BOARD OF COUNSELING
REGULATORY COMMITTEE MEETING
Thursday, May 17, 2018– 1:00 p.m.
Second Floor – Perimeter Center, Board Room 3

1:00 p.m. **Call to Order – Johnston Brendel, Ed.D, LPC, LMFT, Chairperson**

Ordering of the Agenda

Approval of Minutes*

Public Comment

Unfinished Business

- Foreign Degrees
- Criminal Background Checks

New Business

- Proposed Qualified Mental Health Professionals (QMHP) and Registered Peer Recovery Specialists (RPRS) Regulations*
  - Public Comments
- Accreditation Standards for Counseling Degrees
- Code of Virginia Definitions
  - Marriage and Family Therapist
  - Professional Counselor
  - Qualified Mental Health Professional Trainee(QMHP-Trainee)
- Review of Guidance Documents
  - Guidance Document: 115.2.1
  - Guidance Document: 115.4.1
  - Guidance Document: 115.4.11
  - Guidance Document: 115.5
- Periodic Review of Regulations
- Continuing Competency Activity
  - Attending Board Meetings
- Examination Trends
  - Taking the NCMHCE and AMFTRB Prior or During Residency
- Scope of Practice
  - Psychological Testing
  - Blood and Urine Testing
- Next Regulatory Meeting

4:00 p.m. **Adjourn**

Approval of Board of Counseling Regulatory Committee Meeting Minutes

February 8, 2018

VIRGINIA BOARD OF COUNSELING
REGULATORY COMMITTEE MEETING
DRAFT MINUTES
Thursday, February 8, 2018

TIME AND PLACE: The meeting was called to order at 1:04 p.m. on Thursday, February 8, 2018, in Board Room 1 at the Department of Health Professions, 9960 Mayland Drive, Henrico, Virginia.

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

COMMITTEE MEMBERS PRESENT:
Kevin Doyle, Ed.D., LPC, LSATP
Danielle Hunt, LPC
Vivian Sanchez-Jones, Citizen Member
Holly Tracy, LPC, LMFT

STAFF PRESENT:
Tracey Arrington-Edmonds, Licensing Specialist
Christy Evans, Discipline Case Specialist
Jaime Hoyle, J.D., Executive Director
Jennifer Lang, Deputy Executive Director
Charlotte Lenart, Licensing Manager
Elaine Yeatts, Senior Policy Analyst

ORDERING OF THE AGENDA:

The Agenda was accepted as presented.

APPROVAL OF MINUTES:

Upon a motion by Dr. Doyle, which was properly seconded by Ms. Sanchez-Jones, the Committee voted unanimously to approve the minutes of the November 2, 2017 meeting.

PUBLIC IN ATTENDANCE:

Arnold Woodruff of the Virginia Association of Marriage and Family Therapists (VAMFT), Janet Moore and Heavenly Weaver of Odyssey Community Services, Erin Smith of the Department of Medical Assistance Services (DMAS), Lilyana B. Sintayehu (resident/applicant) and Representative(s) from the Virginia Department of Behavioral Health & Developmental Services (DBHDS)

PUBLIC COMMENT:

No comments

DISCUSSION:

I. **Old Business:**

- **Review definition of required courses -** The Committee agreed to discuss the definitions of required courses at a future Committee meeting.

- **Foreign degree discussion –** The current regulations do not clearly allow for the acceptance of foreign degrees. Upon a motion by Dr. Doyle, which was properly seconded by Ms. Tracy, the Committee voted unanimously to recommend the Board adopt a Notice of Intended Regulatory Action (NOIRA) to amend the Regulations to ensure applicants with foreign degrees have a pathway to licensure.

- **Bylaws -** Upon a motion by Ms. Hunt, which was properly seconded by Ms. Tracy, the Committee voted unanimously to recommend the following changes to the Bylaws.

    - New language to include the authority of the Board to approve Qualified Mental Health Professionals (QMHP) & Registered Peer Recovery Specialist (RPRS) regulations and other registrations.
    - Add "licensed" in front of "professional counselors" under Article II The Board A. Membership a.i;
    - Move item #4 listed under Article II The Board, B. Officers, to Article IV General Delegation of Authority.
    - Ensure "Chairman" is replaced with "Chairperson".

  Ms. Yeatts requested the Committee consider amending the bylaws to decrease the amount of time an officer can serve on the Board from a two-year term to a one-year term. The Committee agreed to bring this issue to the Board for discussion.

- **Criminal Background Check Requirement Discussion –** The Committee discussed requiring a criminal background check for applicants. Upon a motion by Ms. Hunt, which was properly seconded by Ms. Tracy, the Committee voted unanimously to request the Board recommend DHP include in its 2019 legislative packet, a requirement that Board of Counseling applicants undergo a criminal background.

  Upon a motion by Dr. Doyle, which was properly seconded by Ms. Tracy, the Committee voted unanimously to recommend the Board amend Guidance Document 115-2: Impact of Criminal Convictions to reflect that the document applies to registrants as well as licensees and certificate holders.

- **Discussion on Draft Joint Guidance Document Titles and Signatures –** The Committee discussed the Board of Psychology's Draft Joint Guidance Document on Assessment Titles and Signatures. The Committee declined to move forward and concluded no formal response was necessary.

II. **New Business:**

- **New Proposed Qualified Mental Health Professionals (QMHP) & Registered Peer Recovery Specialist (RPRS) –** Ms. Yeatts outlined areas of the regulations that would require changes per the public comments received and suggested that the

Board/Committee hold another Regulatory Advisory Panel (RAP) to work with stakeholders to address the issues raised in the public comment. The RAP would need to take place prior to the May 2018 meetings.

Ms. Yeatts suggested that the Committee could address immediately the issue of approved degrees by amending the current Guidance Document 115-8: Approved Degrees in Human Services and Related Fields for QMHP. Upon a motion by Ms. Tracy, that was properly seconded by Ms. Hunt, the Committee voted unanimously to recommend the Board amend the Guidance Document to allow a Sociology degree and not to add criminal justice to the list of acceptable degrees.

- **Licensure Portability** – Dr. Doyle recommended the Committee take no action at this time.

- **Art Therapy Licensure** – The Committee recommended that no action be taken at this time.

- **Guidance Document 115-1.9 –Consider Adding NBCC-MAC Certification as a National Certification Accepted by the Board** – Upon a motion by Dr. Doyle, which was properly seconded, the Committee voted unanimously to recommend the Board amend Guidance Document 115-1.9: National Certifications Approved by the Board for certification as a Substance Abuse Counselor by endorsement to include the NBCC-MAC.

- **NEXT SCHEDULED MEETING -** 1:00 p.m. on May 17, 2018

ADJOURNMENT:
The meeting adjourned at 3:09 p.m.

____________________________________ ________________________

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

____________________________________ ________________________

Jaime Hoyle, JD Date
Executive Director

Proposed Qualified Mental Health Professional (QMHP) Regulations

Commonwealth of Virginia

<u>DRAFT</u>

REGULATIONS

GOVERNING THE REGISTRATION OF QUALIFIED MENTAL HEALTH PROFESSIONALS

VIRGINIA BOARD OF COUNSELING

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

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

Effective Date: December 18, 2017

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Part I. General Provisions.

18VAC115-80-10. Definitions.

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

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

"Board" means the Virginia Board of Counseling.

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

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

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

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

"Qualified mental health professional or QMHP" means a person who by education and experience is professionally qualified and registered by the board to provide collaborative mental health services for adults or children. A QMHP shall not engage in independent or autonomous practice. A QMHP shall provide such services as an employee or independent contractor of the DBHDS, the Department of Corrections or a provider licensed by the DBHDS.

"Qualified Mental Health Professional-Adult or QMHP-A" means a registered QMHP who is trained and experienced in providing mental health services to adults who have a mental illness. A QMHP-A shall provide such services as an employee or independent contractor of the DBHDS, the Department of Corrections or a provider licensed by the DBHDS.

"Qualified Mental Health Professional-Child or QMHP-C" means a registered QMHP who is trained and experienced in providing mental health services to children or adolescents up to the age of 22 who have a mental illness. A QMHP-C shall provide such services as an employee or independent contractor of the DBHDS, the Department of Corrections or a provider licensed by the DBHDS.

"Registrant" means a QMHP registered with the board.

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

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

Registration	$50
Renewal of registration	$30
Late renewal	$20
Reinstatement of a lapsed registration	$75
Duplicate certificate of registration	$10
Returned check	$35
Reinstatement following revocation or suspension	$500

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

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

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

Part II. Requirements for Registration.

18VAC115-80-40. Requirements for registration as a QMHP-A.

A. An applicant for registration shall submit a completed application on forms provided by the board and any applicable fee as prescribed in 18VAC115-80-20.

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

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

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

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

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

5. A licensed occupational therapist with no less than 1,500 hours of supervised experience to be obtained within a five-year period immediately preceding application for registration and as specified in subsection C of this section.

C. Experience required for registration.

1. In order to be registered as a QMHP-A, an applicant who does not have a master's degree as set forth in subsection B 1 of this section shall provide documentation of experience in providing direct services to individuals as part of a population of adults with mental illness in a setting where mental health treatment, practice, observation or diagnosis occurs. The services provided shall be appropriate to the practice of a QMHP-A and under the supervision of a licensed mental health professional or a person under supervision that has been approved by the Boards of Counseling, Psychology, or Social Work as a pre-requisite for licensure. <u>Supervision obtained in another U. S. jurisdiction may be provided by a mental health professional licensed in that jurisdiction.</u>

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

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

4. A person receiving supervised training in order to qualify as a QMHP-A may register with the board. <u>A trainee registration shall expire five years from its date of issuance.</u>

18VAC115-80-50. Requirements for registration as a QMHP-C.

A. An applicant for registration shall submit a completed application for forms provided by the board and any applicable fee as prescribed in 18VAC115-80-20.

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

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

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

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

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

C. Experience required for registration.

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

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

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

4. A person receiving supervised training in order to qualify as a QMHP-C may register with the board. A trainee registration shall expire five years from its date of issuance.

18VAC115-80-60. Registration of QMHPs with prior experience.

Until December 31, 2018, persons who have been employed as QMHPs prior to December 31, 2017, may be registered with the board by submission of a completed application, payment of the application fee, and submission of an attestation from an employer that they met the qualifications for a QMHP-A or a QMHP-C during the time of employment. Such persons may continue to renew their registration without meeting current requirements for registration provided they do not allow their registration to lapse or have board action to revoke or suspend, in which case they shall meet the requirements for reinstatement.

