Virginia Department of Health Professions
Board of Counseling

Agenda
Full Board Meeting

November 22, 2019
Board Room 3
10:00 a.m.

10:00 a.m. Call to Order – Johnston Brendel, Ed.D, LPC, LMFT, Board Chair

- Welcome and Introductions
- Emergency Egress Procedures
- Mission of the Board

Adoption of Agenda

Public Comment

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

Approval of Minutes

- Board Meeting – August 16, 2019* **Page 5**
- Regulatory Committee Meeting – August 15, 2019 **Page 47**

Agency Report - David E. Brown, DC

Chairperson Report – Johnston Brendel **Page 50**

Board Counsel Report – James Rutkowski, Assistant Attorney General

Legislation and Regulatory Report – Elaine Yeatts

- Report on 2019 Legislative Actions
- Report on Status of Regulations **Page 53**
- Regulatory Actions
  - Adoption of Exempt Action to reduce fees for qualified mental health professional-trainee for Regulations Governing the Registration of Qualified Mental Health Professionals.* **Page 56**
  - Adoption of Fast-Track Regulations Governing the Registration of Qualified Mental Health Professionals related to the qualified mental health professional-trainee.* **Page 59**
  - Review public comment on Final Regulations Governing the Registration of Qualified Mental Health Professionals. **Page 77**
  - Adoption of Final regulations related to foreign degrees for Regulations Governing the Practice of Professional Counseling, Marriage and Family Therapy and Substance Abuse Practitioners.* **Page 82**

Committee Reports

- Board of Health Professions Report – Kevin Doyle
- Legislative/Regulatory Committee – John Brendel
- Ad Hoc Committee on Tele-Assisted Counseling and Supervision – Terry Tinsley

Unfinished Business

- National Counselor Licensure Endorsement (NCLEP 2.0) **Page 332**

Closed Session – Consideration of Recommended Decisions

Next Meeting – February 7, 2020

Meeting Adjournment

*Indicates a Board Vote is required

This information is in **DRAFT** form and is subject to change. The official agenda and packet will be approved by the Board at the Quarterly Board meeting. One printed copy of the agenda packet will be available for the public to view at the Board Meeting pursuant to Virginia Code Section 2.2-3707(F).

Counseling Quarterly Board Meeting Minutes

August 16, 2019

DRAFT
BOARD OF COUNSELING
QUARTERLY BOARD MEETING
Friday, August 16, 2019

TIME AND PLACE:	Dr. Doyle called the meeting to order at 9:05 a.m. on Friday, August 16, 2019, in Board Room 2 at the Department of Health Professions ("DHP"), 9960 Mayland Drive, Henrico, Virginia.
PRESIDING:	Kevin Doyle, Ed.D., LPC, LSATP, Chairperson
BOARD MEMBERS PRESENT:	Barry Alvarez, LMFT Johnston Brendel, Ed.D., LPC, LMFT Jane Engelken, LPC, LSATP Natalie Harris, LPC, LMFT Danielle Hunt, LPC Bev-Freda L. Jackson, Ph.D., MA, Citizen Member Maria Stransky, LPC, CSAC, CSOTP Terry R. Tinsley, Ph.D., LPC, LMFT, CSOTP, NCC Holly Tracy, LPC, LMFT Tiffinee Yancey, Ph.D., LPC
BOARD MEMBERS ABSENT:	Vivian Sanchez-Jones, Citizen Member
STAFF PRESENT:	Christy Evans, Discipline Case Specialists Jennifer Lang, Deputy Executive Director Charlotte Lenart, Licensing Manager Brenda Maida, Licensing Specialist
OTHERS PRESENT:	Barbara Allison-Bryan, DHP Chief Deputy David E. Brown, D.C., DHP Director James Rutkowski, Assistant Attorney General Elaine Yeatts, DHP Senior Policy Analyst
WELCOME & INTRODUCTIONS:	Dr. Doyle welcomed the Board members, staff, and general-public in attendance.
PUBLIC HEARING:	See "Attachment A"
SUMMARY SUPENSION CONSIDERATION:	See "Attachment B"
APPROVAL OF MINUTES:	Upon a motion made by Dr. Brendel, and seconded by Ms. Harris, the Board voted unanimously to approve the May 31, 2019 Quarterly Board meeting minutes.
ADOPTION OF AGENDA:	The Board adopted the agenda after agreeing to move the public comment immediately after the public hearing and moving the presentation by Dr. Wibberly directly after summary suspension consideration.

PUBLIC COMMENT: Patrick McCloud, CEO of Virginia Apartment Management Association provided information on the issues and concerns of counselors submitting letters recommending an Emotional Support Animal ("ESA") without having the training, qualifications and existing therapeutic relationship.

DHP DIRECTOR'S REPORT: Dr. Brown informed the Board that DHP will offer a Board member training for new and existing Board member on October 7, 2019

Dr. Brown provided an update on Agency activities including the Telemedicine workgroup and International Medical Graduate Workgroup.

CHAIRMAN REPORT: Dr. Doyle congratulated Dr. Brendel and Ms. Hunt on their reappointment and thanked them for their continuing service.

Dr. Doyle noted that the Board was well represented at the American Association of State Counseling Boards (AASCB) and National Board for Certified Counselor (NBCC) joint conference August 7-9th, 2019 in Washington, DC.

Mr. Alvarez, Ms. Hunt, Dr. Tinsley and Ms. Tracy each discussed the topics and issues addressed at the conference.

LEGISTLATION AND REGULATORY ACTIONS:

Regulatory/Legislative Report

Ms. Yeatts provided a chart of current regulatory actions as of August 5, 2019 that listed:

- 18VAC 115-15 Regulations Governing Delegation to an Agency Subordinate – Period Review (action 5301); Fast-Track – *At Secretary's Office*

- 18VAC 115-20 Regulations Governing the Practice of Professional Counseling – Unprofessional conduct - conversion therapy (action 5225); NOIRA – Register Date: 7/8/19, Comment closed: 8/7/19, Board to adopt proposed regulations: 8/16/19

- 18VAC 115-20 Regulations Governing the Practice of Professional Counseling – Periodic review (action 5230); NOIRA – Register Date: 8/19/19, Comment closes: 9/18/19

- 18VAC 115-20 Regulations Governing the Practice of Professional Counseling – Credential review for foreign graduates (Action 5089); Proposed – Register Date: 7/22/19, Comment closes:9/20/19

- 18VAC 115-20 Regulations Governing the Practice of Professional Counseling - requirement for CACREP accreditation for educational programs (action 4259); Proposed- *At Secretary's*

Office

- 18VAC 115-20 Regulations Governing the Practice of Professional Counseling - acceptance of doctoral practicum/internship hours towards residency requirements (action 4829); Final – At *Secretary's Office*

- 18VAC 115-30 Regulations Governing the Certification of Substance Abuse Counselors updating and clarifying regulations (Action 4691); Final – *At Secretary's Office*

- 18VAC 114-40 Regulations Governing the Certification of Rehabilitation Providers (Action 5305); Periodic review – NOIRA – *At Secretary's Office*

- 18VAC 115-50 Regulations Governing the Practice of Marriage and Family Therapy - acceptance of doctoral hours towards residency (action 5226); Fast-Track – Registered Date: 7/22/19, Effective:9/6/19

- 18VAC115-70 Regulations Governing the Registration of Peer Recovery Specialist– Initial regulations for registration (action 4890) Final – *At Secretary's Office*

- 18VAC115-80 Regulations Governing the Registration Qualified Mental Health Professionals– Initial regulations for registration (action 4891) Final – *At Secretary's Office*

Regulatory Actions:

Consideration of public comment on the Notice of Intended Regulatory Action (NOIRA) and proposed regulations on practice of conversion therapy for the Regulations Governing the Practice of Professional Counseling, Substance Abuse Counselors, Practice of Marriage and Family Therapy and Substance Abuse Practitioners. Dr. Brendel moved, and Ms. Stransky properly seconded, to move forward with the drafted proposed language on the practice of conversion therapy. The motion passed with six in favor, four in opposition and one abstention.

Discussion and Recommendations from the Regulatory Committee:

Petition of Rulemaking to amend the Regulations Governing the Practice of Professional Counseling to allow a licensed counselor to supervise residents without the two-year post-

licensure clinical experience requirement, if the licensee has complete a doctoral level supervision course or doctoral level supervision internship as a part of the completion of a doctoral degree. The Regulatory Committee recommended that the full board deny the petitioner's request for changes to the supervisor requirements. All Board members agreed with the Regulatory Committee's recommendation.

Petition of Rulemaking to amend the Regulations Governing the Practice of Professional Counseling to amend the criteria for a supervisor to have a minimum of five years of post-licensure experience or have documentation that the supervisor has experience in all clinical areas. The Board concurred with the concept that the qualifications for a supervisor should be examined to ensure a quality clinical experience for residents and for protection of the public. However, the Board was concerned that requiring additional years of clinical experience or other qualifications would result in reducing the supply of supervisors and restricting the number of residents pursuing licensure. To address all these concerns, the Board will be looking at requirements in other states and at the opportunities for credentialing supervisors to improve supervision quality. The Regulatory Committee recommended that the board deny the petitioner's request for changes to the supervisor requirements. All Board members agreed with the Regulatory Committee's recommendation.

Adopt emergency regulations related to the issuance of temporary licenses engaged in counseling residency. The Board reviewed the proposed language for the temporary resident license. Mr. Alvarez moved, which was seconded by Ms. Stransky, to approve the presented changes and recommended emergency regulations for issuance of temporary resident license. The motion passed unanimously. See "Attachment C"

Supervisor designation and qualifications. The Board stated that this was a timely topic to discuss and asked staff to research the minimum requirements for supervisors in other states and to research the Board's authority to credential supervisors.

PRESENTATION:

Dr. Kathy Wibberly, Director, Mid-Atlantic Telehealth Resource Center provided an in-depth presentation on Telebehavioral Health.

EXECUTIVE DIRECTOR'S REPORT:

In Ms. Hoyle absence, Ms. Lang presented the Executive Director's Report. Ms. Lang provided a staffing update to include a position for a part-time professional reviewer to reduce the burden of the Board members in the review of probable cause cases, the plan to continue to use the agency subordinate for Qualified Mental Health Professionals (QMHPs) cases and the approval to move forward with licensing staffing changes.

Ms. Lang provided information on the Board's financials. The

Financial statement was provided in the agenda packet. Ms. Lang also indicated that the spending for overtime is decreasing and staff continues to do a wonderful job getting things accomplished as efficiently as possible.

Ms. Hoyle also wanted to take the time to thank Dr. Doyle for his dedication and service as the Chairperson for the Virginia Board of Counseling from February 2015 to August 2019. Under his tenure as chair, Dr. Doyle has overseen many changes and increases in the volume of applications and licensees regulated by the Board.

DEPUTY EXECUTIVE DIRECTOR'S DISCIPLINE REPORT:

Ms. Lang presented information on the AASCB Business Meeting in which 35 states were represented. Ms. Lang recognized Dr. Doyle for being voted as the President-Elect for the AASCB and encouraged board members and staff to get involved in the position within the AASCB organization.

Ms. Lang thanked the Board for their hard work reviewing probable cause cases. A recent report from the Agency showed that the cases for Counseling have increased this year by 99%.

LICENSING MANAGER'S REPORT:

In addition to the statistical information provided in the agenda packet, Ms. Lenart thanked her staff for their hard work and dedication.

BOARD COUNSEL REPORT:

No report.

BOARD OF HEALTH PROFESSIONS REPORT:

Dr. Doyle reported that the Board of Health Professions Regulatory Research Committee completed a study on the issuance of licensure for music therapists in the Commonwealth of Virginia and on July 31, 2019 voted to recommend to the full Board of Health Professions the licensing of music therapists under the Board of Counseling. It was noted that this license will need action from the General Assembly.

LEGISLATIVE/REGULATORY COMMITTEE REPORT:

Dr. Brendel wanted to thank the Regulatory Committee members and staff for their time and dedication.

AD HOC COMMITTEE ON TELE-ASSISTED COUNSELING AND SUPERVISON REPORT:

Dr. Tinsley commented that the Adhoc Committee meeting on telehealth will be held directly after following the Board meeting.

ELECTION OF OFFICERS:

Ms. Hunt moved, which was seconded by Dr. Yancey, to nominate Dr. Brendel as Board Chair for the Virginia Board of Counseling. The motion passed unanimously.

Ms. Tracy moved, which was seconded by Ms. Stransky, to nominate

Ms. Hunt as Board Vice-Chair for the Virginia Board of Counseling. The motion passed unanimously.

Dr. Doyle asked the Board members to consider serving on a committee and to let Dr. Brendel know their intentions and preference. Dr. Brendel will appoint and approve committee members.

NEW BUSINESS:

Discuss the need for a workforce survey on Qualified Mental Health Professionals (QMHP) and Registered Peer Recovery Specialists (RPRS). Dr. Carter, Executive Director, Board of Health Professions presented the Boards options for a survey. The Board asked staff to work with Department of Behavioral Health & Developmental Services (DBHDS) and Department of Medical Assistance to come up with viable question.

Discussion on Emotional Support Animals. The Board acknowledges the growing concern with this issue and will discuss the need of a guidance document at a later meeting.

NEXT MEETING: Next scheduled Quarterly Board Meeting is November 1, 2019 at 10 a.m.

ADJOURN: The meeting adjourned at 2:11 p.m.

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Kevin Doyle, Ed.D., LPC, LSATP
Chairperson

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Jaime Hoyle, J.D
Executive Director

Attachment A

DRAFT
BOARD OF COUNSELING
PUBLIC HEARING
Friday, August 16, 2019

TIME AND PLACE: The Public Hearing took place within the Board of Counseling's Quarterly Board Meeting, which was called to order at 9:05am on Friday, August 16, 2019, in Board Room 2 at the Department of Health Professions (DHP), 9960 Mayland Drive, Henrico, Virginia.

PRESIDING: Kevin Doyle, Ed.D., LPC, LSATP, Chairperson

BOARD MEMBERS PRESENT:
Barry Alvarez, LMFT
Johnston Brendel, Ed.D., LPC, LMFT
Natalie Harris, LPC, LMFT
Danielle Hunt, LPC
Bev-Freda L. Jackson, Ph.D., MA, Citizen Member
Maria Stransky, LPC, CSAC, CSOTP
Holly Tracy, LPC, LMFT
Tiffinee Yancey, Ph.D., LPC
Terry R. Tinsley, Ph.D., LPC, LMFT, CSOTP, NCC

BOARD MEMBERS ABSENT:
Jane Engelken, LPC, LSATP
Vivian Sanchez-Jones, Citizen Member

STAFF PRESENT:
Jennifer Lang, Deputy Executive Director
Charlotte Lenart, Licensing Manager
Brenda Maida, Licensing Specialist
Christy Evans, Discipline Case Specialist

OTHERS PRESENT:
Barbara Allison-Bryan, DHP Chief Deputy
David E. Brown, D.C., DHP Director
James Rutkowski, Assistant Attorney General
Elaine Yeatts, DHP Senior Policy Analyst

PUBLIC HEARING: The purpose of the public hearing was to allow for public comment on the proposed regulations to allow for the credential review of foreign graduates for the Regulations Governing the Practice of Professional Counseling, Marriage and Family Therapy and Substance Abuse Practitioners.

PUBLIC COMMENT: There was no public comment.

Kevin Doyle, Ed.D., LPC, LSATP Chairperson	Jaime Hoyle, J.D Executive Director

Attachment B

Re: **Kirk Saunders, LPC**
License # 0701-006528
Case #: 188903 and 192959

Time: 9:26 a.m.

Commonwealth's Representation: Wayne Halbleib, Senior Assistant Attorney General
Emily Tatum, Adjudication Specialist, APD

Purpose of the Meeting: Mr. Halbleib presented a summary of evidence in case #188903 and 192959 for the Board's consideration of a summary suspension of the license of Mr. Saunders.

Closed Meeting: Dr. Brendel moved that the Board convene in a closed meeting pursuant to § 2.2-3711(A)(27) of the *Code of Virginia* for the purpose of deliberation to reach a decision in the matter of Kirk Saunders, LPC. Additionally, he moved that James Rutkowski, Jennifer Lang, Christy Evans, Charlotte Lenart, and Brenda Maida attend the closed session because their presence was deemed necessary and would aid the Board in its deliberations. The motion was seconded by Mr. Alvarez and passed unanimously.

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

Decision: Ms. Engelken moved to summarily suspend the license of Kirk Saunders, LPC and offer a Consent Order for indefinite suspension for no less than 30 months. The motion was seconded by Ms. Stransky and passed by the Board with a unanimous vote.

Dr. Brendel moved to allow the Board Chairperson to negotiate terms of the Consent Order on behalf of the Board. Ms. Engelken seconded the motion and it passed by a unanimous vote.

Re: **Owen Holland, LPC**
License #: 0701-005857
Case #: 191099

Time: 10:03 a.m.

Commonwealth's Representation: Sean Murphy, Assistant Attorney General
Emily Tatum, Adjudication Specialist, APD

Purpose of the Meeting: Mr. Murphy presented a summary of evidence in case #191099 for the Board's consideration of a summary suspension of the license of Mr. Holland.

Decision: Dr. Brendel moved to summarily suspend the license of Owen Holland, LPC and offer a Consent Order for revocation. The motion was seconded by Ms. Hunt and passed by the Board with a unanimous vote.

Ms. Hunt moved to allow the Board Chairperson to negotiate terms of the Consent Order on behalf of the Board. Ms. Stransky seconded the motion and it passed by a unanimous vote.

Adjournment: The Board adjourned the summary suspension considerations at 10:17 a.m.

Attachment C

Project 6111 - Emergency/NOIRA

BOARD OF COUNSELING

Resident license

Part I

General Provisions

18VAC115-20-10. Definitions.

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

"Board"

"Counseling"

"Professional counselor"

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

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

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

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

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

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

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

"CORE" means Council on Rehabilitation Education.

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

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

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

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

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

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

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

"Residency" means a postgraduate, supervised, clinical experience ~~registered with the board~~.

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

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

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

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

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

~~Active annual license renewal~~	~~$130~~
~~Inactive annual license renewal~~	~~$65~~
Initial licensure by examination: Application processing and initial licensure as a professional counselor	~~$175~~ $140
Initial licensure by endorsement: Application processing and initial licensure as a professional counselor	$175
~~Registration of supervision~~ Application and initial licensure as a resident in counseling	~~$65~~ $100
~~Add or change supervisor~~ Pre-review of education only	~~$30~~ $75
~~Duplicate license~~	~~$10~~
Active annual license renewal for a professional counselor	$130

Inactive annual license renewal for a professional counselor	$65
Annual renewal for resident in counseling	$30
Late renewal for a professional counselor	$45
Late renewal for a resident in counseling	$10
Reinstatement of a lapsed license for a professional counselor	$200
Reinstatement following revocation or suspension	$600
Replacement of or additional wall certificate	$25
Returned check	$35
~~Reinstatement following revocation or suspension~~	~~$600~~

B. All fees are nonrefundable.

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

Part II

Requirements for Licensure as a Professional Counselor

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

Every applicant for licensure examination by the board shall:

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

2. Pass the licensure examination specified by the board;

3. Submit the following to the board:

a. A completed application;

b. Official transcripts documenting the applicant's completion of the degree program and coursework requirements prescribed in 18VAC115-20-49 and 18VAC115-20-51. Transcripts

previously submitted for ~~registration of supervision~~ board approval of a resident license do not have to be resubmitted unless additional coursework was subsequently obtained;

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

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

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

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

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

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

A. ~~Registration.~~ Resident license. Applicants ~~who render counseling services~~ for temporary licensure as a resident in counseling shall:

1. ~~With their supervisor, register their supervisory contract on the appropriate forms for board approval before starting to practice under supervision~~ Apply for licensure on a form provided by the board to include (a) verification of a supervisory contract; (b) the name and licensure number of the clinical supervisor and location for the supervised practice; and (c) an attestation that the applicant will be providing clinical counseling services.

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

3. Pay the registration fee;

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

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

B. Residency requirements.

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

a. Assessment and diagnosis using psychotherapy techniques;

b. Appraisal, evaluation, and diagnostic procedures;

c. Treatment planning and implementation;

d. Case management and recordkeeping;

e. Professional counselor identity and function; and

f. Professional ethics and standards of practice.

2. The residency shall include a minimum of 200 hours of in-person supervision between supervisor and resident in the consultation and review of clinical counseling services provided by the resident. Supervision shall occur at a minimum of one hour and a maximum of four hours per 40 hours of work experience during the period of the residency. For the purpose of meeting the

200-hour supervision requirement, in-person may include the use of secured technology that maintains client confidentiality and provides real-time, visual contact between the supervisor and the resident. Up to 20 hours of the supervision received during the supervised internship may be counted towards the 200 hours of in-person supervision if the supervision was provided by a licensed professional counselor.

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

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

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

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

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

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

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

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

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

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

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

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

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

D. Supervisory responsibilities.

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

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

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

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

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

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

Part III

Examinations

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

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

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

~~C. A candidate approved to sit for the examination shall pass the examination within two years from the date of such initial approval. If the candidate has not passed the examination by the end of the two-year period here prescribed:~~

~~1. The initial approval to sit for the examination shall then become invalid; and~~

~~2. The applicant shall file a new application with the board, meet the requirements in effect at that time, and provide evidence of why the board should approve the reapplication for examination. If approved by the board, the applicant shall pass the examination within two years of such approval. If the examination is not passed within the additional two-year period, a new application will not be accepted.~~

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

~~E.~~D. A ~~candidate for examination or an applicant shall not provide clinical counseling services unless he is under supervision approved by the board~~ A resident shall remain in a residency practicing under supervision until he has passed the licensure examination and been granted a license as a professional counselor.

Part IV

Licensure Renewal; Reinstatement

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

A. ~~All licensees shall renew licenses on or before June 30 of each year.~~

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

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

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

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

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

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

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

3. On the annual renewal, residents in counseling shall attest to completion of three hours in continuing education courses that emphasize the ethics, standards of practice, or laws governing behavioral science professions in Virginia, offered by an approved provider as set forth in subsection B of 18VAC115-20-105.

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

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

18VAC115-50-10. Definitions.

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

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

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

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

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

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

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

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

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

"Residency" means a postgraduate, supervised, clinical experience ~~registered with the board~~.

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

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

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

18VAC115-50-20. Fees.

A. The board has established fees for the following:

~~Registration of supervision~~ Application and initial licensure as a resident	~~$65~~ $100
~~Add or change supervisor~~ Pre-review of education only	~~$30~~ $75
Initial licensure by examination: Processing and initial licensure as a marriage and family therapist	~~$175~~ $140
Initial licensure by endorsement: Processing and initial licensure as a marriage and family therapist	$175
Active annual license renewal for a marriage and family therapist	$130
Inactive annual license renewal for a marriage and family therapist	$65
Annual renewal for resident in marriage and family therapy	$30
Penalty for late renewal for a marriage and family therapist	$45
Late renewal for resident in marriage and family therapy	$10
Reinstatement of a lapsed license for a marriage and family therapist	$200
Verification of license to another jurisdiction	$30
Additional or replacement licenses	$10
Additional or replacement wall certificates	$25
Returned check	$35
Reinstatement following revocation or suspension	$600

B. All fees are nonrefundable.

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

18VAC115-50-30. Application for licensure as a marriage and family therapist by examination.

Every applicant for licensure by examination by the board shall:

1. Meet the education and experience requirements prescribed in 18VAC115-50-50, 18VAC115-50-55 and 18VAC115-50-60;

2. Meet the examination requirements prescribed in 18VAC115-50-70;

3. Submit to the board office the following items:

a. A completed application;

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

c. Documentation, on the appropriate forms, of the successful completion of the residency requirements of 18VAC115-50-60 along with documentation of the supervisor's out-of-state license where applicable;

d. Official transcript or transcripts submitted from the appropriate institutions of higher education, verifying satisfactory completion of the education requirements set forth in 18VAC115-50-50 and 18VAC115-50-55. Previously submitted transcripts for ~~registration of supervision~~ board approval of a resident license do not have to be resubmitted unless additional coursework was subsequently obtained;

e. Verification on a board-approved form of any mental health or health out-of-state license, certification, or registration ever held in another jurisdiction; and

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

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

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

A. ~~Registration.~~ Resident license. Applicants ~~who render~~ for temporary licensure as a resident in marriage and family therapy ~~services~~ shall:

1. ~~With their supervisor, register their supervisory contract on the appropriate forms for board approval before starting to practice under supervision~~ Apply for licensure on a form provided by the board to include (a) verification of a supervisory contract; (b) the name and licensure number of the supervisor and location for the supervised practice; and (c) an attestation that the applicant will be providing marriage and family services.

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

3. Pay the registration fee;

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

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

B. Residency requirements.

1. The applicant for licensure as a marriage and family therapist shall have completed no fewer than 3,400 hours of supervised residency in the role of a marriage and family therapist, to include

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

D. Supervisory responsibilities.

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

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

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

18VAC115-50-70. General examination requirements.

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

B. ~~The examination shall concentrate on the core areas of marriage and family therapy set forth in subsection A of 18VAC115-50-55.~~ An applicant is required to pass the prescribed examination within six years from the date of initial issuance of a resident license.

C. ~~A candidate approved to sit for the examination shall pass the examination within two years from the initial notification date of approval. If the candidate has not passed the examination within two years from the date of initial approval:~~

~~1. The initial approval to sit for the examination shall then become invalid; and~~

~~2. The applicant shall file a new application with the board, meet the requirements in effect at that time, and provide evidence of why the board should approve the reapplication for examination. If approved by the board, the candidate shall pass the examination within two years of such approval. If the examination is not passed within the additional two-year period, a new application will not be accepted.~~

~~D. Applicants or candidates for examination shall not provide marriage and family services unless they are under supervision approved by the board~~ A resident shall remain in a residency practicing under supervision until he has passed the licensure examination and been granted a license as a marriage and family therapist.

18VAC115-50-90. Annual renewal of license.

A. ~~All licensees shall renew licenses on or before June 30 of each year.~~

~~B.~~ All ~~licensees~~ licensed marriage and family therapists who intend to continue an active practice shall submit to the board on or before June 30 of each year:

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

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

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

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

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

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

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

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

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

Part I

General Provisions

18VAC115-60-10. Definitions.

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

"Board"

"Licensed substance abuse treatment practitioner"

"Substance abuse"

"Substance abuse treatment"

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Residency" means a postgraduate, supervised, clinical experience ~~registered with~~ ~~the board~~.

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

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

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

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

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

~~Registration of supervision (initial)~~ Application and initial licensure as a resident in substance abuse treatment	~~$65~~ $100
~~Add/change supervisor~~ Pre-view of education only	~~$30~~ $75
Initial licensure by examination: Processing and initial licensure as a substance abuse treatment practitioner	~~$175~~ $140
Initial licensure by endorsement: Processing and initial licensure as a substance abuse treatment practitioner	$175
Active annual license renewal for a substance abuse treatment practitioner	$130
Inactive annual license renewal for a substance abuse treatment practitioner	$65
Annual renewal for resident in substance abuse treatment	$30
Duplicate license	$10
Verification of license to another jurisdiction	$30
Late renewal for a substance abuse treatment practitioner	$45
Late renewal for a resident in substance abuse treatment	$10
Reinstatement of a lapsed license of a substance abuse	$200

treatment practitioner	
Replacement of or additional wall certificate	$25
Returned check	$35
Reinstatement following revocation or suspension	$600

B. All fees are nonrefundable.

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

Part II

Requirements for Licensure as a Substance Abuse Treatment Practitioner

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

Every applicant for licensure by examination by the board shall:

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

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

3. Submit the following items to the board:

a. A completed application;

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

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

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

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

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

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

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

A. ~~Registration~~ Licensure. Applicants ~~who render~~ for a temporary resident license in substance abuse treatment ~~services~~ shall:

1. ~~With their supervisor, register their supervisory contract on the appropriate forms for board approval before starting to practice under supervision~~ Apply for licensure on a form provided by the board to include (a) verification of a supervisory contract; (b) the name and licensure number of the supervisor and location for the supervised practice; and (c) an attestation that the applicant will be providing substance abuse treatment services;

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

3. Pay the registration fee;

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

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

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

C. Residency requirements.

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

a. Clinical evaluation;

b. Treatment planning, documentation and implementation;

c. Referral and service coordination;

d. Individual and group counseling and case management;

e. Client family and community education; and

f. Professional and ethical responsibility.

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

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

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

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

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

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

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

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

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

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

7. Residents may not call themselves substance abuse treatment practitioners,–directly bill for services rendered, or in any way represent themselves as independent, autonomous practitioners

or substance abuse treatment practitioners. During the residency, residents shall use their names and the initials of their degree, their resident license number, and the title "Resident in Substance Abuse Treatment" in all written communications. Clients shall be informed in writing ~~of the resident's status,~~ that the resident does not have authority for independent practice and is under supervision and shall provide the supervisor's name, professional address, and telephone number.

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

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

D. Supervisory qualifications.

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

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

E. Supervisory responsibilities.

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

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

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

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

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

Part III

Examinations

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

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

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

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

D. ~~A candidate approved by the board to sit for the examination shall pass the examination within two years from the date of such initial board approval. If the candidate has not passed the examination within two years from the date of initial approval:~~

~~1. The initial board approval to sit for the examination shall then become invalid; and~~

~~2. The applicant shall file a complete new application with the board, meet the requirements in effect at that time, and provide evidence of why the board should approve the reapplication for examination. If approved by the board, the applicant shall pass the examination within two years of such approval. If the examination is not passed within the additional two-year period, a new application will not be accepted.~~

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

~~F.~~ E. ~~A candidate for examination or an applicant shall not provide clinical services unless he is under supervision approved by the board.~~ A resident shall remain in a residency practicing under supervision until he has passed the licensure examination and been granted a license as a substance abuse treatment practitioner.

Part IV

Licensure Renewal; Reinstatement

18VAC115-60-110. Renewal of licensure.

A. ~~All licensees shall renew licenses on or before June 30 of each year.~~

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

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

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

~~C.~~B. A ~~licensee~~ substance abuse treatment practitioner who wishes to place his license in an inactive status may do so upon payment of the inactive renewal fee as established in 18VAC115-60-20. No person shall practice substance abuse treatment in Virginia unless he holds a current active license. A licensee who has placed himself in inactive status may become active by fulfilling the reactivation requirements set forth in 18VAC115-60-120 C.

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

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

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

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

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

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

Counseling Regulatory Committee Meeting Minutes

August 15, 2019

VIRGINIA BOARD OF COUNSELING
REGULATORY COMMITTEE MEETING
DRAFT MINUTES
Thursday, August 15, 2019

TIME AND PLACE: The meeting was called to order at 10:02 a.m. on Thursday, August 15, 2019, in Board Room 2 at the Department of Health Professions (DHP), 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
Holly Tracy, LPC, LMFT

COMMITTEE MEMBER ABSENT: Vivian Sanchez-Jones, Citizen Member

STAFF PRESENT: Jaime Hoyle, JD, Executive Director
Jennifer Lang, Deputy Executive Director
Charlotte Lenart, Licensing Manager
Brenda Maida, Licensing Specialist

OTHERS PRESENT: Barbara Allison-Bryan, DHP Chief Deputy
Elaine Yeatts, DHP Senior Policy Analyst

APPROVAL OF MINUTES: Ms. Tracy moved to approve the minutes of the May 30, 2019 meeting. Ms. Hunt seconded the motion, and it passed unanimously.

PUBLIC COMMENT: There was no public comment.

DISCUSSIONS:

I. **Unfinished Business:**

Petition for Rulemaking Discussion:

- Aimee Brickner, petitioned the Board to amend the Regulations Governing the Practice of Professional Counseling to allow a licensed counselor to supervise residents without the two-year post-licensure clinical experience requirement, if the licensee has complete a doctoral level supervision course or doctoral level supervision internship as a part of the completion of a doctoral degree. The Board received five public comments in opposition of the petition. Ms. Hunt moved, which was seconded by Ms. Tracy, to recommend the full Board deny the petitioners request for changes to the supervisor requirements. The motion passed unanimously.

- Joyce Samples, petitioned the Board to amend the Regulations Governing the Practice of Professional Counseling to amend the criteria for a supervisor to have a minimum of five years of post-licensure experience or have documentation that the supervisor has experience in all clinical areas. The Committee discussed the petition to amend regulations. The Board concurred with the concept that the qualifications for a supervisor should be examined to ensure a quality clinical experience for residents and protection of the public.

However, the Committee was concerned that requiring additional years of clinical experience or other qualifications would result in reducing the supply of supervisors and restricting the number of residents pursuing licensure. To address all these concerns, the Board will be looking at requirements in other states and at the opportunities for credentialing supervisors.

Ms. Tracy moved, which was seconded by Ms. Hunt, to recommend the full Board approve and initiate regulations per the petitioner's request. After discussion, Ms Tracey moved to withdraw her motion and Ms. Hunt agreed.

Ms. Tracy moved, which was seconded by Ms. Hunt, to recommend the full Board deny the petitioners request for changes to the supervisor requirements. The motion passed unanimously.

II. **New Business:**

- **Recommendation for emergency regulations related to the issuance of temporary licenses engaged in counseling residency.** The Committee reviewed and discussed the draft suggestions from staff and the workgroup. Dr. Doyle moved, which was seconded by Ms. Hunt, to recommend the presented recommended emergency regulations for issuance of temporary resident license to the full Board. The motion passed unanimously.

- **Discussion on a supervisor designation and qualifications.** The Committee discussed this issue and asked staff to research the minimum requirements for supervisors in other states and to research the Board's authority to credential supervisors.

- **Discussion on creating didactic training in substance abuse definitions for each required area.** After discussion, the Committee recommended that staff contact the Board members who hold a substance abuse license or certification to help create definitions for each of the required didactic substance abuse training areas.

Dr. Brendel asked that the requirement of criminal background checks be added to the unfinished business going forward.

NEXT SCHEDULED MEETING: The next Committee meeting is scheduled for October 31, 2019 at 10:00a.m.

ADJOURNMENT: The meeting adjourned at 1:16 p.m.

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

Date

Jaime Hoyle, JD
Executive Director

Date

Chairperson Report

Chairperson's Report: Quarterly Accomplishments

07/26/2019 – 10/31/2019

* SCC (Special Conference Committee)
* Ad Hoc (Telehealth Working Group)

Board Member/ Meeting Attendance	Discipline Case Reviews	Board Service (07/26/19 – 10/31/19) ** current assignments are highlighted
Alvarez, Barry, LMFT 08/16/19 (Board Meeting) 08/16/19 (Ad Hoc Committee)	3	• Ad Hoc Committee (Telehealth)
Brendel, Johnston, Ed.D., LPC, LMFT 08/15/19 (Regulatory Committee) 08/16/19 (Board Meeting) 10/31/19 (Regulatory Committee)	2	• Board Chairperson (as of 08/16/19)\ • Regulatory Committee • Regulatory Committee Chairperson (until 10/31/19) • Special Conference Cmte Chairperson (until 08/16/19) • Credentials/Application Reviews
Doyle, Kevin, Ed.D., LPC, LSATP 08/15/19 (Regulatory Committee) 08/16/19 (Board Meeting) 10/31/19 (Regulatory Committee)	3	• Regulatory Committee • Board of Health Professions – Board Member • Board Chairperson (until 08/16/19) • Credentials/Application Reviews
Engelken, Jane, LPC, LSATP 08/16/19 (Board Meeting)	0	• Board Vice-Chairperson (until 08/16/19)
Harris, Natalie, LPC, LMFT 08/16/19 (Board Meeting)	3	• Special Conference Committee (Alternate)
Hunt, Danielle, LPC 08/15/19 (Regulatory Committee) 08/16/19 (Board Meeting) 08/16/19 (Ad Hoc Committee) 09/13/19 (4 Informal Conferences)	8	• Board Vice-Chairperson (as of 08/16/19) • Special Conference Committee-A Chairperson • Ad Hoc Committee (Teleheath) • Regulatory Committee (until 08/16/19) • Supervisory Contract Consultation • Credentials/Application Reviews
Jackson, Bev-Freda, PhD, MA, Citizen Member 08/16/19 (Board Meeting)	n/a	• Special Conference Committee-B
Sanchez-Jones, Vivian, Citizen Member	n/a	• Reg. Committee (until 08/16/19)
Stransky, Maria, LPC, CSAC, CSOTP 08/16/19 (Board Meeting) 09/13/19 (4 Informal Conferences) 10/11/19 (2 Informal Conferences)	16	• Special Conference Committee-A • Credentials/Application Reviews
Tinsley, Terry, Ph.D., LPC, LMFT, CSOTP 08/16/19 (Board Meeting) 08/16/19 (Ad Hoc Committee) 10/11/19 (2 Informal Conferences) 10/31/19 (Regulatory Committee)	3	• Regulatory Committee • Special Conference Committee-B Chairperson • Ad Hoc Committee (Telehealth) Chairperson
Tracy, Holly, LPC, LMFT 08/15/19 (Regulatory Committee) 08/16/19 (Board Meeting)	5	• Regulatory Committee Chairperson (as of 10/31/19) • Special Conference Committee (Alternate)
Yancey, Tiffinee, Ph.D., LPC 08/16/19 (Board Meeting) 08/16/19 (Ad Hoc Committee)	1	• Special Conference Committee (Alternate) • Ad Hoc Committee (Telehealth)

Chairperson's Report: Assistance Requested

Additional Members for Standing Committees

11/22/2019 – 02/07/2020

Regulatory Committee

- One additional member needed
- The Regulatory Committee makes recommendations to the Board for changes in law and regulations, petitions for rulemaking, and guidance documents. *See Guidance Document 115-1.2, Bylaws.*
- Typically meets once per quarter, on a Friday afternoon, approximately 2 weeks prior to the full Board meeting.

Credentials Committee

- Three to five members needed
- The Credentials Committee will review non-routine licensure applications and provide guidance to staff on action to be taken. *See Guidance Document 115-1.2, Bylaws*
- Will begin meeting once per quarter; schedule to be determined.

Discipline Case Reviews:

- 53 cases awaiting assignment for Board member review.
- Goal for review time is 2 weeks.
- Except in extenuating circumstances, cases should be completed within 30 days.

