical supervisors continue to be trained in the most recent information to enhance their clinical supervision practice and assure adherence to ethical best practice.	10/6/24 8:28 pm CommentID:228062

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 reduction of residency requirements

Included in your agenda package:

- Draft fast-track regulatory amendments to Chapters 20, 50, and 60 to reduce residency requirements.

Staff note: The Regulatory Committee met on October 18, 2024 and considered reductions to residency requirements to become a licensed professional counselor, licensed marriage and family therapist, and licensed substance abuse treatment provider. The Regulatory Committee recommended that the full Board adopt the attached amendments by fast-track regulatory action. The amendments generally:

- Remove the requirement to obtain 3,400 hours of residency, leaving in place the requirement of a minimum of 2,000 hours fast-to-face client contact;
- Require that 1,000 hours face-to-face experience and 100 hours of supervision be completed within two years preceding application to the Board for licensure;
- Remove the maximum time that an applicant must complete supervised experience;
- Create an option for residents to move to inactive status;
- Make other changes consistent with changes described here (for example, eliminating the definition of "ancillary counseling services").

Action needed:

- Motion to accept the recommendation of the regulatory committee and adopt the proposed language as a fast-track regulatory action.

Project 8176 - Fast-Track

Board of Counseling

Reduction of residency requirements

18VAC115-20-10. Definitions.

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

"Board"

"Counseling"

"Professional counselor"

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

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

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

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

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

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

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

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

"CORE" means Council on Rehabilitation Education.

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

"Face-to-face" means the in-person delivery of clinical counseling services for a client.

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

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

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

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

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

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

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

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

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

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

A. The board has established the following fees applicable to licensure as a professional counselor or a resident in counseling:

Initial licensure by examination: Application processing and initial licensure as a professional counselor	$175
Initial licensure by endorsement: Application processing and initial licensure as a professional counselor	$175
Application and initial licensure as a resident in counseling	$65
Pre-review of education only	$75
Duplicate license	$10
Verification of licensure to another jurisdiction	$30
Active annual license renewal for a professional counselor	$130
Inactive annual license renewal for a professional counselor	$65
Annual renewal for a resident in counseling	$30
Inactive annual renewal for a resident in counseling	$15
Late renewal for a professional counselor	$45
Late renewal for a resident in counseling	$10

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Reinstatement of a lapsed license for a professional counselor	$200
Reinstatement following revocation or suspension	$600
Replacement of or additional wall certificate	$25
Returned check or dishonored credit or debit card	$50

B. All fees are nonrefundable.

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

18VAC115-20-51. Coursework requirements.

A. The applicant shall have successfully completed 60 semester hours or 90 quarter hours of graduate study in the following core coursework with a minimum of three semester hours or 4.0 quarter hours in each of subdivisions 1 through 12 of this subsection:

1. Professional counseling identity, function, and ethics;

2. Theories of counseling and psychotherapy;

3. Counseling and psychotherapy techniques;

4. Human growth and development;

5. Group counseling and psychotherapy theories and techniques;

6. Career counseling and development theories and techniques;

7. Appraisal, evaluation, and diagnostic procedures;

8. Abnormal behavior and psychopathology;

9. Multicultural counseling theories and techniques;

10. Research;

11. Diagnosis and treatment of addictive disorders;

12. Marriage and family systems theory; and

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13. Supervised internship of at least 600 hours to include 240 hours of face-to-face client contact. ~~Only internship hours earned after completion of 30 graduate semester hours may be counted towards residency hours.~~

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

18VAC115-20-52. Resident license and residency 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.

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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 2,000 hours of face-to-face client contact providing clinical counseling services.

3. 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.

a. 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.

b. 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.~~

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~~3.~~ c. 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. The resident will complete a minimum of 1,000 hours of face-to-face client contact and 100 hours of supervision within two years immediately preceding application to the board for licensure as a professional counselor.

5. 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.~~ 6. 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.~~

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7. 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.~~ 8. 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.~~ 9. 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.~~ 10. Residents shall not engage in practice under supervision in any areas for which they have not had appropriate education.

~~12.~~ 11. The board will accept residency ~~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

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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.~~

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18VAC115-20-70. General examination requirements~~; schedules; time limits~~.

A. Every applicant for initial licensure by examination by the board as a professional counselor shall pass a written examination as prescribed by the board. ~~An applicant is required to have passed the prescribed examination within six years from the date of initial issuance of a resident license by the board.~~

B. Every applicant for licensure by endorsement shall have passed a licensure examination in the jurisdiction in which licensure was obtained.

C. The board shall establish a passing score on the written examination.

D. A resident shall remain in a residency practicing under supervision until the resident has passed the licensure examination and been granted a license as a professional counselor.

18VAC115-20-100. ~~Annual renewal of licensure~~ Licensure renewal.

A. Every ~~licensed professional counselor~~ licensee who intends to continue an active practice shall submit to the board on or before June 30 of each year:

1. A completed form for renewal of the license on which the licensee attests to compliance with the continuing competency requirements prescribed in this chapter; and

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

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

C. For renewal of a resident license in counseling, the following shall apply:

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1. ~~A resident license shall expire annually in the month the resident license was initially issued and may be renewed up to five times by submission of the renewal form and payment of the fee prescribed in 18VAC115-20-20.~~

~~2.~~ On the annual renewal, the resident shall attest that a supervisory contract is in effect with a board-approved supervisor for each of the locations at which the resident is currently providing clinical counseling services.

~~3.~~ 2. On the annual renewal, the resident in counseling shall attest to completion of three hours in continuing education courses that emphasize the ethics, standards of practice, or laws governing behavioral science professions in Virginia, offered by an approved provider as set forth in subsection B of 18VAC115-20-106.

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

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

18VAC115-50-10. Definitions.

A. The following words and terms when used in this chapter shall have the meaning ascribed to them in § 54.1-3500 of the Code of Virginia: (i) "board," (ii) "marriage and family therapy," (iii) "marriage and family therapist," and (iv) "practice of marriage and family therapy."

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

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

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

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

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

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

"Face-to-face" means the in-person delivery of clinical marriage and family services for a client.

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

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

"Residency" means a postgraduate, supervised clinical experience.

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

"Supervision" means an ongoing process performed by a supervisor who monitors the performance of the person supervised and provides regular, documented, individual or group

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consultation, guidance, and instruction with respect to the clinical skills and competencies of the person or persons being supervised.

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

18VAC115-50-20. Fees.

A. The board has established fees for the following:

Application and initial licensure as a resident	$65
Pre-review of education only	$75
Initial licensure by examination: Processing and initial licensure as a marriage and family therapist	$175
Initial licensure by endorsement: Processing and initial licensure as a marriage and family therapist	$175
Active annual license renewal for a marriage and family therapist	$130
Inactive annual license renewal for a marriage and family therapist	$65
Annual renewal for a resident in marriage and family therapy	$30
Inactive annual renewal for a resident in marriage and family therapy	$15
Penalty for late renewal for a marriage and family therapist	$45
Late renewal for resident in marriage and family therapy	$10
Reinstatement of a lapsed license for a marriage and family therapist	$200
Verification of license to another jurisdiction	$30
Additional or replacement licenses	$10
Additional or replacement wall certificates	$25
Returned check or dishonored credit or debit card	$50
Reinstatement following revocation or suspension	$600

B. All fees are nonrefundable.

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

18VAC115-50-55. Coursework requirements.

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

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

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

3. Human growth and development across the lifespan;

4. Abnormal behaviors;

5. Diagnosis and treatment of addictive behaviors;

6. Multicultural counseling;

7. Professional identity and ethics;

8. Research (research methods; quantitative methods; statistics);

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

10. Supervised internship of at least 600 hours to include 240 hours of direct client contact, of which 200 hours shall be with couples and families. ~~Only internship hours earned after completion of 30 graduate semester hours may be counted towards residency hours.~~

B. If the applicant holds a current, unrestricted license as a professional counselor, clinical psychologist, or clinical social worker, the board may accept evidence of successful completion of 60 semester hours or 90 quarter hours of graduate study, including a minimum of six semester hours or nine quarter hours completed in marriage and family studies (marital and family

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development; family systems theory) and six semester hours or nine quarter hours completed in marriage and family therapy (systemic therapeutic interventions and application of major theoretical approaches).

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

~~**Resident license and requirements for a residency**~~

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

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

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

3. Pay the registration 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~~ a supervised residency in the role of a marriage and family

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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~~ 100 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.

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4. The resident will complete a minimum of 1,000 hours of face-to-face client contact and 100 hours of supervision within two years immediately preceding application to the board for licensure as a marriage and family therapist.