Part III. Renewal of registration.

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

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

18VAC115-80-80. Continued competency requirements for renewal of registration.

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

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

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

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

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

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

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

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

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

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

1. Official transcripts showing credit hours earned; or

2. Certificates of participation.

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

Part IV. Standards of practice; disciplinary action; reinstatement.

18VAC115-80-90. Standards of practice.

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

B. Persons registered by the board shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Procuring**, attempting to procure,** or maintaining a registration~~, including submission of an application or applicable board forms,~~ by fraud or misrepresentation;

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

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

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

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

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

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

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

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

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

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

B. A person who fails to renew registration after one year or more shall:

1. Apply for reinstatement;

2. Pay the reinstatement fee for a lapsed registration;

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

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

Qualified Mental Health Professionals (QMHP) Public Comment

Agency **Department of Health Professions**

Board **Board of Counseling**

Chapter **Regulations Governing the Registration of Qualified Mental Health Professionals [under development] [18 VAC 115 – 80]**

Action	Initial regulations for registration
Stage	Emergency/NOIRA
Comment Period	Ends 2/7/2018

All comments for this forum

Back to List of Comments

Commenter: Alyce Dantzler 1/9/18 5:21 pm

Registration for QMHP's

1. Sociology used to be an approved degree and still should be. This was voted on at a Board of Counseling meeting on November 2nd and appears that there was no discussion at all concerning this. Sociology is as related to this field if not more than other degrees that are on the list.
2. While I understand the reasoning behind doing this and support the move this direction 100%, I am very concerned about the delay in hiring providers will experience related to us requesting that applicants register before we hire them.
3. I am very concerned that the 8 hours of continuing education be so narrowly defined as to who can provide this training. I believe that other entities should be allowed to train, there shoud be "train the trainer" opportunities for providers so they can provide in-house training, or some other avenue should be found. Providers are already required to provide a vast amount of training annually to staff and much of this, if done in a quality manner could count as continuing education.
4. There are very loose definitions surrounding supervision of community based programs. We are concerned about if the board expects that Licensed or Licensed Type individuals supervise the day-to-day operations of programming. In our part of the state, Licensed individuals or residents are very scarce, especially now that CCC+ has been implemented and the insurance companies have recruited our licensed staff away from us. In addition, many of the programs that we are talking about are seen as non-clinical by the state and thus should not require that level of supervision.

Thank you for you consideration of these concerns.

Commenter: Andrew Peddy, LPC, Mt. Rogers CSB 1/10/18 3:54 pm

QMHP-C

I would like to suggest that QMHP-C could work with certain individuals past age 17. Specific examples would include 18-21 year olds who are involved with foster care through the independent living program, or individuals who are over 18 who are still enrolled in high school. This would allow youth services staff to maintain their QMHP-C status without having to also be registered as a QMHP-A just in order to work with one or two individuals who are 18 years old and still in the school system. If staff work with adults on a regular basis I think it would be sensible to be registered as QMHP-C and QMHP-A, but I think it is burdensome for youth staff who would be working with 18 year olds and the occasional 19 year old.

Suggestions for ideas on the regulations for this would possibly be.

QMHP-C staff may work with individuals through the age of 21 years old.

or

QMHP-c staff my work with individuals who are still enrolled in school.

Thank you for your consideration of this topic.

Commenter: Jenny Brummitt/ EHS

1/16/18 10:05 am

QMHP Registration

My concern is in regards to our hiring process within our company and approved degrees. We hire based upon referrals and typically we see approximately 2 to 3 referrals within a two weeks span and as this continues to grow, those individuals we are able to interview based upon qualifications have to be registered with the board. Though I understand this, my worry is the time period that it takes for those applicants to be approved, and how quickly we can get those applicants trained efficiently in order to serve our population affectively. I do feel that Sociology should be on the list of approved degrees as this has been in the past and I'm unclear as to why this does not now apply in this case.

I do wish to appreciate the efforts to ensue fraudulent activity is ceased by stripping one of their registration immediately and placing a high reinstatement fee and/or declining to reinstate. One who commits fraud or places harm/takes advantage of those within our services, should not be allowed to practice within the State of VA.

Commenter: Melissa Peddy, LPC, Mount Rogers Community Services Board

1/16/18 10:08 am

Considerations for QMHP regulations

I agree that the registration and supervision of qualified mental health professionals is beneficial for the individuals receiving mental health services. Providing registration online is especially helpful for those registering as a QMHP. It may be somewhat discouraging for those who work with both adults and children to have to register as both a QMHP-A and QMHP-C and pay the full fee for both of these credentials. It would be helpful to have a reduced fee if registering as both a QMHP-A and QMHP-C in order to have an incentive those with the most experience and knowledge in a wide range of ages. Another consideration for those working in the school system as therapeutic day treatment counselors would be to extend the ages for QMHP-C providers until age 21, as some young adults are still enrolled in public school and receiving mental health services from QMHPs. Additionally as a LMHP, it would helpful for my supervision of QMHPs to have clear guidelines and guidance documents related to registration, supervision, and reporting any

disciplinary action.Consid

Commenter: Scott Philbrook, EHS

1/16/18 4:46 pm

Registration of new hire QMHPS.

Although I understand and support the efforts to ensure a standard for professionals in the field of behavioral services the concern that I have is that bureaucracy and paperwork lengthens the amount of time for new hires and may be a hindrance to providing consumers with service in an effective and timely manner. Especially in crisis stabilization services where the emphasis is to reach out as soon as possible to clients who are at risk for hospitalization, homelessness or sucidiality/homicidality. If the process is held to a two week turn around that would be very beneficial, if it proves to be lengthier this could be a hindrance.

In addition, the area of the state where our agency operates has a limited amount of LMHPS. This presents a problem with requiring that supervision of the daily implementation of individualized service plans fall on LMHPS or LMHP-E individuals. This again may prove to be inefficient in serving the behavioral health population in our rural locality.

Scott Philbrook, Clinical Coordinater/Crisis Team Leader

Commenter: Jordan Hyde, DPCS

1/23/18 8:43 am

QMHP registration

While I understand the reasoning behind registration of QMHP staff for adults and/or children, the way the regulation is currently being presented poses many problems to those of us actually working in the mental health field.

1. QMHP-C only goes to age 17, many students with behavioral issues continue through the community-based “child services” through age 21.This means a youth who has had a staff person working with them potentially for all of their life, might have to get transferred to a QMHP-A solely because they turn 18.This will disrupt treatment, especially in school settings.
    1. I request that some consideration be granted that a QMHP be ONE definition where staff can move between children and adult community-based services given experience with both children and adults.

2. The hiring of staff as of January 1, 2018 is already being negatively affected by the way the regulations are reading.Because applicants after January 1, 2018 have not been given the opportunity to be grandfathered in, we are trying to follow the posed regulations for positions that require QMHP staff.Since Sociology has been removed from the list of accepted Human Services Field degrees, our applicant pools have decreased as this has historically been a widely known and accepted degree to work in the human services field.In addition, staff have gained experience with children AND adolescents and having to differentiate between the two could cause someone’s experience to keep them from being eligible under the new regulations.
    1. Can it be clarified that a degree in sociology is still considered a human services field.

3. I need clarification as to who can directly supervise registered QMHP-A’s and C’s.In the

southern part of the state, we are significantly lacking in licensed staff and even staff who are eligible to be licensed.If the requirement is to require a QMHP to be directly supervised by a licensed type, organizations in the southern part of the state will have to cease services until we can hire more licensed type staff.

1. Can it be clarified that a QMHP-A or C can be directly supervised by another QMHP-A or C as long as there is overall oversight by a licensed-type staff person in the chain of command?
    1. Consider the situation where someone desires to maintain their QMHP-A or C, but their position does not require it, but want to have the opportunity for upward advancement.If their supervisor is required to have this credential, it could pose a problem for retaining staff.

4. I am one of those folks who has experience working with children and adults; I am in a position where I am not actively providing services though.I would like to retain my QMHP-A AND QMHP-C status as I continue my education to be licensed.However, this regulation would require me (and MANY others across the state) to register as both, with two fees just to keep our opportunities open in the wide field of mental health services that overlap between children and adults.
    1. Again, can it be considered that the QMHP fee allow for someone to maintain both a QMHP-A and C status?

Thank you in advance for your consideration in updating the regulations to better meet the needs of all folks receiving mental health services in Virginia.

Commenter: Bob Horne, Norfolk CSB

1/23/18 11:33 am

Comments related to QMHP Regulations

Sociology used to be an approved degree and I believe that sociology should still be an approved degree. Sociology is as related to this field (if not more so) than other degrees that were included on the list of approved degrees. Eliminating sociology as a approved degree substantially limits the pool of qualified available candidates for this credential.

The registration and supervision of qualified mental health professionals is certainly beneficial for the individuals receiving behavioral healthcare services. However, it is a discouragement for those who work with both adults and children to have to register as both a QMHP-A and QMHP-C and pay the full fee for each of these credentials. It would be helpful to have a reduced fee if registering as both a QMHP-A and QMHP-C. This would serve as an incentive those with the most experience and knowledge in a wide range of ages. As an alternative, consider extending the age range of QMHP-Cs to serve individuals up to 21 years of age.

I share the concerns that others have expressed about the delay we will experience in hiring providers. this is bacuase applicants will need to be registered as QMHPs before we hire them in order that we can bill for their services. Also; I would express concern about the expectation that Licensed or Licensed-Type individuals must supervise the day-to-day operations of services provided by QMHPs. Licensed individuals are scarce, especially since CCC Plus has been implemented and MCOs have recruited many of our licensed staff. In addition, many of the programs that are employing QMHPs are viewed as 'non-clinical' by both DMAS and the MCOs, but CCC Plus is requirning LMHP or LMHP-Types to sign all authorizations for CMHRS services..

I would like to echo concerns regarding the 8 hours of continuing education being narrowly defined regarding who can provide the training. Many of the organizations providing behavioral health services in the communities in Virginia already have extensive continuing education requirements under the DBHDS Licensure regulations. I believe that these organizations should be allowed to provide the required continuing education to their staff in accordance with their annual compliance with DBHDS Licensure regulations. I would also request that the regulations clarify the nature and extent of supervision that LMHPs and LMHP-Types must provide to registered QMHP-A's and C's. Must the LMHP, or LMHP-Type, be the direct supervisor of the QMHP?