Regulatory Actions

Agenda Item: **Regulatory Actions - Chart of Regulatory Actions**

Staff Note: Attached is a chart with the status of regulations for the Board as of August 5, 2019

Chapter		Action / Stage Information
[18 VAC 115 - 15]	Regulations Governing Delegation to an Agency Subordinate	Periodic review [Action 5301] Fast-Track - *At Secretary's Office for 12 days*
[18 VAC 115 - 20]	Regulations Governing the Practice of Professional Counseling	Unprofessional conduct - conversion therapy [Action 5225] NOIRA - *Register Date: 7/8/19* *Comment closed: 8/7/19* *Board to adopt proposed regulations: 8/16/19*
[18 VAC 115 - 20]	Regulations Governing the Practice of Professional Counseling	Periodic review [Action 5230] NOIRA - *Register Date: 8/19/19* *Comment closes: 9/18/19*
[18 VAC 115 - 20]	Regulations Governing the Practice of Professional Counseling	Credential review for foreign graduates [Action 5089] Proposed - *Register Date: 7/22/19* *Comment closes: 9/20/19*
[18 VAC 115 - 20]	Regulations Governing the Practice of Professional Counseling	Requirement for CACREP accreditation for educational programs [Action 4259] Proposed - *At Secretary's Office for 112 days*
[18 VAC 115 - 20]	Regulations Governing the Practice of Professional Counseling	Acceptance of doctoral practicum/internship hours towards residency requirements [Action 4829] Final - *At Secretary's Office for 196 days*
[18 VAC 115 - 30]	Regulations Governing the Certification of Substance Abuse Counselors	Updating and clarifying regulations [Action 4691] Final - *At Secretary's Office for 151 days*
[18 VAC 115 - 40]	Regulations Governing the Certification of Rehabilitation Providers	Periodic review [Action 5305] NOIRA - *At Secretary's Office for 41 days*
[18 VAC 115 - 50]	Regulations Governing the Practice of Marriage and Family Therapy	Acceptance of doctoral hours towards residency [Action 5226] Fast-Track - *Register Date: 7/22/19* *Effective: 9/6/19*
[18 VAC 115 - 70]	Regulations Governing the Registration of Peer Recovery Specialists [under	Initial regulations for registration [Action 4890]

	development]	Final - *At Secretary's Office for 39 days*
[18 VAC 115 - 80]	Regulations Governing the Registration of Qualified Mental Health Professionals [under development]	Initial regulations for registration of Qualified Mental Health Professionals [Action 4891] Final - *At Secretary's Office for 39 days*

Adoption of Exempt Action to reduce fees for qualified mental health professional-trainees (QMHP-Trainee)

Agenda Item: Regulations for Registration of Qualified Mental Health Professionals

Included in the agenda package:

Copy of final regulations with reduction in fee for QMHP-trainees

Action:

Board to adopt amendment relating to fees for QMHP-trainees

Trainee Fee

BOARD OF COUNSELING

CHAPTER 80

REGULATIONS GOVERNING THE REGISTRATION OF QUALIFIED MENTAL HEALTH PROFESSIONALS

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

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

Registration as a QMHP-A	$50
Registration as a QMHP-C	$50
Registration as a QMHP-trainee	$25
Renewal of registration	$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.

Adoption of Fast-Track Regulations related to the qualified mental health professional-trainee (QMHP-Trainee)

Agenda Item: Regulations for Registration of Qualified Mental Health Professionals

Included in the agenda package:

Copy of Chapter 217 (HB2693) of the 2019 Acts of the Assembly

Copy of final regulations that became effective 11/13/19 with changes recommended by the Regulatory Committee

Action:

Board to adopt amendments relating to requirements for QMHP-trainees

CHAPTER 217

An Act to amend and reenact §§ 54.1-2400.1, 54.1-3500, and 54.1-3505 of the Code of Virginia, relating to the Board of Counseling; qualified mental health professionals.

[H 2693]

Approved March 5, 2019

Be it enacted by the General Assembly of Virginia:

1. That §§ 54.1-2400.1, 54.1-3500, and 54.1-3505 of the Code of Virginia are amended and reenacted as follows:

§ 54.1-2400.1. Mental health service providers; duty to protect third parties; immunity.

A. As used in this section:

"Certified substance abuse counselor" means a person certified to provide substance abuse counseling in a state-approved public or private substance abuse program or facility.

"Client" or "patient" means any person who is voluntarily or involuntarily receiving mental health services or substance abuse services from any mental health service provider.

"Clinical psychologist" means a person who practices clinical psychology as defined in § 54.1-3600.

"Clinical social worker" means a person who practices social work as defined in § 54.1-3700.

"Licensed practical nurse" means a person licensed to practice practical nursing as defined in § 54.1-3000.

"Licensed substance abuse treatment practitioner" means any person licensed to engage in the practice of substance abuse treatment as defined in § 54.1-3500.

"Marriage and family therapist" means a person licensed to engage in the practice of marriage and family therapy as defined in § 54.1-3500.

"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.

"Mental health service provider" or "provider" refers to any of the following: (i) a person who provides professional services as a certified substance abuse counselor, clinical psychologist, clinical social worker, licensed substance abuse treatment practitioner, licensed practical nurse, marriage and family therapist, mental health professional, physician, physician assistant, professional counselor, psychologist, qualified mental health professional, registered nurse, registered peer recovery specialist, school psychologist, or social worker; (ii) a professional corporation, all of whose shareholders or members are so licensed; or (iii) a partnership, all of whose partners are so licensed.

"Professional counselor" means a person who practices counseling as defined in § 54.1-3500.

"Psychologist" means a person who practices psychology as defined in § 54.1-3600.

"Qualified mental health professional" ~~means a person who by education and experience is professionally qualified and registered by the Board of Counseling 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, the Department of Corrections, or a provider licensed by the Department of Behavioral Health and Developmental Services~~ *has the same meaning as provided in § 54.1-3500.*

"Registered nurse" means a person licensed to practice professional nursing as defined in § 54.1-3000.

"Registered peer recovery specialist" means a person who by education and experience is professionally qualified and registered by the Board of Counseling 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.

"School psychologist" means a person who practices school psychology as defined in § 54.1-3600.

"Social worker" means a person who practices social work as defined in § 54.1-3700.

B. A mental health service provider has a duty to take precautions to protect third parties from violent behavior or other serious harm only when the client has orally, in writing, or via sign language, communicated to the provider a specific and immediate threat to cause serious bodily injury or death to an identified or readily identifiable person or persons, if the provider reasonably believes, or should believe according to the standards of his profession, that the client has the intent and ability to carry out

that threat immediately or imminently. If the third party is a child, in addition to taking precautions to protect the child from the behaviors in the above types of threats, the provider also has a duty to take precautions to protect the child if the client threatens to engage in behaviors that would constitute physical abuse or sexual abuse as defined in § 18.2-67.10. The duty to protect does not attach unless the threat has been communicated to the provider by the threatening client while the provider is engaged in his professional duties.

C. The duty set forth in subsection B is discharged by a mental health service provider who takes one or more of the following actions:

1. Seeks involuntary admission of the client under Article 16 (§ 16.1-335 et seq.) of Chapter 11 of Title 16.1 or Chapter 8 (§ 37.2-800 et seq.) of Title 37.2.

2. Makes reasonable attempts to warn the potential victims or the parent or guardian of the potential victim if the potential victim is under the age of 18.

3. Makes reasonable efforts to notify a law-enforcement official having jurisdiction in the client's or potential victim's place of residence or place of work, or place of work of the parent or guardian if the potential victim is under age 18, or both.

4. Takes steps reasonably available to the provider to prevent the client from using physical violence or other means of harm to others until the appropriate law-enforcement agency can be summoned and takes custody of the client.

5. Provides therapy or counseling to the client or patient in the session in which the threat has been communicated until the mental health service provider reasonably believes that the client no longer has the intent or the ability to carry out the threat.

6. In the case of a registered peer recovery specialist, or a qualified mental health professional who is not otherwise licensed by a health regulatory board at the Department of Health Professions, reports immediately to a licensed mental health service provider to take one or more of the actions set forth in this subsection.

D. A mental health service provider shall not be held civilly liable to any person for:

1. Breaching confidentiality with the limited purpose of protecting third parties by communicating the threats described in subsection B made by his clients to potential third party victims or law-enforcement agencies or by taking any of the actions specified in subsection C.

2. Failing to predict, in the absence of a threat described in subsection B, that the client would cause the third party serious physical harm.

3. Failing to take precautions other than those enumerated in subsection C to protect a potential third party victim from the client's violent behavior.

§ 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 appraisal and treatment of cognitive, affective, or behavioral mental and emotional disorders within the context of marriage and family systems through the application of therapeutic and family systems theories and techniques.

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

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

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

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

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

"Qualified mental health professional" ~~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, the Department of Corrections, or a provider licensed by the Department of Behavioral Health and Developmental Services~~ *includes qualified mental health professionals-adult and qualified mental health professionals-child.*

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

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

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

"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.

§ 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, *and for the registration of persons receiving supervised training in order to qualify as a qualified mental health professional.*

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.

BOARD OF COUNSELING

Initial regulations for registration of Qualified Mental Health Professionals

CHAPTER 80

REGULATIONS GOVERNING THE REGISTRATION OF QUALIFIED MENTAL HEALTH PROFESSIONALS

Part I

General Provisions

18VAC115-80-10. Definitions.

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

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

"Board" means the Virginia Board of Counseling.

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

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

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

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

"Qualified mental health professional" or "QMHP" ~~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 DBHDS, the Department of Corrections, or a provider licensed by DBHDS~~ includes qualified mental health professionals-adult and qualified mental health professionals-child.

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

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

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

"Registrant" means a QMHP registered with the board.

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

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

Registration as a QMHP-A	$50
Registration as a QMHP-C	$50
Registration as a QMHP-trainee	$25
Renewal of registration	$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.

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

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

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

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

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

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

5. Licensure as a registered nurse in Virginia; or

6. Licensure as an occupational therapist.

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

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

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

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

3. Licensure as a registered nurse in Virginia; or

4. Licensure as an occupational therapist.

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

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

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

A. An applicant for registration shall submit:

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

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

3. Verification of any other mental health or health professional license, certification, or registration ever held in another jurisdiction. An applicant for registration as a QMHP-A

shall have no unresolved disciplinary action. The board will consider a history of disciplinary action on a case-by-case basis.

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

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

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

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

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

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

C. Experience required for registration.

1. To be registered as a QMHP-A, an applicant who does not have a master's degree as set forth in subdivision B 1 of this section shall provide documentation of experience in providing direct services to individuals as part of a population of adults 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 Board of Counseling, Board of Psychology, or Board of Social Work as a prerequisite for licensure. Supervision obtained in another United States jurisdiction shall be provided by a mental health professional licensed in Virginia or licensed in that jurisdiction.

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

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

4. ~~A person receiving supervised training to qualify as a QMHP-A may register with the board. A trainee registration shall expire five years from its date of issuance.~~ Supervised experience obtained prior to meeting the education requirements of subsection B of this section shall not be accepted.

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

A. An applicant for registration shall submit:

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

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

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

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

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

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

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

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

C. Experience required for registration.

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

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

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

4. ~~A person receiving supervised training to qualify as a QMHP-C may register with the board. A trainee registration shall expire five years from its date of issuance.~~ Supervised experience obtained prior to meeting the education requirements of subsection B of this section shall not be accepted.

Part III

Renewal of Registration

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

All registrants as a QMHP-A or QMHP-C shall renew their registrations 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, licensed health facilities, or an agency licensed by DBDHS; and

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

D. Attestation of completion 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.

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

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

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

1. Apply for reinstatement;

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

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

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

Review of public comments on Final Regulations for Qualified Mental Health Professionals (QMHP)

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VIRGINIA REGULATORY TOWN HALL

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 of Qualified Mental Health Professionals**
Stage	**Final**
Comment Period	Ends 11/13/2019

3 comments

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

Back to List of Comments

Commenter: Joseph G. Lynch, LCSW, Virginia Society for Clinical SocialWork 10/22/19 3:36 pm

QMHP regulations

October 21, 2019

PUBLIC COMMENT
TO THE VIRGINIA BOARD OF COUNSELING
Regarding
REGULATIONS GOVERNING THE REGISTRATION OF QUALIFIED MENTAL HEALTH PROFESSIONALS
18VAC115-80-10

The Virginia Society for Clinical Social Work and the Northern Virginia members of the Greater Washington Society for Clinical Social Work appreciate the opportunity to make public comment concerning the final text of the *Regulations governing the registration of qualified mental health professionals, 18vac115-80-10.*

We are concerned that the process of the development of these regulations appears to have created an anti-competitive impact on social workers and also raise antitrust and constitutional concerns. Outlined below is the rationale for our concerns.

In the Agency Background Document of the Final Stage in the "Purpose" section (Amended 9/24/2019) it identifies several issues:

	Agency Background Document of the Final Stage (Amended 9/24/2019)		VSCSW Comments
1	*"...This regulation is the result of collaborative efforts by DHP, DBHDS, DMAS, private providers, and other licensing boards to address concerns about the use of unlicensed and unregistered persons in the provision of services to clients and the lack of accountability for those services..."*	1	• This documents that three departments of the Executive Branch collaborated to create these regulations. • None of the names of the "private providers" are provided in this document.

			• A review of the Agendas of the Virginia Board of Social Work between January 2017 and October 2019 reveals that the QMHP regulations were never on the agenda as an item for Board discussion. Thus, the VBSW was not one of the licensing Boards involved with this collaborative effort (See copies of agendas attached).
2	*"...The intent of the emergency regulation is to establish a registry of QMHPs, so there is some accountability for their practice and a listing of qualified persons for the purpose of reimbursement by DMAS...."*	2	• Clearly the intent of the regulations involved the "...purpose of reimbursement by DMAS..." • The determination of which providers are reimbursed by DMAS directly impacts anticompetition and antitrust concerns.

This collaborative effort that failed to include the VBSW resulted in regulations that establish the necessity for Licensed Bachelors Social Workers (LBSW) and Licensed Masters Social Workers (LMSW) to acquire registration as a Qualified Mental Health Provider from the Board of Counseling in order to be paid by DMAS for providing services that are within the scope of practice of their license. The Competitive Impact Analysis failed to take this impact on LBSW's and LMSW's into consideration.

The Department of Health Professions, Board of Health Professions in *"Policies and Procedures for the Evaluation of the Need to Regulate Health Occupations and Professions"* defined three levels of government regulation of a profession as:

> ***Registration***. *Registration requires only that an individual file his name, location, and possibly background information with the State. No entry standard is typically established for a registration program.*
>
> ***Statutory Certification.*** *Certification by the state is also known as "title protection." No scope of practice is reserved to a particular group, but only those individuals who meet certification standards (defined in terms of education and minimum competencies which can be measured) may title or call themselves by the protected title.*
>
> ***Licensure***. *Licensure confers a monopoly upon a specific profession whose practice is well defined. It is the most restrictive level of occupational regulation. It generally involves the delineation in statute of a scope of practice which is reserved to a select group based upon their possession of unique, identifiable, minimal competencies for safe practice. In this sense, state licensure typically endows a particular occupation or profession with a monopoly in a specified scope of practice.*

It seems contrary to public policy to require a person meeting the highest level of regulation- "Licensure" to acquire the lowest level of regulation- "Registration" in order to be paid by DMAS for providing services that are within the scope of practice of their license.

In Rebecca Haw Allensworth's 2016 article *"The New Antitrust Federalism,"* in the Virginia Law Review, she notes:

> *"...Because the special risk of self-regulation, or inherent capture, is that "interstitial policies" will suppress competition to the advantage of industry, it follows that supervision should directly address the competitive effects of the reviewed regulation...."*

Allensworth points out that when reviewing agency regulation, it should include an appraisal of the regulation's impact on competition. The Board of Counseling, the majority of whose members are

counselors, created regulations that are anti-competitive to social workers. It appears that multiple Departments of the Commonwealth collaborated in efforts that created anti-competitive impacts on social workers.

Both the Constitution of the United States and the Constitution of the Commonwealth of Virginia clearly protect the right of every person to engage in any lawful profession, trade, or occupation of his choice. The Commonwealth cannot abridge such rights except as a reasonable exercise of its police powers when

(i) it is clearly found that such abridgment is necessary for the protection or preservation of the health, safety, and welfare of the public and

(ii) any such abridgment is no greater than necessary to protect or preserve the public health, safety, and welfare.

(See *Code of Virginia, Title 54.1. Professions and Occupations Chapter 1. General Provisions § 54.1-100. Regulations of professions and occupations*)

The requirement on LBSW's and LMSW's licensees to acquire registration as a Qualified Mental Health Provider from the Board of Counseling in order to be paid by DMAS for providing services that are within the scope of practice of their license appears to be an abridgement of their constitutional rights that is not for the protection or preservation of the health, safety, and welfare of the public. Also, this requirement appears to be an abridgement that is greater than necessary to protect or preserve the public health safety, and welfare. These social workers are already licensed by the Board of Social Work which has as it's mission

"To ensure the delivery of safe and competent patient care by licensing health professionals, enforcing standards of practice, and providing information to healthcare practitioners and the public." The public is already protected by the licensure process of the Board of Social Work.

The process involved in the development of the QMHP regulations raises, anti-competitive, antitrust, and constitutional concerns. For the above enumerated reasons, we request that these regulations be revised so as to not create negative impacts on social workers and allow LBSW's and LMSW's to provide services within their scope of practice and be reimbursed by DMAS for providing those services.

Submitted by,

Joseph G. Lynch LCSW
Legislative Vice President VSCSW

Commenter: Lisa Snider, Loudoun County MHSADS 10/31/19 1:32 pm

Disagreement with regulations

Registration of QMHPs was meant to ensure appropriate service delivery in Virginia and ensure appropriate review, training and supervision of QMHPs. The regulations, as written, place unnecessary restrictions on services and do not improve service delivery quality. There was not response to comments posted during the review process. Below are some examples of concerns.

1. Why is direct supervision of services by a LMHP required? The LMHP does not perform the same role and responsibilities as a QMHP. What evidence is there that a LMHP supervisor improves the supervision for QMHPs? Agree, a LMHP is overseeing the clinical plans and to be available for consultation; however, QMHPs with several years of experience are better equipped to provide the supervision and insight for how to perform the work. Were there discussions and observations of QMHP staff and inclusion of current QMHPs in the development? I completely disagree with the Boards decision

and question if having a Board responsible for licensing LMHPs created a bias in the creation of the regulations.

2. There has been no evidence provided indicating why a person with a Sociology degree cannot perform QMHP responsibilities as those with the other human service degrees. What data and evidence was utilized in making this determination? Additionally, there was a request for a study about the current QMHP workforce to determine the effects on service delivery by eliminating workforce with this degree. No information has been provided.
3. The regulations impose unreasonably high hours of supervision requirements.
4. For experience, QMHP type work is most often about years of experience, not measured in hours. Indicating the years of full time experience required rather than hours required is more reasonable for QMHP work. required to be a QMHP and also Requiring hours high and unreasonable hours

The regulations as written impose impractical restrictions without evidence indicating the requirements provide better supervision and service delivery.

Commenter: Danville-Pittsylvania Community Services 11/1/19 4:11 pm

QMHP

The requirement to have a licensed mental health professional provide supervision for a QMHP will put a stress on the system making the supervision virtually impossible to accomplish. In our local area, we have very few LMHP types to provide supervision for professional licensure at this time. Adding additional supervision of QMHP would strain the resources that are already scarce in the community. A QMHP that has experience could provide this supervision for new QMHP without adding yet another responsibility to a LMHP to provide. These new rules for services requiring LMHP type credentials is driving these professionals out of the field because the load is too great to handle with very little return.

Adoption of Final regulations related to foreign degrees for Regulations Governing the Practice of Professional Counseling, Marriage and Family Therapy and Substance Abuse Practitioners

Agenda Item: Adoption of Final Amendments for Graduates of Foreign Educational programs

Included in the agenda package:

A copy of the proposed announcement on Townhall

Proposed regulations - (No public comment on the Proposed regulation)

Action:

Adoption of final amendments identical to those proposed

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VIRGINIA REGULATORY TOWN HALL

Agency **Department of Health Professions**

Board **Board of Counseling**

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

Action: Credential review for foreign graduates

Proposed Stage

Action 5089 / Stage 8461

Edit Stage | Withdraw Stage | Go to RIS Project

Documents		
Proposed Text	7/11/2019 8:49 am	Sync Text with RIS
Agency Statement	11/6/2018 (modified 12/19/2018)	Upload / Replace
Attorney General Certification	12/12/2018	
DPB Economic Impact Analysis	1/25/2019	
Agency Response to EIA	4/17/2019	Upload / Replace
Governor's Review Memo	7/1/2019	
Registrar Transmittal	7/1/2019	

Status	
Incorporation by Reference	No
Exempt from APA	No, this stage/action is subject to article 2 of the *Administrative Process Act* and the standard executive branch review process.
Attorney General Review	Submitted to OAG: 11/6/2018 Review Completed: 12/12/2018 Result: Certified
DPB Review	Submitted on 12/12/2018 Economist: Oscar Ozfidan Policy Analyst: Jerry Gentile Review Completed: 1/25/2019 *DPB's policy memo is "Governor's Confidential Working Papers"*
Secretary Review	Secretary of Health and Human Resources Review Completed: 5/27/2019
Governor's Review	Review Completed: 7/1/2019 Result: Approved
Virginia Registrar	Submitted on 7/1/2019 The Virginia Register of Regulations Publication Date: 7/22/2019 Volume: 35 Issue: 24
Public Hearings	08/16/2019 9:05 AM

Comment Period	Ended 9/20/2019 0 comments

Contact Information	
Name / Title:	Jaime Hoyle / *Executive Director*
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Email Address:	jaime.hoyle@dhp.virginia.gov
Telephone:	(804)367-4406 FAX: (804)527-4435 TDD: ()-

This person is the primary contact for this board.
This stage was created by Elaine J. Yeatts on 11/06/2018
16

Project 5643 - Proposed

BOARD OF COUNSELING

Credential review for foreign graduates

18VAC115-20-49. Degree program requirements.

A. The applicant shall have completed a graduate degree from a program that prepares individuals to practice counseling~~,~~ as defined in § 54.1-3500 of the Code of Virginia, ~~which~~ is offered by a college or university accredited by a regional accrediting agency, and ~~which~~ meets the following criteria:

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

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

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

B. Programs that are approved by CACREP or CORE are recognized as meeting the requirements of subsection A of this section.

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

18VAC115-50-50. Degree program requirements.

A. The applicant shall have completed a graduate degree from a program that prepares individuals to practice marriage and family therapy as defined in § 54.1-3500 of the Code of Virginia from a college or university ~~which~~ that is accredited by a regional accrediting agency and ~~which~~ that meets the following criteria:

1. There must be a sequence of academic study with the expressed intent to prepare students to practice marriage and family therapy as documented by the institution;

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

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

B. Programs that are approved by CACREP as programs in marriage and family ~~counseling/therapy~~ counseling or therapy or by COAMFTE are recognized as meeting the requirements of subsection A of this section.

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

18VAC115-60-60. Degree program requirements.

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

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

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

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

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

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

Petition for Rule-Making (Giddens)

To amend regulations 18VAC115-20-52 to eliminate the restriction on residents' ability to directly bill for their services.

COMMONWEALTH OF VIRGINIA
Board of Counseling

RECEIVED SEP 09 2019

9960 Mayland Drive, Suite 300
Richmond, Virginia 23233-1463

(804) 367-4610 (Tel)
(804) 527-4435(Fax)

Petition for Rule-making

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

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

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

Rev Giddens, Steven R.

Street Address

5 Village Square

Area Code and Telephone Number

(802) 673-2717

City

Harrisonburg

State

VA

Zip Code

22802

Email Address (optional)

S.ryan.giddens@gmail.com

Fax (optional)

N/A

Respond to the following questions:

1. What regulation are you petitioning the board to amend? Please state the title of the regulation and the section/sections you want the board to consider amending. 18 VAC 115-20-25. Residency Requirements.
   Specifically "B → 2 → "...Once by Bill.."

2. Please summarize the substance of the change you are requesting and state the rationale or purpose for the new or amended rule.
   If a Resident in Counseling has own private practice → LLC or PLLC → Own business entity; even if 'Sole Proprietorship' Bill? Otherwise Resident must formed mergers through another entity which is Fraud or Supervisor which is unfair.
   If Resident makes 21k/yr & pays $100/hr for Supervision then Supervisor Taxes for additional 21k not 85!?
   I believe there are ways in which Residents who own LLC/PLLC can Contractually Meet the intent of #9 & Still Be IT

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

Signature:

Date: 26 Aug 2019

Request for Comment on Petition for Rulemaking

X

Promulgating Board: **Board of Counseling**

Regulatory Coordinator: Elaine J. Yeatts
(804)367-4688
elaine.yeatts@dhp.virginia.gov

Agency Contact: Jaime Hoyle
Executive Director
(804)367-4406
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Contact Address: Department of Health Professions
9960 Mayland Drive
Suite 300
Richmond, VA 23233

Chapter Affected:

18 vac 115 - 20: Regulations Governing the Practice of Professional Counseling

Statutory Authority: State: Chapter 35 of Title 54.1

Date Petition Received 09/10/2019

Petitioner Rev. Steven Giddens

Petitioner's Request

To amend 18VAC115-20-52 to eliminate the restriction on residents' ability to directly bill for their services

Agency Plan

In accordance with Virginia law, the petition will be filed with the Register of Regulations and published on September 30, 2019 with comment requested until October 25, 2019. It will also be placed on the Virginia Regulatory Townhall and available for comments to be posted electronically. At its first meeting following the close of comment, which is scheduled for November 1, 2019, the Board will consider the request to amend regulations and all comment received in support or opposition. The Board will inform the petitioner of the its response and any action it approves.

Publication Date 09/30/2019 *(comment period will also begin on this date)*

Comment End Date 10/25/2019

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Agency **Department of Health Professions**

Board **Board of Counseling**

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

70 comments

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

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Commenter: Sharon Watson, LPC, LMFT, LSATP, NCC, ACS 10/4/19 1:16 pm

ABSOLUTELY IN FAVOR of allowing Residents in Counseling to directly accept client payments

The regulation that Residents in Counseling may not "directly bill for services" is an antiquated concept and places a tremendous strain on both residents and supervisors.

It's often difficult for a master's level graduate to find a job in our field because of: a lack of job openings (due to increasingly diminished funding for public mental health treatment), low paying jobs that don't provide a living wage (let alone repayment of student debt), or limited opportunities to contract in an established private practice. So, unable to find a job after months of searching, some graduates turn to the only option left, even if it isn't their first choice, of starting a private practice. Unfortunately they are often stopped in the process because they can't find a supervisor who will take client payments.

But supervisors took client payments in the past, so what's changed? Why are supervisors more reluctant to take their residents' client payments? The possibilities are: 1. Depositing someone else's income into their account increases their own income (even though all the payment is returned to the resident); 2. Split payments, which were typical in the past (splitting the client payment between supervisor and resident) would not increase the supervisor's income, but were deemed illegal and no longer an option; 3. In the past a supervisor could accept the residents' client payments by check and simply endorse the check and return it to the resident, but with new technology based banking that's no longer an easy option; 4. It's extremely time-consuming to take residents' multiple client payments and electronically transfer the funds back to the resident especially if a supervisor has more than one resident in private practice; and 5. Many supervisors don't understand or are afraid of the process.

So this regulation is incredibly unnecessary when the entire amount of the client payment must be given to the resident in it's entirety. It's likely that clients don't understand this behind the scenes process and may be confused by why their payment goes to the supervisor when it's the resident that provided the counseling. What message does this send to clients about the value of the resident's work?

It's understandable that the intent of the regulation was to assure that clients understood that the resident in counseling is not an independently practicing clinician and is under supervision during residency. However, this requirement is incredibly redundant when residents must have their supervisor's name and information on everything they give to a client (practice forms, business cards, advertising, etc.) as well as verbally inform their clients they are under supervision and by whom. Doing that already makes it crystal clear that a resident is NOT working independently and whether or not a resident takes payment seems superfluous. It would be more important to spend the energy to confirm that a resident is, in fact, informing their clients they are in a residency under supervision.

Becoming licensed as an LPC is already a lengthy, costly, and time-consuming process. Let's support our residents and their supervisors by removing this truly unnecessary impediment for both.

Commenter: Michelle Cantrell, LPC 10/4/19 6:33 pm

IN FAVOR of allowing Residents in Counseling to directly accept client payments

I agree with Sharon Watson. Denying Residents' ability to accept payment is unnecessary and burdensome on the both the Resident and the supervisor responsible for accepting payments. Please consider allowing Residents to accept payments.

Commenter: Deborah Vara, Resident-In-Counseling 10/5/19 11:24 am

IN FAVOR of residents in counseling accepting direct payments

Commenter: Megan MacCutcheon, LPC 10/8/19 8:51 am

In favor of removing restriction on residents directly accepting payment

I am in favor of removing the restriction regarding residents directly accepting payment from clients per all of the reasoning Sharon Watson provided in her comments. This restriction creates an unnecessary burden on residents and supervisors. It leads to discrepancies in how residents are handling billing, which creates inconsistencies and confusion in the field. As long as residents are following the regulations that state they must not represent themselves as sole practitioners and must inform clients of their status as a resident/use the title "Resident in Counseling," billing methods should not be regulated.

Commenter: Taqwa Abdallah, Resident in Counseling 10/8/19 2:37 pm

In FAVOR of residents in counseling accepting direct payments

I STRONGLY believe that it is necessary for Residents in Counseling be able to accept payments directly. It reflects on our reliability to our clients as well as our professionalism.

Commenter: Rebecca Hogg, LPC 10/9/19 12:41 pm

In Favor of Billing by Residents

While a resident it can be hard enough to find a job to fulfill the needed hours, the choices often end up being employed below training level, at a low pay rate. It can also be difficult to find a local supervisor who is willing to accept payment on behalf of their resident. Additionally society has moved from making payment for services by using cash/checks to primarily using credit/debit/online payment services. When a resident has to go through one of these and requires the payment go to the supervisor first it becomes a financial tangle that can be difficult to navigate for many. I feel that residents would benefit from being able to bill for their own services as long as

all forms, documents, websites, etc clearly display the Resident in Counseling status and contact name/information of the supervisor.

Commenter: Crystal Hamling, Resident in Counseling, NCC, CCMHC 10/10/19 5:15 pm

In favor of residents in counseling directly accepting payment

I am in favor of removing the restriction regarding residents directly accepting payment for their services, in agreement with Sharon Watson and many other commenters here. I fully support the idea of residents needing to make it clear to their clients that they are working under clinical supervision and are not practicing independently, and residents are required to communicate this to the public in a number of ways. But residents not being able to directly accept payment for their services is an unnecessary hurtle that makes things more complicated for residents and supervisors and does not increase public safety, and in fact often confuses the public. The amount of increased administrative difficulty that this regulation imposes is not proportional to the amount of benefit that it intends to provide to the public, and in fact seems to confuse the public rather than benefit it. Let's remove this unnecessary impediment in order to streamline things for residents, supervisors, and clients alike.

Commenter: Pearl Breeden, BS, CSAC, graduate 3/20, MS in Clinical MH counseling 10/10/19 5:39 pm

In favor

In favor of removing the restriction and allowing residents to Bill for services provided

Commenter: Amanda Moseley 10/10/19 5:59 pm

In favor of allowing residents in counseling to direct bill

I am in favor of removing the restriction on residents in counseling directly billing and accepting payment for their services. Residents do need to make it clear that they are working under clinical supervision and are not practicing independently. Residents inability to directly bill and accept payments for services is an unneeded hurtle that complicates issues for both the resident and his/her clinical supervisor. This regulation imposes a hardship on clerical duties with no benefit. Please remove this obstacle.

Commenter: Olivia Withers, Professional Psychological Services 10/10/19 6:46 pm

To amend 18VAC115-20-52 to eliminate the restriction on residents' ability to directly bill for thei

In favor of residents billing directly for services.

Commenter: Suzan Thompson, PhD, LPC 10/10/19 6:51 pm

NOT in favor of this petition.

NOT in favor of this petition. As a long time LPC Supervisor I do not believe it is in the best Interest of Residents to permit them to receive direct payment from clients for counseling services as

learning the aspects of having a business is a different skill set. I would rather allow Residents to focus on strengthening their counseling skills - an already complex set of tasks.

Commenter: Lynn Banez 10/11/19 1:20 pm

Not in favor

I am not in favor of this unless the Board also develops detailed guidelines for Residents and Supervisors. In theory then, new Residents could have their own practice which requires more skill sets than the ones they need to really focus on and learn. Allowing them to bill directly also does not mean that insurance companies will agree. We continue to fight to get paid by Medicare and the VA. This would continue to muddy waters.

Commenter: JackMallery 10/11/19 4:15 pm

I am in favor of allowing licensed residents to bill insurance.

Commenter: Anne Beverly Chow, Bluebird Counseling Center 10/12/19 2:24 pm

DEFINITELY IN FAVOR of residents taking payments directly from clients!

Commenter: Natasha Yilmaz, Resident in Counseling 10/12/19 4:00 pm

That makes so much sense!! In support of the petition!

Commenter: Natasha Sharpe, Resident in Counseling 10/12/19 6:08 pm

In favor or residents accepting payment

Commenter: Torre Boyd 10/12/19 10:05 pm

In favor of Residents accepting payment

In favor of residents accepting payment. Not all clinicians accept insurance and this makes running a business and being self-sufficient possible.

Commenter: LaTrease L. Nwosu 10/12/19 11:57 pm

In favor

I am in favor of amending the current regulations preventing residents from accepting direct payment from clients.

Many states already allow provisionally licensed clinicians this role and has not created any harm to the system of obtaining complete licensure. In fact it increases clinicians drive and ability to gain more clients.

This is also a positive acknowledgement of the current economic needs of residents. Times have changes and clinicians are unable to make ends meet by such restrictions.

Commenter: lawrence uman 10/13/19 7:46 am

In favor of residents accepting payment and billing directly.

Commenter: Danielle McDowell, Resident in Counseling 10/13/19 7:49 am

In Favor

As a current resident who is navigating the process towards licensure, I am in favor of accepting payments for counseling services. Unlicensed counselors are working towards developing the skills for counseling and some are also interested in learning the private practice side as well. This opportunity to manage money helps residents to learn the business part of counseling as well for private practice. I'm grateful that my supervisor continues to educate me regarding the additional skill sets and would appreciate the board's approval of allowing me to manage the money for the services that I provide as I work towards my licensure. Lastly, I am aware of colleagues in the field in other states who accept money and have not seen how that ability has challenged their abilities to learn the counseling skills while managing the income piece as well. I'm grateful for this dialogue and the opportunity to consider making this change, thanks for your consideration.

Commenter: Angela Montgomery, LPC 10/13/19 7:53 am

Not in favor

Commenter: Jill A. Hagen, LPC 10/13/19 8:24 am

Reimbursement for services rendered by residents

While allowing residents to charge for services enhances credibility it may send message to clients of level of skill they do not possess as residents. It would encourage more people to stick with the process, however. If working in an agency they would be reimbursed for their services. As a private practitioner it might cut into my client pool. Perhaps setting rates across the board would work more equitably.

Clinica

Commenter: Lourie Reichenberg, LPC 10/13/19 8:57 am

Not in Favor

I am a supervisor and an LPC. I, too, am concerned about the impact that changing the rule could have on the public. There are already cases in which the public is not being informed when a resident is not licensed and is under supervision. This misleads the public and hurts the profession as a whole.
As LPCs, we have a responsibility to maintain professional standards, and while allowing residents to accept payments in their name would make it easier for residents, it would destroy the checks and balances already built into the system.

Commenter: Joanne M Moore LPC, BCETS, CCH, Clinical Supervisor 10/13/19 9:35 am

Not in favor

I understand the inconvenience of not having the ability to directly accept payments. However, much more is at stake. It is important to recognize and understand the purpose of this rule.

This rule is in place to ensure that the Resident in no way represents him or herself as an independent practitioner. This rule requires that some overarching entity provide protection against such a misrepresentation by requiring all payments to go through that entity. This rule is in place to protect the public from inexperienced clinicians who might attempt to practice independently. As stated by a previous respondent, this change would enable Residents with little experience to practice independently in any setting including private practice. Absent intensive and frequent, quality supervision, this change would be ripe for abuse.

Second, our profession should not differ from related professions in our rigor for preparing our Residents for independent practice.. No one wants to see an MD open a practice while still in Resdency . The same holds true for other health professions. We should not differ in our application of professional rigor to ensure our Residents are fully qualified before enabling them to work on their own. This change would likely stigmatize our profession in Virginia since it essentially would permit Residents to practice independently before their training in complete. No other profession allows this.

This rule was created for a purpose- protection of the public and our profession. This change would put both at risk.

Commenter: Loretta Schulz 10/13/19 10:52 am

Residents Accepting Direct Payment from Clients

I am firmly in favor of residents accepting direct payment from clients as long as they are and reporting those direct payments to their supervisors, attesting to the accuracy of those direct payments, and agreeing to not holding their supervisors responsible for any conflict between themselves and their clients with regard to those payments.

10/13/19 10:55 am

Commenter: Catherine A Love, LPC/LMFT

Allowing residents to collect fees before licensure

Not in favor. Very little experience; no direct supervision. Do not agree that Residents should be allowed to have their own private practice.

Commenter: Catherine A Love 10/13/19 10:57 am

NOT in favor

Commenter: Carmen Greiner, Lighthouse Counseling of Fredericksburg 10/13/19 2:24 pm

In Favor

I am in favor of removing the requirement that residents not be allowed to accept payments. As a supervisor of an agency with several employees and no reception staff, disallowing residents to take payments significantly inhibits my abilities to employ residents.

Commenter: Christopher David Clotez, Resident in Marriage and Family Therapy/Counselin 10/13/19 7:11 pm

In favor of allowing this for residents

Commenter: Cathleen Lindgens 10/13/19 8:23 pm

In Favor

Commenter: Dr. Tracy Bushkoff 10/13/19 8:53 pm

Residents

In favor of Residents, while under supervision, to bill and collect directly.