~~4.~~ 5. 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.~~ 6. The board may consider special requests in the event that the regulations create an undue burden in regard to geography or disability that limits the resident's access to qualified supervision.

~~8.~~ 7. 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.~~ 8. Residents shall not engage in practice under supervision in any areas for which they do not have appropriate education.

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~~10.~~ 9. 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.~~ 10. The board will accept residency ~~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.

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

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

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

18VAC115-50-70. General examination requirements.

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

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

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

18VAC115-50-90. ~~Annual renewal of license~~ <u>Licensure renewal</u>.

A. ~~All licensed marriage and family therapists~~ <u>Every licensee</u> who ~~intend~~ <u>intends</u> to continue an active practice shall submit to the board on or before June 30 of each year:

1. A completed form for renewal of the license on which the licensee attests to compliance with the continuing competency requirements prescribed in this chapter; and

2. The renewal fee prescribed in 18VAC115-50-20.

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B. A ~~licensed marriage and family therapist~~ licensee who wishes to place his license in an inactive status may do so upon payment of the inactive renewal fee as established in 18VAC115-50-20. No person shall practice marriage and family therapy in Virginia unless he holds a current active license. A licensee who has placed himself in inactive status may become active by fulfilling the reactivation requirements set forth in 18VAC115-50-100 C.

C. For renewal of a resident license in marriage and family therapy, the following shall apply:

1. ~~A resident license shall expire annually in the month the license was initially issued and may be renewed up to five times by submission of the renewal form and payment of the fee prescribed in 18VAC115-50-20.~~

~~2.~~ On the annual renewal, the resident shall attest that a supervisory contract is in effect with a board-approved supervisor for each of the locations at which the resident is currently providing marriage and family therapy.

3. On the annual renewal, residents in marriage and family therapy shall attest to completion of three hours in continuing education courses that emphasize the ethics, standards of practice, or laws governing behavioral science professions in Virginia, offered by an approved provider as set forth in subsection B of 18VAC115-50-96.

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

E. After the renewal date, the license is expired; practice with an expired license is prohibited and may constitute grounds for disciplinary action.

18VAC115-60-10. Definitions.

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

"Board"

"Licensed substance abuse treatment practitioner"

"Substance abuse"

"Substance abuse treatment"

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

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

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

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

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

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

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

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

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

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

"Face-to-face" means the in-person delivery of clinical substance abuse treatment services for a client.

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

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

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

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

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

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

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

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

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

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

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

Application and initial licensure as a resident in substance abuse treatment	$65
Pre-review of education only	$75
Initial licensure by examination: Processing and initial licensure as a substance abuse treatment practitioner	$175
Initial licensure by endorsement: Processing and initial licensure as a substance abuse treatment practitioner	$175
Active annual license renewal for a substance abuse treatment practitioner	$130
Inactive annual license renewal for a substance abuse treatment practitioner	$65
Annual renewal for a resident in substance abuse treatment	$30
Inactive annual renewal for resident in substance abuse treatment	$15
Duplicate license	$10
Verification of license to another jurisdiction	$30
Late renewal for a substance abuse treatment practitioner	$45
Late renewal for a resident in substance abuse treatment	$10
Reinstatement of a lapsed license of a substance abuse treatment practitioner	$200
Replacement of or additional wall certificate	$25

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Returned check or dishonored credit or debit card	$50
Reinstatement following revocation or suspension	$600

B. All fees are nonrefundable.

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

18VAC115-60-70. Coursework requirements.

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

B. The applicant shall have completed a general core curriculum containing a minimum of three semester hours or 4.0 quarter hours in each of the areas identified in this section:

1. Professional identity, function and ethics;

2. Theories of counseling and psychotherapy;

3. Counseling and psychotherapy techniques;

4. Group counseling and psychotherapy, theories and techniques;

5. Appraisal, evaluation and diagnostic procedures;

6. Abnormal behavior and psychopathology;

7. Multicultural counseling, theories and techniques;

8. Research; and

9. Marriage and family systems theory.

C. The applicant shall also have completed 12 graduate semester credit hours or 18 graduate quarter hours in the following substance abuse treatment competencies.

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

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

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

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

5. Client and community education.

D. The applicant shall have completed a supervised internship of 600 hours to include 240 hours of direct client contact, of which 200 hours shall be in treating substance abuse-specific treatment problems. ~~Only internship hours earned after completion of 30 graduate semester hours may be counted towards residency hours.~~

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

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

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

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

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

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

3. Pay the registration fee;

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

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

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

C. Residency requirements.

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

~~a. Clinical evaluation;~~

~~b. Treatment planning, documentation, and implementation;~~

~~c. Referral and service coordination;~~

~~d. Individual and group counseling and case management;~~

~~e. Client family and community education; and~~

~~f. Professional and ethical responsibility.~~

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2. The residency shall include at least 2,000 hours of face-to-face client contact in providing clinical substance abuse treatment services with individuals, families, or groups of individuals suffering from the effects of substance abuse or dependence.

3. The residency shall include a minimum of 200 hours of in-person supervision between supervisor and resident occurring at a minimum of one hour and a maximum of four hours per 40 hours of work experience during the period of the residency.

a. No more than half of these hours may be satisfied with group supervision.

b. One hour of group supervision will be deemed equivalent to one hour of individual supervision.

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

d. For the purpose of meeting the 200-hour supervision requirement, in-person supervision may include the use of technology that maintains client confidentiality and provides real-time, visual contact between the supervisor and the resident.

~~e. Up to 20 hours of the supervision received during the supervised internship may be counted towards the 200 hours of in-person supervision if the supervision was provided by a licensed professional counselor.~~

~~3. The residency shall include at least 2,000 hours of face-to-face client contact in providing clinical substance abuse treatment services with individuals, families, or groups of individuals suffering from the effects of substance abuse or dependence. The remaining hours may be spent in the performance of ancillary services.~~

~~4. A graduate level degree internship in excess of 600 hours, which is completed in a program that meets the requirements set forth in 18VAC115-60-70, may count for up to an additional 300 hours towards the requirements of a residency.~~

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4. The resident will complete a minimum of 1,000 hours of face-to-face client contact and 100 hours of supervision within two years immediately preceding application to the board for licensure as a substance abuse treatment practitioner.

5. The residency shall be completed in not less than 21 months ~~or more than four years. Residents who began a residency before August 24, 2016, shall complete the residency by August 24, 2020. An individual who does not complete the residency after four years shall submit evidence to the board showing why the supervised experience should be allowed to continue~~. A resident shall meet the renewal requirements of ~~subsection C of~~ 18VAC115-60-110 in order to maintain a license in current, active status.

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

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

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

9. The board will accept residency ~~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~~.

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D. Supervisory qualifications.

1. A person who provides supervision for a resident in substance abuse treatment shall hold an active, unrestricted license as a professional counselor or substance abuse treatment practitioner in the jurisdiction where the supervision is being provided. ~~Supervisors who are marriage and family therapists, school psychologists, clinical psychologists, clinical social workers, clinical nurse specialists, or psychiatrists and have been approved to provide supervision may continue to do so until August 24, 2017.~~

2. All supervisors shall document two years post-licensure substance abuse treatment experience and at least 100 hours of didactic instruction in substance abuse treatment. Supervisors must document a three-credit-hour course in supervision, a 4.0-quarter-hour course in supervision, or at least 20 hours of continuing education in supervision offered by a provider approved under 18VAC115-60-116.

E. Supervisory responsibilities.

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

2. The supervisor of a resident shall assume full responsibility for the clinical activities of that resident specified within the supervisory contract for the duration of the residency.

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

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

F. Documentation of supervision. Applicants shall document successful completion of their residency on the Verification of Supervision form at the time of application. Applicants must receive a satisfactory competency evaluation on each item on the evaluation sheet.

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

A. Every applicant for licensure as a substance abuse treatment practitioner by examination shall pass a written examination as prescribed by the board. ~~Such applicant is required to pass the prescribed examination within six years from the date of initial issuance of a resident license by the board.~~

B. Every applicant for licensure as a substance abuse treatment practitioner by endorsement shall have passed a substance abuse examination deemed by the board to be substantially equivalent to the Virginia examination.

C. The examination is waived for an applicant who holds a current and unrestricted license as a professional counselor issued by the board.

D. The board shall establish a passing score on the written examination.

E. A resident shall remain in a residency practicing under supervision until the resident has passed the licensure examination and been granted a license as a substance abuse treatment practitioner.

18VAC115-60-110. ~~Renewal of licensure~~ Licensure renewal.