Thank you in advance for your consideration of these comments when updating these regulations to better meet the needs of all individuals receiving behavioral healthcare services in Virginia.

Commenter: Julia Campbell, BSW Quality Assurance----Piedmont CSB

1/24/18 4:50 pm

QMHP-A/ C Registration Concerns

Concerns with QMHP A/C Registration:

I think the Registration is a great idea. However, I do ask that consideration be given to current DMAS/ DBHDS Regulations, which at this point make every attempt to mirror one another. In the Regulations as it relates to QMHP-C/ A, if one has the credential of QMHP-C, then they are deemed appropriate to provide QMHP-A services to adult indivduals, as current QMHP-A requires that there is mental health experience provided to "Individuals"....which would include children. I think that asking providers to pay for 2 Registrations is asking a bit much. I feel that a **QMHP** credential overall should be considered.

In order to address the issue of the need to pay for 2 Registrations, I would suggest possibly having a registration for QMHP-C…. with Adult experience Endorsement (if applicable). And, if the mental health experience has been with adults only, then that person could register as QMHP-A.

Commenter: Kathy Nelson HRCSB

1/25/18 1:31 pm

QMHP Regulation Comment

1. Sociology should continue to be an approved degree . Sociology is very much related to the field . Removing Sociology from the approved list of degrees has reduced our pool of possible applicants for QMHP positions, positions that are already difficult to fill.

2. The BOC description of the QMHP role and scope of practice / types of services on the recent FAQs do not match the DMAS regulations- so which description/regulation will agencies follow? It would be most helpful if the BOC ; DMAS and DBHDS regulations and expectations were in sync.

3. Clarification of the Supervision component of the regulations is needed:

- Does the LMHP/LMHP-Type level of Supervision that is required have to be provided by the Supervisor of the Program?
- Are all registered QMHPs required to be Supervised by an LMHP/Type or is this just for the registered QMHP-Trainees?
- If someone is grandfathered in as a QMHP and then works in a program that does not require QMHP level of credential to bill for the service (i.e. MH Case Management) and the program is not Supervised by an LMHP/Type – will these employees no longer meet the requirements for

continued QMHP credentialed status at the time of renewal?

- Does the LMHP/Type have to be present with the QMHP and/or QMHP-Trainee when the QMHP and/or QMHP-trainee is in the community working with a client, providing a service ? …
- What does the Supervision documentation need to include?

4. QMHP- Trainees registration

- Additional clarification of this status is needed ....what is required of the provider to make sure the provider has everything in place to hire a potential QMHP-Trainee . As mentioned above, clarification of the Supervision requirements for a QMHP-Trainee is needed.
- It would be most helpful if the BOC , DBHDS and DMAS were all on the same page regarding the requirements for the QMHP –Trainee status. DMAS has a limit to the # of Trainees per agency and per LMHP/Type Supervision .It is concern if a QMHP applicant is not credentialed due to insufficient experience , they could potentially be considered a QMHP-Trainee level . The DMAS restrictions to the # of QMHP-Trainees could very well impact our ability to fill positions and serve our clients. In addition, it is my understandings that DBHDS needs to approve a QMHP-Trainee Training program before a provider can even consider using a QMHP-Trainee but as an agency, we have been waiting since June for an approval for a submitted QMHP-Eligible Training program and recently received an e-mail from a DBHDS representative that this now falls under the BOC . Clarification is very much needed.

5. The requirement for QMHP Credential or QMHP-Trainee registration before a provider can bill for services using the employee(that require this level of credential) puts a great financial burden on Providers . It essentially means that we will have staff on board for whom we cannot use to provide a service until we receive confirmation from the BOC. Even if the BOC can meet their intended 30 day turn around period , it is still a great burden. This can potentially and very likely reduce our ability to serve individuals already in service and/or take on new clients in need of the service when a position is vacated. This is particularly a concern for services working with high risk individuals such as a residential Crisis Stabilization Program.

6. Requiring separate Credentials for Adults vs Children/Adolescents sounds good until you get into the details of how services are provided. The ages of 18 thru 21 are somewhat blurry when it comes to whether these individuals are considered Adolescents or Adults. DMAS considers them Adolescents, Our agency, in most cases, view an 18 to 21 year old as adolescents only if they are still in the educational system, and receive services through our Children's Programs. So, would a QMHP-C credential be sufficient for a staff person providing a service to an 18 – 21 year old who is in school and is receiving an agency defined child level service?....Or would this person require both the QMHP –A and QMHP –C credential.

7. I would like to echo concerns regarding the 8 hours of continuing education being too narrowly defined regarding who can provide the training as mentioned in other comments submitted.

Commenter: Denise Malone

1/26/18 8:45 am

QMHP registration

Any and every mental health professional who meets the education, experience, and training requirements should be eligible to register and KEEP the QMHP title.

Furthermore, the mandate in the reg that every person who seeks services of a QMHP would need a formal "service plan" is problematic. An organization's clinical supervisors can make those decisions based on the population and particular cases served.

Lastly, clinical supervisors should decide the QMHP's services and roles within an organization and its structure, based on professional standards of practice, agency policies, existing laws and regs, and the QMHP's individual skills, experience, and training.

Commenter: Joanna Bryant 1/26/18 11:34 am

QMHP credential

I agree with previous comments posted that the limitations of the QMHP certification should be expanded. At a time when mental health beds are at an all time low and a significant proportion of mentally ill individuals end up in the justice system, we should not be creating an artificial bottleneck concerning access to treatment providers as well. Therefore I concur with the following recommendations:

There should not be two QMHP credentials.

Any and every mental health professional who meets the education, experience, and training requirements should be eligible to register and KEEP the QMHP title.

Furthermore, the mandate in the reg that every person who seeks services of a QMHP would need a formal "service plan" is problematic. An organization's clinical supervisors can make those decisions based on the population and particular cases served.

Lastly, clinical supervisors should decide the QMHP's services and roles within an organization and its structure, based on professional standards of practice, agency policies, existing laws and regs, and the QMHP's individual skills, experience, and training.

Commenter: Genhi Whitmer, LPC, Region Ten CSB 1/27/18 6:26 pm

QMHP

Thank you for the opportunity to comment on this proposed regulation. I would like to submit the following for consideration:

It appears that the BOC description of the QMHP role and scope of practice/types of services on the recent FAQs do not match the DMAS regulations. Please refer to current DMAS regulations and insure that the regulations are lined up so as to avoid confusion. Likewise with DBHDS requirements.

I am very concerned about the requirement that QMHPs be registered before they can bill. This places undue hardship on agencies and may result in loss of applicants and/or lost billing in a time when most agencies cannot sustain either loss. Many agencies are already feeling a negative impact. With the rate of turnover experienced by many agencies, a requirement like this could also have a serious negative impact for persons served, such as in residential and crisis stabilization programs, etc.

Sociology should remain an approved degree. It is a relevant degree for the field and has been so for many years. Individuals interested in entering the field have planned college educations around this. To remove it reduces our pool of applicants.

The registration and supervision of qualified mental health professionals can be beneficial to the

individuals served. However, please consider having a reduced joint fee for individuals registering for both QMHP-A and QMHP-C. Also, please consider that QMHPs will now be asked to pay for registration and ongoing renewal fees and possibly continuing education costs - without increased salary as reimbursement rates for these positions don't seem to be addressed with added requirements, as well as no increase for related administrative costs to agencies.

Please consider extending the age range of QMHP-C to serve individuals up to age 21 years of age. Many children with behavioral issues continue through the community-based "child services" through age 21. Requiring them to change providers at age 18 interrupts continuity of care and may disrupt treatment. Please also consider language that would allow clinical judgment to guide the transition of care between "child" and "adult" and to allow for variances in the best interest of the persons served.

I share concerns that there is an expectation that licensed or licensed-eligible individuals must supervise the day-to-day operations of services provided by QMHPs. Licensed individuals are scarce in many parts of the state, especially since CCC Plus has been implemented and MCOs have recruited many of our licensed staff. While I understand the intent is to insure that individuals receive services from qualified staff, it is equally critical to have licensed staff provide direct services to individuals who need them most. As we see more and more administrative and supervision requirements for our agencies, without added funding support, the strain on the system takes a toll on agencies, staff, and the people we serve. Please take this into serious consideration when regulations are passed.

I would request that regulations clarify the nature and extent of supervision that LMHPs and LMHP-types must provide to registered QMHPs. Must the LMHP be the direct supervisor? Can group supervision be used to meet this requirement? How many QMHPs can someone supervise? Does the supervisor have to be registered as QMHP, as an approved supervisor? Are all registered QMHPs required by to be supervised by an LMHP, LMHP-type or is this just for QMHP Trainees? What supervision documentation is required?

I would echo concerns regarding the 8 hours of continuing education being narrowly defined regarding who can provide the training. Please consider making requirements line up with current DBHDS requirements and expectations.

Can licensed individuals provide services that require QMHP registration? Does having a license (LPC, LCSW, RN, LPN) negate the need to register as a QMHP?

Please take into consideration options for those registered as QMHP-A or QMHP-C to be able to work across these boundaries in order to learn new skills and expand their ability to provide services in our system of care. Locking registration down in silos can only serve to limit the options of both staff and agencies to meet the dire needs of our communities. As someone who has worked with both adults and children, I believe there is great value to be added to our services by creating more opportunities for staff to cross train and expand their abilities and value taken away by reducing these opportunities.

Will staff who were grandfathered in as QMHP be able to take their newly-registered status with them if they leave the home agency? If so, this could result in a loss of staff for some agencies. If not, then these individuals will be required to register with the state, complete all continuing education, and yet remained locked into a current job or agency without potential for much advancement. This seems unfair to hard working professionals. Also, can QMHP registered staff move into non-QMHP positions and maintain their registration should they wish to move back into a QMHP position in the future?

Should QMHP-Es begin to register now as either QMHP-A or QMHP-C or to seek to be prepared to move into either?

Thank you in advance for your consideration of these comments when updating these regulations to better meet the needs of all individuals receiving behavioral healthcare services in Virginia.

Commenter: Jennifer Switzer, PhD, LPC; Horizon Behavioral Health 1/29/18 12:29 pm

QMHP

Thank you for the opportunity to comment. The online option for registrations was a very good idea, and I believe it will be the most efficient avenue to navigate this process. I would like to offer the following concerns/suggestions with other elements of this proposed regulation change:

1. Allow the QMHP-C to provide services to individuals past age 17, and change it to age 21 (beneficial for those serving individuals in independent living programs, school-based services, etc. where services should continue seamlessly for our individuals).