Commenter: DAVE M JENKINS, Fredericksburg Relationship Center 10/13/19 9:43 pm

In favor

In favor

Commenter: Cortney Zeigler, MA, Resident in Counseling 10/14/19 8:32 am

In Favor

I am in favor of allowing residents to be able to bill directly for services because I believe this would allow for Resident's in Counseling to gain more experience and open more opportunities for them to practice. There are currently few opportunities and most of them are community based work with QMHP's. I believe that the more opportunities residents have to provide services while under supervision while allow them to gain valuable experiences while still protecting their clients. Most counselor's are not able to get outpatient therapy experience while in their residency which makes it a more difficult transition once they are licensed. Allowing resident's to develop competency in different areas is to allow them more ways to gain experiences while under supervision. I think it should be allowed and then be up to the supervisor to monitor the resident's training and progress.

Commenter: Jonathan Ugalde, LPC, NCC 10/14/19 8:43 am

In Favor

I am in favor of the change as Sharon Watson and many others have identified the multiple merits of allowing for this change to occur.

Commenter: Elizabeth Sloan 10/14/19 8:56 am

Do not agree

I have supervised residents for more than 10 years. I disagree with allowing residents to accept payment. 1--If residents accept payment directly, they will seem like licensed professionals no matter how hard they try to fight that perception. Making payment to the resident's supervisor makes it crystal clear to the client that the resident is unlicensed. 2--If residents accept payment, it is more difficult for supervisors to have checks and balances on their activities. Residents are busy people. Logging their hours is cumbersome and when residents must report their hours in order to be paid, it keeps the supervision process transparent and timely. 3--Supervisors are busy people and the same applies to them. 4--I agree with the comment that if we allow residents to accept payment, Virginia will be less stringent than other jurisdictions. We are standard-bearers and should remain so. 5--I agree with the comment that residents face barriers because of few opportunities for jobs in the public sector. Virginia should address those barriers through systemic changes and changing this reg will not solve the problem. 6--Supervisors accept a lot of responsibility when admitting residents to their practices. It is part of the service we do for the profession and the public. It is inconvenient to accept payments for residents and handle disbursement to them. But there is nothing particularly convenient about supervising a resident! Respectfully, Elizabeth Sloan, LPC

Commenter: Madeline Vann 10/14/19 9:41 am

In Favor

Commenter: Laurie Ferreri, LPC, NCC, MAC 10/14/19 10:16 am

Not in favor

The whole purpose of a residency is to be mentored and trained. It's a long process but necessary one. If residents are allowed charge clients directly, what's the difference between a residency and a private practice? Let's do one thing at a time please.

Commenter: Sandra K. Molle LPC, Integrative Counseling Services PLLC 10/14/19 2:23 pm

In Favor

I am in favor of allowing residents to bill and collect payments for their services through their established businesses (LLCs). There are some residents who are quite capable of establishing a private counseling practice. It is, therefore, incumbent on supervisors to assess whether they are prepared to supervise a particular resident wanting to start a private practice.

Like all residents, those who establish a private practice are still required to inform clients "*in writing of the resident's status and the supervisor's name, professional address, and phone number.*" They are not allowed to ". . . *represent themselves as independent, autonomous practitioners or professional counselors. During the residency, residents shall use their names and the initials of their degree, and the title "Resident in Counseling" in all written communications.*"

However, requiring the supervisor to collect payments on behalf of the resident's business not only creates a redundant exercise in creative accounting, but it puts an undue legal responsibility for the resident's business on the supervisor. This only serves to discourage supervisors from accepting any responsibility for helping those very capable residents.

Commenter: Bethany DuPre, Resident in Counseling 10/14/19 3:26 pm

In Favor

Commenter: Erin Gossage, LPC, NCC 10/14/19 6:56 pm

In Favor

I am in favor of lifting this restriction on Residents and allowing them to receive direct payments for their services. There are many reasons for this. The most compelling reason in my opinion, is the barriers it would remove, allowing opportunity for Residents to both complete necessary requirements of their Residency and make a reasonable living at the same time.

Commenter: Dayra Marshall-Brown 10/17/19 10:13 am

In favor

Commenter: Tamara Sheridan, private practice 10/17/19 10:34 am

In favor

I am in favor of residents taking payment directly from clients with the understanding that they are already under supervision of a licensed clinician. However, I do believe that the board should have guidelines that specify the scope of this happening under direct supervision. The board has gone to great lengths to clarify in writing the restriction of residents taking payment; therefore, if the rule was changed I can only imagine that there would be clarification and guidelines for the allowance of such practice.

Commenter: Marianne S. Coad, MAMFC, LMFT, LPC Synergy Counseling, LLC 10/18/19 7:46 am

ABSOLUTELY NOT IN FAVOR

I have been a supervisor for many years as both an LMFT and an LPC in three states. Virginia has always been the standard bearer as one of my colleagues has stated. As a supervisor, I consciously choose to take enormous risk to my license by directly supervising Residents in my practice. Allowing a Resident to take direct payment will only increase malpractice risk to both Supervisor and Resident. A Resident will be able to "Hang a Shingle" and operate independently by receiving direct client payment and I believe many will do just this and be very excited about it and be too young in the profession to clearly comprehend the risk involved. I often receive phone calls from graduating Interns planning on opening their own business in Residency to which I gently help them understand the regulations and the protection provided for them through the regulations. I urge the VA Board of Counseling to NOT APPROVE this petition.

The Residency period is for learning and increasing therapeutic skills and should not be a time for learning how to run a private practice on your own with a minimum of one hour of supervision per 40 hours. As a colleague has stated, no other profession allows for a Resident to accept direct payment as this one act clearly identifies the Resident as an independent practitioner to the public and creates confusion and one might even go so far as to say is deceptive.

Regarding the accounting of Resident's Client payment records: There are so many software systems that automatically do all of the accounting for you and will determine exactly how much a Resident is due within any time frame a supervisor would create. Accounting should not be an issue in this discussion rather this discussion should focus of increased malpractice risk for both Resident and Supervisor. As a Supervisor who directly hires Residents, my malpractice insurance for each Resident is astronomically high due to the risk. The malpractice insurance will only increase with the approval of this petition. If this happens, the existing shortage of Supervisors in VA will also increase. Supervision of Residents is a method of giving back to the field of counseling, so why would a supervisor want to increase risk?

In summary, The process of becoming a fully licensed counselor is in place for a reason: To do no harm and protect the public specifically our Clients. I understand the desire for this petition to pass. However, the increased risk to both Residents, Supervisors and our Clients does not warrant its approval.

Commenter: Tiffany Jones, RACSB 10/18/19 2:46 pm

Absolutely in favor

Commenter: Katie Fields 10/18/19 5:44 pm

In Favor

Commenter: Resident in Counseling 10/19/19 9:52 am

Not in favor

Due to increased malpractice risk for both Resident and Supervisor.

Commenter: Harold 10/19/19 12:07 pm

I say no!

I do not support this

Commenter: Lawrence 10/19/19 12:14 pm

I do not agree

Each courteous fellow realizes that extraordinary prepping makes him feel better. The procedure begins in a space that is helpful for improving his certainty.We're not saying you need to set out candles and make a whole playlist that is exclusively included melodies by Marvin Gaye (albeit, honestly, we're not saying you shouldn't do that, either in light of the fact that that seems like the ideal method to begin any night experience in which you'll before long be bringing back a partner.) We're trying to say your space ought to have the majority of the basics that will empower you to set out on your men's grooming experience in a manner that will guarantee an ideal result.

Commenter: Vivien Bligh 10/20/19 6:57 pm

In favor

unnecessary requirement that complicates the provision of supervision and doesn't confirm either the skill level of a resident or that they are under supervision.

Commenter: Sharon Watson LPC, LMFT, LSATP, NCC, ACS 10/21/19 3:50 am

ABSOLUTELY IN FAVOR - Additional support points and clarifying misinformation

I am writing to address previous responses, correct some misinformation, and add additional support for allowing residents to take direct payment from their clients. I have been in the field for 30 years, licensed as an LPC for 25 years, and supervised residents for over 20 years in Virginia in exempt and non-exempt settings. I have been a provider of the 20-hour Clinical Supervision Training required for becoming a supervisor and have trained many supervisors over the years. Here are my points:

1. In Virginia a resident is allowed to have a private practice if they are under Board approved supervision with a Board approved supervisor and if they identify themselves as a Resident in Counseling under supervision and by whom. This petition is not about whether or not a resident can have a private practice. Suggesting to a graduate that they can't or shouldn't have a private practice is giving misinformation.

2. There are not enough jobs available, including working in an established practice, so for many graduates there is no alternative but to start a private practice, even if they would rather not do so. In terms of one response that suggested Virginia should do something about the job opportunities, I agree that it would be great to have more funding for mental health, but that's a future goal and shouldn't be a determining factor in making a decision about residents' ability to take direct payment now.

3. I require my residents to carry their own malpractice insurance. My malpractice coverage doesn't change with additional residents, so it's possible that the increased malpractice costs

discussed in previous responses are for taking on employees (residents or interns) and not for those residents who are contractors or simply rent space in a practice.

4. The risk to a supervisor (i.e. vicarious liability) is the same whether or not the resident takes direct client payment. That's why a supervisor does due diligence in choosing who to supervise.

5. Accounting isn't an issue if your residents are your employees or if payment goes through the front desk of a practice. But because in Virginia a resident's supervisor is not required to be on-site and virtual supervision is allowed, the issue is for supervisors who are not supervising residents within their own practice. They must therefore set up bank accounts to accept client payments and then transfer the entire amount back to the resident. The gyrations of having payment pass through the supervisor is unnecessary when both the resident and supervisor are following the regulations by identifying that the resident is under supervision. And why shouldn't the payment go to the resident - they are the one providing the service? I believe it's more confusing to clients to be told they must pay a supervisor and not the counselor with whom they have made the therapeutic alliance. And in response to the idea that withholding a resident's client earnings in order to be sure they report their hours is holding their earnings as ransom and a misuse of a supervisor's current requirement to take client payments.

6. I suspect the shortage of supervisors is more due to the unwillingness to take on the time-consuming process of making multiple bank transfers to send client payments back to their residents (giving them the income they earned) rather than concerns about increased risk having a resident in private practice.

7. I believe there is a confusion between payment and competency. Payment for services is a mechanical issue and has nothing to do with counselor competency. In fact, some graduates seeking supervision may have already taken the licensing exam and be an NCC.

8. How are graduates to get experience if they don't see clients? It puts residents in a Catch 22 situation if they can't get a job without experience but can't get experience without getting a job. The purpose of being supervised is to allow graduates to identify themselves as residents, practice, and be supervised so they can learn the skills to be a good therapist.

9. There is concern expressed that a resident in private practice may lack skills, but that's why they are under supervision. It's important to note that in some exempt settings graduates are practicing as counselors without Board approved supervision, may have a supervisor who isn't even licensed, are required to see the next client who walks in the door whether or not they have expertise in the client's issues, and are often in very intense and difficult situations with typically seriously mentally ill clients. The supervisor of a resident in private practice on the other hand can guide the resident in taking only those clients within the resident's skill set and who can be appropriately managed in the private sector.

10. The suggestion that the regulations are there to protect residents and supervisors is a misunderstanding. The regulations are taken directly from Virginia law and are meant to protect the public.

11. Regarding Virginia being the standard bearer in the profession: yes, indeed, Virginia was the first state to license counselors but there are other states with equivalent requirements and in fact some with stricter requirements. This is an opportunity for Virginia to again be in the forefront by taking into consideration the changing technological landscape and take advantage of the opportunities this brings. Paper checks made out to the supervisor and signed back over to the resident are a thing of the past now with instantaneous payments and cash transfers. Dictating that a resident not take direct client payment doesn't make our regulations better, it just keeps us from adapting to the present.

12. Regarding the statement that no other profession allows residents to take payment is actually incorrect regarding our own profession because in some states residents are allowed to take payment. In my research, of the 18 states that have responded to date, 5 allow residents to take client payment, 7 report it's not regulated or not addressed at all (which means the resident can take payment). It's important to note that the Virginia Board doesn't regulate insurance

reimbursement for residents because it's outside their purview. Which begs the question of why they regulate another form of payment.

13. The implication that allowing residents to take client payments in their private practice will make graduates more willing to break the law by practicing without a supervisor or license is inappropriate. If a graduate is practicing outside of the regulations, that is what should be policed and reported. The bottom line is, if you see something, say something. If you see someone practicing illegally, report it. That's how we protect the public. The public isn't protected by not allowing a resident, who is practicing according to the regulations, take direct client payment. It's unconscionable to penalize residents adhering to the regulations because of individuals who might not be.

14. In response to changing this regulation meaning there would be no difference between a residency and a private practice is a misunderstanding. The answer is they can be one in the same. A residency can be done in a supervisor's practice, in a private company, in an exempting setting, or while running a private practice.

In summary, I hope this addresses some of the concerns voiced by some and supports all of those in favor of changing this regulation.

Commenter: Nicole J. Low M.Ed, NCC, PPS, Resident in Counseling 10/22/19 2:17 pm

In Favor

I am strongly in favor of changing the VA Board Regulations, to enable Residents in Counseling to accept payments directly from clients. As others have stated, this eliminates the challenge of securing a supervisor to bill through; which are few and far between, it allows the Resident more flexibility in scheduling clients (i.e. no specific days to work) and to maintain a living wage. Other states permit graduates in our situations to bill clients directly via granting them graduate licensure (Ex. LGPC, Licensed Graduate Professional Counselor- Maryland) and they can also bill insurance- at the time of writing this Blue Cross Blue Shield does (also in Maryland) while under supervision. Taking away this complication will help more Residents that choose this route accomplish their goal of licensure more smoothly.

Commenter: Eleanor Huff, MA,RN,NCC,Resident in Counseling 10/22/19 8:03 pm

In Favor, Residents Accepting Payments

Supervisors are valuable to Residents in Counseling. Their time, knowledge and efforts are best served in that role, not with the amount of time involved in accounting, with Residents in Counseling payments. Residents accepting payments allows Supervisors to continue their focus and time where it should be directed. Residents in Counseling on the path to licensure following the rules and regulations have many ways they demonstrate they are not practicing autonomously. Allowing Residents in Counseling to accept payments is demonstrating support and acknowledgement that the Residents also have their priorities focused on the profession.

Commenter: Melat Johnson, MS, Resident-in-Counseling 10/23/19 4:09 am

In favor

I am in favor of Residents being able to take payments from clients directly.

10/23/19 7:00 am

Commenter: Mary Wiggins, Atlantic Counseling Group

In Favor

I am in favor of LPC Residents to collect payments directly for services.

Commenter: Shana Storms, MS, CSAC, Resident in Counseling 10/23/19 7:20 am

In favor

In favor of LPC residents collecting payments directly from from clients.

Commenter: Megan MacCutcheon, LPC 10/23/19 8:44 am

In favor - Issue of accepting payment vs. starting a practice

I want to add that there is a major difference between whether residents working in private practice can accept payment directly and whether residents should be ALLOWED to work in private practice. As Sharon Watson mentioned, "In Virginia a resident is allowed to have a private practice if they are under Board approved supervision with a Board approved supervisor and if they identify themselves as a Resident in Counseling under supervision and by whom." Residents are already allowed to run a private practice. The debate here is where they can personally accept their own payment in such a setting.

I personally think that it is beneficial for therapists who plan to start a private practice to do so DURING residency, when they are under supervision and can get input on how to do it in the most ethical and "best practice" ways.

Yes, running a business is a separate skill set and it's one that can be learned and fine tuned with the help of an experienced supervisor. Residents would benefit from experience and guidance in terms of navigating renting space, obtaining malpractice insurance, creating forms, writing/enforcing policies, setting fees, etc. I do think it's useful to have a supervisor lay eyes on the more mechanical side of the business, as it is ultimately all important aspects of the clinical work.

Once a therapist is licensed, there is no oversight regarding whether they choose to get appropriate consultation and guidance in terms of setting up a private practice. Licensure ensures they have clinical experience, but they may not have the experience of starting up of a business nor the "business-savvy" to navigate all the necessary details of running a successful and ethically-sound practice. Thus, I think there's a major benefit to residents doing it during the period where they are being supervised and can consult about the start-up and ins-and-outs of running a business. It's not hard to find a balance in terms of focusing on client cases while also discussing the various aspects of setting up/running a business and dealing with various issues that come up regarding the business side that DO impact clients and the clinical work.

That said, I do think it is case-by-case whether a resident is actually READY to begin a private practice and I believe it is the responsibility of the supervisor to gauge readiness and advise their supervisee as to whether or not they are in favor of them starting a private practice at any given them. The input and direction about readiness and timing around starting a private practice from an experienced supervisor can be INVALUABLE to a resident who is navigating all that is involved with the start up and considerations regarding work/life balance, impact to current and future clients, etc.

A supervisor's support or lack thereof is the gate-keeper to the public, not the collection of money. If a supervisor has agreed to supervise a resident's private practice caseload, whether or not they collect the payment, they have indicated their belief that the supervisee is ready and has enough clinical knowledge to be in private practice.

If residents are adhering to regulations regarding how they represent themselves and if supervisors are doing their due diligence by responsibly deciding whether residents have the clinical experience and personality/skill set to successful run a practice, then the issue of who payment is made out to is a moot point.

Commenter: Carlinda Kleck, MHSADS 10/23/19 9:33 am

In Favor

In favor of the proposed regulation change.

Commenter: Vittoria Grant LPC 10/23/19 11:07 am

Not in favor

Commenter: Kathi Scholz 10/23/19 11:19 am

Not in favor

Commenter: MIchelle Market, LPC, Private Practice 10/23/19 11:23 am

In Favor

In favor of Residents to bill and collect money directly, while under direct supervision. That receipts given to the clients and all business cards continue to reflect and highlight that the resident is under the supervision of (supervisor's name and license) which is common practice.

Commenter: Valeria D'Amato Caputi, Resident in Counseling 10/23/19 11:38 am

In favor

Absolutely in favor

Commenter: Jane Yaun, for VACSB Regulatory Committee 10/24/19 10:16 am

Eligible to bill directly

VACSB Regulatory Committee is in favor of this petition and would also recommend that "supervisees in social work" language be added so as not to limit to residents in counseling.

Commenter: Catwana Elliott, MS, Resident in Counseling 10/24/19 10:20 am

In favor

Commenter: Katara Ratliff 10/24/19 10:38 am

In FAVOR

Commenter: Anonymous 10/24/19 5:34 pm

Not In Favor

It is my opinion that residents accepting payment from patients creates the perception that the resident-therapist has attained the same level of competence as all licensed professional counselors in Virginia. In my experience, residents frequently neglect to explain themselves to patients properly and this causes confusion for the public. It seems to be an unnecessary change at this time.

Commenter: Emily Goff Trkula, LPC 10/25/19 9:53 am

Not in favor

Commenter: Amy Clay, Sunstone Counseling 10/25/19 3:24 pm

Not in Favor

Not in favor.

It is my understanding that the restriction regarding Counselors in Residence not being able to directly accept client payment is in place to ensure that a Counselor in Residence can not create or operate an independent entity until fully licensed.

A Resident in Counseling should be working for an agency/ mental health organization or pre-established private practice business that employs the Resident in Counseling. All payments should be going to said business/agency. If this payment restriction is removed, Residents in Counseling could theoretically "hang their own shingle" or create their own private practice if they find a supervisor willing to agree to this model. I agree with another respondent, "This rule requires that some overarching entity provide protection against such misrepresentation by requiring all payments to go through that entity. This rule is in place to protect the public from inexperienced clinicians who might attempt to practice independently... Absent of intensive and frequent, quality supervision, this change would be ripe for abuse."

Furthermore, if a Resident in Counseling can start accepting payment and create a "private practice entity" to work with clients creating the perception to the public that the "practice", especially when the Resident in Counseling is the only therapist on staff, is on the same level of experience, support, and credibility as other private practices. I think this puts a burden on the clients seeking services to distinguish who they are engaging in services with and causes confusion for the public.

This change would put a lot at risk for Counselors in Residence, Supervisors and the Clients looking for services if the above-mentioned example could be permitted.

Finally, the Board of Social Work and Psychology do not allow residents to accept payment. Why would Counselors be an exception?

Amy Clay, LPC

Commenter: Kim Dellinger, Bacon Street Youth and Family Services 10/25/19 9:46 pm

strong support in allowing counselors in residence to be able to bill for services

We are a local non profit organization in Williamsburg and provide services for youth and families struggling with mental health and substance use disorders, regardless of their ability to pay for services. We greatly depend on our counselors in residence to help us provide services, and they are always under supervision from a licensed clinician who works for the agency. Counselors in residence are already challenged in finding placements with agencies, and it's hard on agencies to pay for the living wages of these counselors while they are working toward licensure. By not being able to bill for their time, the burden is placed on the agency to figure out how to cover their compensation, as we ask counselors in residence to work to serve clients who often can't pay their bills.

We believe strongly in being a teaching agency for our counselors in residence and take this part of our mission very seriously. We want them to have a great experience and come out as seasoned, well trained professionals. But it's hard to make ends meet if we have to meet a high need in our client base but can't financially afford to support the clinicians who are providing the services to address this need.

We are already struggling with finding licensed clinicians who are willing to work for a nonprofit agency, when they could be making more money as a private counselor with their own practice. By employing counselors in residence, this meets the need of the counselors, they are able to get their hours for licensure and we provide the supervision they are required to have as a part of their compensation package. In turn, this also meets the needs of our clients who desperately need services but often struggle with paying the higher rates that are charged by private clinicians.

By allowing for us to be able to bill directly for counselors in residence, this would allow us to do our jobs more effectively and serve more low income clients. We could continue to provide the services we provide to our clients, we can provide the supervision and experience needed for the counselors in residence and have a financially viable model that will allow our agency to serve more clients more effectively.

With the increasing need in the rising number of youth and young adults struggling from addiction and mental illness, we NEED more counselors in the field. If we can provide a way for counselors to have a viable way to be successful, we might have more counselors entering the field. This is a pathway to success for the field of counseling, and will draw more potential counselors into the field. As an agency, we understand the need to train and mentor new professionals. Please consider voting in favor of this proposal, it will allow for tomorrow's professionals to be able to help today's clients and families who are struggling.

Commenter: Cherra Barbour 10/25/19 10:57 pm

In favor

Commenter: Sharon Watson, LPC, LMFT, LSATP, NCC, ACS 10/26/19 12:01 am

In Favor and continuing to correct errors.

In response to a recent response: residents ARE allowed to have a private practice and a business name because that is not addressed in the regulations. It's mixing apples with oranges to argue whether or not this should be true and has nothing to do with this petition regarding residents accepting payment. It's also complicating matters expecting a graduate should first work in an exempt setting or private practice because that is NOT required by the regulations. It's also inaccurate to make the assumption that licensed clinicians are better than residents. If that were true there would be no need for multiple disciplinary actions against licensed clinicians in Virginia.

18VAC115-20-52. Residency Requirements.

A. Registration. Applicants who render counseling services shall:

1. With their supervisor, register their supervisory contract on the appropriate forms for board approval before starting to practice under supervision;

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

3. Pay the registration fee.

B. Residency requirements.

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

a. Assessment and diagnosis using psychotherapy techniques;

b. Appraisal, evaluation, and diagnostic procedures;

c. Treatment planning and implementation;

d. Case management and recordkeeping;

e. Professional counselor identity and function; and

f. Professional ethics and standards of practice.

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

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

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

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

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

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

8. The residency shall be completed in not less than 21 months or more than four years. Residents who began a residency before August 24, 2016, shall complete the residency by August 24, 2020. An individual who does not complete the residency after four years shall submit evidence to the board showing why the supervised experience should be allowed to continue.

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

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

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

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

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

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

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

3. Hold an active, unrestricted license as a professional counselor or a marriage and family therapist in the jurisdiction where the supervision is being provided. At least 100 hours of the supervision shall be rendered by a licensed professional counselor. Supervisors who are substance abuse treatment practitioners, school psychologists, clinical psychologists, clinical social workers,

or psychiatrists and have been approved to provide supervision may continue to do so until August 24, 2017.

D. Supervisory responsibilities.

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

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

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

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

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

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

Statutory Authority

§ 54.1-2400 of the Code of Virginia.

Historical Notes

Derived from Volume 16, Issue 13, eff. April 12, 2000; amended, Virginia Register Volume 24, Issue 24, eff. September 3, 2008; Volume 30, Issue 19, eff. July 3, 2014; Volume 32, Issue 24, eff. August 24, 2016; Volume 36, Issue 03, eff. October 16, 2019.

Petition for Rule-Making (Mikkelson)

To amend regulations section 18VAC115-50-55 to reduce the required internship number of hours of experience with couples and families from 200 of the 240 to 120 of the required 240 hours.

COMMONWEALTH OF VIRGINIA
Board of Counseling

9960 Mayland Drive, Suite 300
Richmond, Virginia 23233-1463

(804) 367-4610 (Tel)
(804) 527-4435(Fax)

Petition for Rule-making

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

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

Petitioner's full name (Last, First, Middle initial, Suffix,) **Mikkelson, David P. and Mikkelson, Suzanne E.**		
Street Address **603 Lake Vista Dr.**	**Area Code and Telephone Number** 434-258-0591	
City **Forest**	**State** **VA**	**Zip Code** **24551**
Email Address (optional) [redacted]	**Fax (optional)**	

Respond to the following questions:

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

We are petitioning the board to amend 18 VAC 115-50-10 et seq., the Regulations Governing the Practice of Marriage Family Therapy, section 18VAC115-50-55 on Coursework requirements, paragraph A.10. on the number of required internship hours with couples and families.

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

We are asking to change the required number of couple and family internship hours for LMFT interns from 200 of the 240 direct client contact hours during internship to 120 of the required 240 hours. We believe the requirement for 83% of an intern's clinical experience to be "relational" hours is both excessive and unrealistic, and we recommend a ratio of 50% which supports the training goal for LMFT interns.

We believe the current requirement is excessive because it is a higher rate of couple and family experience than the board requires for LMFT Residents, which is 50% (1,000 of 2,000 direct client hours as stated in Section 18VAC115-50-60 Residency requirements, paragraph B.2). We are not aware of a licensure requirement for LMFTs for relational hours beyond 50% in any other state. Even in COAMFTE training programs, the relational hours requirement is 40%, or 200 hours of the 500-hour internship requirement. Changing the Virginia requirement to 120 of 240 hours brings it into line with many others states and accrediting bodies such as COAMFTE.

We also believe the current requirement is unrealistic as graduate interns have the least amount of influence on the types of clients they are assigned during their clinical experience. Even as experienced LMFTs, we rarely have more than half of our clients attend sessions as a couple or family, and never in our careers have we had a ratio of 83%. We have a very high percentage of clients who see us about couple or family issues, but many of those clients are distressed spouses or frustrated parents who attend as individuals; we are using MFT methods for MFT issues, but the hours are counted as individual. We believe a 50% requirement is a much more realistic requirement.

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

No additional reference.

Signature: David P. McClellan Suzanne E. McClellan **Date:** 9/3/2019

Response to Petition for Rulemaking

X

Initial Agency Notice
Agency Decision

Promulgating Board: Board of Counseling

Regulatory Coordinator: Elaine J. Yeatts
(804)367-4688
elaine.yeatts@dhp.virginia.gov

Agency Contact: Jaime Hoyle
Executive Director
(804)367-4406
jaime.hoyle@dhp.virginia.gov

Contact Address: Department of Health Professions
9960 Mayland Drive
Suite 300
Richmond, VA 23233

Chapter Affected:

18VAC115 - 50: Regulations Governing the Practice of Marriage and Family Therapy

Statutory Authority: State: Chapter 35 of Title 54.1:

Date Petition Received 09/16/2019

Petitioner David and Suzanne Mikkelson

Petitioner's Request

To amendment section 18VAC115-50-55 to reduce the required internship number of hours of experience with couples and families from 200 of the 240 to 120 of the required 240 hours.

Agency Plan

In accordance with Virginia law, the petition will be filed with the Register of Regulations and published on October 14, 2019 with comment requested until November 13, 2019. It will also be placed on the Virginia Regulatory Townhall and available for comments to be posted electronically. At its first meeting following the close of comment, which is scheduled for February 7, 2010, the Board will consider the request to amend regulations and all comment received in support or opposition. The petitioner will be informed of the board's response and any action it approves.

Publication Date 10/14/2019 *(comment period will also begin on this date)*

Comment End Date 11/13/2019

Virginia.gov Agencies | Governor

VIRGINIA REGULATORY TOWN HALL

Agency Department of Health Professions

Board Board of Counseling

Chapter **Regulations Governing the Practice of Marriage and Family Therapy [18 VAC 115 - 50]**

10 comments

All good comments for this forum Show Only Flagged

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Commenter: Emily 10/17/19 11:58 am

not in favor

It seems counter intuitive to reduce contact hours for couples and families for those seeking distinction as a marriage and family therapist, even at the internship level.

Commenter: David P Mikkelson, PhD, AAMFT Approved Supervisor 10/17/19 11:13 pm

Strongly in Favor of this Change

The current requirement for 83% of an intern's clinical experience to be "relational" hours is both excessive and unrealistic. The ratio for an LMFT Resident in Virginia is 50% (1,000 of 2,000 direct hours), and graduate school interns should not be held to a higher ratio. In COAMFTE training programs, the relational hours requirement is 40%, or 200 hours of the 500-hour internship requirement. Changing the Virginia requirement to 120 of 240 hours brings it into line with national accrediting bodies and many other states (50%).

The current requirement is also unrealistic as graduate interns typically have the least amount of influence on the types of clients they are assigned during their clinical experience. Functionally, the current regulation may force interns to accumulate over 400 total direct hours in order to get 200 relational hours, a heavy burden for MFT/MFC interns. Interns who graduate with less than 200 relational hours cannot be approved for residency, even though they met the university requirements. How will they be able to gain additional hours after graduation without residency status? They can get stuck with no way forward to pursue licensure.

Commenter: Suzanne Mikkelson, Ph. D., LMFT, Hill City Counseling and Consulting 10/17/19 11:17 pm

In Favor

As an LMFT, an AAMFT Approved Supervisor, and a Virginia board-approved supervisor, I am completely in favor of this petition. The current requirement of 200/240 direct hours being relational for graduate internship places an unreasonable burden on students to find sites with 80% relational clients. Residents in Marriage and Family Therapy should have experience with both relational and individual hours to build clinical competency as a mental health professional. To require students to attain such a high ratio of relational hours hampers their overall clinical competency and

severely limits their experience with applying systemic and individual theoretical models when counseling individuals. Furthermore, the board's requirement greatly exceeds the COAMFTE requirement for internships of 40% relational hours as well as the 50% relational hours required for licensure as an LMFT in Virginia.

I recommend reducing the requirement to 50% or 120/240 direct hours. This balance of 50% relational hours will ensure clinical competence for working with couples and families as well as with individual clients, be more reasonably attainable for students, and be more consistent with residency requirements.

Commenter: Steve Johnson 11/1/19 2:12 pm

Strongly favor

As the Director of Clinical Training for a university that provides training for both residential and online MFT students, I strongly support this proposal. Our office receives regular feedback from students preparing for VA licensure that they have significant difficultly in gaining the required direct couple/family hours at their site/s. Furthermore, our office does not receive similar concerns from other students across the country, which leads me to believe that this heavy educational requirement may not exist in other states. While I am unaware of the initial rationale for the current requirement (200/240), it certainly is not commensurate with the COAMFTE ratio for training programs nor with the VA residency requirements. It would seem much more consistent to require similar couples/family hours between the educational and residency components rather than placing this undue stress on students during their educational experience. As stated in the proposal, I support the recommended 50% (120/240) requirement of seeing couple/families.

Commenter: Synergy Counseling 11/3/19 11:11 am

Fully Supportive

I have been an AAMFT Supervisor for many years. As always Virginia is the standard bearer for the counseling profession. I respect this very much and appreciate the efforts of the Board to maintain high standards.

I wholeheartedly agree and support the current proposal based on the following reasons:

The Virginia Board requires relational hours for MFT **residency** at 50% (1,000 of 2,000 direct hours) to apply for licensure. I believe the **internship** requirement should be consistent with residency requirements. The current Virginia Board internship percentage of 83% (200 of 240 direct hours) is unrealistic because interns have the least influence over the types of clients they are assigned. Just finding an internship is a challenge for students and then the unrealistic expectations of relational hours makes it even more difficult. In addition, COAMFTE only requires a 40% relational hours ratio for internships (200 of 500 direct hours).

A review of the licensure regulations of about 20 states reveals requirements of no more than 50% relational hours. MFT/MFC interns also need clinical skills for individual clients, not just couples and families; a balance of 50% during internship is very appropriate. Under the current rule, interns may need to complete up to 400 direct client hours in order to obtain the minimum 200 relational hours needed for the VA Board requirement. This places unnecessary stress and financial burden on the intern to extend internship of up to two additional semesters just to obtain the unrealistic amount of direct relational hours.

In addition MFT/MFC students can meet university requirements and graduate with less than 200 relational hours, but he/she cannot be approved as a resident and has no path to licensure. Interns are often ignorant of the VA Board requirements and frequently depend on their university to guide and direct them towards licensure requirements which seems to rarely happen effectively.

In summary, the required direct relational hours for **internship** needs to reflect the same percentage (50%) as the required direct relational hours for **residency**.

Commenter: Willow Rose Counseling, LLC 11/5/19 12:42 pm

Fully Supportive

Commenter: Jeffrey Boatner 11/7/19 10:33 am

Fully support

This seems like a common sense change that will still provide perspective MFTs with distinctive experience with families and children while removing a burden that could stand in the way of residents getting the required hours needed for licensure. The fact that this change is in alignment with the majority of other state/national accrediting bodies further supports its passage.

Commenter: Amy Morgan with American Association of Marriage & Family Therapy (AAMFT) 11/12/19 6:27 pm

In favor, with reservations

The American Association for Marriage and Family Therapy's Virginia Family TEAM Network (AAMFT Virginia) thanks you for the opportunity to provide input on the Petition for Rulemaking to amend 18 VAC 115-50, which aims to lower the relational experience hour ratio from 83% to 50% during the graduate program supervised practicum. AAMFT is a professional organization representing the interests of Marriage and Family Therapists (MFTs) in Virginia and across the United States. AAMFT Virginia is pleased to support the petition, with reservations.

We empathize with the issue presented in this petition as there can often be a scarcity of places who can provide consistent relational hours to interns. Further, while we want to maintain an expertise in relational work through rigorous training requirements, we also do not want the current relational hour requirement to pose an insurmountable barrier to MFT trainees and result in trainees pursuing another type of licensure. The amendment proposes a change from 83% relational hours to 50% (120/240). We support this petition for a few specific reasons. First, a 50% relational hour requirement is more congruent with both LMFT residency licensure requirements in Virginia (i.e., 50% direct relational hour requirement), as well as COAMFTE (the national accreditation organization for marriage and family therapy training) training requirements (i.e., 40% direct relational hour requirement). Second, therapy interns often do not have control of what cases they are assigned, and therefore, they may not have the power needed to ensure a high relational caseload. Third, rural areas often experience severe provider shortages and disproportionately high rates of mental health issues. For instance, of the 95 counties in Virginia, 7 counties have only LPCs or MFTs rendering services. In three counties, there are no documented mental health providers at all. Given the shortage of providers in these areas, finding a practicum placement site that provides consistent relational hours and onsite supervision can be challenging. The current relational hour requirement (83%) may incentivize MFT trainees to pursue internship placements in more urban counties, where practices and organizations catering to relational services may be more widely available, to ensure meeting the high relational hour requirement in a timely manner. We propose that lowering the relational hour requirement to 50% is not only commensurate with other MFT hour requirements (i.e., COAMFTE and VA LMFT licensure) but may also incentivize MFT trainees to continue practicing in and serving rural counties.

Our reservation with supporting this petition is that it may be "a slippery slope" to further relational hour requirement reductions. We support the current petition as it stands, reducing the relational hour requirement to 50%, with the caveat that we do not support further reductions in the MFT relational hour requirements. A 50% relational hour requirement will both maintain an essential relational hour training experience, thereby upholding MFT expertise and training in relational work, while also becoming more attainable for MFT trainees pursuing MFT licensure.

Amy Morgan, LMFT & Debra Rezendes, LMFT
AAMFT-Virginia Advocacy Leaders

Commenter: Roxana, MFT graduate student in Virginia 11/12/19 7:25 pm

Fully support

I am writing in support of this petition. As an MFT graduate student, and as someone who will in the near future be in the licensure process. I believe this adaptation will be more congruent with other Mental Heath professionals that practice in the state of Virginia, as well as better acknowledge the breadth and depth of the work MFTs so as systemic thinkers and practitioners. This adaptation and adjustment I believe will allow MFTs to be of better service to their community when the hours restriction is less rigid and is more on par with other practitioners in the field. MFTs provide a unique skill set in the mental health profession, and I believe this adjustment will allow for more growth within the MFT community and allows for a more holistic approach to our work. Thank you for considering this change and petition.

Commenter: William Scott, Arnold Woodruff, VAMFT 11/13/19 11:19 pm

Supporting relational practice

We are writing in response to the "Petition for Rule-Making," regarding **18VAC115-50: Regulations Governing the Practice of Marriage and Family Therapy**, dated 9/16/2019 and submitted by David and Suzanne Mikkelson. At issue is the number of "relational" hours required during the internship (18VAC115-50-55) and requesting a reduction of those hours from 200 (of 240) to 120 hours. The Virginia Association for Marriage and Family Therapy (VAMFT) recognizes and understands the difficulties faced by students in acquiring those hours deemed "relational," i.e., with more than one related consumer in the counseling room. The points brought up by the Mikkelson's are valid and have been considered and debated for some time within the family therapy community.

As VAMFT sees and understands this dilemma, we are faced with two competing ideas. The first idea strikes to the very basis of the profession of marriage and family therapy and that is that the training and experience requirement to become a licensed marriage and family therapist (lmft) is strictly defined as the ability to work in a therapy space with more than one consumer. That difference in training and experience is, by definition, what makes our training, experience and supervision unique and has led to the creation of a license that is separate from other mental health professionals. In order to achieve expertise and some assurance of safety to the consuming public, we must be assured that persons granted a degree in mft and subsequently licensed as mft's do have, in fact, the ability to competently navigate in that relational space. It is, of course, arguable as to how many hours would give some assurance of this expertise and presumed safe practice. VAMFT believes that reducing the relational hours in the internship, as currently mandated, would jeopardize the creation of the core of experience that someone heading for independent practice should have.