A. Every ~~substance abuse treatment practitioner~~ licensee who intends to continue an active practice shall submit to the board on or before June 30 of each year:

1. A completed form for renewal of the license on which the licensee attests to compliance with the continuing competency requirements prescribed in this chapter; and

2. The renewal fee prescribed in 18VAC115-60-20.

B. A ~~substance abuse treatment practitioner~~ licensee who wishes to place his license in an inactive status may do so upon payment of the inactive renewal fee as established in 18VAC115-60-20. No person shall practice substance abuse treatment in Virginia unless he holds a current

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active license. A licensee who has placed himself in inactive status may become active by fulfilling the reactivation requirements set forth in subsection C of 18VAC115-60-120.

C. For renewal of a resident license in substance abuse treatment, the following shall apply:

1. ~~A resident license shall expire annually in the month the resident license was initially issued and may be renewed up to five times by submission of the renewal form and payment of the fee prescribed in 18VAC115-60-20.~~

~~2.~~ On the annual renewal, the resident shall attest that a supervisory contract is in effect with a board-approved supervisor for each of the locations at which the resident is currently providing substance abuse treatment services.

~~3.~~ 2. On the annual renewal, residents in substance abuse treatment shall attest to completion of three hours in continuing education courses that emphasize the ethics, standards of practice, or laws governing behavioral science professions in Virginia, offered by an approved provider as set forth in subsection B of 18VAC115-60-116.

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

E. After the renewal date, the license is expired; practice with an expired license is prohibited and may constitute grounds for disciplinary action.

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Agenda Item: Adoption of proposed regulatory language to implement the Counseling Compact

Included in your agenda package:

- Town Hall summary page from NOIRA/Emergency stage showing no comments; and

- Proposed regulatory language identical to the emergency language.

Staff note: The emergency regulations will be in effect until March 8, 2026. This action will create permanent regulations which will supersede the emergency regulations.

Action needed:

- Motion to adopt proposed regulatory language to implement the Counseling Compact.

Agency Department of Health Professions

Board Board of Counseling

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

Action: Implementation of the Counseling Compact

Emergency/NOIRA Stage

Action 6238 / Stage 10003

Edit Stage **Go to RIS Project** **Request Emergency Extension**

Documents		
Emergency Text	9/19/2024 10:59 am	**Sync Text with RIS**
Agency Background Document	5/8/2023	**Upload / Replace**
Attorney General Certification	7/12/2023	
Governor's Review Memo	9/3/2024	
Registrar Transmittal	9/4/2024	

Status	
Public Hearing	Will be held at the **proposed** stage
Emergency Authority	2.2-4011(B)
Attorney General Review	Submitted to OAG: 5/8/2023 Review Completed: 7/12/2023 Result: Certified
DPB Review	Submitted on 7/12/2023 Policy Analyst: Jeannine Rose Review Completed: 7/31/2023
Secretary Review	Secretary of Health and Human Resources Review Completed: 8/29/2024
Governor's Review	ORM Review: ORM Approved 9/3/2024 Governor Review Completed: 9/3/2024 Result: Approved
Virginia Registrar	Submitted on 9/4/2024 **The Virginia Register of Regulations** Publication Date: 10/7/2024 **Volume: 41 Issue: 4**
Comment Period	Ended 11/6/2024 0 comments
Effective Date	9/9/2024
Expiration Date	3/8/2026

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This person is the primary contact for this board.

This stage was created by Erin Barrett on 05/05/2023 at 1:00pm
This stage was last edited by Erin Barrett on 05/05/2023 at 1:01pm

Project 7562 - Proposed

Board of Counseling

Implementation of the Counseling Compact

18VAC115-20-10. Definitions.

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

"Board"

"Counseling"

"Professional counselor"

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

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

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

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

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

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

Draft

"Compact" means the Counseling Compact.

"Compact privilege" means a legal authorization, which is equivalent to a license, permitting the practice of professional counseling in a remote state.

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

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

"CORE" means Council on Rehabilitation Education.

"Counseling Compact Commission" or "commission" means the national administrative body whose membership consists of all states that have enacted the compact.

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

"Face-to-face" means the in-person delivery of clinical counseling services for a client.

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

"Home state" means the member state of the compact that is the licensee's primary state of residence.

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

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

"Member state" means a state that has enacted the compact.

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

"Practitioner" means an individual who holds a license to practice professional counseling, license to practice as a resident in counseling, or a compact privilege to practice professional counseling in Virginia.

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

"Remote state" means a member state of the compact other than the home state where the licensee is exercising or seeking to exercise the privilege to practice.

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

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

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

Draft

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

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

A. The board has established the following fees applicable to licensure as a professional counselor or a resident in counseling:

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

B. All fees are nonrefundable.

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

18VAC115-20-41. Compact privilege to practice professional counseling.

To obtain a compact privilege to practice professional counseling in Virginia, a licensed professional counselor in a member state shall comply with the rules adopted by the Counseling Compact Commission in effect at the time of application.

18VAC115-20-100. Annual renewal of licensure or compact privilege.

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

1. A completed form for renewal of the license on which the licensee attests to compliance with the continuing competency requirements prescribed in this chapter; and

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

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

C. For renewal of a resident license in counseling, the following shall apply:

1. A resident license shall expire annually in the month the resident license was initially issued and may be renewed up to five times by submission of the renewal form and payment of the fee prescribed in 18VAC115-20-20.

2. On the annual renewal, the resident shall attest that a supervisory contract is in effect with a board-approved supervisor for each of the locations at which the resident is currently providing clinical counseling services.

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3. On the annual renewal, the resident in counseling shall attest to completion of three hours in continuing education courses that emphasize the ethics, standards of practice, or laws governing behavioral science professions in Virginia, offered by an approved provider as set forth in subsection B of 18VAC115-20-106.

D. ~~Licensees~~ In order to renew a compact privilege to practice in Virginia, the compact privilege holder shall comply with the rules adopted by the Counseling Compact Commission in effect at the time of the renewal.

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

~~E.~~ F. Practice with an expired license or compact privilege is prohibited and may constitute grounds for disciplinary action.

18VAC115-20-130. Standards of practice.

A. The protection of the public health, safety, and welfare and the best interest of the public shall be the primary guide in determining the appropriate professional conduct of all persons whose activities are regulated by the board. Regardless of the delivery method, whether in person, by phone, or electronically, these standards shall apply to the practice of counseling.

B. ~~Persons licensed or registered by the board~~ Practitioners shall:

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

2. Practice only within the boundaries of their competence, based on their education, training, supervised experience, and appropriate professional experience and represent their education, training, and experience accurately to clients;

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

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

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

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

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

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

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

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

11. Determine whether a client is receiving services from another mental health service provider, and if so, refrain from providing services to the client without having an informed

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consent discussion with the client and having been granted communication privileges with the other professional;

12. Use only in connection with one's practice as a mental health professional those educational and professional degrees or titles that have been earned at a college or university accredited by an accrediting agency recognized by the U.S. Department of Education, or credentials granted by a national certifying agency, and that are counseling in nature;

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

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

C. In regard to patient records, ~~persons licensed by the board~~ practitioners shall:

1. Maintain written or electronic clinical records for each client to include treatment dates and identifying information to substantiate diagnosis and treatment plan, client progress, and termination;

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

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

4. Ensure confidentiality in the usage of client records and clinical materials by obtaining informed consent from the client or the client's legally authorized representative before (i) videotaping, (ii) audio recording, (iii) permitting third party observation, or (iv) using

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identifiable client records and clinical materials in teaching, writing, or public presentations; and

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

a. At minimum, records of a minor child shall be maintained for five years after attaining the age of majority (18 years) or 10 years following termination, whichever comes later;

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

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

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

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

2. Not engage in any type of romantic relationships or sexual intimacies with clients or those included in a collateral relationship with the client and not counsel persons with whom they have had a romantic relationship or sexual intimacy. Counselors shall not engage in romantic relationships or sexual intimacies with former clients within a minimum of five years after terminating the counseling relationship. Counselors who engage in such relationship or intimacy after five years following termination shall have the responsibility to examine and document thoroughly that such relations do not have an exploitive nature,

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based on factors such as duration of counseling, amount of time since counseling, termination circumstances, client's personal history and mental status, or adverse impact on the client. A client's consent to, initiation of, or participation in sexual behavior or involvement with a counselor does not change the nature of the conduct nor lift the regulatory prohibition;

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

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

E. ~~Persons licensed by this board~~ Practitioners shall report to the board known or suspected violations of the laws and regulations governing the practice of professional counseling.

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

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

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

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

2. Procurement of a license or compact privilege, including submission of an application or supervisory forms, by fraud or misrepresentation;

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

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

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

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

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

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

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

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18VAC115-20-150. Reinstatement following disciplinary action.

A. Any person whose license or compact privilege has been suspended or who has been denied reinstatement by board order, having met the terms of the order, may submit a new application and fee for reinstatement of licensure or compact privilege.