2. Sociology should remain as an approved degree- it is relevant to our work, and would significantly impact the applicant pool if removed.

3. I share concerns already given regarding the licensed supervisor's expectations: please clarify the extent of this requirement. Will group supervision be accepted? Will the 1:1 requirement remain between licensed supervisor and QMHP Trainee?

4. Please consider aligning the 8 hours of continuing education with current DBHDS expectations.

5. Please consider lowering the cost for individuals who are dual registering as both a QMHP-C and QMHP-A- this would promote cross-training of staff, and maximize the services available for our communities.

Thank you for your time and consideration.

Commenter: Amit Shah, MD 1/29/18 1:59 pm

QMHP certification

I agree with previous comments posted that the limitations of the QMHP certification should be expanded. At a time when mental health beds are at an all time low and a significant proportion of mentally ill individuals end up in the justice system, we should not be creating an artificial bottleneck concerning access to treatment providers as well. Therefore I concur with the following recommendations:

There should not be two QMHP credentials.

Any and every mental health professional who meets the education, experience, and training requirements should be eligible to register and KEEP the QMHP title.

Furthermore, the mandate in the reg that every person who seeks services of a QMHP would need a formal "service plan" is problematic. An organization's clinical supervisors can make those decisions based on the population and particular cases served.

Lastly, clinical supervisors should decide the QMHP's services and roles within an organization and its structure, based on professional standards of practice, agency policies, existing laws and regs, and the QMHP's individual skills, experience, and training.

Commenter: Lisa Snider, Loudoun County MHSADS

2/1/18 12:40 pm

Concerns and questions regarding 18VAC-115-80

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

1. Given the scope of practice of a QMHP, Sociology should continue to be an approved degree. Those working as a QMHP are providing collaborative mental health services and not engaging in independent or autonomous practice. Many of those who have historically filled roles of the QMHP have been individuals with a Sociology degree. Removing the Sociology degree from the approved list without substantial factual review and reporting could affect service delivery for those in Virginia. This degree should be added back to the list.
2. For those who were not employed as a QMHP prior to December 31, 2017, requiring that the experience be within the past five years, is discriminatory for those who may have stepped out of an employed role for family matters. This stipulation is unfair and should be removed.
3. There has been little to no clarity provided regarding documentation needed for QMHP registration.
   1. There should be a way to print the attestation form needed for staff employed prior to December 31, 2017 prior to paying the registration fee so that staff can ensure an attestation before registering.
   2. For those working after December 31, 2017, there is no clarification on the “evidence” of hours that will be needed. Is this an attestation form?
4. I echo the multiple concerns noted regarding the requirement of registration and payment for registration for credentials as QMHP-A and QMHP-C. Requiring separate registrations and re-registrations is redundant and not needed. The Board of Counseling has indicated that the 8 hours of continued education can be the same hours used for both. How then is a separate registration needed?
5. Requiring nurses with psychiatric experience to register as a QMHP-A and/or QMHP-C, when they are already registered with the Virginia Board of Nursing, seems unnecessary.
6. I echo the concerns noted regarding the list of those who can provide the 8 hours of continuing education being too narrow. Further, the Board of Counseling has indicated that they will not pre-approve trainings which will satisfy the requirement. This puts providers and QMHP staff in a stressful, catch 22 position.
7. I echo the concerns noted about the impact of requiring QMHP or QMHP-trainee registration before a provider can bill for the services provided. This requirement places a significant financial burden on providers as providers will be responsible for paying employees while waiting for the Board of Counseling registration confirmation. This burden exits even if the BOC meets their intended 30 day turn around. The impact will very likely reduce a provider’s ability to serve individuals already in service and/or take on new clients in need of the service when a position is vacated. Thus, individuals and families will be negatively impacted.

Commenter: Christina Laws

2/2/18 11:42 am

QMHP Regulations

As a current QMHP-C and QMHP-A with a sociology degree, these changes in regulations and

degree criteria are especially concerning. While I may be an exception moving forward via grandfathering-in, my fellow sociology majors may lose their opportunity to proceed with further career growth or movement. Sociology is a degree based on humans and our society. This means that college graduates coming out of school with this degree have spent the last 2-8 years studying humans, their behaviors, and how they engage with one another, which is a mental health professional at its best. Limiting criteria for QMHPs will not only have a negative impact on mental health agencies and their ability to hire very competent and prepared candidates, but it will also expand its impact to college and university program progression nationwide. Minimizing educational program growth and stability will lead to federal funding issues in the future and could lead to a major setback to the decades of progress that the sociology community has worked towards throughout its lifetime.

Commenter: Jennifer G Fidura, VNPP, Inc. 2/3/18 2:06 pm

QMHP Regulations

The Virginia Network of Private Providers does support the concept of registration for QMHP for the reasons that the original proposal was made, but offers the following comments on the Emergency Regulations:

1) There should either be an opportunity for registration as a QMHP C/A for an indivudual trained and able to work with both children and adults, or the secondary registration (for either QMHP-C or A) for an individual already registered should be at a significantly reduced rate.

2) CEU requirements for someone with dual registration should not exceed 8 hours.

3) QMHP-C should be qualified to work with any individual up to age 22 who is still in school, or foster care through the independent living program.

We share concerns expressed about the regulations becoming an impediment to building and maintaining an adequate, competent and professional workforce, but are willing to work with the Board of Counseling to manage the process as efficiently as possible.

Commenter: Kim Harrison, LCSW - Lutheran Family Services of Virginia - Winchester, VA 2/5/18 12:56 pm

QMHP Feedback

I fully support the registration of QMHP's in Virginia, as a means of better verifying experience and education among professionals in our field. I have the following comments regarding the process and the emergency regulations pertaining to the process:

1. Clarification of LMHP/Type supervision – TDT regulations require weekly individual/group supervision of staff providing TDT services. Will this meet the requirement of a QMHP-Trainee, or will the LMHP/Type have to provide daily supervision? Will the LMHP/Type have to be present at the location to provide constant supervision of the QMHP-Trainee?
2. The requirements for past experience indicate that the applicant has to have had experience under an LMHP/Type who is registered with the board – how will this impact applicants coming from out of state, from Residential Treatment Centers, from internships, etc? Previously, these applicants met the minimum standard to be hired, based on confirmation of their experience, per the DBHDS and DMAS regulations.
3. I echo the feedback that the age for QMHP-C should be extended to 22, as there are many

individuals being served in public schools, and other settings identified as being for “children”, through the age of 22 due to their emotional and cognitive needs, Special Education Status, etc.

4. I echo the feedback that there should be a discounted rate for someone registering as both a QMHP-C and QMHP-A.
5. I echo the need for clarification of supervised experience, and how that experience is to be documented when hiring new staff, as well as for staff hired as a QMHP-Trainee.
6. I echo the concern that Sociology has been removed as an approved degree area. A professional with a degree and Sociology and the minimum experience as previously defined by DBHDS and DMAS should still be able to qualify as a QMHP- C or A.
7. It would be helpful for all forms pertaining to QMHP registration (for C, A or Trainee) to be available for download/review in a PDF format on the website, as the forms for licensure registration currently are, in order to ensure that all documentation and appropriate information is available when the employee is registering. It will also help us as employers to prepare the employee/potential employee for the process. I requested the forms from the Board of Counseling in January, and was told to review the Handbook, but the forms are not included in the Handbook.
8. I echo the comments and concerns regarding the requirement for CEU's for QMHP level staff, and hope that internal trainings can also be counted toward these CEU requirements.

Commenter: Kathy Nelson HRCSB

2/5/18 2:54 pm

QMHP Comments related to the Application process

In a recent QMHP Application, we noted the following on the application form: “**due to the volume of applications, the processing time can take up to 60 business days.**” This is equivalent to 3 months, not the 30 days we were informed it would take when the regulations first came out. This is both a hardship for agencies as well as our consumers. For the agency, this is huge financial burden. For consumers, it may mean the agency does not have the capacity to service all those in need or may need to provide level of service needed. For crisis services such as a residential Crisis stabilization program, It becomes a safety risk when an agency cannot fill positon vacancies quickly. There needs to be some type of interim status during the application process in which the applicant can provide services until the BOC has been able to determine the applicants level of credential.

The other concern I have is the Verification of Supervised Experience form that must be signed by the Supervisor under which the experience occurred. This is a state wide new requirement. I wonder how well institutions of higher education have been informed/educated of these new regulations so that students are well informed when they choose a practicum. They should know to provide the Practicum Supervisor the Verification form at the start of their practicum to have accurate information at the finish of the practicum and the Licensed/Licensed-Type signature.

Also I am very concerned that QMHP Applicants may not be able to obtain the required information and signature form previous employees for any number of reasons and obtain it in a timely manner, once again adding to the financial hardship to employers.

Commenter: Cumberland Mountain CSB

2/5/18 3:01 pm

Concern About QMHP Regualtions

- Sociology should continue to be an approved degree due to the scope of practice for a QMHP. Individuals working as a QMHP are providing collaborative mental health services and not engaging in independent or autonomous practice. Historically, many of those who have filled roles of the QMHP have been/are individuals with a Sociology degree. Removing the Sociology degree from the approved list without substantial factual review and reporting could affect service delivery for those in Virginia. This degree should be added back to the list.
- Individuals who were not employed prior to 12/31/17 as a QMHP, requiring that the experience be within the past five years, is discriminatory for those who may have stepped out of an employed role for family matters. This is unfair and should be removed.

Commenter: Fabrina Goodell

2/7/18 9:22 am

Qmhp regulation on human services alternative

For the past 3 years I have attended Randolph College as a sociology undergraduate. On January 10th 2018 I graduated with a bachelor's in sociology. Sociology in my mind and everywhere I've looked is listed as a field correlated with human services. For the past month-and-a-half I have been trying to become qmhp certified, I have a lot of experience, however, previous employers refuse to sign based on the current guidelines. I'm am hoping that during the next meeting sociology pick cepted as a human service related field.

Commenter: Holly Albrite

2/7/18 2:09 pm

In order for new staff to be credentialed as a QMHP they must meet both education and experience

Commenter: Cheryl Williams Goochland Powhatan Community Services

2/7/18 2:45 pm

QMHP Regulations

Thank you for the opportunity to comment.