The second, and somewhat opposed concern is, as outlined by the Mikkleson's, the difficulty in assuring that students can get the relational hours in a typical internship setting. Aside from those agencies providing intensive in-home services, an unlicensed intern has few chances to work with more than one designated consumer at a time. In the COAMFTE guidelines, the 500 hour requirement is somewhat modified by the ability to count up to 100 hours in "**alternative hours** or clinical activity (e.g., couple or family groups; live cases where reflecting teams are directly involved..., etc.) (pg. 33 of COAMFTE Accreditation Standards Version 12.0; Effective January 1, 2018) (Bold in original). Use of those hours, also not always available in an internship site, would make the 200 hour requirement at 50%. The somewhat reduced hourly requirement established by COAMFTE is based on the reality that students in an on-going program of mft will be surrounded by others working from the same systemic bedrock that is rarely the milieu in residency settings. If VAMFT had its way, more internship sites would be using family therapy as a model for treatment and even when individuals are seen (as the Mikkelson's highlight), the therapist's focus on the relational rather than the intrapersonal field. Short

of allowing interns and residents who are seeking degrees or licenses in mft and receiving mft-based supervision (VAMFT's fondest wish), the dilemma remains. Both of the undersigned are Approved Supervisors with AAMFT and both supervise interns and residents who are seeking education and licensing as mft's. Both believe that, regardless of the number of consumers in the room with the therapist, the therapist is performing family/relational therapy.

In light of all the above, we would not like to see any diminution in the required experience that aspiring mft's accrue during either their internships or their residencies. We are concerned that the goal of possible portability of the license would result in all standards being devolved to the lowest common denominator. It is difficult to imagine any state regulatory body being willing to increase the requirements for licensing in their jurisdictions. We would, reluctantly and in light of the dilemma outlined above, be willing to support a reduction in those relational hours to 180 of the total of 240.

William Scott, Ph.D.
President, VAMFT

Arnold Woodruff, LMFT
Executive Director, VAMFT

18VAC115-50-55. Coursework Requirements.

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

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

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

3. Human growth and development across the lifespan;

4. Abnormal behaviors;

5. Diagnosis and treatment of addictive behaviors;

6. Multicultural counseling;

7. Professional identity and ethics;

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

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

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

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

Statutory Authority

§ 54.1-2400 of the Code of Virginia.

Historical Notes

Derived from Volume 16, Issue 07, eff. January 19, 2000; amended, Virginia Register Volume 24, Issue 24, eff. September 3, 2008; Volume 32, Issue 24, eff. August 24, 2016.

Consideration of public comment and adoption of proposed regulations related to periodic review for Regulations Governing the Practice of Professional Counseling, Marriage and Family Therapy and Substance Abuse Practitioners

Agenda Item: Adoption of proposed regulations – periodic review

Included in agenda package:

NOIRA announcement on Townhall

Comments on the NOIRA

DRAFT of proposed regulations

Staff Note:

The Regulatory Committee recommended the amendments to the periodic review as noted in the NOIRA for the periodic review and incorporating changes relating to the resident license (previously adopted as emergency regulations)

Action: To adopt proposed regulations as presented or as amended by the Board

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VIRGINIA REGULATORY TOWN HALL

Agency Department of Health Professions

Board Board of Counseling

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

Action: Periodic review

Notice of Intended Regulatory Action (NOIRA)

Action 5230 / Stage 8544

Edit Stage | Withdraw Stage | Go to RIS Project

Documents		
Preliminary Draft Text	7/15/2019 10:49 am	Sync Text with RIS
Agency Statement	2/28/2019	Upload / Replace
Governor's Review Memo	7/25/2019	
Registrar Transmittal	7/25/2019	

Status	
Public Hearing	Will be held at the **proposed** stage
Exempt from APA	No, this stage/action is subject to article 2 of the *Administrative Process Act* and the standard executive branch review process.
DPB Review	Submitted on 2/28/2019 Policy Analyst: Cari Corr Review Completed: 3/14/2019 *DPB's policy memo is "Governor's Confidential Working Papers"*
Secretary Review	Secretary of Health and Human Resources Review Completed: 6/3/2019
Governor's Review	Review Completed: 7/25/2019 Result: Approved
Virginia Registrar	Submitted on 7/25/2019 **The Virginia Register of Regulations** Publication Date: 8/19/2019 **Volume: 35 Issue: 26**
Comment Period	**Ended 9/18/2019** **140 comments**

Contact Information	
Name / Title:	Jaime Hoyle / *Executive Director*
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This person is the primary contact for this board.
This stage was created by Elaine J. Yeatts on 02/28/2019
13

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VIRGINIA REGULATORY TOWN HALL

Agency Department of Health Professions

Board Board of Counseling

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

Action	**Periodic review**
Stage	**NOIRA**
Comment Period	Ends 9/18/2019

140 comments

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

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Commenter: Larry Epp, Ed.D., LCPC, Licensed Clinical Professional Counselors of MD 9/7/19 10:32 pm

Establish Fair Portability Policy for All Maryland Counselors

The Commonwealth of Virginia should correct the proposed policy to insure that all Maryland Counselors, whether graduating from a CACREP or non-CACREP program, should be able to transfer their license after three years of practice. Virtually every school in Maryland up to three years ago was not accredited by CACREP and this included a number of the nation's most respected graduate programs in counseling, such as Johns Hopkins, University of Maryland, Towson, Bowie State, UB, among many other respected universities. CACREP will not recognize the graduates of Counseling Psychology Programs, and this policy stance by the accrediting body marginalizes the graduates of these programs. Counseling Psychology has been a major contributor to the development of professional counseling, and excluding these programs and graduates is puzzling and injurious to the profession, given their immense intellectual contributions.

Commenter: Pamela Foley, Ph.D., Seton Hall University 9/10/19 9:09 pm

Strongly opposed

For over 20 years I have been involved in counselor education, at a university with a long history of graduating responsible and highly qualified practitioners. ACA has provided a reasonable proposal for national licensure portability that would allow counselors from NJ and other states to change their residences while not unreasonably limiting their employability. There is not one shred of evidence to support the need for graduates of non-CACREP programs to practice for 10 years rather than 3 before they are licensable. This cannot be other than a thinly veiled attempt to privilege CACREP programs over other programs that graduate highly qualified counselors, for reasons completely unrelated to the safety of the residents of Virginia. I strongly oppose this proposal.

Commenter: Barbara A. Bradshaw, LCPC 9/10/19 9:22 pm

The fair and simple Portability Model of the American Counseling Association

The Commonwealth of Virginia should correct the proposed policy to insure that all Maryland Counselors, whether graduating from a CACREP or non-CACREP program, should be able to transfer their license after three years of practice. Virtually every school in Maryland up to three years ago was not accredited by CACREP and this included a number of the nation's most respected graduate programs in counseling, such as Johns Hopkins, University of Maryland, Towson, Bowie State, UB, among many other respected universities. CACREP will not recognize the graduates of Counseling Psychology Programs, and this policy stance by the accrediting body marginalizes the graduates of these programs. Counseling Psychology has been a major contributor to the development of professional counseling, and excluding these programs and graduates is puzzling and injurious to the profession, given their immense intellectual contributions.

Commenter: Carol-Ann Trotman 9/10/19 9:35 pm

I oppose this

This is a harmful and limiting policy for professionals and consumers. The Commonwealth of Virginia should correct the proposed policy to insure that all Maryland Counselors, whether graduating from a CACREP or non-CACREP program, should be able to transfer their license after three years of practice. Virtually every school in Maryland up to three years ago was not accredited by CACREP and this included a number of the nation's most respected graduate programs in counseling, such as Johns Hopkins, University of Maryland, Towson, Bowie State, University of Baltimore, among many other respected universities. Also, CACREP will not recognize the graduates of Counseling Psychology Programs, and this policy stance by the accrediting body marginalizes the graduates of these programs. Counseling Psychology has been a major contributor to the development of professional counseling, and excluding these programs and graduates is divisive, puzzling and injurious to the profession, given their immense intellectual contributions.

Commenter: Mark Donovan, Congruent Counseling Services 9/10/19 9:42 pm

I appose the portability plan proposed by Virgnina that gives preferential treatment

I am the owner and director of Congruent Counseling Services, a growing practice in Maryland. If VA imposes such an unfair law, I will not open my planned office in Virginia. There were no CACREP Accredited colleges in MD until after I graduated in 1998. Punishing me, and other licensed counselors for not attuning a CACREP School, particular when Maryland licenser requirement exceeds that of CACREP programs, is unfair, unreasonable, and only political. CACREP only seeks to establish itself as a political entity and has no greater value than other programs. this is all political. I am disgusted by this attempt to disenfranchise experienced licensed therapists.

Commenter: Michelle Schoonmaker, private practice 9/10/19 9:45 pm

Strongly oppose

I oppose any requirement by Virginia to disadvantage licensed counselors who did not attend CACREP-accredited graduate programs. Discrepant requirements for CACREP and Non-CACREP counselors are unfair to Maryland Counselors who did not graduate from CACREP programs, which is the majority of counselors in Maryland. I, and others, are concerned that any CACREP restrictions would further marginalize graduates of Counseling Psychology programs, which CACREP does not recognize as Counseling programs. The Maryland Board of Professional

Counselors recognizes Counseling Psychology as part of the profession of Counseling. We believe this is the correct stance to take, given Counseling Psychology's historic role in the development of our profession.

Commenter: Mollie M. Thorn, LCPC 9/10/19 10:10 pm

I oppose this discriminatory law

I oppose any provision or law that proposes to discriminate counselor license portability.The current proposal in Virginia which favors only CACREP graduate programs unfairly limits counselors who have been practicing for many years from obtaining a Virginia counselor license. Please do not pass this law.

Commenter: Kelric Goodman, LCPC 9/10/19 10:17 pm

I oppose this proposal.

Commenter: Melissa Wesner, LifeSpring Counseling Services 9/10/19 10:47 pm

Strongly opposed

I am strongly opposed to any requirements that would disadvantage clinicians who graduated from non-CACREP schools. Many reputable universities in Maryland, including Johns Hopkins University were previously not CACREP accredited. I am among those graduates.

Pro-CACREP sentiment tries to convince the public that counselors who did not graduate from CACREP programs are not as highly trained. Individuals who don't know any better might actually buy into this misinformation. The reality is that CACREP is invested in this message as it brings significant amounts of money to their table. Pro-CACREP legislation is simply a way for CACREP to keep getting business.

The truth is that there are many highly trained clinicians who did NOT graduate from CACREP programs.

Commenter: Pat Doane 9/11/19 5:47 am

I strongly oppose the portability plan proposed by Virgnia that gives preferential treatment

I oppose any provision or law that proposes to discriminate counselor license portability. The current proposal in Virginia favors only CACREP graduate programs even though many accredited universities meet or exceed the standards of CACREP programs. Virginia needs excellent mental health services for its citizens and this proposal limits availability of highly educated, qualified, and experienced counselors.

Commenter: Paula Catalan 9/11/19 6:14 am

I oppose this law that discriminates counselor license portability

I oppose any provision or law that proposes to discriminate counselor license portability. The current proposal in Virginia favors only CACREP graduate programs even though many accredited

universities meet or exceed the standards of CACREP programs. Virginia needs excellent mental health services for its citizens and this proposal limits availability of highly educated, qualified, and experienced counselors.

Commenter: Kristin Miller, LCPC 9/11/19 6:18 am

I strongly oppose this proposal!

Commenter: Karen Edwards, Corrections 9/11/19 7:36 am

Strongly opposed!

It is patently unfair to make it difficult to find employment for thousands of clinicians.

Commenter: Gina Rassa, LCPC 9/11/19 7:41 am

I strongly oppose this.

I strongly oppose this limitation on qualified, talented therapists..

Commenter: Karla Lawrence, LCPC 9/11/19 8:06 am

I Strongly Oppose this Proposal

I strongly oppose this proposal, which marginalizes highly qualified professionals and limits access to care for the many clients who need their support.

Commenter: Magellan Health 9/11/19 8:07 am

Virginia Counselor License Portability

I am a retired Air Force Colonel with 26 years of active duty service. Following retirement I continue to serve as a mental health counselor licensed in Maryland and Virginia. I have received training at the Beck Institute, the Ellis Institute, the Gottman Institute, and the Baltimore-Washington Center for EFT. However, CACREP was not widely available, nor required, when I received my counseling degree. With the shortage of mental health counselors in the USA, I find it sad that competency is being judged based on the political pundants cry for a relatively new accreditation program that discriminates against highly skilled counselors. I understand the drive for improving the perception of the profession, but portability should not be the tool used to push it. Let the professional organizations work that out with NBCC. Virginia should stay out of the politics and maximize availability to mental health practitioners by supporting counselor portability for those licensed in other states. Let reasoned thought win the day. Thank you.

Commenter: Patricia J. Simpson, MS., LCPC, Pinnacle Center, LLC 9/11/19 8:17 am

I am opposed to Virginia's biased regulatory action that limits professionally educated counselors.

Virginia's limited and biased regulatory decision reduces the numbers of licensed counselors who will provide diagnosis and treatment to the citizens of Virginia. The need for mental health counseling is extremely important with the current opioid epidemic and the stress the American people are experiencing. Please reconsider.

Thank you.

Commenter: Joseph Lemmon, PhD, LCSW-C, CEAP 9/11/19 8:33 am

Adopt a fair and non-discriminatory Portability Act

I strongly favor the adoption of the fair and simple Portability Model of the American Counseling Association.

Commenter: Christopher Hall, LCPC 9/11/19 8:51 am

I strongly oppose this proposal

I oppose this proposal as it limits access of qualified mental health professionals to those in need of services.

Commenter: Allison Pastine 9/11/19 8:59 am

Strongly Appose this proposal

Given that there is quality education provided that is not CACREP affiliated, is reason enough not to pass this regulation. Thousands of very good providers would be affected. A grandfathering approach is more appropriate if necessary.

Commenter: Micaela Beaune 9/11/19 9:13 am

I strongly oppose

This impacts several, highly qualified mental health clinicians from getting employment. Mental health treatment is already hard to find for several seeking these services. Limiting the amount of clinicians, who have the clinical skills, from being able to get employed in the state, would not only impact clinicians, but also people seeking these resources.

Commenter: Holly Sater, LCPC 9/11/19 10:06 am

Virginia should adopt the fair and simple Portability Model of the American Counseling Association

I oppose any requirements by Virginia that disadvantage licensed counselors for not attending CACREP accredited institutions.

Commenter: Gretchen Williams, LCPC-S 9/11/19 10:11 am

I strongly oppose Virginia's biased regulation against licensed counselors

I believe that Virginia should adopt the fair and simple Portability Model of the American Counseling Association:

A counselor who is licensed at the independent practice level in their home state and who has no disciplinary record shall be eligible for licensure at the independent practice level in any state or U.S. jurisdiction in which they are seeking residence. The state to which the licensed counselor is moving may require a jurisprudence examination based on the rules and procedures of that state.

Gretchen Williams, LCPC-S

Commenter: Lillian Audette 9/11/19 10:41 am

Discriminatory towards non-CACREP programs

This proposal is biased and discriminatory against programs of long standing which are not CACREP accredited but fulfill all other requirements of accreditation. By discriminating based on CACREP accreditation, Virginia would be creating a defacto requirement for CACREP accreditation for counseling programs and their graduates.

Commenter: Katie Loomis, PsyD, Loyola University Maryland 9/11/19 11:53 am

I oppose this proposal

I strongly oppose this proposal. I am confident that Virginia would be greatly limiting their access to clinicians who are well-trained and eager to treat their most vulnerable by approving this regulation.

Commenter: Kris Wright, LCPC 9/11/19 12:12 pm

Opposing discrimination against non-CACREP accredited programs

To Whom It May Concern,

I am a resident of Northern Virginia and an LCPC working in Maryland, where I completed my education and first began the licensure process before moving to Alexandria. When I moved to Virginia in 2008, I considered applying for Virginia licensure but was discouraged when I discovered that my accumulated supervision hours would not be honored by my home state. Having been licensed in good standing for many years, I could submit for license now, and would be eligible, but have hesitated because I continue to see examples of VA policies being driven more by lobbyists than by quality practices. In this case, providing preference to a single accrediting body rather than nationally established and accepted guidelines puts Virginia constituents at a disadvantage - there are unmet needs, particularly in Virginia's Public Behavioral Health System, and these needs could be met by qualified and capable counselors educated at non-CACREP accredited schools.

As an Approved Clinical Supervisor in Maryland, I have personally supervised Licensed Graduate Professional Counselors pursuing independent licensure, including several from highly qualified

graduates from Johns Hopkins University and University of Maryland whose counseling psychology programs are not CACREP accredited but continue to provide all the foundational skills and education required to start out in a career as a counseling professional.

Virginia should adopt the fair and simple Portability Model of the American Counseling Association:

A counselor who is licensed at the independent practice level in their home state and who has no disciplinary record shall be eligible for licensure at the independent practice level in any state or U.S. jurisdiction in which they are seeking residence. The state to which the licensed counselor is moving may require a jurisprudence examination based on the rules and procedures of that state.

Thank you for considering the perspectives of clinical professionals working in this field.

Sincerely,

Kris Wright, LCPC

Commenter: Patrick LoPresto, Loyola University MD 9/11/19 12:31 pm

I strongly oppose this!

Commenter: James N. Tanner 9/11/19 12:58 pm

portability

I am in favor of Virginia adopting the Portability put forth by the ACA that includes counselors trained in any accredited institution not just CACREP ones.

James N. Tanner, LCPC

Commenter: Sarah Pargan, M.S. 9/11/19 1:10 pm

I oppose this proposal

I oppose any requirements by Virginia that disadvantage licensed counselors for not attending CACREP accredited institutions and believe that Virginia should adopt the Portability Model of the American Counseling Association (ACA).

Commenter: Emily Rutledge 9/11/19 1:27 pm

I oppose this proposal

Commenter: Madeline Rose, Loyola University Maryland 9/11/19 1:30 pm

I oppose this!

I strongly oppose this!

Commenter: Angelina Tolen, Loyola University Maryland 9/11/19 1:31 pm

I Strongly Oppose this!

I strongly oppose this!

Commenter: Natalie Konig, BS, Loyola University Maryland 9/11/19 1:41 pm

I oppose this proposal.

I strongly oppose this proposal. Virginia would be preventing well-trained clinicians from a multitude of opportunities, as well as limiting their own access to these clinicians.

Commenter: michael misterka, LCSW-C 9/11/19 1:47 pm

Adopt a fair and non-discriminatory Portability Act

Commenter: Courtney Gasser, University of Baltimore 9/11/19 2:11 pm

Strongly oppose

The current proposal, while offering several options for all licensed counselors, falsely suggests that licensed counselors who graduated from programs accredited by CACREP (who would need 3 years post-licensure experience) are more qualified than those who graduated from other programs (who would need 10 years post-licensure experience).

According to the current proposal, licensed counselors from other jurisdictions would be qualified for licensure by endorsement in Virginia if they either 1) meet *all* requirements for initial licensure in Virginia including specific coursework, supervised experience, and residency, or 2) have 2 years post-licensure clinical practice in counseling in the last 5 years, which includes teaching graduate courses in counseling, or 3) hold NBCC's Certified Clinical Mental Health Counselor (CCMHC) for which the NCC and therefore, effective 2024, graduation from programs accredited by CACREP, are prerequisites, or **4) have held an active license in the other jurisdiction for ten years, or 5) have held an active license in another jurisdiction for 3 years and have either graduated from a program accredited by CACREP or hold the NCC credential (which, as above, will be limited to graduates of programs accredited by CACREP effective 2024).**

There is no documented evidence that licensed counselors who graduated from programs accredited by CACREP are better prepared than their peers who graduated from other programs! Why then should the majority of licensed counselors who did not graduate from programs accredited by CACREP be required to show 7 more years of experience than their peers who graduated from programs accredited by CACREP?
The ACA Portability Plan (see above) is a significantly better option than this proposal.

Commenter: Madeline Leffler, University of Baltimore 9/11/19 2:22 pm

I Strongly Appose

I **strongly** appose.

There is no documented evidence that licensed counselors who graduated from programs accredited by CACREP are better prepared than their peers who graduated from other programs! Why then should the majority of licensed counselors who did not graduate from programs accredited by CACREP be required to show 7 more years of experience than their peers who graduated from programs accredited by CACREP?

The ACA Portability Plan is a significantly better option than this proposal.

Commenter: Christine Gunn, Univeristy of Baltimore 9/11/19 2:40 pm

I strongly oppose!

As as counseling psychology graduate student pursuing licensure in the state of Maryland, I am extremely interested in the possibility of being able to practice in the surrounding states, and the proposed regulations for licensure by endorsement in the state of Virginia are unnecessarily restrictive. Not only are these restrictions founded on exactly zero documented evidence, but the entirely false assumption that CACREP program graduates are more qualified than any other M.S. graduate is insulting and actively harmful to young counselors and the clients they will ultimately be tasked with helping. These "regulations" would provide *unequal* footing for *equally qualified* young counselors in the state of Virginia, unnecessarily restricting the pool of professionals available to the citizens seeking help in that state. There is *no evidence* to support these regulations, and the citizens of Virginia will pay the price for such a grave error in judgement.

Commenter: Lynn Bañez 9/11/19 3:13 pm

Strongly oppose proposal

I strongly oppose this proposal. We need to move the portability of our licenses forward.

Commenter: Rachel Friedman, LGPC 9/11/19 3:19 pm

Strongly opposed

This proposal discrimates against non-CACREP programs and it is unfair. The education and counseling skills acquired through non-CACREP programs is of the highest quality. We need to move forward with license portability and allow counselors to practice where they see fit regardless of the program they attended.

Commenter: Gaudenzia, Inc 9/11/19 3:40 pm

Counseling regulations

I oppose any laws and/or any regulations would prevent or impede anyone the opportunity to provide substance and/or mental health services to any client. Virginia needs to rethink this matter.

9/11/19 4:05 pm

Commenter: Bruke Tadesse Psy. D,LCPC,ACS,CAS. Family Health Center

Fairness in license transfer / LCPC

At least the DC MD VA should get an exemption from re licensing but the requirements to take the respective state seems prudent.

Commenter: Nazie Spurrier, LCPC 9/11/19 4:27 pm

STRONGLY APPOSED

This proposal discriminates against non-CACREP programs and it is unfair. The education and counseling skills acquired through non-CACREP programs is of the highest quality. We need to move forward with license portability and allow counselors to practice where they see fit regardless of the program they attended.

Commenter: DANA GRIMMEL LOYOLA UNIVERSITY OF MARYLAND 9/11/19 5:17 pm

APPOSED

As a current MS student in my last year at Loyola University of Maryland, I am very disheartened to hear that there is even a consideration to provide special privileges to counselors who attended a school with a different accreditation. Students who have attended many years of schooling and spent a tremendous amount of time and heart into their work are being mistreated simply because they did not attend a CACREP approved school? This matter is clearly political and business driven, which has no place in our field of serving others on a humanistic level. Please do not harm our fellow counselors who have worked so hard to get where they are with their only goal in mind to serve our communities. Let us do our job and serve others despite "CACREP" seal. I know this can seem as a challenging issue considering the headquarters in in Richmond, VA. However, my fellow counselors/ therapists/ practitioners and I humbly ask you to let us do our jobs, help others, and treat us all equally. Equality is vital in our profession, it is the core of our profession and our ethical standards.

Commenter: Jon Phillips, LGPC 9/11/19 5:33 pm

Wrong Choice

CACRP is not the only standard bearer in providing excellent counseling services to those in need. Virginia only hurts itself by adopting such a wrong-headed policy and discouraging skilled workers to move inside its borders.

Commenter: Laura Duncan 9/11/19 6:31 pm

What an INJUSTICE

Commenter: Jake Jackson-Wolf 9/11/19 6:58 pm

Strongly Opposed

This type of proposal is not inline with the values of the profession of professional counseling. The profession promotes equity and inclusion of a diversity of approaches. CACREP promoters are acting in ways inconsistent with these values.

There is no documented evidence that licensed counselors who graduated from programs accredited by CACREP are better prepared than their peers who graduated from other programs! Why then should the majority of licensed counselors who did not graduate from programs accredited by CACREP be required to show 7 more years of experience than their peers who graduated from programs accredited by CACREP?

The ACA Portability Plan (2016) is a significantly better option than this proposal!

Commenter: Sherry McClurkin, LCPC 9/11/19 8:38 pm

No Evidence for CACREP as Better

I graduated from one of the very few CACREP-accredited Counseling Master's programs in the State of Maryland. While I deeply value the training, knowledge, and education I received, there is absolutely no data supporting the implied idea that a CACREP-accredited program is better than a non-CACREP-accredited program. It baffles me why so many legislative decisions on Counselor licensure, including the current one before you about Portability, are based on CACREP vs. non-CACREP, when there are zero studies providing any evidence that one more fully prepares students to be effective counselors than the other.

It is implied by CACREP-accreditation getting preferential treatment in the current legislation on Portability. Not only is it implied that a CACREP-accredited program is better, it's implied it is immensely more complete by more than tripling the years in practice a Counselor/Therapist must be before they can have Portability if they graduated from a non-CACREP-accredited Counseling program.
Further, CACREP accreditation hasn't been available long enough to be established as a viable option. And it excludes the extensive training of Counseling Psychology programs which are usually Doctorates.

The only winner in favoring those who had the opportunity to graduate from a CACREP-accredited program is the CACREP organization itself. Their powerfully persuasive PAC is trying to earn credibility by swaying legislators. By giving into this manipulation, thousands of highly trained and talented Counselors/Therapists and Counseling Psychologists will be Excluded with no real, valid, fact-based reasoning.

Again, I graduated from a CACREP-accredited Counseling Master's program, so there is no personal or professional benefit to me to ask you to oppose the currently proposed Counselor License Portability Legislation before you.

I ask you to adopt the Fair and Simple Portability Model of the American Counseling Association.

Thank you.

Commenter: James Nelms 9/11/19 10:15 pm

Outrageous proposal

Kindly show us evidence to suggest that students who attended CACREP accredited institutions are better prepared to provide therapeutic services and we'll let this settle. To date there is no substantiated evidence for this. None. Zero.

Your broad based focus should be to promote mental health, to reduce stigmatization of those seeking counseling support, and to act as a catalyst for easier access to quality therapy from professionals who graduated from lauded institutions, like the University of Baltimore.

This proposal will have a wide-reaching impact on not only the lives of professionals and the people who need to be able to easier access therapy services, but will also affect the development of future counseling studies and academic journals that support research on new therapeutic and counseling methods.

Please reconsider and do the right thing.

Commenter: Joseph R. Schap, LCPC 9/11/19 10:17 pm

Opposed to discrimination based on CACREP

CACREP has attempted to create a second class of counselors out of the most experienced in Maryland. At the time I graduated (only about 10 years ago), there were virtually no CACREP accredited programs in Maryland. The only one in the Baltimore area was the pastoral counseling program at Loyola. By discriminating against graduates from other institutions, you are ensuring that you won't have experienced counselors. And even with a provision for "grandfathering" us more experienced counselors, the discriminatory language makes it clear to me, for one, that my expertise and experience is not welcome in Virginia.

Commenter: Pamela Gibson Jones 9/12/19 3:42 am

Opposed

Terrible idea. How can you justify limiting ones profession especially after they have put time, money and dedication into their counseling career. This proposal not only short changes the counseling professional but also the clients who benefit from the services provided . Please reconsider, it makes new counselors question whether they have made a good career choice and seasoned counselors question whether they want to remain in the counseling field.

Commenter: Tali Elitzur, LCPC, Maryland Counseling and Wellness 9/12/19 8:22 am

Opposed

I strongly oppose this proposed requirement to limit many clinicians who have been upstanding and valuable members and leaders within our field.

Commenter: Sara Battista, LCPC, LPC 9/12/19 9:00 am

Opposed.

Opposed.

9/12/19 9:20 am

Commenter: Susan P White LCPC

Strongly oppose

Virginia should adopt the fair and simple Portability Model of the American Counseling Association.

Commenter: Dominic Williams, Loyola University Maryland 9/12/19 9:26 am

Strongly Oppose

Bad decision

Commenter: Laura Winn, MA LPC NCC 9/12/19 9:55 am

STRONGLY OPPOSED- unfair, biased, and discriminatory proposal

This proposal is discriminatory for qualified professionals who obtained high quality degrees from universities that do not have CACREP accreditation. This proposal not only harms professionals who need to relocate to the state of Virginia but also the abundant amount of clients who are unable to locate professionals to obtain services. This proposal simply further exempts highly qualified professionals from other states and jurisdictions in assisting with the high demand for mental health an substance abuse services in Virginia.

Virginia should adopt the fair and simple Portability Model of the American Counseling Association in which a counselor who is licensed at the independent practice level in their home state and who has no disciplinary record shall be eligible for licensure at the independent practice level in any state or U.S. jurisdiction in which they are seeking residence. The state to which the licensed counselor is moving may require a jurisprudence examination based on the rules and procedures of that state.

Commenter: Victoria Engel 9/12/19 10:04 am

Strongly oppose restrictions

It is absolutely unfair to restrict thousands of excellent therapists who trained at non-CACREP accredited institutions with legislation. CACREP accrediation does not guarantee a therapist is good. That is as much of a personal journey and can be facilitated in many different programs.

Commenter: Lawrence Jones, LCPC 9/12/19 11:05 am

Strongly oppose

Strongly oppose

Commenter: Melissa Rivero 9/12/19 11:10 am

Strongly Opposed

The current proposal, while offering several options for all licensed counselors, falsely suggests that licensed counselors who graduated from programs accredited by CACREP (who would need 3

years post-licensure experience) are more qualified than those who graduated from other programs (who would need 10 years post-licensure experience).

According to the current proposal, licensed counselors from other jurisdictions would be qualified for licensure by endorsement in Virginia if they either 1) meet all requirements for initial licensure in Virginia including specific coursework, supervised experience, and residency, or 2) have 2 years post-licensure clinical practice in counseling in the last 5 years, which includes teaching graduate courses in counseling, or 3) hold NBCC's Certified Clinical Mental Health Counselor (CCMHC) for which the NCC and therefore, effective 2024, graduation from programs accredited by CACREP, are prerequisites, or 4) have held an active license in the other jurisdiction for ten years, or 5) have held an active license in another jurisdiction for 3 years and have either graduated from a program accredited by CACREP or hold the NCC credential (which, as above, will be limited to graduates of programs accredited by CACREP effective 2024).

There is no documented evidence that licensed counselors who graduated from programs accredited by CACREP are better prepared than their peers who graduated from other programs! Why then should the majority of licensed counselors who did not graduate from programs accredited by CACREP be required to show 7 more years of experience than their peers who graduated from programs accredited by CACREP?

The ACA Portability Plan is a significantly better option than this proposal! The Alliance for Professional Counselors fully supports portability for all counselors and the American Counseling Association's (ACA) 2016 Portability Plan. The ACA Portability Plan would permit counselors licensed at the independent level in one state (who do not have any disciplinary actions against them) to qualify for independent licensure in any other state in which they are seeking residence. Duly licensed counselors would be treated equally across the nation under this plan.

Commenter: Richard Henrisken Jr., Ph.D., LPCS, Indipendent Texas Counselor 9/12/19 11:10 am

Support the Virginia Portability Model

I want to express my support for the work the Virginia Board has done to address the licensure portability needs of professional counselors. As professional counselors we are a unique and distinct profession with specific training and supervision needs that are encapsulated in the CACREP training model. The fact that you have not only included CACREP as an appropriate training model but also have included a non-CACREP training model that ensures that current and future professionals are trained in the tradition of professional counseling with a professional counseling identity is to be commended. Your training model helps to protect all current licensees and helps to protect professional counseling into the future. In my research on counselor supervision, I have found that there is a tremendous disparity across the 53 licensure jurisdictions when it comes to post-graduate supervised experience requirements. Your requirement for 2 years of post licensure experience can help to bridge that gap in post-graduate supervised experience for licensure and as the profession and Virginia moves toward a more universal post-graduate supervised experience model. Virginia, as the first state to license professional counselors, has always been a leader in the professional development of our unique and distinct profession. It is my hope that you will adopt the present model so that you will stand as the beacon of light for other states and jurisdictions to model.

Commenter: Mark Benander, PhD, LMHC 9/12/19 11:19 am

Strongly Opposed

There is no documented evidence that licensed counselors who graduated from programs accredited by CACREP are better prepared than their peers who graduated from other programs! Why then, should the majority of licensed counselors who did not graduate from programs accredited by CACREP be required to show 7 more years of experience than their peers who graduated from programs accredited by CACREP?

I recommend the ACA portability act:

actual text of the ACA plan and FAQs https://www.counseling.org/knowledge-center/aca-licensure-portability-model-faqs#

There is no evidence that CACREP should be the only viable accrediting agency, or that CACREP schools do any better than other regionally accredited schools that follow the original 60-credit training model.

Thank you.

Mark Benander

Commenter: lynn perlman Ph.D Dean of Graduate Studies, Boston Graduate School o Psych, 9/12/19 11:44 am

Stronly oppose

This is a territory and economic issue. There is no evidence that CACREP trained counselors are any better equipped than other counselors and no reason that non CACREP trained counselors should have to meet addition standards.

Commenter: Mayra Schneider, LGPC, CAC-AD 9/12/19 11:48 am

Strongly oppose

Commenter: Quillian Murphy, LMHCA....Graduate of a CACREP program 9/12/19 12:27 pm

OPPOSE!!!!

Consider the more inclusive ACA proposal!

Commenter: Julie MacEvoy 9/12/19 12:27 pm

Strongly Oppose

Commenter: Penny Haney, mental health counseling program, Boston College 9/12/19 1:14 pm

Strong oppose!

I strongly oppose the proposed regulations for portability of license in VA. I support the ACA and Alliance for Professional Counselors fair and inclusive plan. There is simply no data to support the VA proposed regulations requiring professionals from non-CACREP programs to have 7 more

years of work experience than professionals from CACREP programs to make their license portable --- there is absolutely no evidence that CACREP-accredited training programs are better than non-CACREP.

Commenter: Jane Okech, PhD, University of Vermont 9/12/19 1:20 pm

Strongly support

I strongly support the CACREP training model and view our profession of professional counseling as unique and distinct from the other mental health professions. I support rules and standards that further this recognition.

Commenter: Rachel Reinders, LPC 9/12/19 1:25 pm

Counseling is Diverse

I oppose this measure as it puts too strong of an emphasis on CACREP standards and accreditation. CACREP standards are certainly strong, but many different types of programs prepare well-educated and effective counselors. There is no evidence that CACREP educated counselors are more effective or better prepared than counselors who graduate from other programs. Having more restrictions on becoming a counselor does not help address the need for professionals to be able to become licensed in areas that desperately need their services. Adopting a less restrictive timeline for receiving reciprocity would be beneficial.

Commenter: Corey Ward, University of Baltimore 9/12/19 1:31 pm

Oppose

Disparate impact to non CACREP counselors, particularly recent graduates considering NCC qualifications would be dependent on CACREP accreditation in 2024. Since NCC is a prerequisite for the (CCMHC), **endorsement B & D of section 18VAC115-20-45, Prerequisites for licensure by endorsement,** would become invalid.

This would effectively mean within 5 years non CACREP counselors would need 10yrs of experience to be licensed, without supporting evidence CACREP counselors are better prepared than non CACREP counselors.

We advocate for high counseling standards and fair, useful portability. This isn't it.

Commenter: Claudia Pyland, Ph.D., L.P. Texas Woman's University 9/12/19 1:31 pm

Strongly opposed

I am strongly opposed to this proposed regulation. It is discriminatory against competent, qualified counselors who did not graduate from CACREP programs. There is no evidence that CACREP educated counselors are more effective or better prepared than counselors who graduate from other programs.

Commenter: Meg Connor, MA LMHC, Div. Of Counseling and Psychology, Lesley University 9/12/19 1:33 pm

Oppose: Discriminatory, unsubstantiated preference for CACREP grads over other qualified clinicianss

Commenter: Kerri McCullough 9/12/19 1:43 pm

SUPPORT for the CURRENT VIRGINIA PORTABILITY MODEL

I want to express my support for the work the Virginia Board has done to address the licensure portability needs of professional counselors. As a graduate from a CACREP masters and doctorate program I support the steps that the state of Virginia is taking to ensure that they move forward in a fair way. Also want to point out that I am currently licensed as a professional counselor in Virginia, the District of Columbia, and Maryland; I did not have a problem with the two year waiting period.

I wholeheartedly believe that as professional counselors our field is very distinct with specific training and supervision needs. These needs for our field are encompassed in the CACREP training model.

I commend the board on the fact that they have gone to great pains to been sure that currently licensed professional counselors that would want to have a license in Virginia would be able to do so as long as the classes that have been taken meet the requirement.

It is my belief that this board has done the right and fair thing by including CACREP as an appropriate training model but also by including non-CACREP training model that ensures that current and future professionals are trained in the tradition of professional counseling with a professional counseling identity.

This process works to protect all current licensees and helps to protect professional counseling for the future. Virginia, as the first state to license professional counselors, has always been a leader in our profession. It is my hope that you will adopt the present model and continue to be that leader.

Commenter: Jeffrey Crane 9/12/19 2:23 pm

Support for the Virginia Proposal

I support the Virginia State Board proposal addressing the licensure portability needs of professional counselors.

Commenter: Nilda M Laboy, PsyD, William James College 9/12/19 2:24 pm

Strongly opposed to this proposal

I am the Director of the M.A. in Clinical Mental Health Counseling at William James College and the Chair of the Counseling and Behavioral Health Department. We had M.A. programs in Counseling Psychology from 2007 to 2016, when we collapsed and converted them to Clinical Mental Health Counseling. To date, we have graduated over 500 individuals, the great majority of which are licensed mental health counselors or licensed professional counselors in many states. We are not a CACREP accredited program, mainly due to the faculty restrictions they impose.