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

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Approved Training for Registration as a **Behavioral Health Technician Assistant (BHTA)**

Submit proof of completion of

- one option from List A **OR**
- official transcript documenting completion of a high school diploma/GED AND training from List B

List A – Completion of one of the following:

- 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 community college programs:

- Blue Ridge CC, Human Services, AAS
- Blue Ridge CC, Human Services I, CSC
- Blue Ridge CC, Human Service II, CSC
- Blue Ridge CC, Substance Abuse Counseling, CSC
- Brightpoint CC, Human Services, AAS
- Brightpoint CC, Human Svs-Pre-Social Work Spec, AAS`
- Brightpoint CC, Psychology, AS
- Brightpoint CC, Bereavement and Grief Counseling, CSC
- Brightpoint CC, Substance Abuse Assistant, CSC
- Germanna CC, Paraprofessional Counseling, CSC
- Germanna CC, Behavioral Health Technician, Certificate
- Laurel Ridge CC, Human Services, AAS
- Northern VA CC, Substance Abuse Rehab Coun, Cert
- Rappahannock CC, Psychology/Social Work Spec, AAS
- Reynolds CC, Human Services, AAS
- Reynolds CC, Behavioral Health Technician, CSC
- Reynolds CC, Human Services Tech, CSC
- Reynolds CC, Substance Abuse Counselor Edu, CSC
- Southside CC, Human Services, AAS
- Southside CC, Human Services, CSC
- Southside CC, Human Services, Certificate
- Southside CC, Substance Abuse Counseling Asst, Cert.
- Southside CC, Substance Abuse Counseling Aide, CSC
- Virginia Highlands CC , Human Services, AAS
- Virginia Highlands CC, Human Services Advocate, Cert.
- Virginia Highlands CC, Substance Abuse Coun Asst, CSC
- Virginia Peninsula CC, Human Services, AAS
- Virginia Peninsula CC, Substance Abuse Coun Asst, CSC
- Virginia Western CC, Human Services, AAS
- Virginia Western CC, Human Services: Foundations, CSC
- Wytheville CC, Human Services, AS
- Wytheville CC, Human Services Professional, AAS
- Wytheville CC, Human Services-Mental Health, CSC

List B – High School Diploma/GED AND 20 hours of training in one or more of the following:

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

Approved Training for Registration as a **Behavioral Health Technician (BHT)**

Submit proof of completion of

- one option from List A **OR**
- official transcript documenting completion of an associate's degree AND training from List B

List A – Associate's degree in one of the following programs:

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

List B – Associate's degree AND 40 hours of training in one or more of the following:

- American Association of Psychiatric Techs (AAPT) Level 2 or higher
- Adult Continuing Education (ACE) for Mental Health Tech
- Crisis Intervention Team (CIT)
- DBHDS Academy + additional training from List B
- DBHDS PRS (Peer Recovery) 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
- VHWDA Community Health Worker Training
- Youth Mental Health Corps Training

Certificate from the following community college programs:

- Blue Ridge CC, Human Services I, CSC
- Blue Ridge CC, Human Service II, CSC
- Blue Ridge CC, Substance Abuse Counseling, CSC
- Brightpoint CC, Bereavement and Grief Counseling, CSC
- Brightpoint CC, Substance Abuse Assistant, CSC
- Germanna CC, Paraprofessional Counseling, CSC
- Germanna CC, Behavioral Health Technician, Certificate
- Northern VA CC, Substance Abuse Rehab Coun, Cert
- Reynolds CC, Behavioral Health Technician, CSC
- Reynolds CC, Human Services Technician, CSC
- Reynolds CC, Substance Abuse Counselor Education, CSC
- Southside CC, Human Services, CSC
- Southside CC, Human Services, Certificate
- Southside CC, Substance Abuse Counseling Asst, Cert.
- Southside CC, Substance Abuse Counseling Aide, CSC
- Virginia Highlands CC, Human Services Advocate, Cert.
- Virginia Highlands CC, Substance Abuse Coun Asst, CSC
- Virginia Peninsula CC, Substance Abuse Coun Asst, CSC
- Virginia Western CC, Human Services: Foundations, CSC
- Wytheville CC, Human Services-Mental Health, CSC

Qualifications and Approved Training for Registration as a **Qualified Mental Health Professional-Trainee (QMHP-T)**

Education Requirement

- Official transcript documenting completion of a bachelor's degree, OR
- Proof you are actively enrolled, and in good standing, in a bachelor's program.

Approved Training Programs - 60 hours in one or more of the following:

- American Association of Psychiatric Techs (AAPT) - Level 2 or higher
- Adult Continuing Education (ACE) for Mental Health Tech
- Crisis Intervention Team (CIT) Training (40 hours) + additional training from this list
- High school diploma with successful completion of the Career and Technical Education (CTE) program in Mental Health Assistant or equivalent
- DBHDS Academy + additional training from this list
- 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

Official transcript documenting completion of one of the following community college programs:

- Blue Ridge CC, Human Services, AAS
- Blue Ridge CC, Human Services I, CSC
- Blue Ridge CC, Human Service II, CSC
- Blue Ridge CC, Substance Abuse Counseling, CSC
- Brightpoint CC, Human Services, AAS
- Brightpoint CC, Human Svcs-Pre-Social Work Spec, AAS
- Brightpoint CC, Psychology, AS
- Brightpoint CC, Bereavement and Grief Counseling, CSC
- Brightpoint CC, Substance Abuse Assistant, CSC
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- Northern VA CC, Substance Abuse Rehab Coun, Cert
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- Reynolds CC, Human Services, AAS
- Reynolds CC, Behavioral Health Technician, CSC
- Reynolds CC, Human Services Technician, CSC
- Reynolds CC, Substance Abuse Counselor Edu, CSC
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- Southside CC, Human Services, Certificate
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- Virginia Peninsula CC, Substance Abuse Coun Asst, CSC
- Virginia Western CC, Human Services, AAS
- Virginia Western CC, Human Services: Foundations, CSC
- Wytheville CC, Human Services, AS
- Wytheville CC, Human Services Professional, AAS
- Wytheville CC, Human Services-Mental Health, CSC

Qualifications and Approved Training for Registration as a **Qualified Mental Health Professional (QMHP)**

Education Requirement

- Official transcript documenting completion of a bachelor's degree.

Approved Training Programs - 80 hours in one or more of the following:

***** Education and training approved for QMHP-Trainee can be used towards satisfaction of the QMHP requirements.***

- American Association of Psychiatric Techs (AAPT) - Level 2 or higher
- Adult Continuing Education (ACE) for Mental Health Tech
- Crisis Intervention Team (CIT) Training + additional training from this list
- High school diploma with successful completion of the Career and Technical Education (CTE) program in Mental Health Assistant or equivalent
- DBHDS Academy + additional training from this list
- DBHDS PRS (Peer Recovery) Training + additional training from this list
- 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

Official transcript documenting completion of one of the following community college programs:

- Blue Ridge CC, Human Services, AAS
- Blue Ridge CC, Human Services I, CSC
- Blue Ridge CC, Human Service II, CSC
- Blue Ridge CC, Substance Abuse Counseling, CSC
- Brightpoint CC, Human Services, AAS
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- Germanna CC, Paraprofessional Counseling, CSC
- Germanna CC, Behavioral Health Technician, Certificate
- Laurel Ridge CC, Human Services, AAS
- Northern VA CC, Substance Abuse Rehab Coun, Cert
- Rappahannock CC, Psychology/Social Work Spec, AAS
- Reynolds CC, Human Services, AAS
- Reynolds CC, Behavioral Health Technician, CSC
- Reynolds CC, Human Services Technician, CSC
- Reynolds CC, Substance Abuse Counselor Edu, CSC
- Southside CC, Human Services, AAS
- Southside CC, Human Services, CSC
- Southside CC, Human Services, Certificate
- Southside CC, Substance Abuse Counseling Asst, Cert.
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- Wytheville CC, Human Services, AS
- Wytheville CC, Human Services Professional, AAS
- Wytheville CC, Human Services-Mental Health, CSC