I share the concerns expressed by others in terms of the LMHP/Type individual’s expectations to supervise the day-to-day operations of services provided by QMHPs and QMHP-Trainees. Please clarify the nature and extent of these supervision requirements. Does the LMHP/Type have to be present with the QMHP and/or QMHP-Trainee when the QMHP and/or QMHP-Trainee is providing a service either at a program location or in the community? Can group supervision suffice? In addition, what are the Supervision documentation requirements?

I would like to echo the recommendation to expand the narrow definition of approved organizations, associations, or institutions to provide the annual 8 hours of continued competency training. The BOC FAQs state, “The Board staff cannot pre-approve any CE courses. Each registrant shall use their best and professional judgment to determine if the course meets the

requirements outlined in the regulations." This leaves only federal, state, or local government agencies, public schools, or licensed health facilities as the providers of this training.

Sociology should remain as an approved degree qualified for this credential. As expressed by multiple commenters, removing this degree substantially impacts the qualified applicant pool and those who have filled the roles as QMHPs.

The requirement for documentation of supervised experience by an LMHP/Type for services historically supervised by QMHPs (ie: Mental Health Skill Building and Psychosocial Rehabilitation Services) will significantly limit eligible applicants who are in the process, but have not yet completed, the required experience hours. Will there be any allocation to accept these supervised hours?

Thank you in advance for your consideration of these comments when updating these regulations to better meet the needs of all individuals receiving behavioral healthcare services in Virginia.

Commenter: Holly Albrite

2/7/18 3:18 pm

Education and Experience

Concern that it would be possible for an individual to make application to be credentialed as a QMHP and following several months of work, learn that they are not approved. This may be especially true during the initial start-up of this process when individuals and agencies are less familiar with the requirements. That could mean that an individual would lose a job after several months, conceivably through no fault of their own, particularly related to the education requirement. We may think, and they may think, that their degree will be accepted but learn that it is not. Would it be possible to provide an initial approval/rejection of the education requirement so that we have some confidence that the individual will be at least approved as a trainee, or conversely know right away that they will not qualify based on education. The list of allowable degrees may seem straightforward but we find that there are many variations of degrees out there.

In addition, the requirement for an original transcript will further narrow who we can hire as there will be individuals who graduated a long time ago or from an institution that is no longer in existence who will not be able to be hired.

Commenter: Mike Carlin, Virginia Assocaition of Community Based Providers (VACBP)

2/7/18 6:19 pm

QMHP Regulations

The VACBP would like to confirm the following:

1) That the status of QMHP registration and reimbursement for services is that in addition to grandfathering all QMHPs who were employed during 2017, a person hired during 2018 may work and be reimbursed as long as the employer has verified and has appropriate documentation that the person is eligible to be a QMHP (QMHP-E under DBHDS regulations or QMHP-Trainee in the BOC application) and they are complying with the BOC supervision and training regulations. A person who desires to be a QMHP should apply to be registered in 2018, but they may work and their work may be reimbursed for 2018 without being registered. 2) That a QMHP-C may work as a QMHP-A while under the supervision of an LMHP or licensed eligible person to gain required supervision for accumulation of hours towards their QMHP-A status. Under the DMAS CMHRM

QMHP-Cs are included under adult services, but QMHP-As are not included in children specific services, i.e. Intensive In-Home and Therapeutic Day Treatment. 3) That as licensed health facilities all providers of behavioral health services may provide the required 8 hours of CE training.

The VACBP strongly urges that the Sociology and Criminal Justice degrees be included on the list of degrees eligible for registration as a QMHP. There is a significant shortage of QMHPs and the VACBP believes these degrees are appropriate.

The VACBP also supports a change allowing the BOC to recognize a QMHP-E.

Commenter: Lisa Snider, Loudoun County MHSADS 2/7/18 9:29 pm

Additional concerns related to Documentation requirements

With the recent opportunity to review the Board of Counseling (BOC) applications and additional documentation that must be submitted for QMHP-A and QMHP-C registration, additional concerns are noted. These requirements will make registration more difficult, places a financial burden on providers and will reduce service capacity for individuals in Virginia. Listed below are four noted concerns and proposed solutions to each issue.

- When the information was original presented, providers were told that individuals who currently met the qualifications as a QMHP-A or QMHP-C would be able to register with an attestation from the current employer that they met the qualifications and were employed as of December 31, 2017. However, the attestation BOC included with the application indicates that the person must have been employed as of December 31, 2017 **AND *currently working*** as a QMHP-A or QMHP-C. This creates an issue in the following ways:
  1. We have supervisors who are QMHP-A and/or QMHP-C based on qualifications and previous experience; however, these staff were not currently working as a QMHP-A or QMHP-C providing services, but were supervising services. Thus, this wording creates an issue and problem for providers.
  2. Further, what if the person was hired while meeting the qualifications of a QMHP-C and QMHP-A, but was currently working only as a QMHP-A. Why wouldn't the agency be able to attest that the person met criteria for both QMHP-A and QMHP-C?

Proposed Solution: The attestation form should be changed to attest that the person was employed with the agency as of December 31, 2017 and meets the criteria to be a QMHP-A/QMHP-C as defined at that time.

- The verification form requiring (original) signatures creates a barrier for registration and services. Below are examples of where this creates an issue.
  1. Few, if any, outside of Virginia DBHDS licensed programs heard or dealt with QMHP status until now. This places a barrier for staff registration in numerous cases. How are past supervisors, educators and/or supervisors from outside Virginia to sign off on a form indicating the work was as a QMHP-A and/or QMHP-C if this is not something that they are familiar?
  2. The verification form for hours of work requires original signatures of supervisors verifying that the work meets the QMHP-A/AMHP-C criteria. This is a major barrier for certification. What if the supervisor no longer works at the organization, if the supervisor is deceased, or if the organization no longer exists? The experience should be able to count.

Proposed Solution: An attestation form, should replace the verification form. The attestation form should be completed and signed by the person registering for QMHP-A/QMHP-C credentials and require the following:

1. Dates of experience, work schedule and hours worked
2. Attachment of a job description or job responsibilities summary for the work performed.

- With the application form noting that the “processing time can take up to 60 business days” I echo the concerns about the financial burden placed on the providers and the cost of service time for individuals in Virginia.

Proposed Solution: Establish and recognize a preliminary or provisional QMHP-C/QMHP-A status while the paperwork is being reviewed by BOC.

- As a final note, the requirement of registering and paying online, while requiring that documents be mailed into the BOC, creates a slow and antiquated registration process.

Proposed Solution: Utilize a computer system that allows for the uploading and attachment of documents.

Proposed Registered Peer Recovery Specialists (RPRS) Regulations

Commonwealth of Virginia

DRAFT

REGULATIONS

GOVERNING THE REGISTRATION OF PEER RECOVERY SPECIALISTS

VIRGINIA BOARD OF COUNSELING

Title of Regulations: 18 VAC 115-70-10 et seq.

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

Effective Date: December 18, 2017

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Part I
General Provisions

18VAC115-70-10. Definitions.

"Applicant" means a person applying for registration as a peer recovery specialist.

"Board" means the Virginia Board of Counseling.

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

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

"Peer recovery specialist" means a person who by education and experience is professionally qualified in accordance with 12VAC35-250 to provide collaborative services to assist individuals in achieving sustained recovery from the effects of mental illness, addiction, or both.

"Registered peer recovery specialist" or "registrant" means a person who by education and experience is professionally qualified in accordance with 12VAC35-250 and registered by the board to provide collaborative services to assist individuals in achieving sustained recovery from the effects of mental illness, addiction, or both. A registered peer recovery specialist shall provide such services as an employee or independent contractor of DBHDS, a provider licensed by the DBHDS, a practitioner licensed by or holding a permit issued from the Department of Health Professions, or a facility licensed by the Department of Health.

18VAC115-70-20. Fees required by the board.

A. The board has established the following fees applicable to the registration of peer recovery specialists:

Registration	$30
Renewal of registration	$30
Late renewal	$20
Reinstatement of a lapsed registration	$60
Duplicate certificate of registration	$10
Returned check	$35
Reinstatement following revocation or suspension	$500

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

18VAC115-70-30. Current name and address.

Each registrant shall furnish the board his current name and address of record. Any change of name or address of record or public address, if different from the address of record, shall be furnished

to the board within 60 days of such change. It shall be the duty and responsibility of each registrant to inform the board of his current address.

Part II
Requirements for registration and renewal

18VAC115-70-40. Requirements for registration as a peer recovery specialist.

A. An applicant for registration shall submit a completed application on forms provided by the board and any applicable fee as prescribed in 18VAC115-70-20.

B. An applicant for registration as a peer recovery specialist shall provide evidence of meeting all requirements for peer recovery specialists set by DBHDS in 12VAC35-250-30.

18VAC115-70-50. Annual renewal of registration.

All registrants shall renew their registration on or before June 30 of each year. Along with the renewal form, the registrant shall submit the renewal fee as prescribed in 18VAC115-70-20.

18VAC115-70-60. Continued competency requirements for renewal of peer recovery specialist registration.

A. Registered peer recovery specialists shall be required to have completed a minimum of eight contact hours of continuing education for each annual registration renewal. A minimum of one of these hours shall be in courses that emphasize ethics.

Registered peer recovery specialists shall complete continuing competency activities that focus on increasing knowledge or skills in one or more of the following areas:

a. Current body of mental health/substance abuse knowledge;

b. Promoting services, supports, and strategies for the recovery process;

c. Crisis intervention;

d. Values for role of peer recovery specialist;

e. Basic principles related to health and wellness;

f. Stage appropriate pathways in recovery support;

g. Ethics and boundaries;

h. Cultural sensitivity and practice;

i. Trauma and impact on recovery;

j. Community resources; or

k. Delivering peer services within agencies and organizations.

B. The following organizations, associations, or institutions are approved by the board to provide continuing education:

1. Federal, state, or local governmental agencies, public school systems, or licensed health facilities.

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 recognized by the board.

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. An agency or organization approved by DBHDS.

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

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

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

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

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

1. Official transcripts showing credit hours earned; or

2. Certificates of participation.

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

Part III
Standards of Practice; Disciplinary Actions; Reinstatement

18VAC115-70-70. Standards of practice.

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

B. Persons registered by the board shall:

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

2. Be able to justify all services rendered to clients as necessary.

3. Practice only within the competency area for which they are qualified by training or experience.

4. Report to the board known or suspected violations of the laws and regulations governing the practice of registered peer recovery specialists.