In Massachusetts, out of the 30+ counseling masters programs in existence, only 2 mental health counseling programs are CACREP accredited. I do not have exact figures (the MA Board of Allied Mental Health and Human Services Professions may have them), but I would venture that the majority of 11,000+ licensed mental health counselors in Massachusetts did not graduate from CACREP accredited programs. **Is the Commonwealth of Virginia then saying that our LMHCs need 10 years experience to equal the qualifications of a recent CACREP accredited program graduate to practice as a counselor in Virginia?**

I support the efforts to maintain a counselor identity without discriminating against those who have studied in counseling programs and are licensed as counselors.

Virginia should adopt the fair and simple Portability Model of the American Counseling Association:

"A counselor who is licensed at the independent practice level in their home state and who has no disciplinary record shall be eligible for licensure at the independent practice level in any state or U.S. jurisdiction in which they are seeking residence. The state to which the licensed counselor is moving may require a jurisprudence examination based on the rules and procedures of that state."

Commenter: Sylvia Marotta-Walters 9/12/19 3:07 pm

LPC Portability

I am opposed to the proposed rule on several grounds. There is no research to support that any number of years' experience, whether two or ten years, can compensate for curricular deficiencies. This is an arbitrary requirement with no data foundation.

Setting a CACREP standard would be a good idea, only if there were provisions for accepting the credentials of counselors who received their education and degrees prior to there even being a CACREP, or in geographic areas where access to CACREP programs was limited or nonexistent. Since there is no such provision, I think it's premature to require this. Most professions when they take this step provide for equivalencies for a set period of time so as not to disenfranchise licensed professionals whose record is exemplary in their current state but who want to re-locate. I see this as a restraint of trade issue.

There is already a shortage of mental health providers across the country. The proposed rule would have the unintended consequence of decreasing the pool even more, at a time when we are experiencing a dire shortage of people qualified to treat the crisis we are in with opioids alone, not to mention school shootings, mass disasters, and rampant child maltreatment.

Commenter: David Julius Ford, Jr., Ph.D., LPC, NCC, ACS 9/12/19 3:14 pm

Strongly support Virginia's model

Greetings, I am a proud LPC in VA and I know that our state has always been at the forefront of establishing and protecting our profession. I am also a graduate of a CACREP-accredited program in VA and taught in another CACREP-accredited program in VA. Currently, I am teaching in the oldest CACREP program in NJ and my students are interested in going to other states, especially VA because of my time there and because of the top-notch CACREP-accredited Doctoral programs. They will also seek licensure in VA. As such, I strongly support Virginia's portability model. It has our profession's identity as its foundation, makes room for currently licensees to remain licensed, and provides a smooth process for others from other states to come to VA. VA has a large military population and graduates from CACREP programs who are impacted by the military will come to VA and not have to jump through so many hoops to get licensed in VA. I hope VA continues to be at the forefront of leadership and adopt this model.

Commenter: Thom Field, PhD, LPC 9/12/19 4:15 pm

In support (Virginia LPC)

I am a Virginia LPC who has sought and attained counseling licensure in two other states (MA, WA). Having gone through the reciprocity process several times as a Virginia LPC, this proposal establishes fair "licensure by endorsement" provisions for licensed counselors who are relocating to Virginia. There are several options given for endorsement, that include (a) 2 years of practice at the highest licensure level, (b) CCMHC credential, (c) NCC credential and CACREP accreditation of educational program. These options appear fair and are roughly consistent with the portability plan endorsed by AACSB-ACES-AMHCA-NBCC. Note that, contrary to most critics, graduation from a CACREP accredited program is only one of three pathways to endorsement. I highly support.

Commenter: Simone Warrick-Bell 9/12/19 4:34 pm

Strongly Oppose

Strongly Oppose. The CACREP system is immensely unfair to those who attended accredited universities.

Commenter: Amy Rottier, Congruent Counseling Svcs 9/12/19 5:30 pm

Strongly Oppose

Commenter: Candace M McLain LPC (MI, CO) ACS 9/12/19 5:31 pm

In support

Commenter: Jennifer Molinari, LCPC, NCC 9/12/19 5:33 pm

Strongly oppose!

Commenter: Christine E. Cassidy, M.A., LMHC, Cambridge College 9/12/19 5:36 pm

Strongly opposed bias toward CACREP

I strongly oppose the current proposal, which is biased toward CACREP program graduates and encourage Virginia to support the American Counseling Association Licensure Portability Model: *A counselor who is licensed at the independent practice level in their home state and who has no disciplinary record shall be eligible for licensure at the independent practice level in any state or U.S. jurisdiction in which they are seeking residence. The state to which the licensed counselor is moving may require a jurisprudence examination based on the rules and procedures of that state.*

Christine E. Cassidy, M.A., LMHC

Assistant Dean of Field Experience
School of Psychology and Counseling
Cambridge College
500 Rutherford Avenue
Boston, MA 02129
617-873-0266

Commenter: Kerri Weise Augusto 9/12/19 6:01 pm

Strongly Oppose. Do not divide. Unite.

There is no documented evidence that licensed counselors who graduated from programs accredited by CACREP are better prepared than their peers who graduated from other programs. Why then, should the majority of licensed counselors who did not graduate from programs accredited by CACREP be required to show 7 more years of experience than their peers who graduated from programs accredited by CACREP?

At present our society is experiencing a significant shortage of mental health counselors. The ACA Portability Plan is a significantly better option for addressing this national crisis than the existing proposal.

The existing proposal is clearly a result of a strong CACREP lobby, intended to promote their own agenda rather than address the mental health crisis in this nation.

Case in point, the MHC program at Becker College is only 4 years old. Hence, it is not eligible for CACREP accreditation simply by virtue of its age. This program limits enrollment to 15 students in order to ensure close supervision in its on-site training clinic. Students are involved in supervised (one-way mirror, video and audio) counseling, working as co-therapists with licensed providers with over 25 years experience *before* they begin practicum. Practicum is held in a real clinic, with real clients, and live supervision, not via role play. Students enter internship with well over the required number of supervised practice hours. Further, the courses in the program align with all CACREP standards and meet all learning objectives. Students are engaged in meaningful research with the Department of Public Health or UMASS Medical School, contribute psychoeducational articles to local publications, and receive additional practical experience in DBT and social skill training (social thinking). 100% of the graduates of this program have gone on to be successfully licensed in MA, GA, and NH.

These are not second-class mental health providers, and any patient in VA (or any other state) would be well served by these well-trained professionals.

CACREP must stop lobbying for self-serving causes that do not serve the needs of students, patients, or counselor educators. We must unite as mental health providers, not divide.

Commenter: Mary Carroll, LCPC 9/12/19 7:56 pm

Oppose this stance

I strongly oppose the stance of Virginia which is calling for exclusion of non CACREP independently licensed counselors. My educational background is that I graduated with my Masters Degree from The University of Baltimore's Applied Psychology-Counseling Track in 1997. Finished my Post Masters Certificate in Professional Counseling Studies also from University of Baltimore. I have been an LCPC for 8 yrs. My peers who have graduated from a CACREP program do not have any difference in skill level than I do. To limit my portability to practice in other states based on faulty research regarding CACREP superiority is unjust and criminal. I urge the

state of Virginia to review the research which disputes the claims of CACREP superiority and make their decision based on the facts.

Commenter: Sue Motulsky, Lesley University 9/12/19 8:14 pm

Strongly Oppose

Strongly oppose this measure.

Commenter: Michael Greelis, PhD, LPC, LMFT 9/12/19 8:17 pm

Oppose

Once again, the CACREP organization seems to be restricting public access to counseling by imposing licensing requirements that align with CACREPs accreditation process. This nibbling away at those able to provide services discourages graduate programs not endorsed by CACREP. That, in turn, limits the number of qualified counselors available to provide services.

State licensing is in place and can be used for portability as the ACA proposal makes clear.

Commenter: Eve Adams 9/13/19 12:59 am

Counselor License Portability

There is no evidence that licensed counselors who graduated from CACREP-accredited programs are better prepared than their peers who graduated from other programs. Therefore it is a restraint of trade to make the majority of licensed counselors who did not graduate from CACREP-accredited programs be required to show 7 more years of experience than their peers who graduated from CACREP accredited programs. The ACA Portability Plan is a significantly better option than this proposal!

Commenter: Anthony Isacco, Chatham University 9/13/19 8:46 am

Opposed

There is no documented evidence that licensed counselors who graduated from programs accredited by CACREP are better prepared than their peers who graduated from other programs! Why then, should the majority of licensed counselors who did not graduate from programs accredited by CACREP be required to show 7 more years of experience than their peers who graduated from programs accredited by CACREP?

I strongly oppose this plan!

Anthony Isacco, PhD

Chatham University

Commenter: Connie Elkins, Bluefield College 9/13/19 10:01 am

I agree with the CACREP requirements for a portability model

CACREP has created a training model that can strengthen counselor training and unite counselors. Using CACREP training standards as a metric for license portability makes sense. These standards are already in place, and if Virginia Board of Counseling creates its own requirements for portability, they will be almost identical to training standards already set in place by CACREP. I agree that the counseling profession needs more unity in order to achieve the goals of the profession. CACREP is a response to the need for unity. If we do not recognize the validity of CACREP training, then what will be we as a profession? Continue with the status quo of diverse state requirements and definition of services? Or perhaps form differing accreditation standards more palatable to institutions who decline to pursue CACREP standards? Declining the CACREP requirement for license portability makes the process unnecessarily more complicated.

Commenter: Sidney Trantham / Lesley University 9/13/19 10:37 am

OPPOSED

As the head of a master's level mental health counselor program that prepares professionals to work as Licensed Mental Health Counselors (LMHCs) in Massachusetts, ***I am writing to encourage Virginia to oppose the current proposal related to CACREP requirements for counselor license portability.***

The current proposal, while offering several options for all licensed counselors, falsely suggests that licensed counselors who graduated from programs accredited by CACREP (who would need 3 years post-licensure experience) are more qualified than those who graduated from other programs (who would need 10 years post-licensure experience).

There is no documented evidence that licensed counselors who graduated from programs accredited by CACREP are better prepared than their peers who graduated from other programs! For example, it is rare to find CACREP accredited programs in all of the New England states, in yet we have many mental health counselor training programs that produce exceptional licensed mental health counselors. There are approximately 36 master's level training programs in Massachusetts and only seven of them are CACREP accredited. We know that programs in Massachusetts that are not CACREP accredited are producing exceptional mental health counselors! In addition, there are other accreditation bodies for mental health counselor training programs such as the Masters in Counseling and Psychology Accreditation Council (MPCAC) that set standards for counselor training and education and have accredited programs in approximately 22 states. Why then, should the majority of licensed counselors who did not graduate from programs accredited by CACREP be required to show 7 more years of experience than their peers who graduated from programs accredited by CACREP? **Finally, at time when there is clear evidence of the need for more mental health counselors across this nation, why support a licensing requirement that prohibits well trained, licensed mental health counselors from practicing? The CACREP proposal does not make sense.**

The Alliance for Professional Counselors fully supports portability for all counselors and the American Counseling Association's (ACA) 2016 Portability Plan. The ACA Portability Plan would permit counselors licensed at the independent level in one state (who do not have any disciplinary actions against them) to qualify for independent licensure in any other state in which they are seeking residence. Duly licensed counselors would be treated equally across the nation under this plan. Please see their website for more information about ACA's model if you have not already done so:

https://www.counseling.org/knowledge-center/aca-licensure-portability-model-faqs#

I hope that Virginia (and other states) will support a more inclusive approach to license portability and oppose CACREP's attempt to unduly and unfairly influence mental health counselor training and the counseling profession.

Sincerely,

Sidney M. Trantham, Ph.D.

Associate Professor / Division Director

Division of Counseling & Psychology

Lesley University

Cambridge, MA

Commenter: Rebekah Gildersleeve 9/13/19 11:00 am

Oppose

Oppose

Commenter: Noreen Ammons, LCPC/LCADC 9/13/19 11:58 am

Oppose discrimination CACREP

Not fair to discriminate because of the schools!!! Why drive practitioners away from the field when so many citizens are in need of mental health assistance now? Need more shootings??

Commenter: Peiwei Li, Lesley University 9/13/19 1:27 pm

Oppose

Students shouldn't carry the burden of power play through legislative meanuvers. We need to ask: how benefit from this proposal? who are getting hurt? and why?

Commenter: Darlene Brannigan Smith, University of Baltimore 9/13/19 1:38 pm

University of Baltimore Opposes Changes

September 10, 2019

To Whom it May Concern:

In response to the NOIRA Action 5230 / Stage 8544 (http://www.townhall.virginia.gov/l/ViewStage.cfm?StageID=8544), we are writing this letter to ask you to reject the changes proposed in this action that would unduly restrict or limit counselors from other jurisdictions from securing licensure in the state of Virginia without unnecessary hardship, thus preventing qualified professional counselors from obtaining Virginia LPC licensure and providing services to Virginia's public.

From our read of the document, these proposed changes to Virginia Board of Counseling regulations for licensure portability suggested in this action would marginalize counselors who do not graduate from CACREP -accredited programs (who are the majority of counselors nationwide). The current proposal, while offering several options for all licensed counselors, falsely suggests that licensed counselors who graduated from programs accredited by CACREP (who would need 3 years post-licensure experience) are more qualified than those who graduated from other programs (who would need 10 years post-licensure experience). A better and more inclusive plan is offered by the American Counseling Association (ACA), the professional organization representing *all counselors.* (https://www.counseling.org/knowledge-center/aca-licensure-portability-model-faqs#)

The current proposal indirectly limits graduates of non-CACREP-accredited programs (the majority of programs in the country) by requiring that they either

1) meet all requirements for initial licensure in Virginia including specific coursework, supervised experience, and residency, (which indirectly preferences CACREP standards) or
2) have 2 years post-licensure clinical practice in counseling in the last 5 years, which includes teaching graduate courses in counseling, or
3) hold NBCC's Certified Clinical Mental Health Counselor (CCMHC) for which the NCC and therefore, effective 2024, graduation from programs accredited by CACREP, are prerequisites, or
4) have held an active license in the other jurisdiction for **10 years**, or
5) have held an active license in another jurisdiction for **3 years** and have either graduated from a program accredited by CACREP or hold the NCC credential (which, as noted above, will be limited to graduates of programs accredited by CACREP effective 2024).

Although not stated explicitly, these restrictions clearly preference graduates of CACREP programs when there is no substantive evidence that CACREP graduates are better prepared than their peers to become licensed counselors. In fact, there are other accrediting bodies (notably, the Masters in Psychology and Counseling Accreditation Council, or MPCAC) that accredit counseling and counseling psychology programs. Moreover, most state licensing boards require only regional accreditation *of the institution* in which the counseling program resides – not accreditation of the program itself.

The University of Baltimore (UB) is an institution with a thriving non-CACREP accredited counseling psychology program that prepares professional counselors for licensure. Our students boast a 98% pass rate on the National Counselor Exam. We have many current and former students who wish to practice in Virginia beyond their time at UB, providing necessary mental health services to the public in Virginia. We are concerned about the continued efforts in Virginia to restrict licensure in ways that would exclude many well-prepared counselors (including our graduates) from around the country from obtaining licensure as easily as their CACREP-graduate peers. Licensure requirements in Maryland do not restrict graduates of Virginia counseling programs from seeking licensure in Maryland based on program accreditation. Furthermore, restrictions between states interrupt the good efforts being made toward national licensure portability for *all counselors*.

Again, we urge you to reject these changes to licensure by endorsement regulations in Virginia's counseling regulations.

Thank you for your time and attention to this matter.

Sincerely,

Darlene Brannigan-Smith, Ph.D.

Executive Vice President and Provost

University of Baltimore

Christine Spencer, Ph.D.

Dean

College of Arts and Sciences

Sharon Glazer, Ph.D.

Chair

Division of Applied Behavioral Sciences

Courtney Gasser, Ph.D., L.P., N.C.C.

Program Director

Master's of Science in Applied Psychology-Counseling Psychology Concentration

Commenter: Dr. Margo Jackson, Fordham University 9/13/19 2:54 pm

Strongly oppose limits to single accreditation body

The aim to support quality mental health care is sound, but it does not serve the public well to limit to a single counselor accreditation body (CACREP only); the need is great for well qualified counselors, including those well prepared by programs with other fine accreditation.

Commenter: Michael Cadaret, Chatham University 9/13/19 8:16 pm

Strongly oppose

There is no documented evidence that licensed counselors who graduated from programs accredited by CACREP are better prepared than their peers who graduated from other programs! Why then should the majority of licensed counselors who did not graduate from programs accredited by CACREP be required to show 7 more years of experience than their peers who graduated from programs accredited by CACREP?

The ACA Portability Plan (see above) is a significantly better option than this proposal.

Commenter: Peggy Brady-Amoon, PhD, LPC, Alliance for Professional Counselors 9/14/19 8:38 am

Strong opposition to the current proposal

The Alliance for Professional Counselors (APC), a national organization of counselors and counselor educators that supports interdisciplinary cooperation and licensure portability, strongly urges you to reject the current proposal for licensure by endorsement. The current proposal is an improvement over earlier proposals because it offers options for licensure in Virginia for all licensed counselors.

However, APC strongly objects to current proposal. We particularly object to the provision that licensed counselors who graduated from programs accredited by CACREP would qualify for Virginia licensure with 3 years post-licensure experience while licensed counselors who graduated from programs that are not affiliated with CACREP would need 10 years post-licensure experience. There is no evidence to support this proposed discrepancy.

Furthermore, this proposal would harm the public by unnecessarily limiting the number of licensed counselors who would qualify for licensure (and therefore professional counseling work) in Virginia.

This proposal would also harm the majority of licensed counselors who graduated from programs that are not affiliated with CACREP by making it seem, despite lack of evidence, that they are less qualified. We call your attention to the two successive Virginia Economic Impact Analyses (2016, 2017) for further information. Furthermore, as Virginia has historically been a leader in the profession, this proposal could set a negative precedent.

The American Counseling Association's (ACA) 2016 Portability Plan is a significantly better option for portability than the current (or previous) proposals. The ACA Portability Plan would permit counselors licensed at the independent level in one state (who do not have any disciplinary actions against them) to qualify for independent licensure in any other state in which they are seeking residence. Duly licensed counselors would be treated equally across the nation under this plan. Compared with this – and earlier proposals - the ACA plan respects all counselors, the licenses they hold, and doesn't require a waiting period.

We fully respect that these decisions are within the purview of the Commonwealth of Virginia. However, APC asks your consideration because these proposed regulations are detrimental to the citizens and economy of Virginia. Furthermore, we urge you to consider the national implications of these decisions and take action to prevent the adoption of the current portability proposal in Virginia and all proposals to restrict Virginia counselor licensure to graduates of programs accredited by CACREP.

Thank you for your consideration.

Respectfully,

Peggy Brady-Amoon, PhD, LPC
President, Alliance for Professional Counselors
www.apccounseloralliance.org
&
Associate Professor
Department of Professional Psychology & Family Therapy
Seton Hall University
South Orange, NJ 07079

Commenter: Roger Sandberg, LCPC, LPC Psychotherapy Services, LLC 9/15/19 5:42 pm

Strongly Oppose

I am licensed in Virginia as an LPC, as well as in Maryland as an LCPC. It doesn't make sense why Virginia continues to pursue an alliance with CACREP, which, by it's stated mission statement is discriminatory and excludes well-trained and highly qualified licensees. A number of the most highly recognized graduate programs of counseling psychology in the nation are not CACREP-accredited programs, and yet produce some of the most highly qualified graduates in our profession.

Virginia, please leave it to the regional accrediting organizations (who's purpose is to monitor and accredit undergraduate and graduate programs), as well as the NBCC (who's licensing exam is the standard for professional counselors nationwide), to do their jobs. Additionally, the ACA has a very sensible, inclusive portability plan that works for counselors nationwide. I urge Virginia to reject this CACREP power grab, and instead, lead the pack nationwide by adopting the ACA's portability plan.

9/16/19 9:59 am

Commenter: Beth Greenberg, Becker College

Opposed to Current Proposal

The proposal incorrectly implies that counselors from CACREP accredited programs may be more highly qualified than those from non-CACREP accredited programs. There is no empirical evidence to support this (see the following research results: https://pdfs.semanticscholar.org/c39d/d6d5a4b812687fdca134b5e73d6cd9761732.pdf). The state of Virginia should follow the portability guidelines proposed by the American Counseling Association (ACA). Any alternative restrictions regarding license portability will only serve to reduce the number of qualified mental health counselors who are able to practice in the state, further limiting the availability of mental health services to its citizens.

Commenter: Winnie D. Moore, MA, LCPC, LPC, NCC 9/16/19 12:26 pm

Advocacy Alert - Insure Fairness in License Transfer to Virginia

I oppose this action.

Commenter: Becker College 9/16/19 12:34 pm

Opposed to Current Proposal

The current proposal suggests that there is a need to emphasize the difference between licensed counselors who graduated from programs accredited by CACREP, and those who have not. The focus of the mental health counseling profession would then become skewed and further divide the profession. As mental health counselors, there is a great need for the services provided. There is no evidence to support that CACREP accredited programs provide better professionals to the field. This proposal would be harming the population we swore to protect, and do no harm.

Commenter: Kayla Watson, University of Baltimore 9/16/19 12:49 pm

I strongly Oppose

I oppose any requirements by Virginia that disadvantage licensed counselors for not attending CACREP accredited institutions!

Commenter: Kelly Tyler 9/16/19 1:08 pm

Strongly Oppose!

Your proposal implies that licensed counselors who graduated from programs accredited by CACREP are better prepared for practice than licensed counselors who graduated from programs that are not accredited by CACREP. I **strongly** urge you to re-evaluate this. There is no empirical evidence to prove that this is true. As a student in a fairly new program at Becker College in Massachusetts (that is in line with CACREP standards), you would be contributing to an (already) concerning shortage of mental health professionals. This could create a ripple effect leading to further clinician burnout and increasingly problematic decreases in clinician availability to address the increasing need for mental health services in the United States. It's simply ludicrous to assume that lack of accreditation by CACREP means lack of experience. Please focus your efforts on license portability instead to ensure that licensure can be transferred from state to state.

Commenter: Megan Malandro, Seton Hall University 9/16/19 1:42 pm

Strongly Oppose!

I strongly oppose the current proposal. The importance of mental health professionals in today's society is paramount. Under the provision that licensed counselors who graduate from programs accredited by CACREP would qualify for licensure with 3 years post-licensure experience, while those licensed counselors who are not affiliated with CACREP would need 10 years post-licensure experience would be detrimental to the field. Not only would this harm those licensed counselors who have already graduated from programs that are not affiliated with CACREP, this would further impact students such as me who are now pursuing a career in the field. This would only further deter individuals from pursuing a career in mental health. Considering there is no empirical evidence that licensed counselors who graduated from CACREP accredited programs are better suited that those who did not, is reason enough to forgo this proposal. I support licensure portability and would support reconsidering this current proposal.

Commenter: Jennifer Q. Morse, PhD; Chatham University 9/16/19 2:49 pm

Strongly oppose

I oppose this measure as it over-emphasizes CACREP standards and accreditation. Many different types of programs prepare well-educated and effective counselors, not just CACREP. There is no evidence that CACREP educated counselors are more effective or better prepared than counselors who graduate from other programs. Requiring licensed counselors who did not graduate from CACREP programs show 7 more years of experience than their peers who graduated from programs accredited by CACREP unnecessarily restricts qualified providers.

I strongly oppose this proposal.

Commenter: Rex Stockton, Indiana University 9/16/19 2:56 pm

Counselor Licensure

I am a counselor educator and I have trained school counselors and mental health counselors at the masters level for many years. I also serve on the Indiana state board, Professional Licensing Agency, that licenses mental health workers including counselors. I strongly believe in license portability. We have done that in Indiana. We did it without questioning the status of the program that is licensed by another state. I fully support the ACA plan that allows licensed counselors to be treated equally across the nation. I have participated in many accreditation site visits for CACREP. I have also done a few for non CACREP programs. I have not found any difference in the quality of the training.

Rex Stockton

Chancellors Professor

Commenter: Trish Hernandez 9/16/19 3:50 pm

Oppose

I oppose this proposal.

This proposal prevents well trained and competent professionals from providing services. This proposal will likely hamper relocating credentialed professionals.

Ultimately, this proposal limits resources for constituents.

Trish Hernandez, PsyD, LISAC
Ottawa University
Director, Graduate Studies in Counseling
Professor of Counseling

Commenter: Wendy Kraus, LCPC/Owner Coastal Counseling & Wellness 9/16/19 4:44 pm

Opposed to legislation

Strongly opposed to this legislation as it unfairly limits counselors from Maryland.

Commenter: Seton Hall University 9/16/19 5:04 pm

Stongly opposed

I strongly oppose the current proposal to favor license candidates from CACREP accrediited programs over qualified candidates from other counseling training programs. There is **no empirical evidence** to support the notion that graduates from a program that is CACREP accredited are better prepared than graduates from other programs. Therefore it is not only egregious and unsubstatiated to discriminate between license applicants in this way, but it is also creating a falsehood and actively misleading the public. I strongly urge you to opposed that proposal!

Sincerely,

Margaret Farrelly, PhD

Commenter: Jody Kulstad, Seton Hall University 9/16/19 5:18 pm

Oppose

There is no evidence to support that a CACREP graduate is better prepared than non-CACREP graduates. Further, testing data reveals that Non CACREP students score higher than CACREP graduates on the NCE and NCMHCE (King), which further shows that this action is ill advised with no clear basis.

Commenter: Mary Harrell 9/16/19 8:40 pm

Strongly oppose

I strongly oppose this legislation. It is discriminatory and has no basis in research. It assume facts not in evidence, that graduates from non CACREP universities are lacking in expertise compared to those graduating from CACREP programs despite the rigorous review of coursework, practice and intern experience they undergo to obtain their license. It does nothing but promote division within our profession. Many elite schools in Maryland are not CACREP. I have supervised interns from CACREP and non CACREP institutions and have not found a difference in their course preparation.

Commenter: Austin Widmer 9/16/19 9:02 pm

Strongly Oppose

Good policy should follow established research, and established research does not endorse the need for a program to be CACREP accredited to be a strong program. Virginia will deny itself competent clinicians with the suggested legislation, and by extension deny its people access to mental health services.

Commenter: MaxBet 9/17/19 7:08 am

Best

MaxBet Casino https://maxbetcasino.net/ allows you to play for real money and for free. If you want to play for free, just log in to the portal and select this function in the game. For gambling for money registration is required. The advantage of entering personal information into the MaxBet system is that all the latest news and upcoming promotional offers come to visitors via e-mail or SMS notification to the number indicated when registering on the website.

Commenter: Deanna Hamilton, Chatham University 9/17/19 10:02 am

I strongly oppose this plan!

Requiring 7 more years of experience for counselors who did not graduate from CACREP accredited programs is **BAD** for counselors, for the many people (and their families) who are in need of services, and for the field of counseling/psychology. Additionally, there is **NO** documented evidence that licensed counselors who graduated from programs accredited by CACREP are better prepared than their peers who graduated from other programs.

This requirement is misguided, does more harm than good, and I strongly oppose it.

Deanna Hamilton, PhD

Chatham University

Commenter: Michael Ellis, University at Albany, SUNY 9/17/19 10:14 am

Strongly Oppose

I strongly oppose the proposed regulations for licensure by endorsement. In essence, this proposal is an attempt by CACREP to restrict trade by clearly favoring counselors to be eligible for licensure if they graduated from a program accredited by CACREP or hold the NCC credential (access to which will be limited to graduates of programs accredited by CACREP effective 2024). The current proposal, while offering several options for all licensed counselors, falsely suggests that licensed counselors who graduated from programs accredited by CACREP (who would need 3 years post-licensure experience) are more qualified than those who graduated from other programs (who would need 10 years post-licensure experience).

There is no documented evidence that licensed counselors who graduated from programs accredited by CACREP are better prepared than their peers who graduated from other programs! Why then, should the majority of licensed counselors (who did not graduate from programs

accredited by CACREP) be required to show 7 more years of experience than their peers who graduated from programs accredited by CACREP?

The ACA Portability Plan is a significantly better option than this proposal!

The Alliance for Professional Counselors fully supports portability for all counselors and the American Counseling Association's (ACA) 2016 Portability Plan. The ACA Portability Plan would permit counselors licensed at the independent level in one state (who do not have any disciplinary actions against them) to qualify for independent licensure in any other state in which they are seeking residence. Duly licensed counselors would be treated equally across the nation under this plan.

See this link for a brief intro, actual text of the ACA plan and FAQs
https://www.counseling.org/knowledge-center/aca-licensure-portability-model-faqs#

Thank you for the opportunity to comment on the proposed legislation.

Sincerely,

Michael Ellis, Ph.D.

Commenter: Heidi Hutman 9/17/19 10:32 am

Strongly OPPOSE

There is no evidence to suggest that counselors who graduate from CACREP programs are more qualified than those graduating from non-CACREP programs. Please stop this divisive proposed legislature and consider the ACA Portability Plan, which is a significantly better option than this proposal.

For more info: https://www.counseling.org/knowledge-center/aca-licensure-portability-model-faqs#

Thank you for the opportunity to comment,

Heidi Hutman, Ph.D.

Commenter: Cory Cascalheira 9/17/19 10:47 am

Strongly opposed

There is no evidence that counselors who graduated from CACREP-accredited programs perform better than their peers.

This law severely restricts the ability of qualified counselor to provide services and direct their lives.

Given the current mental health issues in our country, I do not see how this law is helpful for anyone.

Commenter: C. Jacob 9/17/19 11:25 am

Oppose

As a counselor educator with multiple identities in the mental health profession, I oppose this action.

Commenter: Tina Russell-Brown, Chatham University 9/17/19 11:40 am

Strongly oppose

I strongly oppose because the proposal implies that CACREP programs produce better prepared counselors (which has not been empirically verified) and applies undue credentialing hardship on professionals that have degrees from other credentialing organizations. As a graduate from a CACREP program in Virginia, I am disappointed that my home state is interested in exclusionary practices. I have lived and worked in several states simply because they did not penalize me for a CACREP approved degree. In addition, Virginia has many transient residents from the military and other walks of life. I hope that Virginia counselors want to provide a **reasonable** pathway to licensure for well trained counselors from other states which would demonstrate a respect for colleagues outside of the state of Virginia and an attitude of inclusion not exclusion.

Commenter: Susan Woodhouse, Lehigh University 9/17/19 12:00 pm

Opposed to the discriminatory proposal

Portability of licensure is an important issue to address. This proposal, however, is discriminatory. This proposal gives preferential treatment to graduates of CACREP-accredited programs. There is simply no evidence that graduates of CACREP training programs are better trained or do better work than graduates of non-CACREP accredited programs. There are other accrediting bodies, other than CACREP, that are also very good and do a great job of ensuring excellent training. As of 2024 the NCC credential will be limited to graduates of CACREP accredited programs. This means that if this proposal were to be accepted, ultimately graduates of CACREP programs from other states would only need to have 3 years of experience whereas graduate of programs accredited by other bodies would need to have 10 years of experience. This simply does not make sense. CACREP does not have a monopoly on excellence in training. It would be better to have a more sensible licensure portability plan in order to ensure there are sufficient mental health support options available for Virginians.

Commenter: Rich Davino, Becker College 9/17/19 12:11 pm

I oppose this plan for its shortsighted thinking

I implore Virginia not to pursue this preferential treatment, and limitation of licence portability proposal. As a graduate of a CACREP accredited college, and a current instructor in a non CACREP accredited college, I can attest that the barrier to allowing for high quality practitioners in all 50 states will be a disaster. The mental health crisis is severe and the CACREP aspect of an individual's professional development is not the key--deeply caring individuals who are in the profession for the long haul, regardless of where they reside, or will need to reside in the future, is far more important. From the standpoint of the profession, and basic economics, counselors need to be able to live, and as needed, relocate, where the jobs, family, and other factors take them. Virginia will go down a very slippery slope and ultimately will lose more than you gain.

Commenter: Michael J Peters Sr., Becker College 9/17/19 12:26 pm

strongly opposed.

As a current provider of counseling who has graduated from a college that is not CACREP certified and who is seeking licensure I will state emphatically that I am opposed to this legislation. There has been no evidenced gathered that shows a difference between CACREP accredited and non-CACREP accredited colleges.

https://pdfs.semanticscholar.org/c39d/d6d5a4b812687fdca134b5e73d6cd9761732.pdf

As a professional in this field, we struggle to fill needs of communities that are at risk, as there are far more clients than counselors available to service these individuals, who are often on state provided insurance and in the greatest need of services. Putting roadblocks in the way of getting services will further contribute to the crisis of mental health that this country faces. This legislation will also discourage many people from entering the field knowing the amount of time that it will take to get to licensure.

Please consider the long term effects of this legislation and vote not toass ths bill.

Commenter: Lynn Gilman 9/17/19 12:52 pm

Opposed

I oppose this legislation as there is no compelling evidence that counselors who graduate from CACREP programs are more qualified than those graduating from non-CACREP programs. Please consider the ACA Portability Plan, which is a significantly better, more inclusive, and a less fracturing option than this proposal. With the tremendous need for qualified mental health providers the exclusionary nature of this portability proposal is detrimental to the well being of future clients. For more info: https://www.counseling.org/knowledge-center/aca-licensure-portability-model-faqs#

Commenter: Kevin Davis, Seton Hall University 9/17/19 2:41 pm

Strongly Oppose!

I strong oppose the suggestion in making license portability into the state of Virginia more stringent. I believe this proposal is not only counter productive, as it will cause more unnecessary friction within an already underserved field, but it will also deter interest in professionals becoming more involved in the mental health counseling industry. Also, in a rapidly evolving educational sector, where online programs are becoming more effective and efficient, CACREP should not be the only satisfactory accreditation. This should NOT be passed!

Commenter: Timothy Melchert 9/17/19 2:50 pm

Strongly oppose discriminatory plan

Thank you for the opportunity to state my strong opposition to the plan to institute a discriminatory policy for licensed professional counselors. The blatant discrimination requiring a major hurdle for those who don't graduate from a CACREP-accredited program is an embarrassment for the

profession. I worry about the continued viability of the profession when parties such as CACREP pursue such divisive and self-serving policies. Please reject the proposed plan.

Timothy Melchert

Commenter: Cristina Nicolau, Seton Hall University 9/17/19 3:11 pm

Strongly Oppose

I strongly oppose this proposal. This will prevent competent professionals from providing services as well as prevent them from relocating. This in turn will limit the services available for communities that are in need.

Cristina Nicolau

Commenter: Charlotte Bailey, LCPC, Sheppard Pratt Health System 9/17/19 4:57 pm

STRONGLY OPPOSE PROPOSED, BIASED CHANGES

I oppose the changes because they are clearly discriminatory and exclusionary! Shameful!

Commenter: Suzanne Lease, University of Memphis 9/17/19 5:38 pm

Strongly oppose proposal unsupported by data

I teach classes in a CACREP-accredited program, but I know that there are no data supporting that students graduating from the program have better clinical skills than students graduating from other rigorous counselor training programs (either those that are MPCAC accredited or are otherwise designed to follow accepted training standards). Therefore, there is no support for a proposal that requires different amounts of post-licensure experiences for counselors graduating from CAREP programs versus counselors from other programs. To require seven additional years of post-licensure experience for some individuals with no rationale for doing so is ludicrous and likely invites legal challenge.

Commenter: Jess Balk-Huffines, LCPC 9/17/19 6:35 pm

Oppose

Implementing CACREP accreditation is unneeded in the licensing of qualified mental health professionals. Despite my experience and full current independent licensure within the Maryland Board, I would be unable to legally practice in the State of Virginia. While I can appreciate what CACREP accreditation offers schools and their graduates, I feel this is a drastic measure to separate and limit qualified mental health professionals from serving the people of Virginia.

I do approve of additional education if a state's population has specific needs, but these should be more from a continuing education standpoint (must complete this 6-credit course with a provisional license, for example) versus mandating seven additional years of practice before being fully licensed. I believe it is mind-boggling that Virginia is limiting its potential counselor pool, especially from neighboring states, such as Maryland, which have robust and extensive graduate school programs. I oppose including CACREP standards into licensing protocols, and suggest Virginia moves along the lines of full reciprocity for independently licensed clinicians from other states.

Commenter: John Dimoff, Chatham University 9/17/19 7:21 pm

Oppose

To Whom It May Concern:

I am writing to encourage Virginia to oppose the current proposal related to CACREP requirements for counselor license portability.

As others have already commented, the current proposal is dangerous to our profession because it suggests that licensed counselors who graduated from programs accredited by CACREP are more qualified than those who graduated from other programs, for which there is no documented evidence. Counseling psychology relies upon treatments that have been supported by science and so too should its licensing requirements.

John Dimoff, Ph.D.

Chatham University

Commenter: Dan Walinsky, Temple University 9/17/19 8:04 pm

Strongly object

I strongly object to this proposal. It unfairly discriminates against well trained counselors who did not attend programs endorsed by CACREP. There is no evidence *supported by rigorous, well-conducted research* that demonstrates that graduates from CACREP accredited programs are better counselors.

The license portability plan endorsed by the American Counseling Association (ACA) is superior to this proposal, and is more fair to all counselors.

Commenter: Noelany Pelc, Ph.D., LP, Seton Hall University 9/17/19 9:16 pm

Strongly Oppose

As a licensed psychologist, and counseling educator, I strongly oppose the current proposal. The current proposal grants greater license portability and access to licensure in Virginia in a manner that disproportionately impacts clinicians graduated from non-CACREP programs. To date, there is no empirical evidence or body of literature that supports limitations that are disparate based on accreditation status and the quality of services provided by graduates. Offering shorter pathways to licensure for CACREP graduates limits the services that are available to communities in needs and who greatly benefit from having greater access to mental health providers.

Commenter: Samantha Daniel, Ph.D, Private Practice 9/18/19 10:40 am

Strongly oppose

While I strongly support licensure portability laws, I strongly oppose this one that poses an unfair second class citizen status to counselors that have not attended the "right" program. There is absolutely no research evidence to suggest that skills differ among those in CACREP vs non-CACREP programs. Indeed many in non-CACREP are taught by clinicians with the highest skill

level in mental health, those who are licensed psychologists. ACA's rigid rules in accrediting programs based on faculty background have unfairly marginalized programs ran by doctoral level psychologists that have gone to APA accredited programs. It would be a huge disservice to VA to allow ACA's lobbying and increasingly restricted approach to accrediting programs unfairly impose additional loops for those taught in programs headed by psychologists. And until ACA can prove CACREP students are better than non-CACREP this is unfair and could lead to litigation. Do the right thing and apply licensure mobility equally.