Discipline Reports

Sep 21, 2024 to Jan 10, 2025

NEW CASES RECEIVED BY BOARD Sep 21, 2024 to Jan 10, 2025
134

TOTAL OPEN INVESTIGATIONS (ENFORCEMENT)
73

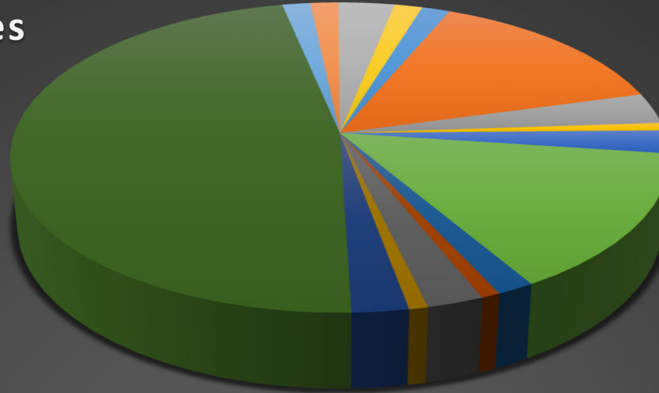
OPEN CASE STAGES as of Jan 10, 2025	
Probable Cause Review	173
Scheduled for Informal Conferences	9
Scheduled for Formal Hearings	6
Other (pending CCA, PHCO, hold, etc.)	20
Cases with APD for processing (IFC, FH, Consent Order)	7
TOTAL ACTIVE CASES AT BOARD LEVEL	**215**

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

CASES CLOSED Sep 21, 2024 to Jan 10, 2025	
No violation	108
Undetermined	7
Violation 1 Informal Conference 2 mandatory suspensions 1 Consent Order entered 3 Confidential Consent Agreements	7
Application Approved 1 Formal Hearing	1
Application Denied 1 Informal Conference 1 Consent Order entered	2
Application Withdrawn	0
TOTAL CASES CLOSED	**125**

Virginia Department of
Health Professions
Board of Counseling

Closed Case Categories



- Abuse/Abandonment/Neglect (2)
- Business Practice Issues (18)
- CE Noncompliance (4)
  2 violations (LPC, QMHP)
- Confidentiality Breach (1)
- Criminal Activity (3)
  2 violations (QMHP, LMFT)
- Diagnosis/Treatment (18)
- Eligibility (2)
  1 approved (RIC Appl)
- Fraud, non patient care (1)
- Fraud, patient care (3)
  1 violation (RIC)
- Inability to Safely Practice (1)
- Inappropriate Relationship (3)
  1 violation (RIC)
- No jurisdiction (59)
- Records Release (2)
  1 violation (LPC)
- Reinstatement (2)
  2 denied (LPC, QMHP)
- Scope of Practice (4)
- Unlicensed Activity (2)

AVERAGE CASE PROCESSING TIMES (counted on closed cases)	
Average time for case closures	**179**
Avg. time in Enforcement (investigations)	76
Avg. time in APD (IFC/FH preparation)	34
Avg. time in Board (includes hearings, reviews, etc).	103

Discipline Staff for Behavioral Science Boards

Jennifer Lang, Deputy Executive Director
Christy Palmore, Discipline and Compliance Case Specialist
Krystal Blanton, Discipline and Compliance Case Specialist
Discipline Reviewer, Board of Counseling (part-time)
Discipline Reviewer, Board of Psychology (part-time)
Discipline Reviewer, Board of Social Work (part-time)

CURRENT OPEN CASES PER BOARD as of Jan 10, 2025	
Board of Counseling	**215**
Board of Psychology	141
Board of Social Work	222
TOTAL OPEN CASES	**578**

BSU Cases Received from Enforcement

	COUNSELING	PSYCHOLOGY	SOCIAL WORK	BSU TOTAL
2021	344	132	94	**570**
2022	381	127	108	**616**
2023	440	124	160	**724**
2024	493	193	198	**884**

Recent Orders entered by the Board of Counseling

*For informational purposes only.
Board action is not required.

BEFORE THE VIRGINIA DEPARTMENT OF HEALTH PROFESSIONS

IN RE: RENAE COMBS SIZEMORE, QMHP-T
Registration Number: 0734-007522
Case Number: 241718

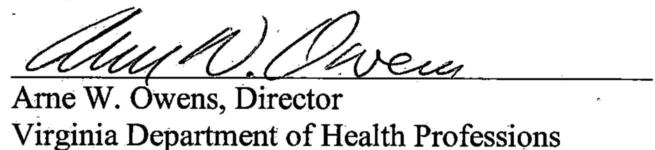
ORDER OF MANDATORY SUSPENSION

In accordance with Virginia Code § 54.1-2409, the Director of the Virginia Department of Health Professions received evidence that Renae Combs Sizemore, QMHP-T, was convicted of a felony offense, to wit: embezzlement, in the Circuit Court of Carroll County, Virginia. A copy of the Conviction and Sentencing Order is attached hereto as Commonwealth's Exhibit 1.

WHEREUPON, by the authority vested in the Director of the Department of Health Professions pursuant to Virginia Code § 54.1-2409, it is hereby ORDERED that the registration of Renae Combs Sizemore, QMHP-T, to practice as a qualified mental health professional-trainee in the Commonwealth of Virginia is hereby SUSPENDED.

Upon entry of this Order, the registration of Renae Combs Sizemore, QMHP-T, will be recorded as suspended. Should Ms. Sizemore seek reinstatement of her registration pursuant to Virginia Code § 54.1-2409, she shall be responsible for any fees that may be required for the reinstatement of the registration prior to issuance of the registration to resume practice.

Pursuant to Virginia Code § 2.2-4023 and § 54.1-2400.2, the signed original of this Order shall remain in the custody of the Department of Health Professions as a public record and shall be made available for public inspection or copying on request.



Arne W. Owens, Director
Virginia Department of Health Professions

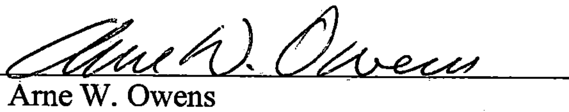
ENTERED:

9-24-24

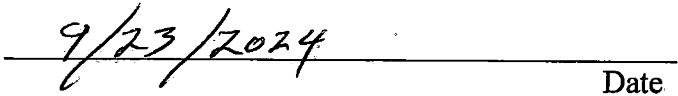
1300-1

CERTIFICATION OF DUPLICATE RECORDS

As Director of the Department of Health Professions, I hereby certify that the attached Conviction and Sentencing Order entered May 30, 2024, regarding Renae Combs Sizemore, QMHP-T, is a true copy of the records received from the Circuit Court of Carroll County, Virginia.



Arne W. Owens



Date

1300-3

CONVICTION AND SENTENCING ORDER

VIRGINIA: IN THE CIRCUIT COURT OF **CARROLL COUNTY**

FEDERAL INFORMATION PROCESSING STANDARDS CODE: **035**

Hearing Date: **May 23, 2024**
Judge: **BRETT L. GEISLER**
COMMONWEALTH OF VIRGINIA

v.

RENAE COMBS SIZEMORE, DEFENDANT

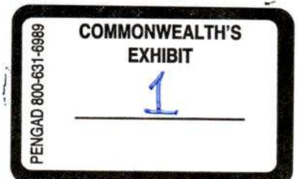
This day came the defendant, who appeared in person with her attorney, **Jonathan L. McGrady.** The Commonwealth was represented by **Lindsay H. Honeycutt, Deputy Commonwealth Attorney.**

Whereupon the defendant waived arraignment and the Court having been advised by the defendant, her counsel, and the Attorney for the Commonwealth that there has been a plea agreement in this case, and such agreement in writing having been presented to the Court, and now filed herein, and having heard the evidence of the Attorney for the Commonwealth none being offered on behalf of the defendant, the Court accepts said agreement and the plea of **guilty** of the defendant tendered in person.

Having heard the evidence and the argument of counsel, the Court finds the defendant guilty of the following offenses:

CASE NUMBER	OFFENSE DESCRIPTION AND INDICATOR (F/M)	OFFENSE DATE	VA. CODE SECTION	VCC CODE SECTION
23-170	**Embezzlement (F)**	**03/18/20-09/15/20**	**18.2-111, 18.2-95**	**LAR-2707-F9**

Pursuant to the provisions of Code § 19.2-298.01, the Court has considered and reviewed the applicable discretionary sentencing guidelines and the guidelines worksheets. The sentencing guidelines worksheets and the written explanation of any departure from the guidelines are ordered filed as a part of the record in this case.



Before pronouncing the sentence, the Court inquired if the defendant desired to make a statement and if the defendant desired to advance any reason why judgment should not be pronounced.

The Court **SENTENCES** the defendant to:

Incarceration with the **Virginia Department of Corrections** for the term of: **Five (5) years**. The total sentence imposed is **Five (5) years.**

The Court **SUSPENDS Five (5) years,** upon the following conditions:

Supervised probation. The defendant is placed on probation, under the supervision of a Probation Officer for **Two (2) years,** or unless sooner released by the court or by the Probation Officer. The defendant shall comply with all the rules and requirements set by the Probation Officer. Probation shall include substance abuse counseling and/or testing as prescribed by the Probation Officer. While on probation, the defendant waives her Fourth Amendment rights regarding search and seizure by law enforcement.