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

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

7. Document the need for and steps taken to terminate services when it becomes clear that the client is not benefiting from the relationship.

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

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

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

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

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

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

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

2. Not engage in sexual intimacies or romantic relationships with current clients. For at least five (5) years after cessation or termination of professional services, practitioners shall not engage in sexual intimacies or romantic relationships with a client or those included in collateral therapeutic services. Because sexual or romantic relationships are potentially exploitative, the practitioner shall bear the burden of demonstrating that there has been no exploitation. A client's consent to, initiation of or participation in sexual behavior or involvement with a practitioner does not change the nature of the conduct nor lift the regulatory prohibition.

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

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

18VAC115-70-80. Grounds for revocation, suspension, restriction, or denial of registration.

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

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

2. Procuring, attempting to procure, or maintaining a registration~~, including submission of an application or applicable board forms,~~ by fraud or misrepresentation;

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

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

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

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

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

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

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

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

18VAC115-70-90. Late renewal and reinstatement.

A. A person whose registration has expired may renew it within one year after its expiration date by paying the late renewal fee and the registration fee as prescribed in 18VAC115-70-20 for the year in which the registration was not renewed and by providing documentation of completion of continuing education as prescribed in 18VAC115-70-60.

B. A person who fails to renew registration after one year or more shall:

1. Apply for reinstatement;

2. Pay the reinstatement fee for a lapsed registration;

3. Submit evidence of current certification as a peer recovery specialist as prescribed by DBHDS in 12VAC35-250-30.

C. A person whose registration has been suspended or who has been denied reinstatement by board order, having met the terms of the order, may submit a new application and fee for reinstatement of registration as prescribed in 18VAC115-70-20. Any person whose registration has been revoked by the board may, three years subsequent to such board action, submit a new application and fee for reinstatement of registration as prescribed in 18VAC115-70-20. The board in its discretion may, after an administrative proceeding, grant the reinstatement sought in this subsection.

Code of Virginia

Chapter 35 of Title 54.1 of the Code of Virginia

Professional Counseling

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§ 54.1-3500. Definitions.

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

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

"Board" means the Board of Counseling.

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

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

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

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

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

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

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

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

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

"Professional counselor" means a person trained in the application of principles, standards, and methods of the counseling profession, including counseling interventions designed to facilitate an individual's achievement of human development goals and remediating mental, emotional, or behavioral disorders and associated distresses that interfere with mental health and development.

"Qualified mental health professional" means a person who by education and experience is professionally qualified and registered by the Board to provide collaborative mental health services for adults or children. A qualified mental health professional shall provide such services as an employee or independent contractor of the Department of Behavioral Health and Developmental Services or a provider licensed by the Department of Behavioral Health and Developmental Services.

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

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

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

"Resident" means an individual who has submitted a supervisory contract to the Board and has received Board approval to provide clinical services in professional counseling under supervision.

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

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

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

1976, c. 608, §§ 54-924, 54-932; 1983, c. 115; 1986, cc. 64, 464; 1988, c. 765; 1993, c. 342; 1995, c. 820; 1997, c. 901; 2000, c. 473; 2001, c. 460; 2013, c. 264; 2017, cc. 418, 426.

§ 54.1-3501. Exemption from requirements of licensure.

The requirements for licensure in this chapter shall not be applicable to:

1. Persons who render services that are like or similar to those falling within the scope of the classifications or categories in this chapter, including persons acting as members of substance abuse self-help groups, so long as the recipients or beneficiaries of such services are not subject to any charge or fee, or any financial requirement, actual or implied, and the person rendering such service is not held out, by himself or otherwise, as a person licensed under this chapter.

2. The activities or services of a student pursuing a course of study in counseling, substance abuse treatment or marriage and family therapy in an institution accredited by an accrediting agency recognized by the Board or under the supervision of a person licensed or certified under this chapter, if such activities or services constitute a part of the student's course of study and are adequately supervised.

3. The activities, including marriage and family therapy, counseling, or substance abuse treatment, of rabbis, priests, ministers or clergymen of any religious denomination or sect when such activities are within the scope of the performance of their regular or specialized ministerial duties, and no separate charge is made or when such activities are performed, whether with or without charge, for or under auspices or sponsorship, individually or in conjunction with others, of an established and legally cognizable church, denomination or sect, and the person rendering service remains accountable to its established authority.

4. Persons employed as salaried employees or volunteers of the federal government, the Commonwealth, a locality, or of any agency established or funded, in whole or part, by any such governmental entity or of a private, nonprofit organization or agency sponsored or funded, in whole or part, by a community-based citizen group or organization. Any person who renders psychological services, as defined in Chapter 36 (§ 54.1-3600 et seq.) of this title, shall be subject to the requirements of that chapter. Any person who, in addition to the above enumerated employment, engages in an independent private practice shall not be exempt from the requirements for licensure.

5. Persons regularly employed by private business firms as personnel managers, deputies or assistants so long as their counseling activities relate only to employees of their employer and in respect to their employment.

6. Persons regulated by this Board as professional counselors or persons regulated by another board within the Department of Health Professions who provide, within the scope of their practice, marriage and family therapy, counseling or substance abuse treatment to individuals or groups.

(1976, c. 608, § 54-944; 1986, c. 581; 1988, c. 765; 1995, c. 820; 1997, c. 901.)

§ 54.1-3502. Administration or prescription of drugs not permitted.

This chapter shall not be construed as permitting the administration or prescribing of drugs or in any way infringing upon the practice of medicine as defined in Chapter 29 (§ 54.1-2900 et seq.) of this title.

(1976, c. 608, § 54-945; 1988, c. 765.)

§ 54.1-3503. Board of Counseling.

The Board of Counseling shall regulate the practice of counseling, substance abuse treatment, and marriage and family therapy.

The Board shall consist of 12 members to be appointed by the Governor, subject to confirmation by the General Assembly. Ten members shall be professionals licensed in the Commonwealth, who shall represent the various specialties recognized in the profession, and two shall be citizen members. Of the 10 professional members, six shall be professional counselors, three shall be licensed marriage and family therapists who have passed the examination for licensure as a marriage and family therapist, and one shall be a licensed substance abuse treatment practitioner.

The terms of the members of the Board shall be four years.

1976, c. 608; § 54-933; 1981, c. 447; 1983, c. 150; 1986, cc. 185, 464; 1988, c. 765; 1995, c. 820; 1997, c. 901; 2000, c. 473; 2013, cc. 201, 590; 2016, c. 105

§ 54.1-3504. Nominations.

Nominations for professional members may be made from a list of at least three names for each vacancy submitted to the Governor by the Virginia Counselors Association, the Virginia Association of Clinical Counselors, the Virginia Association of Alcoholism and Drug Abuse Counselors, and the Virginia Association for Marriage and Family Therapy. The Governor may notify such organizations of any professional vacancy other than by expiration. In no case shall the Governor be bound to make any appointment from among the nominees.

(1986, c. 464, § 54-933.2; 1988, c. 765; 1995, c. 820; 1997, c. 901.)

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

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

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

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

3. To designate specialties within the profession.

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

5. [Expired.]

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

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

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

9. To promulgate regulations for the registration of qualified mental health professionals, including qualifications, education, and experience necessary for such registration.

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

1976, c. 608, §§ 54-929, 54-931; 1983, c. 115; 1986, cc. 64, 100, 464; 1988, c. 765; 1994, cc. 558, 778; 1995, c. 820; 1997, c. 901; 2001, c. 460; 2013, c. 264; 2017, cc. 418, 426.

§ 54.1-3505.1. Continued competency requirements.

The Board shall promulgate regulations establishing requirements for evidence of continued competency as a condition of renewal of a license under the provisions of this chapter. The Board may approve persons who provide or accredit continuing education programs in order to accomplish the purposes of this section. The Board shall have the authority to grant exemptions or waivers or to reduce the number of continuing education hours required in cases of certified illness or undue hardship.

(2002, c. 430.)

§ 54.1-3506. License required.

In order to engage in the practice of counseling or marriage and family therapy or in the independent practice of substance abuse treatment, as defined in this chapter, it shall be necessary to hold a license issued by the Board.

The Board may issue a license, without examination, for the practice of marriage and family therapy or the independent practice of substance abuse treatment to persons who hold a current and unrestricted license as a professional counselor within the Commonwealth and who meet the clinical and academic requirements for licensure as a marriage and family therapist or licensed substance abuse treatment practitioner, respectively. The applicant for such license shall present satisfactory evidence of qualifications equal to those required of applicants for licensure as marriage and family therapists or licensed substance abuse treatment practitioners, respectively, by examination in the Commonwealth.

Any person who renders substance abuse treatment services as defined in this chapter and who is not licensed to do so, other than a person who is exempt pursuant to § 54.1-3501, shall render such services only when he is (i) under the supervision and direction of a person licensed under this chapter who shall be responsible for the services performed by such unlicensed person, or (ii) in compliance with the regulations governing an organization or a facility licensed by the Department of Behavioral Health and Developmental Services.

(1979, c. 408, § 54-935.1; 1988, c. 765; 1995, c. 820; 1997, c. 901; 2009, cc. 813, 840; 2013, c. 264.)

§ 54.1-3506.1. Client notification.

Any person licensed, certified, or registered by the Board and operating in a nonhospital setting shall post a copy of his license, certification, or registration in a conspicuous place. The posting shall also provide clients with (i) the number of the toll-free complaint line at the Department of Health Professions, (ii) the website address of the Department for the purposes of accessing the licensee's, certificate holder's, or registrant's record, and (iii) notice of the client's right to report to the Department if he believes the licensee, certificate holder, or registrant may have engaged in unethical, fraudulent, or unprofessional conduct. If the licensee, certificate holder, or registrant does not operate in a central location at which clients visit, he or his employer shall provide such information on a disclosure form signed by the client and maintained in the client's record.

2015, c. 530; 2017, cc. 418, 426.

§ 54.1-3507. Scope of practice of and qualifications for licensed substance abuse treatment practitioners.

A. A licensed substance abuse treatment practitioner shall be qualified to (i) perform on an independent basis the substance abuse treatment functions of screening, intake, orientation, assessment, treatment planning, treatment, case management, substance abuse or dependence crisis intervention, client education, referral activities, recordkeeping, and consultation with other professionals; (ii) exercise independent professional judgment, based on observations and objective assessments of a client's behavior, to evaluate current functioning, to diagnose and select appropriate remedial treatment for identified problems, and to make appropriate referrals; and (iii) supervise, direct and instruct others who provide substance abuse treatment.