Commenter: John E. Smith, Ed.D. 9/18/19 11:04 am

I very strongly oppose

This proposal is a "restraint of trade/practice" proposal which discriminates against non-CACREP GRADUATES. I am not aware of data which demonstrates that CACREP graduates are more effective counselors than others. Such a regulation limits the options for practitioners who may choose where they will live, based on the opportunities that would be available to them.

Commenter: Augusto C. Garcia Vizcarrondo, University of Baltimore 9/18/19 1:26 pm

I Strongly Oppose

Although licensure portability laws are a step in the right direction in improving the behavioral health care of our clients, I strongly oppose the stipulations outlined in this particular proposal. It is evident that this proposal seeks to limit the ability of behavioral health care professionals graduating from non-CACREP programs to provide counseling to clients across state lines and favors CACREP endorsed programs. There is no evidence to indicate that graduates from CACREP accredited programs provide better care that those who are not, and the fact that most programs in the US are not CACREP accredited, severely limits our client's options for care. Even more concerning is the fact that we are also limiting the care provided to our service members returning from overseas. Virginia is one of the top five states with the highest concentration of veterans as well as Active Duty service members, being home to several military installations such as FT Eustis and FT Lee. When considering future proposals for licensure portability, we must ensure that we are always placing the needs of our clients first.

Commenter: Jake Jackson, National Board for Certified Counselors 9/18/19 9:05 pm

NBCC supports Petition for 18VAC115-20-45, Prerequisites for Licensure by Endorsement

Dr. Johnston Brendle, LPC, LMFT
Chairperson
Virginia Department of Health Professions
Virginia Board of Counseling
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463

Dear Dr. Brendle:

The National Board for Certified Counselors (NBCC) is writing express our support for the proposed rule change for 18VAC115-20-45. Prerequisites for licensure by endorsement. At NBCC, we support and respect the important work that state regulatory boards do to protect the public and identify appropriate qualifications for competence and integrity of practice by counselors. Furthermore, we understand the need

for increased access to qualified counselors and expanded mobility for counselors in the contemporary job market. We believe the proposed rule change helps to advance these aims.

NBCC provides national certification for the counseling profession, representing over 66,000 National Certified Counselors (NCCs) in the United States. NBCC also develops and administers the licensure examinations for professional counselors in all 50 states, Puerto Rico, and the District of Columbia. Professional counselors, counselor educators, regulators and counseling stakeholders are engaged throughout all facets of the development of the national models for counseling, the NCC and the Certified Clinical Mental Health Counselor (CCMHC). These stakeholders are engaged in the development of the assessments, ethics processes, identification of educational eligibility requirements and service and supervision elements. Engaging the profession in defining core eligibility requirements and processes for certification is critically important for ensuring a cohesive model informed by the profession's voice. National certification provides a model and a pathway for the profession to respond to the evolving needs of the public while ensuring that the sustained core requirements include the elements necessary to protect the public and frame the profession.

It is our intention that certification and the national model be a help to our partners on the regulatory boards. Being able to refer to and utilize a national model developed and maintained by counselors for the profession is intended to help facilitate the work of the state boards. We were pleased to see that model and those intentions in action in the proposed rule change. Including the Certified Clinical Mental Health Counselor (CCMHC) credential and the National Certified Counselor (NCC) credential as pathways for the educational and experience requirements allows the Virginia Board to be assured that counselors seeking licensure by endorsement have obtained the education and experience necessary for competent practice, ensuring the ongoing protection of the public. We believe that utilizing the national credentials as a pathway to verify educational and

experience requirements will simplify administration, increasing efficiency and reducing costs for the Board. NBCC also supports the inclusion of a CACREP accredited degree in the proposed endorsement rule. CACREP is the premier accrediting body for mental health counseling graduate programs and the inclusion of its standards here will help to further ensure that candidates for endorsement have the educational preparation necessary to provide quality counseling services to the citizens of Virginia.

Furthermore, we enthusiastically support the inclusion of the broad range of clearly articulated options for documenting educational preparation and counseling experience set forth in the proposed rule change. The proposal your Board is offering will appropriately protect the citizens of Virginia, while also achieving critically important aims, including:

- Significantly increasing public access to qualified care.
- Establishing minimum standards for safe practice.
- Reducing administrative burdens for both the state regulatory board and licensees.

The proposed rule change will support portability and continue the strong history of Virginia leading on meaningful, impactful regulatory processes for counselors. We believe that the proposed rule change facilitates portability for the vast majority of licensed counselors while establishing quality assurances for your citizens.

In closing, NBCC supports the proposed rule change and urges others to support the proposed changes to the licensure by endorsement process in Virginia. The proposed change will continue the long history of Virginia's leadership for the counseling profession, promote counselor portability and facilitate the flow of qualified counselors into the state. The plan balances the priorities of public protection with the demand for increased access to behavioral health services.

Thank you for your consideration of our letter of support. If you have any questions or comments about this letter or about counselor certification, the NCC or the CCMHC, please contact Kylie Dotson-Blake, NBCC's

Interim President and CEO or Jacob Jackson, Manager, Government Affairs for NBCC, at dotson-blake@nbcc.org or jjackson@nbcc.org.

Sincerely,

Kylie Dotson-Blake
Interim President & CEO
National Board for Certified Counselors

Jacob Jackson
Manager, Government Affairs
National Board for Certified Counselors

Commenter: Elisabeth Liptak, Seton Hall University 9/18/19 9:18 pm

Strongly Oppose

I am strongly opposed to the proposed regulation regarding licensure by endorsement that would advantage graduates of CACREP accredited programs. There is no evidence that such graduates are better prepared than counselors from non-CACREP accredited programs. This is a short-sighted move at a time of increased need for mental health professionals and should not be approved.

Commenter: Cynthia Miller 9/18/19 10:00 pm

In support of these updates

I support the proposed regulatory changes and commend the Board of Counseling for expanding the avenues by which counselors from other states can transfer their licenses to Virginia.

Commenter: Cynthia Miller, Ph.D. LPC 9/18/19 10:01 pm

In support of these updates

I support the proposed regulatory changes and commend the Board of Counseling for expanding the avenues by which counselors from other states can transfer their licenses to Virginia.

Commenter: Elaine Johnson, Ph.D. Retired, University of Baltimore 9/18/19 10:29 pm

Opposition to this proposal

The current proposal offers a pathway to licensure that recognizes the value of professional experience in the development of skill and expertise among mental health professionals. This is a laudable effort, however the huge discrepancy in years of experience required, depending on the accreditation of one's graduate program, is highly problematic. For this reason, the proposal should not advance.

License portability is a concern of every practicing professional in our highly mobile society. Barriers for those attached to the military deserve particular attention. Most professional mental health counselors in the U.S. were not trained in CACREP-accredited programs. Thus, most professionals in the country would face a huge roadblock in obtaining a license to practice in Virginia under this proposal. If a candidates is short on any of the state's requirements (such as fewer than 600 hours in supervised internship, a relatively recent development in the field), and the

master's program was not CACREP-accredited, the candidate would have to show 10 years of post-license experience, as opposed to 3 years for an otherwise identically-prepared graduate of a CACREP-accredited degree program.

Given that there is no credible evidence that CACREP training leads to greater competence or faster accumulation of skills in post-license years, the requirement s contained in this proposal are not justifiable.

Other program accreditation exists (see mpcacaccreditation.org) to support excellence in training for master's-level mental health professionals. Marginalizing graduates of programs with this accreditation, or the vast majority of licensed professionals trained before program accreditation became common, lacks empirical justification, undercuts the mobility of duly licensed professionals and does not serve a public with huge and diverse mental health needs. I urge the rejection of this proposal in its current form.

Commenter: Fred Bemak, George Mason University 9/18/19 10:53 pm

Strongly Oppose

To Whom It May Concern:

I am writing to strongly oppose the proposal for licensure by endorsement.. I am writing in my capacity as a faculty member and previous Academic Program Coordinator in the Counseling & Development Program at George Mason University as well as a 2018 recipient of the State Council of High Education of Virginia (SCHEV) Outstanding Faculty Award and a Fellow of the American Counseling Association. The proposed regulation includes a provision that counseling graduates from CACREP accredited programs would be qualified for Virginia licensure 3 years after graduation while non-CACREP counseling graduates would require 10 years of post-licensure practice in order to quality for licensure in Virginia. This proposed regulation is in direct contradiction to the report by the Mental Health America (MHA) 2018 The State of Mental Health Report that noted the serious overall shortage in America in the mental health workforce. Notably, Virginia was rated 42nd nationally in this report, comparatively poor with respect to other states, with a ratio of 730:1 clients to mental health providers. This figure combined with the fact that there is no research to support the determination of waiting 10 years for licensure in Virginia if one does not graduate from a CACREP program raises critical questions regarding the proposed regulation.

As noted by the Dean, Mark Ginsberg, at the College of Education & Human Development at George Mason University, in a recent letter to Kevin Doyle, former Chair and current member of the Virginia Board of Counseling, regarding the current proposal, "We [George Mason University] have been consistent in our view, which remains our perspective, that the intended restrictions of this proposed requirement (which has been proposed and not affirmed multiple times in Virginia) remain of concern and are NOT representative of a Virginia public policy we support. In our view, the proposal unnecessarily limits the availability of mental health professionals in the Commonwealth." Dean Ginsberg continued in his letter, "...Thus, the revised proposal is not a revision at all, rather it is a circular restatement of the original proposal, which was opposed virtually by all persons who submitted comments in response to an invitation for public comments." In fact, when we reviewed the public comments for the proposal out of 446 comments 412, or 92%, were against the proposed CACREP licensure regulations, leading to the withdraw of the proposed by the Virginia Board of Counseling.

Rex Stockton, the Chancellor's Professor in Indiana State University, and a Charter Member of CACREP and a longstanding member of the Indiana Counseling Licensure Board, noted in his public comments to the Virginia Board of Counseling during the public commentary period in 2017 to Governor McAuliffe and the Virginia Board of Counseling, "I urge you to veto the Virginia's Counseling Board Resolution requiring graduating from a Council for Accreditation of Counseling & Related Educational Programs (CACREP) accredited institution in order to obtain a license. I am a proud Charter Member of CACREP and have supported them throughout my career. However, I do not approve of their advocating the position that only CACREP accredited institution graduates

are qualified for licensure. That is simply not true. There are many quality graduate programs that, for one reason or another, don't chose to affiliate with CACREP... All counseling boards have curriculum requirements that ensure that candidates come from a quality program. As a long-time member of the Indiana Board (although not speaking for the Board), I can assure you that there's no sentiment on our Board for requiring CACREP accreditation for our applicants. I every much hope you will veto the Virginia's Board's Counseling Resolution."

I am highly concerned that the proposed regulations are a replication of the two previously proposed CACREP licensure regulations by the Virginia Board of Counseling and are in direct conflict with the documentation of increasing and under-served mental health needs in Virginia. Furthermore, there is no research or scientific base to support the position for a difference between CACREP and non-CACREP graduates. Based on these facts I strongly urge that this regulation is rejected.

Fred Bemak, Ed.D. Professor, George Mason University

Project 5799 - NOIRA

BOARD OF COUNSELING

Periodic review

Part I

General Provisions

18VAC115-20-10. Definitions.

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

"Board"

"Counseling"

"Professional counselor"

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

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

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

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

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

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

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

"CORE" means Council on Rehabilitation Education.

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

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

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

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

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

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

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

"Residency" means a postgraduate, supervised, clinical experience ~~registered with the board~~.

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

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

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

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

A. The board has established the following fees ~~applicable to licensure as a professional counselor~~:

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

Late renewal for a professional counselor	$45
Late renewal for a resident in counseling	$10
Reinstatement of a lapsed license for a professional counselor	$200
Reinstatement of a lapsed license for a resident in counseling	$75
Replacement of or additional wall certificate	$25
Returned check	$35
Reinstatement following revocation or suspension	$600

B. All fees are nonrefundable.

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

Part II

Requirements for Licensure

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

Every applicant for licensure examination by the board shall:

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

2. Pass the licensure examination specified by the board;

3. Submit the following to the board:

a. A completed application;

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

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

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

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

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

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

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

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

1. A completed application;

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

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

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

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

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

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

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

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

1. Educational requirements consistent with those specified in 18VAC115-20-49 and 18VAC115-20-51 and experience requirements consistent with those specified in 18VAC115-20-52. If 60 graduate hours in counseling were completed prior to April 12, 2000, the board may accept those hours if they meet the regulations in effect at the time the 60 hours were completed; or

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

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

~~b.~~ Evidence of post-licensure clinical practice in counseling, as defined in § 54.1-3500 of the Code of Virginia, at the highest level for independent practice for 24 of the last 60 months immediately preceding his licensure application in Virginia. Clinical practice shall mean the rendering of direct clinical counseling services, or clinical supervision of counseling services or teaching graduate-level courses in counseling; or

~~3. In lieu of transcripts verifying education and documentation verifying supervised experience, the board may accept verification~~

b. Verification ~~from the credentials registry of the American Association of State Counseling Boards,~~ of the Certified Clinical Mental Health Counselor (CCMHC) credential from the National Board of Certified Counselors (NBCC) or any other board-recognized entity~~.~~; or

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

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

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

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

18VAC115-20-51. Coursework requirements.

A. The applicant shall have successfully completed the requirements for a degree in a program accredited by CACREP in clinical mental health counseling or any other specialty approved by the board; or

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

1. Professional counseling identity, function, and ethics;

2. Theories of counseling and psychotherapy;

3. Counseling and psychotherapy techniques;

4. Human growth and development;

5. Group counseling and psychotherapy theories and techniques;

6. Career counseling and development theories and techniques;

7. Appraisal, evaluation, and diagnostic procedures;

8. Abnormal behavior and psychopathology;

9. Multicultural counseling theories and techniques;

10. Research;

11. Diagnosis and treatment of addictive disorders;

12. Marriage and family systems theory; and

13. Supervised internship as a formal academic course of at least 600 hours to include 240 hours of face-to-face client contact. Only internship hours earned after completion of 30 graduate semester hours may be counted towards residency hours. If the academic

course was less than 600 hours, the board may approve completion of the deficient hours to be added to the hours required for residency.

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

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

A. ~~Registration.~~ Resident license. Applicants ~~who render counseling services~~ for temporary licensure as a resident in counseling shall:

1. ~~With their supervisor, register their supervisory contract on the appropriate forms for board approval before starting to practice under supervision~~ Apply for licensure on a form provided by the board to include the following: (a) verification of a supervisory contract; (b) the name and licensure number of the clinical supervisor and location for the supervised practice; and (c) an attestation that the applicant will be providing clinical counseling services;

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

3. Pay the registration fee;

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

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

B. Residency requirements.

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

a. Assessment and diagnosis using psychotherapy techniques;

b. Appraisal, evaluation, and diagnostic procedures;

c. Treatment planning and implementation;

d. Case management and recordkeeping;

e. Professional counselor identity and function; and

f. Professional ethics and standards of practice.

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

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

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

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

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

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

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

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

10. Residents may not call themselves professional counselors, directly bill for services rendered, or in any way represent themselves as independent, autonomous practitioners or professional counselors. During the residency, residents shall use their names and the initials of their degree, their resident license number, and the title "Resident in Counseling" in all written communications. Clients shall be informed in writing ~~of the resident's status~~

that the resident does not have authority for independent practice and is under supervision and shall provide the supervisor's name, professional address, and phone number.

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

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

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

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

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

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

D. Supervisory responsibilities.

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

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

3. The supervisor shall ensure accountability for the resident's adherence to residency requirements of this section.

~~3.~~4. The supervisor shall complete evaluation forms to be given to the resident at the end of each three-month period.

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

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

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

Part III

Examinations

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

A. Every applicant for initial licensure by examination by the board as a professional counselor shall pass a written examination as prescribed by the board. An applicant is required to pass the prescribed examination no later than six years from the date of initial issuance of a resident license by the board.

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

C. ~~A candidate approved to sit for the examination shall pass the examination within two years from the date of such initial approval. If the candidate has not passed the examination by the end of the two-year period here prescribed:~~

~~1. The initial approval to sit for the examination shall then become invalid; and~~

~~2. The applicant shall file a new application with the board, meet the requirements in effect at that time, and provide evidence of why the board should approve the reapplication for examination. If approved by the board, the applicant shall pass the examination within two years of such approval. If the examination is not passed within the additional two-year period, a new application will not be accepted.~~

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

~~E.~~D. A ~~candidate for examination or an applicant shall not provide clinical counseling services unless he is under supervision approved by the board~~ resident shall remain in a residency practicing under supervision until he has passed the licensure examination and been granted a license as a professional counselor.

Part IV

Licensure Renewal; Reinstatement

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

A. ~~All licensees shall renew licenses on or before June 30 of each year.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Counseling theory;

3. Human growth and development;

4. Social and cultural foundations;

5. The helping relationship;

6. Group dynamics, processing, and counseling;

7. Lifestyle and career development;

8. Appraisal of individuals;

9. Research and evaluation;

10. Professional orientation;

11. Clinical supervision;

12. Marriage and family therapy; or

13. Addictions.

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

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

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

b. Continuing education programs offered by universities or colleges.

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

d. Workshops, seminars, conferences, or courses in the behavioral health field offered by an individual or organization that has been certified or approved by one of the following:

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

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

(3) The American Association of State Counseling Boards.

(4) The American Counseling Association and its state and local affiliates.

(5) The American Psychological Association and its state affiliates.

(6) The Commission on Rehabilitation Counselor Certification.

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

(8) National Association of Social Workers.

(9) National Board for Certified Counselors.

(10) A national behavioral health organization or certification body.

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

(12) The American Association of Pastoral Counselors.

2. Individual professional activities.

a. Publication/presentation/new program development.

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

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

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

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

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

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

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

d. Leadership. Activity will count for a maximum of eight hours. The following leadership positions are acceptable for continuing competency credit: officer of state or national counseling organization; editor ~~and/or~~ or reviewer of professional

counseling journals; member of state counseling licensure/certification board; member of a national counselor certification board; member of a national ethics disciplinary review committee rendering licenses; active member of a counseling committee producing a substantial written product; chair of a major counseling conference or convention; or other leadership positions with justifiable professional learning experiences. The leadership positions must take place for a minimum of one year after the date of first licensure.

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

18VAC115-20-107. Documenting compliance with continuing competency requirements.

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

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

C. Upon request, a licensee shall provide documentation as follows:

1. To document completion of formal organized learning activities, the licensee shall provide:

a. Official transcripts showing credit hours earned; or

b. Certificates of participation.

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

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

a. Certificates of participation;

b. Proof of presentations made;

c. Reprints of publications;

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

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

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

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

18VAC115-20-110. Late renewal; reinstatement.

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

B. A person who fails to renew a professional counselor license after one year or more and wishes to resume practice shall: (i) apply for reinstatement~~,~~; (ii) pay the reinstatement fee for a

lapsed license~~,~~; (iii) submit verification of any mental health license he holds or has held in another jurisdiction, if applicable~~,~~ (iv) provide a current report from the U.S. Department of Health and Human Services National Practitioner Data Bank (NPDB); and (v) provide evidence of having met all applicable continuing competency requirements not to exceed a maximum of 80 hours. The board may require the applicant for reinstatement to submit evidence regarding the continued ability to perform the functions within the scope of practice of the license.

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

D. A person who fails to renew a resident license after one year or more and wishes to resume his residency within the six-year limitation from the date of initial issuance of a resident license shall: (i) apply for reinstatement; (ii) pay the initial licensure fee for a resident in counseling; and (iii) provide evidence of having met continuing competency requirements not to exceed a maximum of 12 hours. The board may require the applicant for reinstatement to submit evidence regarding the continued ability to perform the functions within the scope of practice of the resident license.

Part V

Standards of Practice; Unprofessional Conduct; Disciplinary Actions; Reinstatement

18VAC115-20-130. Standards of practice.

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

B. Persons licensed or registered by the board shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

14. Make appropriate referrals based on the interest of the client; and

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

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

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

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

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

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

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

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

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

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

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

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

2. Not engage in any type of romantic relationships or sexual intimacies with clients or those included in a collateral relationship with the client and not counsel persons with whom they have had a romantic relationship or sexual intimacy. Counselors shall not engage in romantic relationships or sexual intimacies with former clients within a minimum of five years after terminating the counseling relationship. Counselors who engage in such relationship or intimacy after five years following termination shall have the responsibility to examine and document thoroughly that such relations do not have an exploitive nature, based on factors such as duration of counseling, amount of time since counseling, termination circumstances, client's personal history and mental status, or adverse impact on the client. A client's consent to, initiation of, or participation in sexual behavior or involvement with a counselor does not change the nature of the conduct nor lift the regulatory prohibition;

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

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

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

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

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

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

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

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

3. Conducting one's practice in such a manner as to make it a danger to the health and welfare of one's clients or to the public~~, or if one is unable~~;

4. Demonstrating an inability to practice counseling with reasonable skill and safety to clients by reason of illness~~, abusive use of alcohol, drugs, narcotics, chemicals, or other type of material or result of any mental~~ or substance misuse, or as a result of any mental, emotional, or physical condition~~.~~;

~~4.~~5. Intentional or negligent conduct that causes or is likely to cause injury to a client or clients;

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

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

~~7.~~8. Violating or abetting another person in the violation of any provision of any statute applicable to the practice of counseling, or any part or portion of this chapter; ~~or~~

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

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

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

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

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

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

18VAC115-50-10. Definitions.

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

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

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

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

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

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

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

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

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

"Residency" means a postgraduate, supervised clinical experience ~~registered with the board~~.

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

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

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

18VAC115-50-20. Fees.

A. The board has established fees for the following:

~~Registration of supervision~~ Application and initial licensure as a resident	$65
~~Add or change supervisor~~ Pre-review of education only	~~$30~~ $75
Initial licensure by examination: Processing and ~~initial~~ licensure as a marriage and family therapist	$175
Initial licensure by endorsement: Processing and ~~initial~~ licensure as a marriage and family therapist	$175

Active annual license renewal as a marriage and family therapist	$130
Inactive annual license renewal as a marriage and family therapist	$65
Annual renewal as a resident	$30
~~Penalty for late~~ Late renewal for a marriage and family therapist	$45
Late renewal for a resident	$10
Reinstatement of a lapsed license for a marriage and family therapist	$200
Reinstatement of a lapsed license for a resident	$75
Verification of license to another jurisdiction	$30
Additional or replacement licenses	$10
Additional or replacement wall certificates	$25
Returned check	$35
Reinstatement following revocation or suspension	$600

B. All fees are nonrefundable.

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

18VAC115-50-30. Application for licensure by examination.

Every applicant for licensure by examination by the board shall:

1. Meet the education and experience requirements prescribed in 18VAC115-50-50, 18VAC115-50-55 and 18VAC115-50-60;

2. Meet the examination requirements prescribed in 18VAC115-50-70;

3. Submit to the board office the following items:

a. A completed application;

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

c. Documentation, on the appropriate forms, of the successful completion of the residency requirements of 18VAC115-50-60 along with documentation of the supervisor's out-of-state license where applicable;

d. Official transcript or transcripts submitted from the appropriate institutions of higher education, verifying satisfactory completion of the education requirements set forth in 18VAC115-50-50 and 18VAC115-50-55. Previously submitted transcripts for ~~registration of supervision~~ board approval of a resident license do not have to be resubmitted unless additional coursework was subsequently obtained;

e. Verification on a board-approved form of any mental health or health out-of-state license, certification, or registration ever held in another jurisdiction; and

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

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

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

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

1. A completed application;

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

3. Documentation of licensure as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

18VAC115-50-55. Coursework requirements.

A. The applicant shall have successfully completed the requirements for a degree in a program accredited by COAMFTE or a marriage and family therapy program accredited by CACREP; or

B. The applicant shall have successfully completed 60 semester hours or 90 quarter hours of graduate coursework with:

1. ~~a~~ A minimum of ~~six~~ 12 semester hours or ~~nine~~ 18 quarter hours completed in ~~each of the core areas identified in subdivisions 1 and 2 of this subsection, and~~ marriage and family therapy

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

2. ~~three~~ Three semester hours or 4.0 quarter hours in each of the following core areas ~~identified in subdivisions 3 through 9 of this subsection~~:

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

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

~~3.~~a. Human growth and development across the lifespan;

~~4.~~b. Abnormal behaviors;

~~5.~~c. Diagnosis and treatment of addictive behaviors;

~~6.~~d. Multicultural counseling;

~~7.~~e. Professional identity and ethics;

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

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

~~10.~~3. ~~Supervised~~ A supervised internship as a formal academic course of at least 600 hours to include 240 hours of direct client contact, of which 200 hours shall be with couples and families. Only internship hours earned after completion of 30 graduate semester hours may be counted towards residency hours. If the academic course was less than 600 hours, the board may approve completion of the deficient hours to be added to the hours required for residency.

B. If the applicant holds a current, unrestricted license as a professional counselor, clinical psychologist, or clinical social worker, the board may accept evidence of successful completion of 60 semester hours or 90 quarter hours of graduate study~~,~~. ~~including~~ However, the applicant

must provide evidence of a minimum of ~~six~~ 12 semester hours or ~~nine~~ 18 quarter hours completed in marriage and family ~~studies (marital and family development; family systems theory) and six semester hours or nine quarter hours completed in marriage and family therapy (systemic therapeutic interventions and application of major theoretical approaches)~~ therapy (marital and family development, family systems, theory systemic therapeutic interventions, and application of major theoretical approaches).

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

A. ~~Registration~~ Resident license. Applicants ~~who render~~ for temporary licensure as a resident in marriage and family therapy ~~services~~ shall:

1. ~~With their supervisor, register their supervisory contract on the appropriate forms for board approval before starting to practice under supervision~~ Apply for licensure on a form provided by the board to include the following: (a) verification of a supervisory contract; (b) the name and licensure number of the clinical supervisor and location for the supervised practice; and (c) an attestation that the applicant will be providing clinical marriage and family services;

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

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

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

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

B. Residency requirements.

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

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

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

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

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

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

a. Assessment and diagnosis using psychotherapy techniques;

b. Appraisal, evaluation, and diagnostic procedures;

c. Treatment planning and implementation;

d. Case management and recordkeeping;

e. Marriage and family therapy identity and function; and

f. Professional ethics and standards of practice.

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

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

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

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

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

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

10. The residency shall be completed in not less than 21 months or more than ~~four~~ six years from the start of residency. Residents who began a residency before August 24, 2016, shall complete the residency by August 24, ~~2020~~ 2022. A resident shall met the renewal requirements of subsection C of 18VAC115-50-95 in order to maintain a license in current, active status. ~~An individual who does not complete the residency after four years shall submit evidence to the board showing why the supervised experience should be allowed to continue.~~

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

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

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

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

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

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

D. Supervisory responsibilities.

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

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

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

4. The supervisor shall ensure accountability for the resident's adherence to residency requirements of this section.

18VAC115-50-70. General examination requirements.

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

B. ~~The examination shall concentrate on the core areas of marriage and family therapy set forth in subsection A of 18VAC115-50-55.~~ An applicant is required to pass the prescribed examination no later than six years from the date of initial approval of the residency or within no more seven years if the board has granted an interruption or extension of the residency.

C. ~~A candidate approved to sit for the examination shall pass the examination within two years from the initial notification date of approval. If the candidate has not passed the examination within two years from the date of initial approval:~~

~~1. The initial approval to sit for the examination shall then become invalid; and~~

~~2. The applicant shall file a new application with the board, meet the requirements in effect at that time, and provide evidence of why the board should approve the reapplication for examination. If approved by the board, the candidate shall pass the examination within two years of such approval. If the examination is not passed within the additional two-year period, a new application will not be accepted.~~

~~D.~~ ~~Applicants or candidates for examination shall not provide marriage and family services unless they are under supervision approved by the board~~ A resident shall remain in a residency practicing under supervision until he has passed the licensure examination and been granted a license as a marriage and family therapist.

18VAC115-50-90. Annual renewal of license.

A. ~~All licensees shall renew licenses on or before June 30 of each year.~~

~~B.~~ All ~~licensees~~ marriage and family therapists who intend to continue an active practice shall submit to the board on or before June 30 of each year:

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

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

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

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

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

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

3. On the annual renewal, the resident in marriage and family therapy shall attest to completion of three hours in continuing education courses that emphasize the ethics,

standards of practice, or laws governing behavioral science professions in Virginia, offered by an approved provider as set forth in subsection B of 18VAC115-50-96.

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

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

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

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

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

2. Counseling theory;

3. Human growth and development;

4. Social and cultural foundations;

5. The helping relationship;

6. Group dynamics, processing and counseling;

7. Lifestyle and career development;

8. Appraisal of individuals;

9. Research and evaluation;

10. Professional orientation;

11. Clinical supervision;

12. Marriage and family therapy; or

13. Addictions.

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

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

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

b. Continuing education programs offered by universities or colleges.

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

d. Workshops, seminars, conferences, or courses in the behavioral health field offered by an individual or organization that has been certified or approved by one of the following:

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

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

(3) The American Association of State Counseling Boards.

(4) The American Counseling Association and its state and local affiliates.

(5) The American Psychological Association and its state affiliates.

(6) The Commission on Rehabilitation Counselor Certification.

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

(8) National Association of Social Workers.

(9) National Board for Certified Counselors.

(10) A national behavioral health organization or certification body.

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

(12) The American Association of Pastoral Counselors.

2. Individual professional activities.

a. Publication/presentation/new program development.

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

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

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

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

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

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

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

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

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

18VAC115-50-97. Documenting compliance with continuing competency requirements.

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

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

C. Upon request, a licensee shall provide documentation as follows:

1. To document completion of formal organized learning activities, licensee shall provide:

a. Official transcripts showing credit hours earned; or

b. Certificates of participation.

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

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

a. Certificates of participation;

b. Proof of presentations made;

c. Reprints of publications;

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

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

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

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

18VAC115-50-100. Late renewal, reinstatement.

A. A person whose license has expired may renew it within one year after its expiration date by paying the late fee prescribed in 18VAC115-50-20 as well as the license fee prescribed for the period the license was not renewed and providing evidence of having met all applicable continuing competency requirements.

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

1. Apply for reinstatement and pay the reinstatement fee;

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

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

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

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

C. A person wishing to reactivate an inactive marriage and family license shall submit (i) the renewal fee for active licensure minus any fee already paid for inactive licensure renewal and (ii) documentation of continued competency hours equal to the number of years the license has been inactive, not to exceed a maximum of 80 hours, obtained within the four years immediately preceding application for reinstatement. The board may require additional evidence regarding the person's continued ability to perform the functions within the scope of practice of the license.

D. A person who fails to renew a resident license after one year or more and wishes to resume his residency within the six-year limitation from the date of initial issuance of a resident license shall: (i) apply for reinstatement; (ii) pay the initial licensure fee for a resident in counseling; and (iii) provide evidence of having met continuing competency requirements not to exceed a maximum of 12 hours. The board may require the applicant for reinstatement to submit evidence regarding the continued ability to perform the functions within the scope of practice of the resident license.

18VAC115-50-110. Standards of practice.

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

B. Persons licensed or registered by the board shall:

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

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

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

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

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

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

7. Disclose to clients all experimental methods of treatment and inform client of the risks and benefits of any such treatment. Ensure that the welfare of the client is not compromised in any experimentation or research involving those clients;

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

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

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

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

12. Use only in connection with one's practice as a mental health professional those educational and professional degrees or titles that have been earned at a college or

university accredited by an accrediting agency recognized by the U.S. Department of Education, or credentials granted by a national certifying agency, and that are counseling in nature; ~~and~~

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

14. Make appropriate referrals based on the interest of the client; and

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Not engage in any type of romantic relationships or sexual intimacies with clients or those included in a collateral relationship with the client and also not counsel persons with whom they have had a sexual intimacy or romantic relationship. Marriage and family therapists shall not engage in romantic relationships or sexual intimacies with former clients within a minimum of five years after terminating the counseling relationship. Marriage and family therapists who engage in such relationship or intimacy after five years

following termination shall have the responsibility to examine and document thoroughly that such relations do not have an exploitive nature, based on factors such as duration of counseling, amount of time since counseling, termination circumstances, client's personal history and mental status, or adverse impact on the client. A client's consent to, initiation of or participation in sexual behavior or involvement with a marriage and family therapist does not change the nature of the conduct nor lift the regulatory prohibition;

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

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

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

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

18VAC115-50-120. Disciplinary action.

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

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

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

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

4. Demonstrating an inability to practice marriage and family therapy with reasonable skill and safety to clients by reason of illness or substance misuse, or as a result of any mental, emotional, or physical condition;

~~4.~~5. Intentional or negligent conduct that causes or is likely to cause injury to a client or clients;

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

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

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

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

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

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

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

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

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

Part I

General Provisions

18VAC115-60-10. Definitions.

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

"Board"

"Licensed substance abuse treatment practitioner"

"Substance abuse"

"Substance abuse treatment"

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Residency" means a postgraduate, supervised, clinical experience ~~registered with the board~~.

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

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

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

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

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

~~Registration of supervision (initial)~~ Application and initial licensure as a resident	$65
~~Add/change supervisor~~ Pre-review of education only	~~$30~~ $75
Initial licensure by examination: Processing and ~~initial~~ licensure as a substance abuse treatment practitioner	$175
Initial licensure by endorsement: Processing and ~~initial~~ licensure as a substance abuse treatment practitioner	$175
Active annual license renewal as a substance abuse treatment practitioner	$130
Inactive annual license renewal as a substance abuse treatment practitioner	$65
Annual renewal of a resident license	$30
Duplicate license	$10
Verification of license to another jurisdiction	$30
Late renewal as a substance abuse treatment practitioner	$45
Late renewal of a resident license	$10
Reinstatement of a lapsed license as a substance abuse treatment practitioner	$200
Reinstatement of a resident license	$75
Replacement of or additional wall certificate	$25
Returned check	$35
Reinstatement following revocation or suspension	$600

B. All fees are nonrefundable.

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

Part II

Requirements for Licensure

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

Every applicant for licensure by examination by the board shall:

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

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

3. Submit the following items to the board:

a. A completed application;

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

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

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

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

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

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

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

Every applicant for licensure by endorsement shall submit:

1. A completed application;

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

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

4. Further documentation of one of the following:

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

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

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

(2) If the master's degree was in substance abuse treatment, ~~two years~~ 24 out of the past 60 months of post-licensure experience in providing substance abuse treatment or addiction counseling immediately preceding application to the board;

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

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

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

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

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

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

18VAC115-60-60. Degree program requirements.

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

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

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

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

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

18VAC115-60-70. Coursework requirements.

A. ~~The applicant shall have successfully completed 60 semester hours or 90 quarter hours of graduate study.~~ The applicant shall have successfully completed the requirements for a degree in a program accredited by CACREP in addiction counseling or any other specialty approved by the board; or

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

1. Professional identity, function and ethics;

2. Theories of counseling and psychotherapy;

3. Counseling and psychotherapy techniques;

4. Group counseling and psychotherapy, theories and techniques;

5. Appraisal, evaluation and diagnostic procedures;

6. Abnormal behavior and psychopathology;

7. Multicultural counseling, theories and techniques;

8. Research; and

9. Marriage and family systems theory.

C. The applicant shall also have completed 12 graduate semester credit hours or 18 graduate quarter hours in the following substance abuse treatment competencies. Evidence of current certification as a Master Addictions Counselor (MAC) may be used to verify completion of the required graduate hours specified in this subsection.

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

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

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

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

5. Client and community education.

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

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

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

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

A. ~~Registration~~ Resident license. Applicants ~~who render substance abuse treatment services~~ for temporary licensure as a resident in substance abuse treatment shall:

1. ~~With their supervisor, register their supervisory contract on the appropriate forms for board approval before starting to practice under supervision~~ Apply for licensure on a form provided by the board to include the following: (a) verification of a supervisory contract; (b) the name and licensure number of the clinical supervisor and location for the supervised practice; and (c) an attestation that the applicant will be providing clinical counseling services;

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

3. Pay the registration fee;

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

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

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

C. Residency requirements.

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

a. Clinical evaluation;

b. Treatment planning, documentation and implementation;

c. Referral and service coordination;

d. Individual and group counseling and case management;

e. Client family and community education; and

f. Professional and ethical responsibility.

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

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

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

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

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

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

3. The residency shall include at least 2,000 hours of face-to-face client contact in providing clinical substance abuse treatment or addiction counseling services with at least 1,000 of those hours with individuals, families, or groups of ~~individuals suffering from the effects of substance abuse or dependence~~ people with substance use disorder. The remaining hours may be spent in the performance of ancillary services.

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

5. The residency shall be completed in not less than 21 months or more than ~~four~~ six years from the start of the residency. Residents who began a residency before August 24, 2016,

shall complete the residency by August 24, ~~2020~~ 2022. ~~An individual who does not complete the residency after four years shall submit evidence to the board showing why the supervised experience should be allowed to continue.~~ A resident shall meet the renewal requirements of subsection C of 18VAC115-60-110 in order to maintain a license in current, active status.

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

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

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

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

D. Supervisory qualifications.

1. A person who provides supervision for a resident in substance abuse treatment shall hold an active, unrestricted license as a professional counselor or substance abuse

treatment practitioner in the jurisdiction where the supervision is being provided. ~~Supervisors who are marriage and family therapists, school psychologists, clinical psychologists, clinical social workers, clinical nurse specialists, or psychiatrists and have been approved to provide supervision may continue to do so until August 24, 2017.~~

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

E. Supervisory responsibilities.

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

2. The supervisor of a resident shall assume full responsibility for the clinical activities of that resident specified within the supervisory contract ~~for the duration~~ until completion or termination of the residency, regardless of whether the supervisor is on-site or off-site at the location where services are provided by the resident.

3. The supervisor shall ensure accountability for the resident's adherence to residency requirements of this section.

~~3.~~4. The supervisor shall complete evaluation forms to be given to the resident at the end of each three-month period. The supervisor shall maintain copies of supervisory contracts, quarterly reports, and the verification evaluating an applicant's competency for five years after termination or completion of supervision.