Restitution. The defendant shall make restitution to the Carroll County Circuit Court Clerk's Office as follows: **$6,350.10** to Mayberry Safety Solutions, 210 Laurel Lane, Mt. Airy, North Carolina 27030. Restitution is to be paid in full before collection of costs.

Special Condition. Defendant shall abstain from all drug use except for Defendant's own prescription medications, which medications shall be used in strict compliance with the provider's instructions.

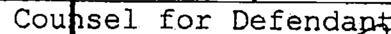
Costs. The defendant is Ordered to pay unto the Commonwealth its costs in this case pursuant to law including any Court appointed counsel fee allowed by this Court. The defendant was advised by the Court that she is subject to further charges as set forth in Virginia Code Section 19.2-358 for failure to pay according to the direction of the Court.

Credit for time served. The defendant shall be given credit for time spent in confinement while awaiting trial pursuant to Code

§ 53.1-187.

DNA. It is further Ordered that pursuant to Section 19.2- 310.2, et. seq. of the Code of Virginia, as amended, the defendant shall have a fluid or tissue sample taken for analysis. The Court Orders the defendant to cooperate fully and promptly in permitting the said taking of the sample as required by law.

The Court certifies that at all times the defendant was personally present with her attorney who capably represented her.

SEEN: 
Counsel for Defendant

5-30-23
DATE

ENTER:
JUDGE

DEFENDANT IDENTIFICATION:

Alias: none known

SSN: *****-**-8676** DOB: **07/22/1970** Sex: **female**

SENTENCING SUMMARY:

TOTAL SENTENCE IMPOSED: **5 yrs**

TOTAL SENTENCE SUSPENDED: **5 yrs**

Docusign Envelope ID: 7B1DFF5C-25E2-43D9-8DBF-59A7460C48FA

BEFORE THE VIRGINIA BOARD OF COUNSELING

IN RE: REBECCA COPELAND PROVOST, L.P.C.
License Number: 0701-005979
Case Number: 239251

CONSENT ORDER

JURISDICTION AND PROCEDURAL HISTORY

The Virginia Board of Counseling ("Board") and Rebecca Copeland Provost, L.P.C., as evidenced by their signatures hereto, in lieu of proceeding to an informal conference, enter into the following Consent Order affecting Ms. Provost's license to practice professional counseling in the Commonwealth of Virginia.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. Rebecca Copeland Provost, L.P.C., was issued License Number 0701-005979 to practice professional counseling on November 6, 2014. Said license is scheduled to expire on June 30, 2025.

2. Ms. Provost violated 18 VAC 115-20-105(A) and18 VAC 115-20-140(A)(6) of the Regulations Governing the Practice of Professional Counseling in that on her application for renewal of her license to practice professional counseling dated June 5, 2023, she attested that she had completed 20 hours of continuing education, including a minimum of two hours of continuing education on the subject of ethics, which she was required to complete between July 1, 2022 and June 30, 2023, in order to renew her license. However, in response to an audit of continuing education by the Board, Ms. Provost only provided documentation demonstrating that she completed 22 hours of continuing education, including two hours on the subject of ethics, in December 2023, after the audit period had passed. In addition, in an email dated February 9, 2024, Ms. Provost informed the Board that she did not complete any continuing education hours between July 1, 2022, and June 30, 2023.

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CONSENT

Rebecca Copeland Provost, L.P.C., by affixing her signature to this Consent Order, agrees to the following:

1. I have been advised to seek advice of counsel prior to signing this document;

2. I am fully aware that without my consent, no legal action can be taken against me or my license except pursuant to the Virginia Administrative Process Act, Virginia Code § 2.2-4000 *et seq.*;

3. I acknowledge that I have the following rights, among others: the right to an informal fact-finding conference before the Board; and the right to representation by counsel;

4. I waive my right to an informal conference;

5. I admit to the Findings of Fact and Conclusions of Law contained herein and waive my right to contest such Findings of Fact and Conclusions of Law and any sanction imposed hereunder in any future judicial or administrative proceeding in which the Board is a party;

6. I consent to the entry of the following Order affecting my license to practice professional counseling in the Commonwealth of Virginia.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, the Virginia Board of Counseling hereby ORDERS as follows:

1. The Board accepts the 22 hours of continuing education Ms. Provost completed in December 2023 in fulfillment of the continuing education hours required for the renewal period between July 1, 2022, and June 30, 2023. Said hours shall not be credited towards those hours of continuing education required for the next annual renewal of her license.

2. Rebecca Copeland Provost, L.P.C., is assessed a MONETARY PENALTY of $300.00. This penalty shall be paid to the Board by certified check or money order made payable to the Treasurer

of Virginia within 30 days from the date of entry of this Order. Failure to pay the full monetary penalty by the due date may cause the matter to be sent for collection and constitutes grounds for an administrative proceeding and further discipline.

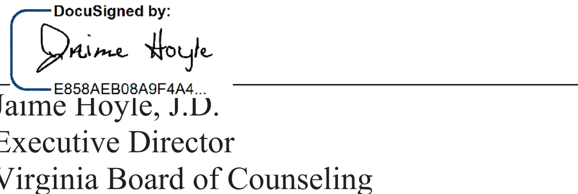
3. Ms. Provost shall bear any costs associated with the terms and conditions of this Order.

4. Ms. Provost shall comply with all laws and regulations governing the practice of professional counseling in the Commonwealth of Virginia.

5. Any violation of the foregoing terms and conditions of this Order or any statute or regulation governing the practice of professional counseling shall constitute grounds for further disciplinary action.

Pursuant to Virginia Code §§ 2.2-4023 and 54.1-2400.2, the signed original of this Order shall remain in the custody of the Department of Health Professions as a public record, and shall be made available for public inspection and copying upon request.

FOR THE BOARD



Jaime Hoyle, J.D.
Executive Director
Virginia Board of Counseling

ENTERED: 9/26/2024

SEEN AND AGREED TO:

Rebecca Copeland Provost, L.P.C.

Date Signed: 9/23/2024

BEFORE THE VIRGINIA DEPARTMENT OF HEALTH PROFESSIONS

IN RE: RAFEE AL-MANSUR, L.M.F.T.
License Number: 0717-001814
Case Number: 243586

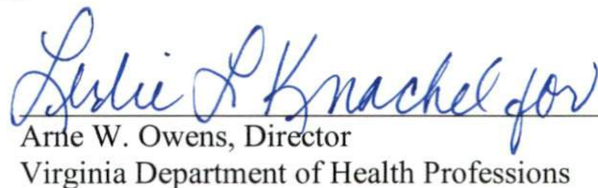
ORDER OF MANDATORY SUSPENSION

In accordance with Virginia Code § 54.1-2409, the Director of the Virginia Department of Health Professions received evidence that Rafee Al-Mansur, L.M.F.T., was convicted of a felony offense, to wit: sexual solicitation of a minor, in the Circuit Court of Anne Arundel County, Maryland. A certified copy of the Probation/Supervision Order is attached hereto as Commonwealth's Exhibit 1.

WHEREUPON, by the authority vested in the Director of the Department of Health Professions pursuant to Virginia Code § 54.1-2409, it is hereby ORDERED that the license of Rafee Al-Mansur, L.M.F.T., to practice as a licensed marriage and family therapist in the Commonwealth of Virginia is hereby SUSPENDED.

Upon entry of this Order, the license of Rafee Al-Mansur, L.M.F.T., will be recorded as suspended. Should Mr. Al-Mansur seek reinstatement of his license pursuant to Virginia Code § 54.1-2409, he shall be responsible for any fees that may be required for the reinstatement of the license prior to issuance of the license to resume practice.

Pursuant to Virginia Code § 2.2-4023 and § 54.1-2400.2, the signed original of this Order shall remain in the custody of the Department of Health Professions as a public record and shall be made available for public inspection or copying on request.



Arne W. Owens, Director
Virginia Department of Health Professions

ENTERED:

December 27, 2024

1300-1

CERTIFICATION OF DUPLICATE RECORDS

As Director of the Department of Health Professions, I hereby certify that the attached Probation/Supervision Order entered December 4, 2024, regarding Rafee Al-Mansur, L.M.F.T., is a true copy of the records received from the Circuit Court of Anne Arundel County, Maryland.

Leslie R Knachel for — December 27, 2024

Arne W. Owens — Date

1300-3

☒ **CIRCUIT COURT** ☐ **DISTRICT COURT OF MARYLAND FOR** Anne Arundel County (CC)
City/County

Located at 8 Church Circle Annapolis, MD 21401-1934 (Court Address) Case No. C02CR241393

STATE OF MARYLAND vs. RAFEE AL-MANSUR (Defendant)

SID No. ____________

(IF AVAILABLE, PLACE LABEL HERE OR AT TOP OF PAGE.)