B. Pursuant to regulations adopted by the Board, an applicant for a license as a licensed substance abuse treatment practitioner shall submit evidence satisfactory to the Board that the applicant has (i) completed a specified number of hours of graduate studies, including a specified number of didactic substance abuse education courses at, and has received a master's degree in substance abuse or a substantially equivalent master's degree from, a college or university accredited by an accrediting agency recognized by the Board; and (ii) completed a specified number of hours of experience involving the practice of substance abuse treatment supervised by a licensed substance abuse treatment practitioner, or by any other mental health professional licensed by the Department, such number of hours being greater than the number of hours required of a certified substance abuse counseling assistant. The applicant shall also pass an examination, as required by the Board.

(1997, c. 901; 2001, c. 460.)

§ 54.1-3507.1. Scope of practice, supervision, and qualifications of certified substance abuse counselors.

A. A certified substance abuse counselor shall be (i) qualified to perform, under appropriate supervision or direction, the substance abuse treatment functions of screening, intake, orientation, the administration of substance abuse assessment instruments, recovery and relapse

prevention planning, substance abuse treatment, case management, substance abuse or dependence crisis intervention, client education, referral activities, record keeping, and consultation with other professionals; (ii) qualified to be responsible for client care of persons with a primary diagnosis of substance abuse or dependence; and (iii) qualified to supervise, direct and instruct certified substance abuse counseling assistants. Certified substance abuse counselors shall not engage in independent or autonomous practice.

B. Such counselor shall also be clinically supervised or directed by a licensed substance abuse treatment practitioner, or any other mental health professional licensed by the Department, or, in an exempt setting as described in § 54.1-3501, another person with substantially equivalent education, training, and experience, or such counselor shall be in compliance with the supervision requirements of a licensed facility.

C. Pursuant to regulations adopted by the Board, an applicant for certification as a substance abuse counselor shall submit evidence satisfactory to the Board that the applicant has (i) completed a specified number of hours of didactic substance abuse education courses in a program or programs recognized or approved by the Board and received a bachelor's degree from a college or university accredited by an accrediting agency recognized by the Board; and (ii) accumulated a specified number of hours of experience involving the practice of substance abuse treatment while supervised by a licensed substance abuse treatment practitioner, or by any other mental health professional licensed by the Department, or by a certified substance abuse counselor who shall submit evidence satisfactory to the Board of clinical supervision qualifications pursuant to regulations adopted by the Board, such number of hours being greater than the number of hours required of a certified substance abuse counseling assistant. The applicant shall also pass an examination as required by the Board.

(2001, c. 460.)

§ 54.1-3507.2. Scope of practice, supervision, and qualifications of certified substance abuse counseling assistants.

A. A certified substance abuse counseling assistant shall be qualified to perform, under appropriate supervision or direction, the substance abuse treatment functions of orientation, implementation of substance abuse treatment plans, case management, substance abuse or dependence crisis intervention, record keeping, and consultation with other professionals. Certified substance abuse counseling assistants may participate in recovery group discussions, but shall not engage in counseling with either individuals or groups or engage in independent or autonomous practice.

B. Such certified substance abuse counseling assistant shall be supervised or directed either by a licensed substance abuse treatment practitioner, or by any other mental health professional licensed by the Department, or by a certified substance abuse counselor, or, in an exempt setting as described in § 54.1-3501, another person with substantially equivalent education, training, and experience, or such counseling assistant shall be in compliance with the supervision requirements of a licensed facility.

C. Pursuant to regulations adopted by the Board, an applicant for certification as a certified substance abuse counseling assistant shall submit evidence satisfactory to the Board that the applicant has (i) received a high school diploma or its equivalent, (ii) completed a specified number of hours of didactic substance abuse education in a program or programs recognized or approved by the Board, and (iii) accumulated a specified number of hours of experience and completed a practicum or an internship involving substance abuse treatment, supervised either by a licensed substance abuse treatment practitioner, or by any other mental health professional licensed by the Department, or by a certified substance abuse counselor. The applicant shall also pass an examination, as required by the Board.

(2001, c. 460.)

§ 54.1-3507.3. Use of titles.

No person shall claim to be, or use the title of, a substance abuse treatment practitioner, a substance abuse counselor, or a substance abuse counseling assistant unless he has been licensed or certified as such pursuant to §§ 54.1-3507, 54.1-3507.1 or § 54.1-3507.2.

(2001, c. 460.)

§ 54.1-3508. Licensure of certain persons possessing substantially equivalent qualifications, education or experience.

Notwithstanding the provisions of § 54.1-3507, (i) the Board may issue a license as a licensed substance abuse treatment practitioner to a person who, after the effective date of the regulations promulgated pursuant to subdivision 7 of § 54.1-3505, has applied for such a license and who, in the judgment of the Board, possesses qualifications, education or experience substantially equivalent to the requirements of § 54.1-3507; however, any such applicant shall have completed at least one year of supervised clinical experience in substance abuse treatment, and (ii) for a period of time to be determined by the Board but not less than one year after the effective date of the regulations, the Board shall issue such a license to any such person who, in the judgment of the Board, possesses qualifications, education or experience acceptable to the Board and has completed at least one year of supervised clinical experience in substance abuse treatment.

(1997, c. 901; 1999, c. 863.)

§ 54.1-3509. Continued certification of certain certified substance abuse counselors.

On and after July 1, 2001, unless such certification is suspended or revoked by the Board, the Board shall continue to certify as a certified substance abuse counselor any person (i) who was certified by the Board as a certified substance abuse counselor prior to July 1, 2001, or (ii) who registered his supervisory contract with the Board or filed an application with the Board prior to July 1, 2001, for certification as a certified substance abuse counselor and was certified by the Board after July 1, 2001. The person's scope of practice shall be limited to that set forth in subsection A of § 54.1-3507.1.

(2001, c. 460.)

§ 54.1-3510. Definitions.

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

"Certified rehabilitation provider" means a person who is certified by the Board as possessing the training, the skills and the experience as a rehabilitation provider to form an opinion by discerning and evaluating, thereby allowing for a sound and reasonable determination or recommendation as to the appropriate employment for a rehabilitation client and who may provide vocational rehabilitation services under subdivision A 3 of § 65.2-603 that involve the exercise of professional judgment.

"Professional judgment" includes consideration of the client's level of disability, functional limitations and capabilities; consideration of client aptitudes, career and technical skills and abilities; education and pre-injury employment; and identification of return-to-work options and service needs which culminate in the determination or recommendation of appropriate employment for the rehabilitation client.

(1994, c. 558; 1995, c. 343; 1997, c. 839; 2001, c. 483; 2004, c. 10.)

§§ 54.1-3511. , 54.1-3512.

Repealed by Acts 2004, c. 10.

§ 54.1-3513. Restriction of practice; use of titles.

A. No person, other than a person licensed by the Boards of Counseling; Medicine; Nursing; Optometry; Psychology; or Social Work, shall hold himself out as a provider of rehabilitation services or use the title "rehabilitation provider" or a similar title or any abbreviation thereof unless he holds a valid certificate under this article.

B. Subsection A shall not apply to employees or independent contractors of the Commonwealth's agencies and sheltered workshops providing vocational rehabilitation services, under the following circumstances: (i) such employees or independent contractors are not providing vocational rehabilitation services under § 65.2-603 or (ii) such employees are providing vocational rehabilitation services under § 65.2-603 as well as other programs and are certified by the Commission on Rehabilitation Counselor Certification (CRCC) as certified rehabilitation counselors (CRC) or by the Commission on Certification of Work Adjustment and Vocational Evaluation Specialists (CCWAVES) as Certified Vocational Evaluation Specialists (CVE).

(1994, c. 558; 2000, c. 473; 2004, c. 271.)

§ 54.1-3514. Certification of existing providers.

The Board of Counseling upon receipt of a completed application and payment of the prescribed fee on or before June 30, 1995, shall issue a certificate to any person who was actively engaged in providing rehabilitation services on January 1, 1994.

(1994, c. 558; 2000, c. 473.)

§ 54.1-3515. Certification renewal of individuals who became certified under the provisions of § 54.1-3514.

After July 1, 2001, the Board of Counseling shall not renew a certificate to any person who became certified under the provisions of § 54.1-3514 without documentation that such person meets the current requirements for certification established by the Board, unless such person provided rehabilitation services for at least two years immediately preceding July 1, 1997, and has done so continuously since that date without interruption and received a passing score on a Board approved examination. The Board of Counseling, pursuant to its authority in this section and in § 54.1-3505, shall adopt regulations to implement the 1997 revisions of the law relating to certified rehabilitation providers in 280 days or less of the date of the enactment of such revisions.

(1997, c. 839; 1999, c. 609; 2000, c. 473.)

Review of Guidance Documents

Virginia Board of Counseling

Guidance on Use of Hypnosis and Hypnotherapy by Professional Counselors

The Board recognizes hypnosis and hypnotherapy as an appropriate counseling tool, useful in the practice of professional counseling, when such techniques are within the training and competency of the licensed professional counselor.

Excerpt from Newsletter, April 1987
Reaffirmed by Board of Counseling, August 9, 2008

Virginia Board of Counseling

Evidence of Clinical Practice for Licensure by Endorsement

Clarification was requested regarding the use of evidence of licensed clinical active practice under one license (i.e. LPC) to apply for another license (i.e. MFT). The Board confirmed that the applicant must verify experience as a licensee holding the same type of license in another jurisdiction that they are applying for in Virginia. Verified experience under any other license type will not be considered. The guidance is consistent with other health regulatory boards that accept evidence of clinical practice in the profession for which a license in Virginia is being sought (i.e. practice experience as a nurse cannot be counted as clinical practice in physical therapy for licensure by endorsement).

CONFIDENTIAL CONSENT AGREEMENTS

Legislation enacted in 2003 authorizes the health regulatory boards to resolve certain allegations of practitioner misconduct by means of a *Confidential Consent Agreement ("CCA")*. This agreement may be used by a board in lieu of public discipline, but only in cases involving minor misconduct and non-practice related infractions, where there is little or no injury to a patient or the public, and little likelihood of repetition by the practitioner.

A CCA shall not be used if the board determines there is probable cause to believe the practitioner has (i) demonstrated gross negligence or intentional misconduct in the care of patients, or (ii) conducted his/her practice in a manner as to be a danger to patients or the public.