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

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

Part III

Examinations

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

A. Every applicant for initial licensure as a substance abuse treatment practitioner by examination shall pass a written examination as prescribed by the board. An applicant is required to pass the prescribed examination no later than six years from the date of initial issuance of a resident license by the board.

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

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

~~D. A candidate approved by the board to sit for the examination shall pass the examination within two years from the date of such initial board approval. If the candidate has not passed the examination within two years from the date of initial approval:~~

~~1. The initial board approval to sit for the examination shall then become invalid; and~~

~~2. The applicant shall file a complete new application with the board, meet the requirements in effect at that time, and provide evidence of why the board should approve the reapplication for examination. If approved by the board, the applicant shall pass the examination within two years of such approval. If the examination is not passed within the additional two-year period, a new application will not be accepted.~~

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

~~F.~~D. A ~~candidate for examination or an applicant shall not provide clinical services unless he is under supervision approved by the board~~ resident shall remain in a residency practicing under supervision until he has passed the licensure examination and been granted a license as a substance abuse treatment practitioner.

Part IV

Licensure Renewal; Reinstatement

18VAC115-60-110. Renewal of licensure.

A. ~~All licensees shall renew licenses on or before June 30 of each year.~~

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

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

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

~~C.~~ B. A licensee who wishes to place his substance abuse treatment practitioner license in an inactive status may do so upon payment of the inactive renewal fee as established in 18VAC115-60-20. No person shall practice substance abuse treatment in Virginia unless he holds a current active license. A licensee who has placed himself in inactive status may become active by fulfilling the reactivation requirements set forth in 18VAC115-60-120 C.

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

1. A resident license shall expire annually in the month the resident license was initially issued and may be renewed up to five times within six years from the date of initial

issuance by submission of the renewal form and payment of the fee prescribed in 18VAC115-60-20.

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

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

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

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

18VAC115-60-116. Continuing competency activity criteria.

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

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

2. Counseling theory;

3. Human growth and development;

4. Social and cultural foundations;

5. The helping relationship;

6. Group dynamics, processing and counseling;

7. Lifestyle and career development;

8. Appraisal of individuals;

9. Research and evaluation;

10. Professional orientation;

11. Clinical supervision;

12. Marriage and family therapy; or

13. Addictions.

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

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

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

b. Continuing education programs offered by universities or colleges.

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

d. Workshops, seminars, conferences, or courses in the behavioral health field offered by an individual or organization that has been certified or approved by one of the following:

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

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

(3) The American Association of State Counseling Boards.

(4) The American Counseling Association and its state and local affiliates.

(5) The American Psychological Association and its state affiliates.

(6) The Commission on Rehabilitation Counselor Certification.

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

(8) National Association of Social Workers.

(9) The National Board for Certified Counselors.

(10) A national behavioral health organization or certification body.

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

2. Individual professional activities.

a. Publication/presentation/new program development.

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

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

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

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

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

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

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

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

e. Practice related programs. Activity will count up to a maximum of eight hours. The board may allow up to eight contact hours of continuing competency as long as the

regulant submits proof of attendance plus a written justification of how the activity assists him in his direct service of his clients. Examples include language courses, software training, medical topics, etc.

18VAC115-60-117. Documenting compliance with continuing competency requirements.

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

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

C. Upon request, a licensee shall provide documentation as follows:

1. To document completion of formal organized learning activities, licensee shall provide:

a. Official transcripts showing credit hours earned; or

b. Certificates of participation.

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

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

a. Certificates of participation;

b. Proof of presentations made;

c. Reprints of publications;

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

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

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

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

18VAC115-60-120. Late renewal; reinstatement.

A. A person whose license has expired may renew it within one year after its expiration date by paying the late renewal fee prescribed in 18VAC115-60-20, as well as the license fee prescribed for the year the license was not renewed and providing evidence of having met all applicable continuing competency requirements.

B. A person who fails to renew a substance abuse treatment practitioner license after one year or more and wishes to resume practice shall: (i) apply for reinstatement~~,~~; (ii) pay the reinstatement fee for a lapsed license~~,~~; (iii) submit verification of any mental health license he holds or has held in another jurisdiction, if applicable~~,~~; (iv) provide a current report from the U.S. Department of Health and Human Services National Practitioner Data Bank (NPDB); and (v) provide evidence of having met all applicable continuing competency requirements not to exceed a maximum of 80 hours obtained within the four years immediately preceding application for reinstatement. The board may require the applicant for reinstatement to submit evidence regarding the continued ability to perform the functions within the scope of practice of the license.

C. A person wishing to reactivate an inactive substance abuse treatment practitioner license shall submit (i) the renewal fee for active licensure minus any fee already paid for inactive licensure renewal; (ii) documentation of continued competency hours equal to the number of

years the license has been inactive not to exceed a maximum of 80 hours obtained within the four years immediately preceding application for reactivation; and (iii) verification of any mental health license he holds or has held in another jurisdiction, if applicable. The board may require the applicant for reactivation to submit evidence regarding the continued ability to perform the functions within the scope of practice of the license.

D. A person who fails to renew a resident license after one year or more and wishes to resume his residency within the six-year limitation from the date of initial issuance of a resident license shall: (i) apply for reinstatement; (ii) pay the initial licensure fee for a resident in substance abuse treatment; and (iii) provide evidence of having met continuing competency requirements not to exceed a maximum of 12 hours. The board may require the applicant for reinstatement to submit evidence regarding the continued ability to perform the functions within the scope of practice of the resident license.

Part V

Standards of Practice; Unprofessional Conduct; Disciplinary Actions; Reinstatement

18VAC115-60-130. Standards of practice.

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

B. Persons licensed or registered by the board shall:

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

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

3. Stay abreast of new substance abuse treatment information, concepts, application and practices that are necessary to providing appropriate, effective professional services;

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

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

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

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

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

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

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

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

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

13. Advertise professional services fairly and accurately in a manner that is not false, misleading or deceptive, including adherence to provision of 18VAC115-60-80 on requirements for representation to the public by residents in counseling;

14. Make appropriate referrals based on the interest of the client; and

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

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

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

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

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

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

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

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

c. Records that have been transferred to another mental health service provider or given to the client; and

5. Ensure confidentiality in the usage of client records and clinical materials by obtaining informed consent from clients or their legally authorized representative before (i) videotaping, (ii) audio recording, (iii) permitting third party observation, or (iv) using identifiable client records and clinical materials in teaching, writing or public presentations.

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

1. Avoid dual or multiple relationships with clients that could impair professional judgment or increase the risk of harm to clients. Examples of such relationships include, but are not limited to, familial, social, financial, business, bartering, or close personal relationships with clients. Counselors shall take appropriate professional precautions when a dual

relationship cannot be avoided, such as informed consent, consultation, supervision, and documentation to ensure that judgment is not impaired and no exploitation or neglect occurs;

2. Not engage in any type of romantic relationships or sexual intimacies with clients or those included in a collateral relationship with the client and not counsel persons with whom they have had a romantic relationship or sexual intimacy. Licensed substance abuse treatment practitioners shall not engage in romantic relationships or sexual intimacies with former clients within a minimum of five years after terminating the counseling relationship. Licensed substance abuse treatment practitioners who engage in such relationship or intimacy after five years following termination shall have the responsibility to examine and document thoroughly that such relations do not have an exploitive nature, based on factors such as duration of counseling, amount of time since counseling, termination circumstances, client's personal history and mental status, or adverse impact on the client. A client's consent to, initiation of or participation in sexual behavior or involvement with a licensed substance abuse treatment practitioner does not change the nature of the conduct nor lift the regulatory prohibition;

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

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

E. Persons licensed or registered by this board shall report to the board known or suspected violations of the laws and regulations governing the practice of substance abuse treatment.

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

18VAC115-60-140. Grounds for revocation, suspension, probation, reprimand, censure, or denial of renewal of license or registration.

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

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

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

3. Conducting one's practice in such a manner as to make it a danger to the health and welfare of one's clients or to the public~~, or if one is unable~~;

4. Demonstrating an inability to practice substance abuse treatment with reasonable skill and safety to clients by reason of illness~~, abusive use of alcohol, drugs, narcotics,~~

~~chemicals, or other type of material or result of any mental~~ or substance misuse, or as a result of any mental, emotional, or physical condition;

~~4.~~5. Intentional or negligent conduct that causes or is likely to cause injury to a client or clients;

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

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

~~7.~~8. Violating or abetting another person in the violation of any provision of any statute applicable to the practice of licensed substance abuse ~~therapy~~ treatment, or any part or portion of this chapter; ~~or~~

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

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

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

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

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

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

Supervisor designation and qualifications.

SUPERVISOR REQUIREMENTS BY STATE

Arizona

Supervisor Credentials

Independently licensed by the Board in the same discipline as the Supervisee.

Years of Post-Licensure Practice Required

2 years

Supervision Training Required

One of the following:

1. 12 hours of training that address specific content outlined in the regulations.
2. Approved clinical supervisor certification from NBCC.
3. Approved clinical supervisor certification from IC/RC
4. Approved clinical supervisor certification from AAMFTRB Additionally, just pass a 3 clock hour Board approved tutorial on Board statues and rules.

Ongoing Training

None

Credential

None

California

Supervisor Credentials

LPC. Additional requirements for LMFT, LCSW and LCP.

Supervision Training Required

6 hours of supervision training.

Ongoing Training

15 hours every 2 years

Years of Post-Licensure Practice Required

2 years within the past 24 of 60 months.

Credential

None

Colorado

Supervisor Credentials

LPC, LMFT, LCP, LCSW

Supervision Training Required

none

Ongoing Training

none

Years of Post-Licensure Practice Required

none

Credential

None

DC

Supervisor Credentials

LPC, LCP, Psychiatrist, LICSW

Supervision Training Required

none

Ongoing Training

none

Years of Post-Licensure Practice Required

none

Credential

None

Florida

Supervisor Credentials

LPC, LMFT, LCP.LCSW

Supervision Training Required

3 semesters or 4 quarter credit course in 3 of the following 6 content areas:

- Counseling theories
- Counseling practice
- Assessment
- Career Counseling
- Substance abuse
- Legal, ethical and professional standards

Ongoing Training

None

Years of Post-Licensure Practice Required

ACS credential, AAMFT credential,
5 years post licensure experience of which
2 years can be during post masters internship.

Credential

None

Georgia

Supervisor Credentials

Any licensed behavioral licensee- LPC, LCSW, LMFT, LCP, Psychiatrist

Years of Post-Licensure Practice Required

- Master's degree+3 years post licensure practice.
- Specialist degree + 2 years of post licensure practice
- Doctoral degree + 1 year of post licensure practice

Supervision Training Required

After 9/30/2018, LPC supervisors must hold a NBCC ACS credential or Licensed Professional Counseling Association of Georgia Certified Professional Counselor Supervisor Credential.

Ongoing Training

none

Credential

LPC-S

Kentucky

Supervisor Credentials

Any licensed behavioral licensee- LPC, LCSW, LMFT, LCP, Psychiatrist

Years of Post-Licensure Practice Required

2 years post licensure practice

Supervision Training Required

15 hours of supervision training.

Ongoing Training

none

Credential

LPCC-S

Maryland

Supervisor Credentials

LCPC, LCSW, LMFT, LPC, Licensed Psychiatric Nurse, Psychiatrist

Years of Post-Licensure Practice Required

2 years post licensure practice

Supervision Training Required

One of the following:
- 3 semester hours in supervision
- 18 CE hours in supervision
- Hold the NBCC ACS credential

Ongoing Training

none

Credential

ALPS
Approved Licensed Professional Supervisor

Michigan

Supervisor Credentials

LPC

Years of Post-Licensure Practice Required

- Prior to 2013, LPC with 3 years post licensure practice
- After 2013, LPC with 3 years experience & 2 semester hours counseling supervision or 30 supervision CE's

Supervision Training Required

After 2013, 2 semester hours counseling supervision or 30 supervision CE's

Ongoing Training

None

Credential

none

Minnesota

Supervisor Credentials

Any licensed behavioral licensee- LPC, LCSW, LMFT, LCP, Psychiatrist

Supervision Training Required

45 hours of supervision training.

Ongoing Training

none

Years of Post-Licensure Practice Required

2 years post licensure practice

Credential

none

North Carolina

Supervisor Credentials

LPC or qualified supervisor as determined by the Board.

Supervision Training Required

3 semester graduate course in supervision or 45 hours of supervision training.

Ongoing Training

10 CE hours every 2 years.

Years of Post-Licensure Practice Required

2 years post licensure practice and 5 years of counseling experience.

Credential

LPC-S

New York

Supervisor Credentials

LMHC, Physician, Physician assistant, Psychologist, LCSW, RN or NP

Years of Post-Licensure Practice Required

None MB(1

Supervision Training Required

None – Supervisor signs an attestation on the Residents application stating they will provide supervision according to the regulations.

Ongoing Training

None

Credential

None

Ohio

Supervisor Credentials

LPC

Years of Post-Licensure Practice Required

1 year post licensure practice AND 1,500 hours clinical experience, post licensed LPCC to include at least 1 supervision experience by a LPCC Supervisor with a follow up review.

Supervision Training Required

24 hours of supervision training.

Ongoing Training

3 hours per year

Credential

LPC-S

Oregon

Supervisor Credentials

LPC, LMFT

Years of Post-Licensure Practice Required

3 years post licensure practice

Supervision Training Required

30 clock hours of post masters degree supervision training and Supervisor law & rules exam.

Ongoing Training

none

Credential

none

Pennsylvania

Supervisor Credentials

LPC

Years of Post-Licensure Practice Required

- LPC with 5 years within the last 10 years active practice
- *"Licensed"* with masters in related field with 5 years experience within the last 10 years in the field.

Supervision Training Required

None

Ongoing Training

30 CE hours every 2 years including 3 hours in ethics and 1 hour in suicide assessment & treatment, 2 hours child abuse recognition and reporting.

Credential

none

South Carolina

Supervisor Credentials

LPC or qualified supervisor as determined by the Board.

Years of Post-Licensure Practice Required

- Doctoral degree in Counselor Education and Supervision
- 5 years post licensure practice

Supervision Training Required

36 CE hours in supervision within 2 years

Ongoing Training

10 CE hours in supervision every 2 years

Credential

LPC-S, LMFT-S

Tennessee

Supervisor Credentials

Any licensed behavioral licensee such as LPC, LCSW, LMFT, LCP, Psychiatrist.

Years of Post-Licensure Practice Required

5 years post licensure practice

Supervision Training Required

One of the following:

- Academic course specific to supervision of counselors
- Supervision certification by AAMFT, AAPC, NBCC or any other organization designated by the Board to provide supervisor qualification verification.
- 12 contact hours related to counseling supervision by an approved professional association or credentialing organization.

Ongoing Training

None

Credential

None

Texas

Supervisor Credentials

LPC, LMFT

Years of Post-Licensure Practice Required

5 years post licensure practice

Supervision Training Required

- Doctoral level graduate course in supervision within the past 5 years.
- 40 hours of supervision training within the past 2 years.

Ongoing Training

6 hours every 2 years

Credential

LPC-S

West Virginia

Supervisor Credentials

LPC or qualified supervisor as determined by the Board.

Years of Post-Licensure Practice Required

2 years post licensure practice *and*
5 years of counseling experience.

Supervision Training Required

- More than 10 years of counseling experience and 15 CE hours training in supervision or 1 semester credit course
- Less than 10 years of counseling experience, needs 30 CE hours training in supervision or 2 semester credit course.

Ongoing Training

None

Credential

ALPS Approved Licensed Professional Supervisor

Define each of the areas of didactic training in substance abuse required for Certified Substance Abuse Counselors.

Thirteen areas of Didactic Training

(Each area will required a minimum of 16 clock hours)

a. Dynamics of human behavior;

b. Signs and symptoms of substance abuse;

c. Counseling theories and techniques;

d. Continuum of care and case management skills;

e. Recovery process and relapse prevention methods;

f. Professional orientation and ethics;

g. Pharmacology of abused substances; and

h. Trauma and crisis intervention;

i. Co-occurring disorders;

j. Cultural competency;

k. Substance abuse counseling approaches and treatment planning;

l. Group counseling; and

m. Prevention, screening, and assessment of substance use and abuse.

Agenda Item: Review of Guidance documents

Staff Note:

Guidance documents must be reviewed every four years. Recommendations from the Regulatory Committee are:

115-1.8 – Reaffirm current guidance

115-11 – Add guidance currently found in 115-2.2

115-2.2 – repeal; incorporated

115-12- New guidance on using training & participation as Disaster Mental Health Worker by Red Cross for up to 8 hours of CE

Board action:

Approve recommendations of the Regulation Committee or other action by Board

Reaffirm Guidance Document 115-1.8: Examinations approved by the Board for Certification as a Rehabilitation Counselor, adopted September 11, 2015

Virginia Board of Counseling

Examinations approved by the Board for Certification as a Rehabilitation Counselor

In Regulations Governing the Certification of Rehabilitation Providers, Section 18VAC115-40-28 states that: "Every applicant for certification as a rehabilitation provider shall take a written examination approved by the board and achieve a passing score as determined by the board."

For the purpose of meeting the requirement of Section 28, the Board approves the following examinations:

- The examination for CRC certification (Certified Rehabilitation Counselor) given by the Commission on Rehabilitation Counselor Certification
- The examination for CDMS (Certification of Disability Management Specialist) given by the CDMS Commission
- The examination for ADMS (Associate Disability Management Specialist) given by the CDMS Commission

The passing score for each examination shall be the score determined by the Commission for passage.

Repeal Guidance Document 115-2.2: Guidance on participation by substance abuse counselors in interventions, revised November 13, 2015

and

incorporate into Guidance Document 115-11: Scope of Practice for Persons Regulated by the Board to provide Substance Abuse Treatment**.**

Board of Counseling

Scopes of Practice for Persons Regulated by the Board to provide Substance Abuse Treatment

The Code of Virginia § 54.1-3500 defines "counseling" as "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."

The Code of Virginia § 54.1-3500 defines "Substance abuse treatment" as "(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."

License Required

The Code of Virginia § 54.1-3506 requires a license to engage in the practice of counseling, marriage and family therapy, or the independent practice of substance abuse treatment. The scopes of practice for Licensed Professional Counselors (LPCs) and Licensed Marriage and Family Therapists (LMFTs) include counseling and substance abuse treatment. No other license or certification is required for these licensees to perform these functions.

Scope of Practice for a Licensed Substance Abuse Treatment Practitioner (LSATP)

The scope of practice for a Licensed Substance Abuse Treatment Practitioner (LSATP) is defined in § 54.1-3507, which states that: "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."

Scope of Practice for a Certified Substance Abuse Counselor (CSAC)

The scope of practice for a Certified Substance Abuse Counselor is defined in § 54.1-3507.1, which states that: "A certified substance abuse counselor shall be (i) qualified to perform, under appropriate supervision or direction, the substance abuse treatment functions of screening, intake, orientation, the administration of substance abuse assessment instruments, recovery and

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

Facilitation or participation in "planned interventions" by Certified Substance Abuse Counselors is within the scope of their practice as long as they are practicing under supervision as required by law and regulation.

Scope of Practice for a Certified Substance Abuse Counselor Assistant (CSAC-A)

The scope of practice for Certified Substance Abuse Counselor Assistants is defined in § 54.1-3507.2, which states that: "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."

Scope of Practice for a Peer Recovery Specialist

Code of Virginia § 54.1-3500 defines a peer recovery specialist is "a person who by education and experience is professionally qualified in accordance with 12VAC35-20 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 (RPRS) shall provide such services as an employee or independent contractor of DBHDS, a provider licensed by 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."

A peer recovery specialist offers support and assistance in helping others in the recovery and community-integration process.

Clarifying Information

The scope of practice for CSACs includes substance abuse counseling with individuals and groups. The Code of Virginia § 54.1-3507.1 indicates that CSACs are "qualified to be responsible for client care of persons with a primary diagnosis of substance abuse or dependence." Providing counseling to persons for a mental health diagnosis other than substance abuse or dependency is outside the scope of practice for CSACs.

A "diagnostic" assessment and a "multidimensional" assessment, conducted according to criteria of the American Society of Addiction Medicine, are both required for Medicaid reimbursement for services. CSACs are not allowed to do a diagnostic assessment but are allowed to do the

multidimensional assessment to make recommendations for a level of care that must then be signed off on or approved by a licensed professional who is supervising the CSAC.

The Board of Counseling interprets the function of "record keeping" to include the gathering of demographic information. CSAC-As can perform this function as within their scope of practice. However, CSAC-As cannot perform the function of intake or screening. Only a CSAC, LSATP, LPC, or LMFT shall perform these functions.

Scopes of Practice for Persons Regulated by the Board of Counseling to provide Substance Abuse Treatment

	LPC	LMFT	LSATP	CSAC	CSAC-A
Provide Substance Abuse Treatment Independently	yes	yes	yes	No	No
Perform only under supervision of Licensed Mental Health Professional				Yes	Yes
Screening	Yes	Yes	Yes	Yes	No
Intake	Yes	Yes	Yes	Yes	No
Orientation	Yes	Yes	Yes	Yes	Yes
Administration of Substance Abuse Assessment Instruments	Yes	Yes	Yes	Yes	No
Recovery and relapse Prevention Planning	Yes	Yes	Yes	Yes	No
Diagnostic Assessment	Yes	Yes	Yes	No	No
Multidimensional Assessment	Yes	Yes	Yes	Yes	No
Treatment Planning	Yes	Yes	Yes	Yes	No
Substance Abuse Treatment	Yes	Yes	Yes	Yes	No
Implementation of Substance Abuse Treatment Plans	Yes	Yes	Yes	Yes	Yes
Case Management	Yes	Yes	Yes	Yes	Yes
Substance Abuse or dependence crisis intervention	Yes	Yes	Yes	Yes	Yes
Client Education	Yes	Yes	Yes	Yes	No
Referral Activities	Yes	Yes	Yes	Yes	No
Recordkeeping	Yes	Yes	Yes	Yes	Yes
Consultation with other Professionals	Yes	Yes	Yes	Yes	Yes
Exercise Independent Professional Judgment, to evaluate current functioning	Yes	Yes	Yes	No	No
Exercise Independent Professional Judgment to diagnose and select appropriate remedial treatment for identified problems	Yes	Yes	Yes	No	No
Exercise Independent Professional judgment to make appropriate referrals	Yes	Yes	Yes	No	No
Supervise, Direct and Instruct others who provide Substance Abuse Treatment	Yes	Yes	Yes	Yes (Only CSAC-A's)	No
Provide Independent Substance Abuse Counseling	Yes	Yes	Yes	No	No
Provide counseling to persons with for a Mental Health Diagnosis other than Substance Abuse	Yes	Yes	Yes	No	No
Coordinate, Facilitate, Participate in Recovery Group Discussions	Yes	Yes	Yes	Yes	Yes
Lead Recovery Group Discussions	Yes	Yes	Yes	Yes	No
Substance Abuse Counseling with Individuals	Yes	Yes	Yes	Yes	No
Substance Abuse Counseling with Groups	Yes	Yes	Yes	Yes	No

Supervision Requirements for Persons Providing Substance Abuse Treatment Pursuant to Code of Virginia 54.1-3500 et.seq.

	Independent	Authority to Supervise, Direct, or Instruct	Required to be under the Supervision of:
LMHP*	Yes	Yes	Not required
LSATP	Yes	Yes	Not required
LSATP Applicant	No (Must practice under supervision)	No	LSATP or LMHP
CSAC	No (Must practice under supervision)	Only CSAC-As and CSAC Applicants	LSATP or LMHP
CSAC Applicant	No (Must practice under supervision)	No	LSATP, LMHP, or CSAC
CSAC-A	No (Must practice under supervision)	No	LSATP, LMHP, or CSAC
CSAC-A Applicant	No (Must practice under supervision)	No	LSATP, LMHP, or CSAC

*LMHP means a Licensed Mental Health Provider and includes Licensed Professional Counselors (LPCs), Licensed Marriage and Family Therapists (LMFTs), Licensed Clinical Psychologists (LCPs), and Licensed Clinical Social Workers (LCSWs)

Virginia Board of Counseling

Guidance on Planned Intervention Process

Facilitation or participation in "planned interventions" by Certified Substance Abuse Counselors is within the scope of their practice as long as they are practicing under supervision as required by law and regulation.

Adoption of Guidance Document 115-12: Guidance on Acceptance of Disaster Mental Health Worker for Continuing Competency Regulations

Virginia Board of Counseling

Guidance on Acceptance of Disaster Mental Health Worker for Continuing Competency Requirements

Persons licensed by the Board of Counseling may count the training and participation as a Disaster Mental Health Worker through the American Red Cross for continuing education. Licensed professional counselors, marriage and family therapists, and substance abuse treatment practitioners may count up to a maximum of eight hours per renewal as specified in 18VAC115-20-106(B)(2)(e), 18VAC115-50-96(B)(2)(e), or 18VAC115-60-116(B)(2)(e).

Next steps to become a Disaster Mental Health volunteer:

- Visit redcross.org
- Click Volunteer, then click Apply Now to create a Red Cross ID
- Complete a volunteer application
- Respond to contact from your local chapter and discuss volunteer options
- Complete Red Cross Disaster Mental Health training courses

Other Red Cross volunteer opportunities for mental health professionals:

- Service to the Armed Forces
- Disaster Action Team
- Disaster Casework
- Home Fire Campaign

Interested in volunteering?
Contact MNRecruit@redcross.org or call 612-501-1925

Join the **Red Cross Disaster Mental Health** team in your community!

American Red Cross

redcross.org

MAKE A DIFFERENCE

VOLUNTEER

Are you a mental health professional?

Yes! Then **YOU** can help disaster survivors!

Join the **Red Cross Disaster Mental Health** team in your community!

American Red Cross

What types of disasters does Red Cross respond to?

- Home fire (most common Red Cross disaster response)
- Earthquake
- Wildfire
- Tornado
- Hurricane
- Flooding
- Transportation Disasters (e.g., plane, train)
- Shooting/Terrorism/Mass Casualty Incidents

What does a Disaster Mental Health team do?

- Respond to the immediate emotional distress and psychosocial needs of disaster survivors and Red Cross disaster responders.
- Supplement local mental health resources during times of disaster.
- Support the community in building resilience.

Where do Disaster Mental Health volunteers work?

- At Red Cross Chapter offices
- At home - supporting clients via telephone or "on-call"
- Wherever disaster survivors or Red Cross disaster responders are:
  - Driveways or hotel lobbies
  - Shelters
  - Service Centers (established temporarily in community settings)
  - Outreach or home visits in communities

Who can be a Disaster Mental Health team member?

- Mental Health Professionals with:
  - A Master's Degree AND
  - A Current License or Certification in any US State or Territory as a:
    - Social worker
    - Psychiatrist
    - Psychologist
    - School psychologist
    - Professional counselor
    - School counselor
    - Marriage and family therapist
- Current Psychiatric Nurses with:
  - A state license as a registered nurse
  - A minimum of 2 years of experience working in a psychiatric setting
- Recently retired mental health professionals or psychiatric nurses (within the last 5 years)

American Red Cross

Eligibility Criteria for Disaster Mental Health Workers

Disaster Mental Health workers are required to meet eligibility standards, competencies and training requirements outlined by the Disaster Mental Health program.

Volunteers who meet one of the following criteria are eligible to participate as a Disaster Mental Health worker:

A. CURRENTLY LICENSED MENTAL HEALTH PROFESSIONALS:

- At minimum, holds a Master's Degree in one of the mental health professions listed below; and
- Holds a current, unencumbered license from, or is registered with, any U.S. state or territory as a social worker, psychologist, professional counselor, marriage and family therapist, or psychiatrist (any level license/registration, including non-clinical licenses such as Licensed Masters Social Worker or LMSW)

B. CURRENT SCHOOL PSYCHOLOGISTS AND SCHOOL COUNSELORS:

- At minimum, holds a Master's Degree in school psychology or school counseling; and
- Holds a current, unencumbered license or certification as a school psychologist or school counselor issued by an appropriate state board.

C. CURRENT PSYCHIATRIC NURSES:

- Have a state license as a registered nurse; and
- Have a minimum of two years of experience working in a psychiatric setting, verified by a letter from a current or previous employer.

D. RETIRED MENTAL HEALTH PROFESSIONALS:

- Meet the above educational criteria for specified profession; and
- Held a license (any level license) from any U.S. state or territory as a social worker, psychologist, professional counselor, marriage and family therapist, psychiatric nurse or psychiatrist, or a certificate as a school psychologist or school counselor, within the five years* prior to on-boarding as a Disaster Mental Health worker; and
- Maintained a license or certification in good standing upon retirement and without any disciplinary action taken by the issuing U.S. state or territory licensing or certification board.

*If a prospective Disaster Mental Health volunteer has been retired for more than five years, the corresponding Disaster Mental Health Division Advisor should be consulted.

EXCEPTION: An individual enrolled in the Disaster Mental Health program prior to May 2010 who does not meet these eligibility criteria can continue to work in the Disaster Mental Health activity given good standing with his/her chapter and a positive performance history while working on local and/or national relief operations.

Disaster Mental Health workers are expected to work within their areas of competence when serving the Red Cross. The licensing or certification of mental health professionals is determined by the issuing U.S. state's or territory's regulations which must be followed by the Red Cross.

Graduate Student Teams

Graduate students are eligible to work in the Disaster Mental Health program when they meet both the following criteria:

- Enrolled in a graduate program leading to a master's or doctoral degree in a Disaster Mental Health-eligible field of study (for example: social work, psychology, professional counseling, school counseling, school psychology, marriage and family therapy, psychiatric nursing, or psychiatry);
- Supervised on-site by a faculty or field supervisor.

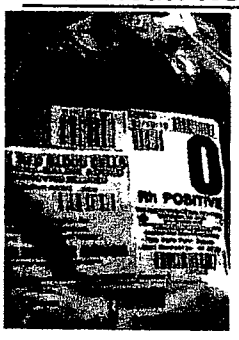
Prior to deployment, the graduate student team and supervisor must complete the required Red Cross Disaster Mental Health trainings. The faculty or field supervisor must meet ALL of the following criteria:

- Be a current Disaster Mental Health worker and meets all eligibility standards, competencies and training requirements outlined by the Disaster Mental Health program;
- Assume responsibility for the graduate student's work;
- Be able to provide on-site direct supervision of the student when both individuals are deployed on a local or national relief operation;
- Be able to review work and provide consultation of the student's work multiple times a day; and
- Supervise a maximum of five graduate students at any time.

American Red Cross: Five Lines of Service

American Red Cross
Minnesota Region

Preparedness and Health & Safety Services



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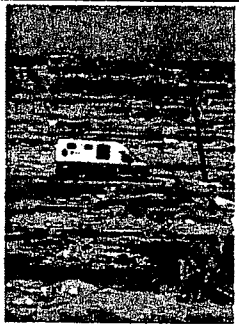

Disaster Services

Service to the Armed Forces

International

Preparedness and Health & Safety Services: The Red Cross provides training in first aid, CPR/AED, swimming and water safety, care giving and more. These courses empower the entire community to activate immediately.

Blood Services: The Red Cross is one of the nation's largest blood collection organizations. Blood donors play an important role in today's healthcare system. Many life-saving medical treatments and procedures involve blood transfusions. That would not be possible without a safe and reliable blood supply from our donors. Every unit of blood a person donates can help save up to three lives.

Disaster Services: The Red Cross responds to more than 66,000 disasters each year, including house or apartment fires, hurricanes, floods, earthquakes, tornadoes, hazardous material spills, transportation accidents, explosions, and other natural and man-made disasters.

Service to the Armed Forces: The Red Cross provides a continuum of care throughout a service member's career and after their military service ends. The American Red Cross provides training opportunities and services to military members, veterans and their families to build resiliency. This includes PHSS courses, outreach with preparedness information and coping skills.

The Red Cross responds to military families experiencing an immediate need by providing emergency communications, family follow up, access to financial assistance, and disaster services.

International: The Red Cross helps vulnerable people and communities around the world prepare for, respond to, and recover from natural disasters, humanitarian crises, and health emergencies, through mobilizing the power of the International Red Cross and Red Crescent Movement.

To Apply to Volunteer contact: [illegible]@redcross.org or call 612-391-1923

Virginia's Licensed Professional Counselor Workforce: 2019

DRAFT

Virginia's Licensed Professional Counselor Workforce: 2019

Healthcare Workforce Data Center

August 2019

Virginia Department of Health Professions
Healthcare Workforce Data Center
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Henrico, VA 23233
804-367-2115, 804-527-4466(fax)
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Follow us on Tumblr: ***www.vahwdc.tumblr.com***
Get a copy of this report from:
http://www.dhp.virginia.gov/PublicResources/HealthcareWorkforceDataCenter/ProfessionReports/

5,193 Licensed Professional Counselors voluntarily participated in this survey. *Without their efforts the work of the center would not be possible. The Department of Health Professions, the Healthcare Workforce Data Center, and the Board of Counseling express our sincerest appreciation for your ongoing cooperation.*

Thank You!

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Contents

The Licensed Professional Counselor Workforce: At a Glance:

The Workforce

Licensees:	5,973
Virginia's Workforce:	5,175
FTEs:	4,402

Survey Response Rate

All Licensees:	87%
Renewing Practitioners:	96%

Demographics

Female:	80%
Diversity Index:	37%
Median Age:	48

Background

Rural Childhood:	31%
HS Degree in VA:	48%
Prof. Degree in VA:	65%

Education

Masters:	87%
Ph.D.:	13%

Finances

Median Income:	$60k-$70k
Health Benefits:	61%
Under 40 w/ Ed debt:	70%

Current Employment

Employed in Prof.:	94%
Hold 1 Full-time Job:	53%
Satisfied?:	96%

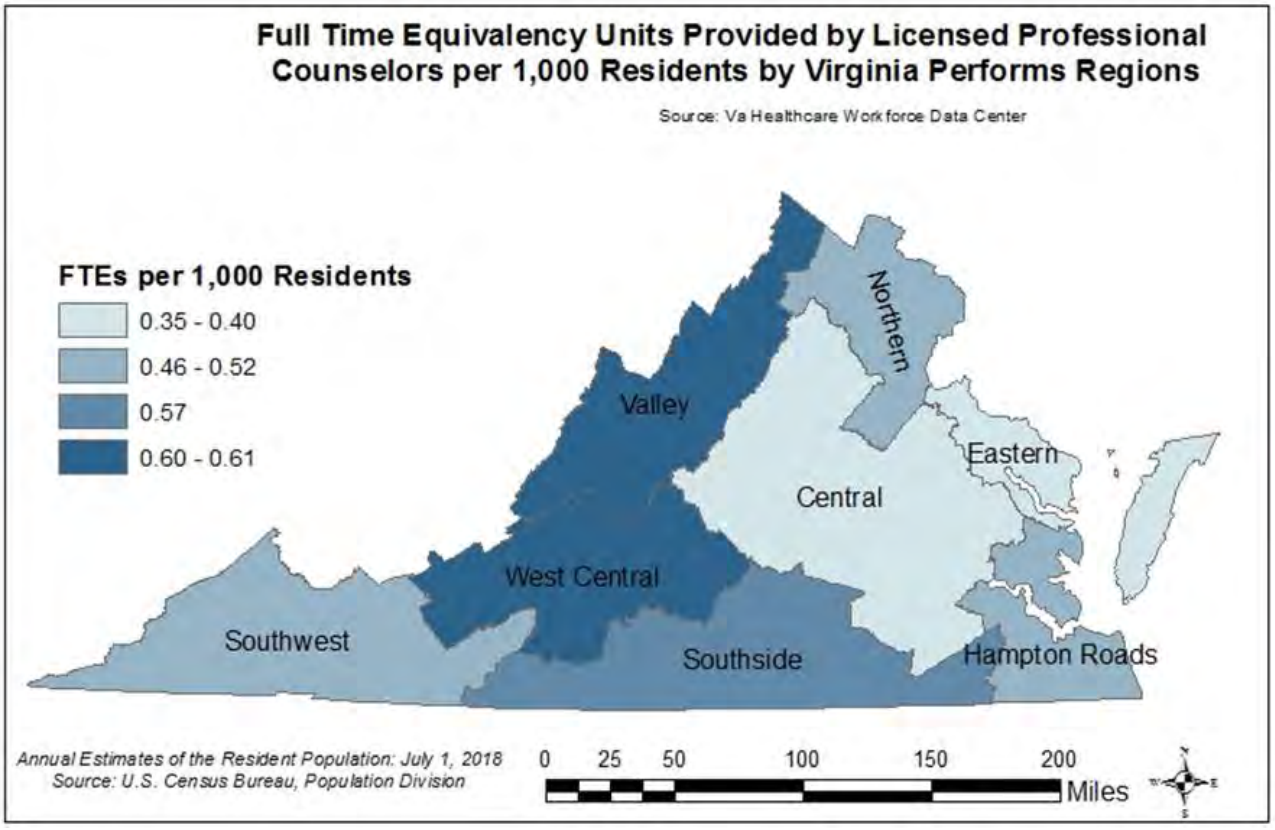
Job Turnover

Switched Jobs:	8%
Employed over 2 yrs:	66%

Time Allocation

Patient Care:	70%-79%
Administration:	10%-19%
Patient Care Role:	59%

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

Results in Brief

The Virginia Department of Health Professions' Healthcare Workforce Data Center (HWDC) administers the Licensed Professional Counselors (LPCs) survey during the license renewal process, which takes place every June. Survey respondents represent 87% of the 5,973 LPCs who are licensed in the state and 96% of renewing practitioners. Between July 2018 and June 2019, an estimated 5,175 LPCs participated in Virginia's workforce, which is defined as those who worked at least a portion of the period in the state or who live in the state and intend to return to work as a LPC at some point in the future. This workforce provided 4,402 full-time equivalency units (FTEs), which the HWDC defines simply as working 2,000 hours a year.

Eighty percent of all LPCs are female, including 86% of those under the age of 40. In a random encounter between two LPCs, there is a 37% chance that they would be of different races or ethnicities, a measure known as the diversity index. For LPCs under age 40, however, this value was 41%; by comparison, the diversity index for the state is 57%. Only 31% of all LPCs grew up in a rural area of Virginia, but 22% of these LPCs work in non-Metro areas of the state. Overall, 9% of Virginia's LPCs currently work in non-Metro areas of the state.