Tracking No. 241003215784

Other Reference No. ____________

Convicted count(s): 1) Sexual Solicitation of a Minor

Sentence: 10 years suspend all but 113 days

Part of sentence executed: ____________ Suspended: ____________

☐ Balance of sentence suspended upon admission to treatment pursuant to HG § 8-507

Credit for time served: 113 days Length of Probation: 5 Month(s)/Year(s) Comet

PROBATION/SUPERVISION ORDER

☐ Probation Before Judgment (Criminal Procedure Article, § 6-220)
☐ Probation Agreement Deferring Judgment (Criminal Procedure Article, § 6-220)

IT IS ORDERED that the above named defendant:

☐ Participate and pay for psychological counseling
☐ Be supervised by Parole and Probation.
☒ Be supervised by Sexual Offender Management Team.
☐ Be supervised by Other Agency: ____________.
☐ Be unsupervised.

Probation begins ☒ on Today (Date) ☐ upon admission to residential substance abuse program.

Your first appointment with the supervising agency is on Card Provided (Date) and the place to report is Card Provided (Address). Your failure to report could result in your arrest.

A. Standard Conditions (1-10): ☒ All Standard Conditions ☐ All Standard Conditions except No.(s) ____________

1. Report as directed and follow your supervising agent's lawful instructions.
2. Work and/or attend school regularly as directed and provide verification to your supervising agent.
3. Get permission from your supervising agent before changing your home address, changing your job, and/or leaving Maryland. Additional Comments: Must notify Agent before leaving the state for any reason
4. Obey all laws.
5. Notify your supervising agent at once if charged with a criminal offense, including jailable traffic offenses. Additional Comments: ____________
6. Get permission from the court before owning, possessing, using, or having under your control any dangerous weapon or firearm of any description. Additional Comments: ____________
7. Permit your supervising agent to visit your home.
8. Do not illegally possess, use, or sell any narcotic drug, controlled substance, counterfeit substance, or related paraphernalia. Additional Comments: ____________
9. Appear in court when notified to do so.

I, Scott A. Poyer, Clerk of the Circuit Court for Anne Arundel County hereby certify that this is a true copy from the record in this court.
Witness the hand and act of the undersigned this 5th day December 2024

Scott A. Poyer /KAS

Circuit Court for Anne Arundel County, Maryland

Case No. C02CR241393

10. Pay all fines, costs, restitution, and fees as ordered by the court or as directed by your supervising agent through a payment schedule.

☐ Fines of $ ______ paid through ☐ Parole and Probation ☐ Clerk's Office ☐ Sheriff's Office

☒ Court costs of $ Waived paid through ☐ Parole and Probation ☐ Clerk's Office

☐ Supervision fee of $50/month paid through Parole and Probation ☒ Supervision fee waived

☐ Restitution of $ ______ to ______

paid through Maryland Division of Parole and Probation, Maryland Department of Juvenile Services, Division of Corrections, or local correctional facility, if applicable by ______ (Date).

☐ Public Defender fees of $______ to the Office of the Public Defender for counsel fees.

☐ Pay the following fees through Parole and Probation or ______:

☐ Victims of Crime Fund $______

☐ CICF costs $______

☐ Other costs (*specify*) $______

☐ The Division of Parole and Probation is granted the discretion to refer the collection of funds it is authorized to collect to the State's Central Collection Unit without the need of further court approval.

B. Special Conditions (11-35):

11. ☐ Provide DNA sample as required by law by ______ (Date).

12. ☒ Submit to evaluation and attend and successfully complete mental health treatment as directed by your supervising agent. Psychosexual

13. ☐ Submit to, successfully complete, and pay required costs for evaluation, testing and treatment education, as directed by your supervising agent.

14. ☐ Attend and successfully complete ☐ alcohol ☐ drug ☐ alcohol and drug treatment

☐ education program ______ (Name of Program).

15. ☐ Enroll in, pay any required costs for, and successfully complete treatment at ______ (Treatment Facility).

16. ☐ Attend and successfully complete parenting class.

17. ☐ Attend ______ self-help group meetings for ______ weeks. ☐ Attendance may be modified by your supervising agent after ______ weeks.

18. ☐ Totally abstain from alcohol, marijuana (cannabis) (unless medically prescribed), all illegal substances, and abusive use of any prescription drug.

19. ☐ Apply for alcohol restriction on driver's license within ten (10) days of trial date for ______ (Year(s)/Month(s)).

20. ☐ Refrain from driving and/or attempting to drive after consuming alcohol.

21. ☐ Attend Victim Impact Panel meeting when notified.

22. ☐ Attend and successfully complete MVA Driver Improvement Program.

23. ☐ Attend and successfully complete MVA Alcohol Education Program. (Social Drinkers Only)

24. ☐ Have Ignition Interlock installed for ______ months and pay costs. ☐ Employment vehicle exempted.

I, Scott A. Poyer, Clerk of the Circuit Court for Anne Arundel County, hereby certify that this is a true copy from the record in this court. Witness the hand and act of the undersigned this 5th d. December 20 24

Scott A. Poyer KAS

Circuit Court for Anne Arundel County, Maryland

Case No. C02CR241393

25. ☐ Complete ____________ hours of community service by ____________ (Date), under the direction of ______________________________ and pay required fees.

26. ☐ Attend and successfully complete domestic violence counseling at ______________________________ ______________________________ by ____________ (Date) and pay required costs.

27. ☐ Have no contact with ______________________________.

28. ☐ Do not enter or be found near ______________________________.

29. ☐ Home confinement/detention to ____________ for ____________ months.

☐ Special conditions (e.g., doctor's appointments, attending classes, etc.) ______________________________.

30. ☒ **Register as sexual offender** with the supervising authority under the provision of Criminal Procedure Article, Title 11, Subtitle 7:

☐ (1) A Tier I Sex Offender;

☒ (2) A Tier II Sex Offender;

☐ (3) A Tier III Sex Offender;

☐ (4) A sexually violent predator;

☐ (5) A Tier I Sex Offender who, before moving into this state, was required to register in another state;

☐ (6) A Tier II Sex Offender, Tier III Sex Offender, or sexually violent predator who, before moving into this state, was required to register in another state;

☐ (7) A Tier I, Tier II, Tier III Sex Offender, or a Sex Offender who is required to register in another state, jurisdiction, a federal, military, or tribal court, or a foreign government, who is not a resident of this state, and who enters this state:

(i) to reside or habitually live.

(ii) to carry on employment or vocation that is full-time or part-time for a period exceeding fourteen (14) days or an aggregate period exceeding 30 days during a calendar year, whether financially compensated, volunteered, or for the purpose of government or educational benefit; or

(iii) to attend a public or private educational institution, including a secondary school, trade or professional institution, or institution of higher education, as a full-time or part-time student.

(iv) as a transient with the intent to be in the State for a period exceeding fourteen (14) days or an aggregate period exceeding 30 days during the calendar year.

31. ☐ Defendant shall keep appointment for HG § 8-505 evaluation and shall immediately enter the recommended program upon admission.

☐ Defendant shall enter treatment program immediately upon admission.

☐ Defendant shall successfully complete treatment program and comply with terms of aftercare plan.

32. ☐ To be supervised by means of ☐ electric monitoring ☐ electric monitoring with victim stay-away alert technology.

33. ☒ Other See attached Conditions listed A-I.

Additional> *May not counsel minor children or family therapy involving children

*Δ May attend wedding in Bangladesh in January 2025

*Δ to discuss with Agent

I, Scott A. Poyer, Clerk of the Circuit Court for Anne Arundel County, hereby certify that this is a true copy from the record in this court. Witness the hand and act of the undersigned this 5th day December 2024

Scott A. Poyer |KAS

Circuit Court for Anne Arundel County, Maryland

C-02-CR-24-1393 **State v. Rafee Al-Mansur**

Tracking number:241003215784

Plea to Count 1: Sexual Solicitation of a Minor

COMET SUPERVISION

Additional Conditions of Probation

Condition 33

A. The Defendant shall have no unsupervised contact with minor children (other than biological children).

B. The Defendant shall forfeit to the Maryland State Police Internet Crimes Against Children Task Force any computer equipment, cell phone equipment, and related items seized by the Maryland State Police.

C. The Defendant shall not own, possess, or use any computer or internet access device unless through his lawful employment (or as authorized by Parole and Probation). The Defendant agrees that should a computer or internet access device be used for either of these purposes, such devices are subject to inspection/monitoring by Parole and Probation or their representative.