A CCA shall be considered neither a notice nor an order of a health regulatory board, both of which are public documents. The acceptance and content of a CCA shall not be disclosed by either the board or the practitioner who is the subject of the agreement.

A CCA may be offered and accepted any time prior to the issuance of a notice of informal conference by the board. By law, the agreement document must include findings of fact and may include an admission or a finding of a violation. The entry of a CCA in the past may be considered by a board in future disciplinary proceedings. A practitioner may only enter into only two confidential consent agreements involving a standard of care violation within a 10-year period. The practitioner shall receive public discipline for any subsequent violation within the 10-year period, unless the board finds there are sufficient facts and circumstances to rebut the presumption that such further disciplinary action should be made public.

Confidential Consent Agreements
Board of Counseling

At the February 27, 2004 meeting, the Board voted unanimously to adopt guidelines for possible uses of Confidential Consent Agreements. These guidelines were taken from recommendations resulting from work done on this issue by the Chairs of the Behavioral Science Boards of the Department of Health Professions.

The **Board of Counseling** adopted the following list of violations of Regulation or Statute that may qualify for resolution by a Confidential Consent Agreement:

1. Advertising

Example: A licensee or certificate holder using the title "Dr." without specifying "Ph.D.," "Ed.D.," or such similar designation after his or her name.

2. Continuing education

Example: Insufficient or improper coursework to meet the requirements. Confidential Consent Agreements will not, however, be used in instances where a licensee is found to have untruthfully reported compliance.

3. Record keeping

Example: To include such infractions as failure to record in a timely fashion; omission or inaccurate recording of dates, names, or times; and illegibility to the point of reasonably being unreadable.

4. Inadvertent breach of confidentiality

Example: Providing information about a client to another person without authorization, such as responding to, "what time is my wife's appointment?" By acknowledging the appointment the licensee has verified that he or she is treating someone.

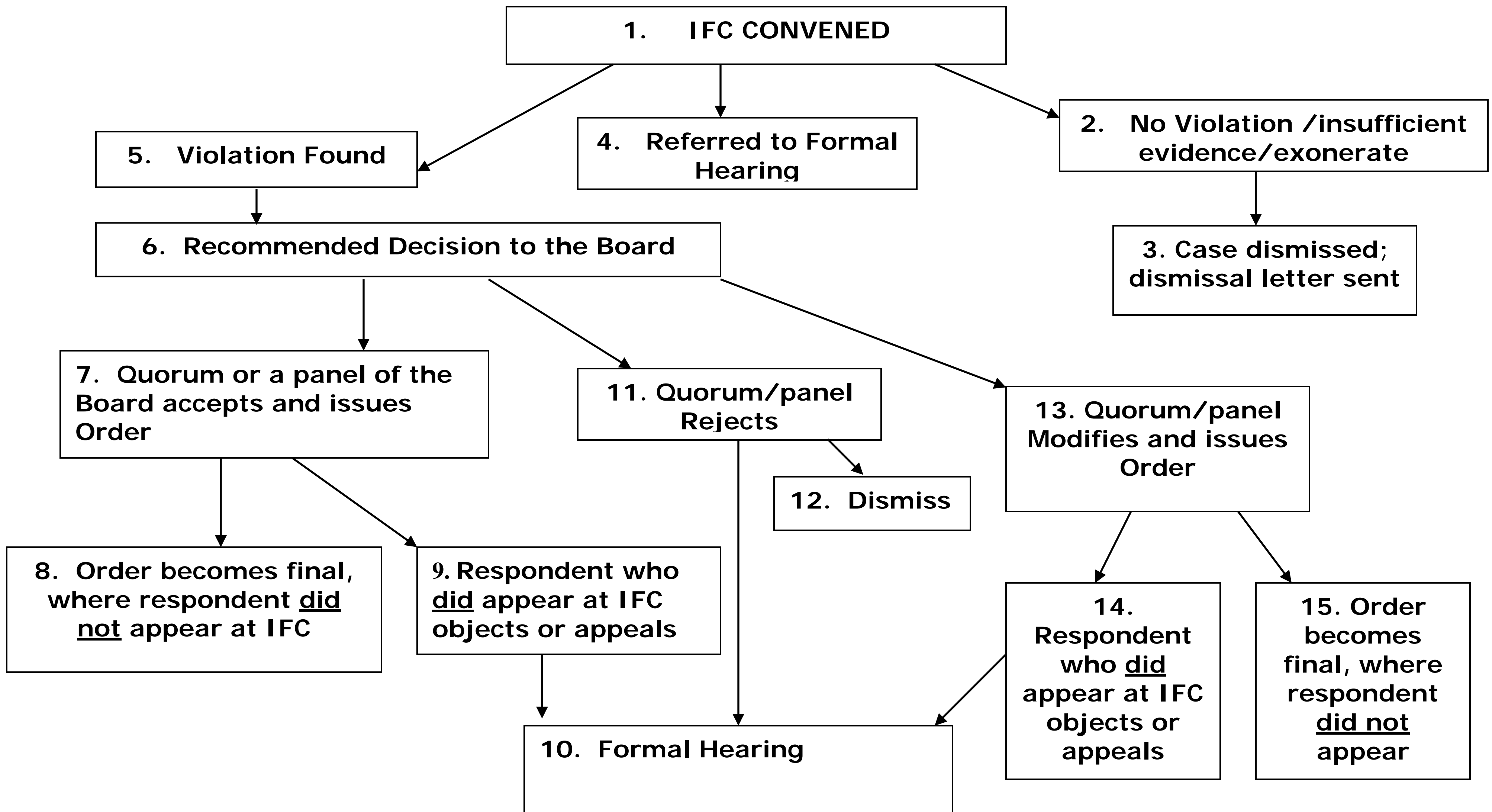
5. Failure to report a known violation

Example: A licensee working at an agency is "instructed" by a supervisor (non-licensee) not to report a violation. As a result, the licensee does not report the violation under fear of action from his or her employer.

6. Fees and billing issues

Example: The licensee charges more than originally agreed upon. This would also apply in situations of unintentionally billing for the wrong date(s).

Guidance for Conduct of an Informal Conference by an Agency Subordinate of a Health Regulatory Board at the Department of Health Professions



Narrative explanation of Flow Chart on Delegation to an Agency Subordinate

This describes the process in which a subordinate hears a case at an informal conference up to a case that may be referred to a formal hearing.

1. Pursuant to a notice, the designated agency subordinate ("subordinate") will convene the informal conference ("IFC"). An IFC before a subordinate is conducted in the same manner as an IFC before a committee of the board. Following the presentation of information by the parties, the subordinate will consider the evidence presented and render a recommended decision regarding the findings of fact, conclusions of law, and if appropriate, the sanction to be imposed.

2. The subordinate may recommend that the respondent be exonerated, that there be a finding of no violation, or that insufficient evidence exists to determine that a statutory and/or regulatory violation has occurred.

> **3.** If the subordinate makes such a finding, the case is dismissed and a dismissal letter is issued to the respondent notifying him of the determination.

4. The subordinate may decide that the case should be referred to a formal hearing. A hearing before the board would then be scheduled and notice sent to the respondent.

5. The subordinate may determine that a violation has occurred and recommend the findings of fact and conclusions of law along with an appropriate sanction.

> **6.** With the assistance of APD, the subordinate drafts a recommended decision, which includes the findings of fact, conclusions of law and sanction. The recommendation is provided to the respondent and to the board and must be ratified by a quorum of the board or a panel consisting of at least five members of the board.

7. If the quorum or panel of the board accepts the recommended decision and:

> **8.** If the respondent did not appear at the IFC, the board's decision becomes a final order that can only be appealed to a circuit court; or
>
> **9-10.** If the respondent did appear at the IFC and objects to and appeals the order, he may request a

formal hearing before the board. A case referred to a formal hearing proceeds in the same manner as cases considered by special conference committees convened pursuant to Va. Code § 54.1-2400(10). If the respondent who appeared at the IFC does not request a formal hearing, the order becomes final after a specified timeframe.

11. A quorum or panel of the board may reject the recommended decision of the subordinate, in which case:

The quorum/panel may decide to refer the case for a formal hearing **(10)**; or the quorum/panel may decide to dismiss the case and a dismissal letter is issued to the respondent notifying him of the decision of the board **(12)**.

13. A quorum or panel of the board may modify the subordinate's recommended decision and issue an order reflecting the modified decision to the respondent.

15. If the respondent did not appear at the informal conference, then the board's decision becomes a final order that can only be appealed to a circuit court.

14-10. If the respondent did appear at the informal conference and objects to and appeals the order, he may request a formal hearing before the board. A case referred to a formal hearing proceeds in the same manner as cases considered by special conference committees convened pursuant to Va. Code § 54.1-2400(10). If the respondent who appeared at the IFC does not request a formal hearing, the order becomes final after a specified timeframe.

Periodic Review of Regulations

Notice of Periodic Review of Regulations

Request for Comment

Virginia Board of Counseling

The Virginia Board of Counseling is conducting a periodic review of the following regulations and is requesting comment on the current regulations:

Chapter	Board of Counseling
18 VAC 115-15	Regulations Governing Delegation to an Agency Subordinate
18 VAC 115-20	Regulations Governing the Practice of Professional Counseling
18 VAC 115-50	Regulations Governing the Practice of Marriage and Family Therapy
18 VAC 115-60	Regulations Governing the Licensure of Substance Abuse Professionals

The purpose of this review is to determine whether this regulation should be repealed, amended, or retained in its current form. Public comment is sought on the review of any issue relating to this regulation, including whether the regulation (i) is necessary for the protection of public health, safety, and welfare or for the economical performance of important governmental functions; (ii) minimizes the economic impact on small businesses in a manner consistent with the stated objectives of applicable law; and (iii) is clearly written and easily understandable.

Comment Begins: June 11, 2018 Comment Ends: July 11, 2018

If any member of the public would like to comment on these regulations, please comment on the Virginia Regulatory Townhall at: www.townhall.virginia.gov

Or send comments by the close of the comment period to:

Elaine J. Yeatts
Senior Policy Analyst
Department of Health Professions
9960 Mayland Drive, Suite 300
Richmond, VA 23233

Comments may also be e-mailed to: elaine.yeatts@dhp.virginia.gov or faxed to: (804) 527-4434

Regulations may be viewed on-line at www.dhp.virginia.gov or copies will be sent upon request.