D. The Defendant shall not access any internet site that displays or distributes child pornography.

E. The Defendant shall not view adult or child pornography.

F. The Defendant shall not use any internet access, or communication device whatsoever to contact any minor child for the purpose of sexual arousal or sexual conduct, or for the purpose of transmitting obscene material.

G. The Defendant shall register as a Tier II sex offender under MD Code Ann., Courts & Jud. Proceedings section 11-208. The current period of registration for sexual solicitation of a minor is 25 years (this is required by statute).

H. The Defendant shall submit to and successfully complete a psychosexual evaluation and treatment/certified sex offender treatment recommended by his probation agent during the period of probation.

I. The Defendant shall participate in the COMET program and submit to COMET conditions, while abiding by their rules and regulations.

Defendant's Signature: **Date:** 12/4/2024

Page 4 of 5

I, Scott A. Poyer, Clerk of the Circuit Court for Anne Arundel County, hereby certify that this is a true copy from the record in this court.
Witness the hand and act of the undersigned this 5th day December 2024

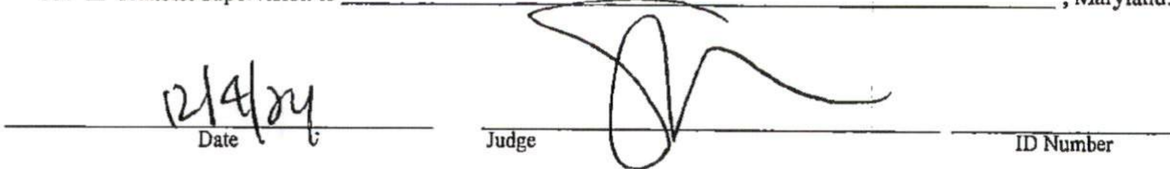
Scott A. Poyer IKAS
Circuit Court for Anne Arundel County, Maryland

Case No. C02CR241393

C. 34. ☐ **Comply with special conditions of lifetime supervision - see form CC-DC-CR-136.**

D. Recommendations to the supervising agency:

35. ☐ Transfer supervision to ______________________________, Maryland.



12/4/24
Date | Judge | ID Number

CONSENT

I have read, or have had read to me, the above conditions of probation. I understand these conditions and agree to follow them. I understand that if I do not follow these conditions, I could be charged with a violation of probation.

If I fail to abide by the above conditions, the court could proceed with sentencing as if I had not been placed under probation. I have been notified and understand that by consenting to and receiving a stay of judgment under Criminal Procedure Article, § 6-220, I waive my right to appeal from a judgment of guilty by the court in this case.

I understand that my failure to pay fines, costs, and fees may result in my case being referred to the State's Central Collection Unit, resulting in an additional collection fee as permitted by law without further approval of the court.

I understand that Parole and Probation may impose graduated sanctions upon me for any technical violation of the above conditions of probation, as authorized pursuant to Correctional Services Article, §§ 6-111 and 6-121.

12/4/2024
Date

Defendant's Signature

Date of Birth

3210 Nobility Ct,
Address

301 905 2816
Telephone Number

Cell Phone Number

Waldorf, MD 20603
City, State, Zip

E-mail

Witness' Signature

Peter J. O'Neill
Printed Name

I, Scott A. Poyer, Clerk of the Circuit Court
for Anne Arundel County hereby certify that this is
a true copy from the record in this court.
Witness the hand and seal of the undersigned
this 5th day December 20 24

Scott A. Poyer |KAS

Circuit Court for Anne Arundel County, Maryland

Virginia Department of
Health Professions
Board of Counseling

LICENSING REPORT

Satisfaction Survey Results	
2025 1st Quarter (July 1 – September 30, 2024)	89.3%
2024 4th Quarter (April 1 – June 30, 2024)	92.9%

Totals as of January 6, 2025*

Current Active Licenses	
Certified Substance Abuse Counselor	1,753
CSAC Supervisee	2,745
Substance Abuse Counseling Assistant	315
Licensed Marriage and Family Therapist	1,270
Marriage & Family Therapist Resident	191
Licensed Professional Counselor	10,327
Resident in Counseling	3,420
Substance Abuse Treatment Practitioner	501
Substance Abuse Treatment Residents	19
Rehabilitation Provider	140
Qualified Mental Health Prof-Adult	6,661
Qualified Mental Health Prof-Child	4,267
Trainee for Qualified Mental Health Prof	9,521
Registered Peer Recovery Specialist	870
Total	**42,000***

*Unofficial numbers (for informational purposes only)

Virginia Department of
Health Professions
Board of Counseling

Licenses, Certifications and Registrations Issued

License Type	August 2024	September 2024	October 2024	November 2024	December 2024*
Certified Substance Abuse Counselor	5	9	15	12	11
CSAC Supervisee	39	65	65	57	48
Certified Substance Abuse Counseling Assistant	5	8	11	11	6
Licensed Marriage and Family Therapist	32	31	23	33	18
Marriage & Family Therapist Resident	10	3	4	1	1
Pre-Education Review for LMFT	0	0	0	0	0
Licensed Professional Counselor	113	91	136	103	104
Resident in Counseling	103	138	87	53	52
Pre-Education Review for LPC	6	8	2	12	8
Substance Abuse Treatment Practitioner	1	4	1	0	4
Substance Abuse Treatment Residents	0	1	0	0	0
Pre-Education Review for LSATP	0	1	0	0	0
Rehabilitation Provider	0	0	0	0	0
Qualified Mental Health Prof-Adult	83	34	66	79	50
Qualified Mental Health Prof-Child	51	24	39	50	22
Trainee for Qualified Mental Health Prof	243	171	181	180	127
Registered Peer Recovery Specialist	23	14	30	25	23
Total	**714**	**602**	**660**	**616**	**474**

*Unofficial numbers (for informational purposes only)

Virginia Department of
Health Professions
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Licenses, Certifications and Registration Applications Received

Applications Received	August 2024*	September 2024*	October 2024*	November 2024*	December 2024*
Certified Substance Abuse Counselor	14	18	20	9	14
CSAC Supervisee	52	70	69	53	53
Certified Substance Abuse Counseling Assistant	16	6	16	9	1
Licensed Marriage and Family Therapist	31	35	23	33	17
Marriage & Family Therapist Resident	8	5	7	2	1
Pre-Education Review for LMFT	0	1	0	0	0
Licensed Professional Counselor	130	137	133	113	103
Resident in Counseling	143	138	68	47	69
Pre-Education Review for LPC	12	8	9	10	5
Substance Abuse Treatment Practitioner	9	6	5	1	12
Substance Abuse Treatment Residents	1	0	3	0	2
Pre-Education Review for LSATP	0	0	0	0	0
Rehabilitation Provider	1	0	0	0	0
Qualified Mental Health Prof-Adult	102	99	78	70	64
Qualified Mental Health Prof-Child	67	66	67	39	33
Trainee for Qualified Mental Health Prof	281	222	190	152	150
Registered Peer Recovery Specialist	31	22	34	21	37
Total	**898**	**833**	**722**	**559**	**561**

*Unofficial numbers (for informational purposes only)

Virginia Department of
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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 - Manager
      - Latasha Austin – Licensing and Operations Manager (Full-Time)
    - Licensing Staff:
      - Victoria Cunningham – Sr. Licensing Specialist (Full-Time)
      - Dalyce Logan – Sr. Licensing Specialist (Full-Time)
      - Trasean Boatwright – Sr. Licensing Specialist (Full -Time)
      - Regina Dyson - Licensing Administration Assistant (Part-Time)
    - Registration Staff:
      - Sandie Cotman – Program Manager (Full-Time)
      - Shannon Brogan – Sr. Licensing Specialists (Full-Time)
      - Alesia Baskin – Sr. Licensing Specialists (Full-Time)

- **Business Process Updates**

  - Updated Licensure Process Handbooks:
    - Licensed Professional Counselor (LPC)
    - Licensed Marriage and Family Therapy (LMFT)
    - Licensed Substance Abuse Treatment Practitioner (LSATP)
    - Certified Substance Abuse Counselor (CSAC) and Certified Substance Abuse Counselor-Assistant (CSAC-A)
  - Developed individual website pages that provide information on which application to select, step-by-step process instructions and direct links to information and forms for each registration, certification or license type.
  - Updated licensure and substance abuse forms and applications.
  - Migrated pre-review of education paper applications to online applications.
  - Updated all compliance forms.
  - Updated wording to all automated emails.
  - Updated all online checklist items.
  - Updated licensure online applications screens.
  - Created new license verification page.

- **Renewal Date Change for Certified Rehabilitation Providers**
  - Certified Rehabilitation Providers (CRP's) are now required to renew their certificates on or before June 30th instead of January 31st.