Eighty-seven percent of the state's LPC workforce have a Master's degree as their highest professional degree, while the remainder have a doctorate. In addition, 57% have a primary specialty in mental health. Forty-seven percent of all LPCs currently carry educational debt. The median debt for those with debt is between $70,000 and $80,000. Meanwhile, LPCs' median annual income is between $60,000 and $70,000. Ninety-six percent of LPCs are satisfied with their current employment situation, including 71% who indicate they are "very satisfied". Only 1% of Virginia's LPCs experienced involuntary unemployment in the past year and 94% of LPCs are currently employed in the profession. Three quarters of all LPCs work in the private sector, including 58% who work at a for-profit institution. Meanwhile, private solo practices are the most common establishment type, employing 18% of the state's LPC workforce. A quarter of all LPCs expect to retire by age 65 and 22% of the current workforce expect to retire in the next decade. Over the next two years, 15% of LPCs plan to increase patient care activities and 12% plan to pursue additional education.

Summary of Trends

The number of LPCs has increased significantly over the past six years. There are 59% more LPCs since 2013. Similarly, the number in the state workforce and the FTEs they produce have increased by 54% and 47%, respectively.

The LPC workforce has also become significantly more racially/ethnically diverse and younger over the past six years. The diversity index has increased from 25% to 37%. The median age has also declined from 53 in 2013 to 48 in 2019. The percent of LPCs under age 40 has increased significantly from 19% to 29% between 2013 and 2019. Not surprisingly, the percent over age 55 declined from 45% to 35% in the same period. Gender diversity is, however, declining. The percent female has inched up by 1% nearly every year from 76% in 2013 to 80% in 2018 and 2019.

The educational attainment of Virginia's LPCs has declined over the years. Compared to 2013 when 17% reported a doctorate degree and 83% reported a Master's degree, only 13% reported a doctorate degree in 2019; 87% now report a Master's degree. Surprisingly, this decline in educational attainment is accompanied by an increase in the proportion carrying education debt and an increase in median debt. Forty-seven percent now have education debt compared to 32% in 2013. Further, median debt has increased three times; from $30,000-$40,000 in 2013 to $40,000-$50,000 in 2014, to $50,000-$60,000 in 2015, and now to $70,000-$80,000 in 2019. Meanwhile, the median income of LPCs has increased only once in six years from $50,000-$60,000 to $60,000-$70,000 in 2018.

The geographical and establishment distribution of LPCs around the state remains unchanged; most work in Northern Virginia. Further, most (36%) LPCs work in private solo or group practice. However, fewer work in the public sector and more work in the for-profit private sector. Only 21% of LPCs work in state or local government now compared to 27% in 2013. Meanwhile, 58% now work in the for-profit compared to 52% in 2013.

Virginia's LPCs plan to stay in the workforce longer now than they did in 2013. Compared to 2013 when 27% reported that they planned to leave the workforce within a decade, only 22% now plan to leave in a decade. Half of the workforce plan to retire within 25 years compared to 2013 when half planned to retire within 20 years.

A Closer Look:

Licensees		
License Status	#	%
Renewing Practitioners	5,040	84%
New Licensees	707	12%
Non-Renewals	226	4%
All Licensees	**5,973**	**100%**

Source: Va. Healthcare Workforce Data Center

HWDC surveys tend to achieve very high response rates. 96% of renewing LPCs submitted a survey. These represent 87% of LPCs who held a license at some point during the survey period.

Response Rates			
Statistic	**Non Respondents**	**Respondent**	**Response Rate**
By Age			
Under 35	186	605	77%
35 to 39	111	725	87%
40 to 44	86	672	89%
45 to 49	79	625	89%
50 to 54	48	587	92%
55 to 59	71	508	88%
60 to 64	48	520	92%
65 and Over	151	951	86%
Total	**780**	**5,193**	**87%**
New Licenses			
Issued in Past Year	402	305	43%
Metro Status			
Non-Metro	55	391	88%
Metro	585	4,146	88%
Not in Virginia	140	655	82%

Source: Va. Healthcare Workforce Data Center

Definitions

1. **The Survey Period:** The survey was conducted in June 2019.
2. **Target Population:** All LPCs who held a Virginia license at some point between July 2018 and June 2019.
3. **Survey Population:** The survey was available to LPCs who renewed their licenses online. It was not available to those who did not renew, including LPCs newly licensed in 2019.

Response Rates	
Completed Surveys	5,193
Response Rate, all licensees	87%
Response Rate, Renewals	96%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Licensed LPCs

Number:	5,973
New:	12%
Not Renewed:	4%

Response Rates

All Licensees:	87%
Renewing Practitioners:	96%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Workforce

Virginia's LPC Workforce:	5,175
FTEs:	4,402

Utilization Ratios

Licensees in VA Workforce:	87%
Licensees per FTE:	1.36
Workers per FTE:	1.18

Source: Va. Healthcare Workforce Data Center

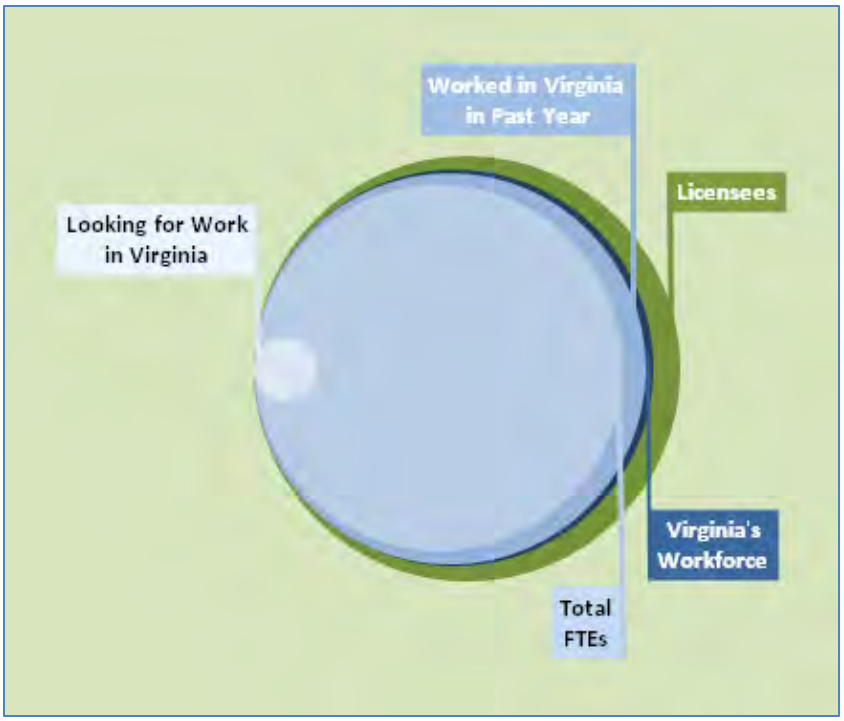
Virginia's LPC Workforce		
Status	#	%
Worked in Virginia in Past Year	5,079	98%
Looking for Work in Virginia	95	2%
Virginia's Workforce	**5,175**	**100%**
Total FTEs	**4,402**	
Licensees	**5,973**	

Source: Va. Healthcare Workforce Data Center

This report uses weighting to estimate the figures in this report. Unless otherwise noted, figures refer to the Virginia Workforce only. For more information on HWDC's methodology visit: www.dhp.virginia.gov/hwdc

Definitions

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



Source: Va. Healthcare Workforce Data Center

A Closer Look:

Age & Gender						
Age	Male		Female		Total	
	#	% Male	#	% Female	#	% in Age Group
Under 35	91	14%	579	86%	671	15%
35 to 39	94	15%	527	85%	620	14%
40 to 44	93	16%	502	84%	596	13%
45 to 49	79	15%	448	85%	528	12%
50 to 54	100	21%	380	79%	480	11%
55 to 59	91	21%	335	79%	426	10%
60 to 64	115	28%	292	72%	406	9%
65 +	233	32%	491	68%	724	16%
Total	**896**	**20%**	**3,555**	**80%**	**4,451**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Gender

% Female:	80%
% Under 40 Female:	86%

Age

Median Age:	48
% Under 40:	29%
% 55+:	35%

Diversity

Diversity Index:	37%
Under 40 Div. Index:	41%

Source: Va. Healthcare Workforce Data Center

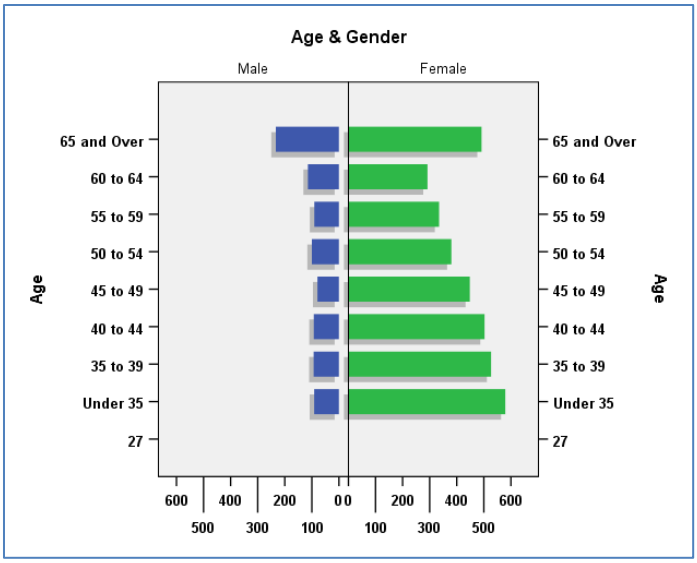
Race & Ethnicity					
Race/ Ethnicity	Virginia*	LPCs		LPCs under 40	
	%	#	%	#	%
White	61%	3,482	78%	961	74%
Black	19%	669	15%	228	18%
Asian	7%	49	1%	14	1%
Other Race	0%	28	1%	6	0%
Two or more races	3%	71	2%	34	3%
Hispanic	10%	158	4%	50	4%
Total	**100%**	**4,457**	**100%**	**1,293**	**100%**

*Population data in this chart is from the US Census, Annual Estimates of the Resident Population by Sex, Race, and Hispanic Origin for the United States, States, and Counties: July 1, 2017.

Source: Va. Healthcare Workforce Data Center

In a chance encounter between two LPCs, there is a 37% chance that they would be of a different race/ethnicity (a measure known as the Diversity Index).

29% of all LPCs are under the age of 40, and 86% of these professionals are female. In addition, the diversity index among LPCs who are under the age of 40 is 41%.



Source: Va. Healthcare Workforce Data Center

At a Glance:

Childhood

Urban Childhood:	14%
Rural Childhood:	31%

Virginia Background

HS in Virginia:	48%
Prof. Ed. in VA:	65%
HS or Prof. Ed. in VA:	74%

Location Choice

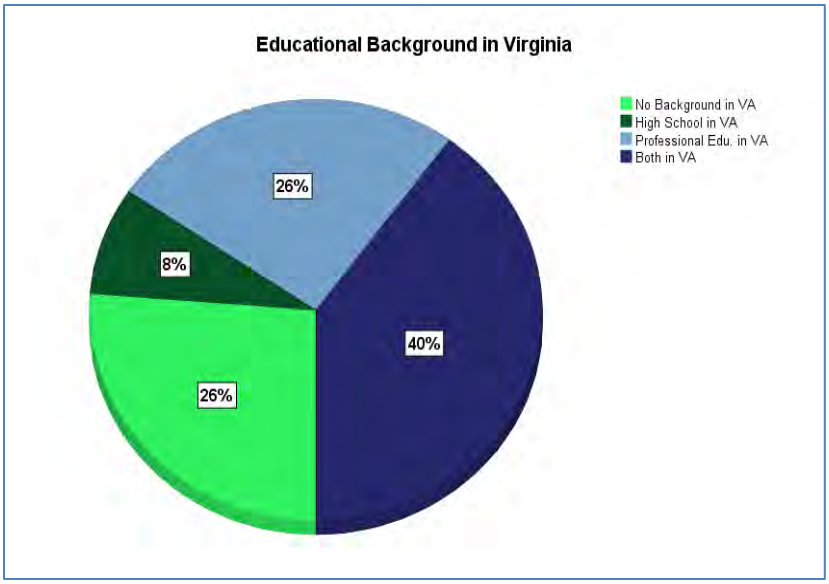
% Rural to Non-Metro:	22%
% Urban/Suburban to Non-Metro:	4%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Primary Location: USDA Rural Urban Continuum		Rural Status of Childhood Location		
Code	Description	Rural	Suburban	Urban
	Metro Counties			
1	Metro, 1 million+	20%	63%	17%
2	Metro, 250,000 to 1 million	42%	46%	12%
3	Metro, 250,000 or less	42%	49%	9%
	Non-Metro Counties			
4	Urban pop 20,000+, Metro adj	63%	26%	11%
6	Urban pop, 2,500-19,999, Metro adj	64%	30%	6%
7	Urban pop, 2,500-19,999, nonadj	91%	8%	1%
8	Rural, Metro adj	73%	24%	2%
9	Rural, nonadj	53%	45%	3%
	Overall	**31%**	**56%**	**14%**

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

31% of LPCs grew up in self-described rural areas, and 22% of these professionals currently work in non-metro counties. Overall, 9% of all LPCs in the state currently work in non-metro counties.

Top Ten States for Licensed Professional Counselor Recruitment

Rank	All LPCs			
	High School	#	Init. Prof Degree	#
1	Virginia	2,131	Virginia	2,886
2	New York	261	Maryland	141
3	Pennsylvania	223	Washington, D.C.	129
4	Maryland	189	North Carolina	93
5	Outside U.S./Canada	155	Florida	88
6	North Carolina	144	Minnesota	84
7	New Jersey	121	Pennsylvania	84
8	Florida	112	Ohio	72
9	Ohio	112	New York	71
10	California	71	Texas	63

Source: Va. Healthcare Workforce Data Center

48% of licensed LPCs received their high school degree in Virginia, and 65% received their initial professional degree in the state.

Among LPCs who received their initial license in the past five years, 49% received their high school degree in Virginia, while 63% received their initial professional degree in the state.

Rank	Licensed in the Past 5 Years			
	High School	#	Init. Prof Degree	#
1	Virginia	1,204	Virginia	1,541
2	New York	128	Minnesota	79
3	Maryland	108	Washington, D.C.	74
4	Pennsylvania	107	Maryland	70
5	Outside U.S./Canada	94	Florida	61
6	North Carolina	91	North Carolina	51
7	Florida	66	New York	46
8	Ohio	64	Pennsylvania	43
9	New Jersey	60	Ohio	40
10	California	37	Texas	36

Source: Va. Healthcare Workforce Data Center

13% of Virginia's licensees did not participate in the state's LPC workforce during the past year. 83% of these professionals worked at some point in the past year, including 72% who worked in a job related to behavioral sciences.

At a Glance:

Not in VA Workforce

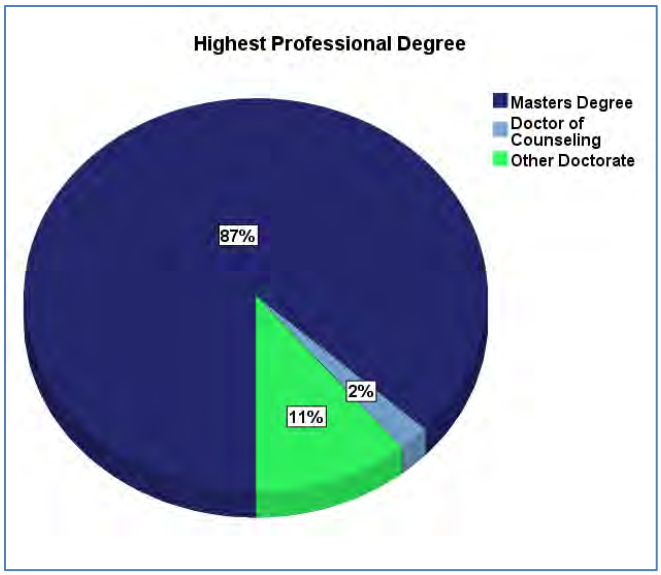
Total:	799
% of Licensees:	13%
Federal/Military:	8%
Va. Border State/DC:	22%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Highest Degree		
Degree	#	%
Master's Degree	3,813	87%
Doctor of Counseling	96	2%
Other Doctorate	478	11%
Total	**4,388**	**100%**

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

87% of LPCs hold a Master's degree as their highest professional degree. 47% of LPCs carry educational debt, including 70% of those under the age of 40. The median debt burden among LPCs with educational debt is between $70,000 and $80,000.

At a Glance:

Education

Master's Degree: 87%
Doctorate: 13%

Educational Debt

Carry debt: 47%
Under age 40 w/ debt: 70%
Median debt: $70k-$80k

Source: Va. Healthcare Workforce Data Center

Educational Debt				
Amount Carried	All LPCs		LPCs under 40	
	#	%	#	%
None	2,095	53%	346	30%
Less than $10,000	178	5%	59	5%
$10,000-$19,999	136	3%	51	4%
$20,000-$29,999	112	3%	51	4%
$30,000-$39,999	134	3%	55	5%
$40,000-$49,999	118	3%	56	5%
$50,000-$59,999	119	3%	54	5%
$60,000-$69,999	97	2%	42	4%
$70,000-$79,999	120	3%	66	6%
$80,000-$89,999	88	2%	52	5%
$90,000-$99,999	84	2%	35	3%
$100,000-$109,999	125	3%	56	5%
$110,000-$119,999	82	2%	47	4%
$120,000-$129,999	78	2%	44	4%
$130,000-$139,999	60	2%	30	3%
$140,000-$149,999	46	1%	17	1%
$150,000 or More	282	7%	88	8%
Total	**3,954**	**100%**	**1,149**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Primary Specialty

Mental Health:	57%
Child:	8%
Substance Abuse:	7%

Secondary Specialty

Mental Health:	15%
Substance Abuse:	15%
Behavioral Disorder:	12%

Source: Va. Healthcare Workforce Data Center

57% of all LPCs have a primary specialty in mental health. Another 8% have a primary specialty in children, while 7% have a primary specialty in substance abuse.

A Closer Look:

Specialties				
Specialty	Primary		Secondary	
	#	%	#	%
Mental Health	2,464	57%	593	15%
Child	357	8%	386	10%
Substance Abuse	288	7%	568	15%
Behavioral Disorders	240	6%	457	12%
Family	145	3%	362	9%
Marriage	112	3%	302	8%
School/Educational	83	2%	126	3%
Sex Offender Treatment	36	1%	49	1%
Forensic	24	1%	51	1%
Rehabilitation	22	1%	25	1%
Vocational/Work Environment	21	0%	31	1%
Health/Medical	9	0%	34	1%
Public Health	5	0%	7	0%
Social	5	0%	4	0%
Gerontologic	5	0%	17	0%
Neurology/Neuropsychology	3	0%	10	0%
Industrial-Organizational	2	0%	5	0%
Experimental or Research	0	0%	7	0%
Other Specialty Area	184	4%	335	9%
General Practice (Non-Specialty)	335	8%	540	14%
Total	**4,340**	**100%**	**3,910**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Employment

Employed in Profession:	94%
Involuntarily Unemployed:	< 1%

Positions Held

1 Full-time:	53%
2 or More Positions:	26%

Weekly Hours:

40 to 49:	45%
60 or more:	6%
Less than 30:	19%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Current Work Status		
Status	#	%
Employed, capacity unknown	2	0%
Employed in a behavioral sciences-related capacity	4,141	94%
Employed, NOT in a behavioral sciences-related capacity	105	2%
Not working, reason unknown	0	0%
Involuntarily unemployed	7	0%
Voluntarily unemployed	77	2%
Retired	73	2%
Total	**4,405**	**100%**

Source: Va. Healthcare Workforce Data Center

94% of LPCs are currently employed in their profession. 53% of LPCs hold one full-time job, and 45% work between 40 and 49 hours per week.

Current Weekly Hours		
Hours	#	%
0 hours	157	4%
1 to 9 hours	118	3%
10 to 19 hours	282	6%
20 to 29 hours	406	9%
30 to 39 hours	643	15%
40 to 49 hours	1,932	45%
50 to 59 hours	536	12%
60 to 69 hours	206	5%
70 to 79 hours	41	1%
80 or more hours	19	0%
Total	**4,340**	**100%**

Source: Va. Healthcare Workforce Data Center

Current Positions		
Positions	#	%
No Positions	157	4%
One Part-Time Position	719	17%
Two Part-Time Positions	199	5%
One Full-Time Position	2,320	53%
One Full-Time Position & One Part-Time Position	791	18%
Two Full-Time Positions	35	1%
More than Two Positions	116	3%
Total	**4,337**	**100%**

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Income		
Hourly Wage	#	%
Volunteer Work Only	41	1%
Less than $20,000	230	7%
$20,000-$29,999	203	6%
$30,000-$39,999	220	6%
$40,000-$49,999	367	10%
$50,000-$59,999	583	16%
$60,000-$69,999	626	18%
$70,000-$79,999	485	14%
$80,000-$89,999	285	8%
$90,000-$99,999	157	4%
$100,000-$109,999	149	4%
$110,000 or More	208	6%
Total	**3,556**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Earnings

Median Income: $60k-$70k

Benefits

(Salary & Wage Employees only)

Health Insurance: 61%

Retirement: 56%

Satisfaction

Satisfied: 96%

Very Satisfied: 71%

Source: Va. Healthcare Workforce Data Center

Job Satisfaction		
Level	#	%
Very Satisfied	3,031	70.5%
Somewhat Satisfied	1,109	25.8%
Somewhat Dissatisfied	120	2.8%
Very Dissatisfied	38	0.9%
Total	**4,299**	**100%**

Source: Va. Healthcare Workforce Data Center

The typical LPC earned between $60,000 and $70,000 per year. Among LPCs who received either an hourly wage or salary as compensation at the primary work location, 61% received health insurance and 56% also had access to some form of a retirement plan.

Employer-Sponsored Benefits			
Benefit	#	%	% of Wage/Salary Employees
Paid Vacation	2,036	49%	66%
Health Insurance	1,894	46%	61%
Paid Sick Leave	1,861	45%	61%
Dental Insurance	1,802	44%	59%
Retirement	1,718	41%	56%
Group Life Insurance	1,400	34%	46%
Signing/Retention Bonus	136	3%	4%
Received At Least One Benefit	**2,309**	**56%**	**73%**

*From any employer at time of survey.

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Employment Instability in Past Year		
In the past year did you . . .?	#	%
Experience Involuntary Unemployment?	41	1%
Experience Voluntary Unemployment?	212	4%
Work Part-time or temporary positions, but would have preferred a full-time/permanent position?	137	3%
Work two or more positions at the same time?	1,316	25%
Switch employers or practices?	397	8%
Experienced at least one	**1,742**	**34%**

Source: Va. Healthcare Workforce Data Center

Only 1% of Virginia's LPCs experienced involuntary unemployment at some point during the past year. By comparison, Virginia's average monthly unemployment rate was 2.9% during the past 12 months.[1]

Location Tenure				
Tenure	Primary		Secondary	
	#	%	#	%
Not Currently Working at this Location	74	2%	43	3%
Less than 6 Months	250	6%	138	11%
6 Months to 1 Year	373	9%	143	11%
1 to 2 Years	752	18%	263	21%
3 to 5 Years	1,006	24%	329	26%
6 to 10 Years	759	18%	160	13%
More than 10 Years	1,014	24%	185	15%
Subtotal	**4,229**	**100%**	**1,262**	**100%**
Did not have location	108		3,839	
Item Missing	837		73	
Total	**5,175**		**5,175**	

Source: Va. Healthcare Workforce Data Center

58% of LPCs are salaried employees, while 20% receive income from their own business/practice.

At a Glance:

Unemployment Experience

Involuntarily Unemployed:	1%
Underemployed:	3%

Turnover & Tenure

Switched Jobs:	8%
New Location:	21%
Over 2 years:	66%
Over 2 yrs, 2nd location:	53%

Employment Type

Salary/Commission:	58%
Business/Practice Income:	20%
Hourly Wage:	14%

Source: Va. Healthcare Workforce Data Center

66% of LPCs have worked at their primary location for more than two years, while 8% have switched jobs during the past 12 months.

Employment Type		
Primary Work Site	#	%
Salary/ Commission	2,013	58%
Business/ Practice Income	703	20%
Hourly Wage	490	14%
By Contract	254	7%
Unpaid	25	1%
Subtotal	**3,484**	**100%**
Did not have location	108	
Item Missing	1,583	

Source: Va. Healthcare Workforce Data Center

[1] The non-seasonally adjusted monthly unemployment rate ranged from 2.5% in April 2019 to 3.2% in January and February 2019. The rate for June 2019 was preliminary at the time of this report.

At a Glance:

Concentration

Top Region:	28%
Top 3 Regions:	69%
Lowest Region:	1%

Locations

2 or more (Past Year):	31%
2 or more (Now*):	29%

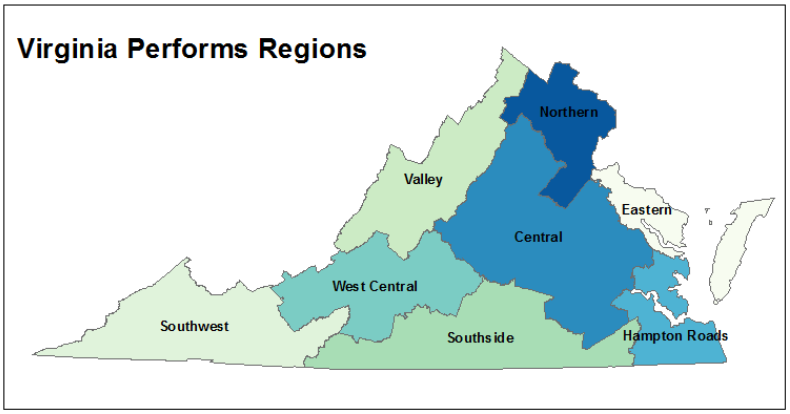
Source: Va. Healthcare Workforce Data Center

28% of LPCs work in Northern Virginia, the most of any region in the state. Another 21% work in Central Virginia whereas 20% work in Hampton Roads.

A Closer Look:

Regional Distribution of Work Locations				
Virginia Performs Region	Primary Location		Secondary Location	
	#	%	#	%
Central	872	21%	242	18%
Eastern	51	1%	21	2%
Hampton Roads	829	20%	273	21%
Northern	1,203	28%	354	27%
Southside	160	4%	53	4%
Southwest	173	4%	54	4%
Valley	330	8%	80	6%
West Central	572	14%	177	13%
Virginia Border State/DC	26	1%	22	2%
Other US State	19	0%	35	3%
Outside of the US	2	0%	4	0%
Total	**4,237**	**100%**	**1,315**	**100%**
Item Missing	828		19	

Source: Va. Healthcare Workforce Data Center



Number of Work Locations				
Locations	Work Locations in Past Year		Work Locations Now*	
	#	%	#	%
0	95	2%	151	4%
1	2,892	67%	2,932	68%
2	687	16%	671	16%
3	560	13%	514	12%
4	45	1%	28	1%
5	14	0%	7	0%
6 or More	24	1%	14	0%
Total	**4,317**	**100%**	**4,317**	**100%**

*At the time of survey completion, June 2019.

Source: Va. Healthcare Workforce Data Center

29% of all LPCs currently have multiple work locations, while 31% have had multiple work locations during the past year.

A Closer Look:

Location Sector				
Sector	Primary Location		Secondary Location	
	#	%	#	%
For-Profit	2,292	58%	863	73%
Non-Profit	713	18%	174	15%
State/Local Government	851	21%	129	11%
Veterans Administration	9	0%	1	0%
U.S. Military	81	2%	5	0%
Other Federal Government	38	1%	7	1%
Total	**3,984**	**100%**	**1,179**	**100%**
Did not have location	108		3839	
Item Missing	1,083		156	

Source: Va. Healthcare Workforce Data Center

At a Glance:
(Primary Locations)

Sector

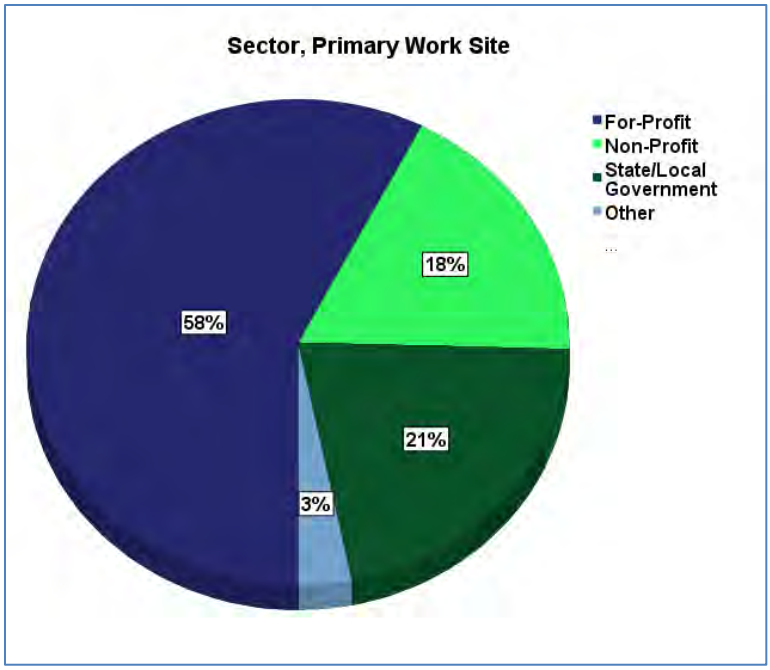
For Profit: 58%
Federal: 3%

Top Establishments

Private Practice, Solo: 18%
Private Practice, Group: 18%
Comm. Services Board: 15%

Source: Va. Healthcare Workforce Data Center

76% of LPCs work in the private sector, including 58% who work at for-profit establishments. Another 21% of LPCs work for state or local governments.



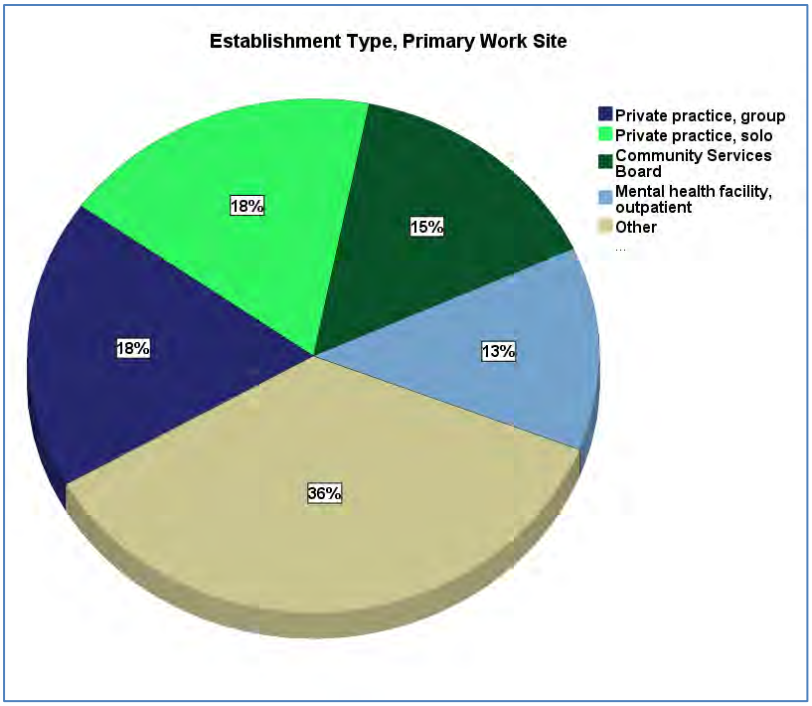
Source: Va. Healthcare Workforce Data Center

Location Type				
Establishment Type	Primary Location		Secondary Location	
	#	%	#	%
Private practice, group	686	18%	271	24%
Private practice, solo	686	18%	222	20%
Community Services Board	565	15%	75	7%
Mental health facility, outpatient	481	13%	161	14%
Community-based clinic or health center	330	9%	107	9%
School (providing care to clients)	206	5%	23	2%
Academic institution (teaching health professions students)	123	3%	59	5%
Residential mental health/substance abuse facility	71	2%	12	1%
Corrections/Jail	68	2%	10	1%
Hospital, psychiatric	68	2%	25	2%
Hospital, general	65	2%	22	2%
Administrative or regulatory	61	2%	7	1%
Rehabilitation facility	25	1%	8	1%
Other practice setting	327	9%	126	11%
Total	**3,762**	**100%**	**1,128**	**100%**
Did Not Have a Location	108		3,839	

Source: Va. Healthcare Workforce Data Center

36% of all LPCs work at either a solo or group private practice, while another 15% works at a community services board.

Among those LPCs who also have a secondary work location, 44% work at either a solo or group private practice, while 14% work at an outpatient mental health facility.



Source: Va. Healthcare Workforce Data Center

At a Glance:
(Primary Locations)

Typical Time Allocation

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

Roles

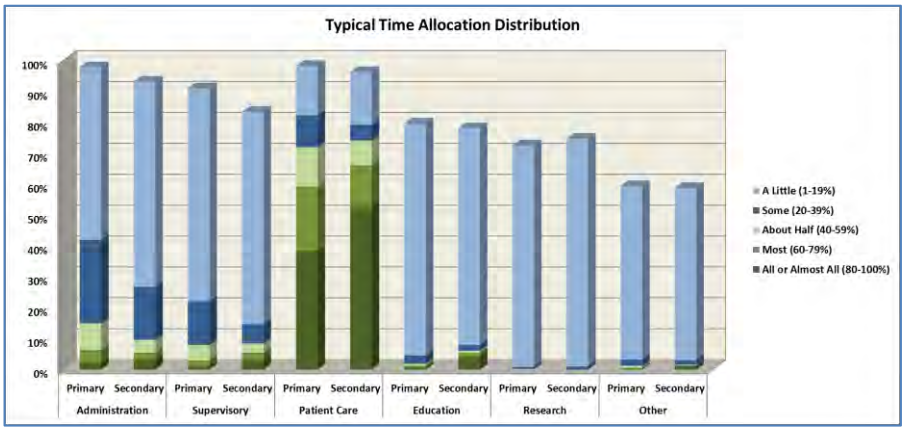
Patient Care:	59%
Administrative:	6%
Supervisory:	3%

Patient Care LPCs

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

Source: Va. Healthcare Workforce Data Center

A Closer Look:



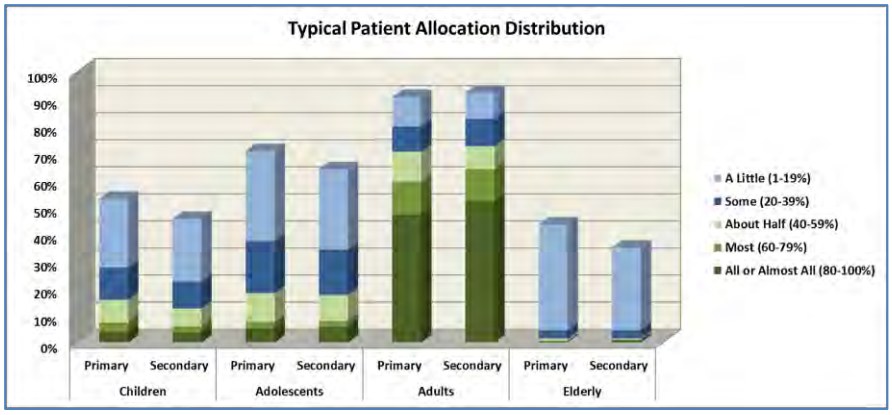
Source: Va. Healthcare Workforce Data Center

The typical LPC spends approximately two-thirds of her time treating patients. In fact, 59% of all LPCs fill a patient care role, defined as spending 60% or more of their time on patient care activities.

Time Allocation												
Time Spent	**Admin.**		**Supervisory**		**Patient Care**		**Education**		**Research**		**Other**	
	Prim. Site	Sec. Site	Prim. Site	Sec. Site	Prim. Site	Sec. Site	Prim. Site	Sec. Site	Prim. Site	Sec. Site	Prim. Site	Sec. Site
All or Almost All (80-100%)	2%	3%	1%	3%	38%	52%	1%	4%	0%	0%	0%	1%
Most (60-79%)	4%	2%	2%	2%	21%	13%	1%	1%	0%	0%	0%	0%
About Half (40-59%)	9%	4%	5%	3%	13%	8%	1%	1%	0%	0%	1%	0%
Some (20-39%)	27%	17%	14%	6%	10%	5%	3%	2%	1%	1%	2%	1%
A Little (1-19%)	56%	66%	69%	69%	16%	17%	75%	70%	72%	74%	56%	56%
None (0%)	2%	7%	9%	17%	2%	4%	20%	22%	27%	25%	41%	41%

Source: Va. Healthcare Workforce Data Center

A Closer Look:



Source: Va. Healthcare Workforce Data Center

Approximately three-quarters of all patients seen by a typical LPC at her primary work location are adults. In addition, 59% of LPCs serve an adult patient care role, meaning that at least 60% of their patients are adults.

At a Glance:
(Primary Locations)

Typical Patient Allocation

Children:	1%-9%
Adolescents:	10%-19%
Adults:	70%-79%
Elderly:	None

Roles

Children:	7%
Adolescents:	8%
Adults:	59%
Elderly:	1%

Source: Va. Healthcare Workforce Data Center

Patient Allocation								
Time Spent	Children		Adolescents		Adults		Elderly	
	Prim. Site	Sec. Site	Prim. Site	Sec. Site	Prim. Site	Sec. Site	Prim. Site	Sec. Site
All or Almost All (80-100%)	4%	4%	5%	6%	47%	52%	0%	1%
Most (60-79%)	3%	2%	2%	2%	12%	12%	0%	0%
About Half (40-59%)	8%	7%	11%	10%	11%	9%	1%	1%
Some (20-39%)	12%	10%	19%	17%	9%	10%	3%	3%
A Little (1-19%)	25%	23%	33%	30%	11%	10%	39%	30%
None (0%)	47%	54%	29%	36%	9%	8%	56%	65%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Patients Per Week

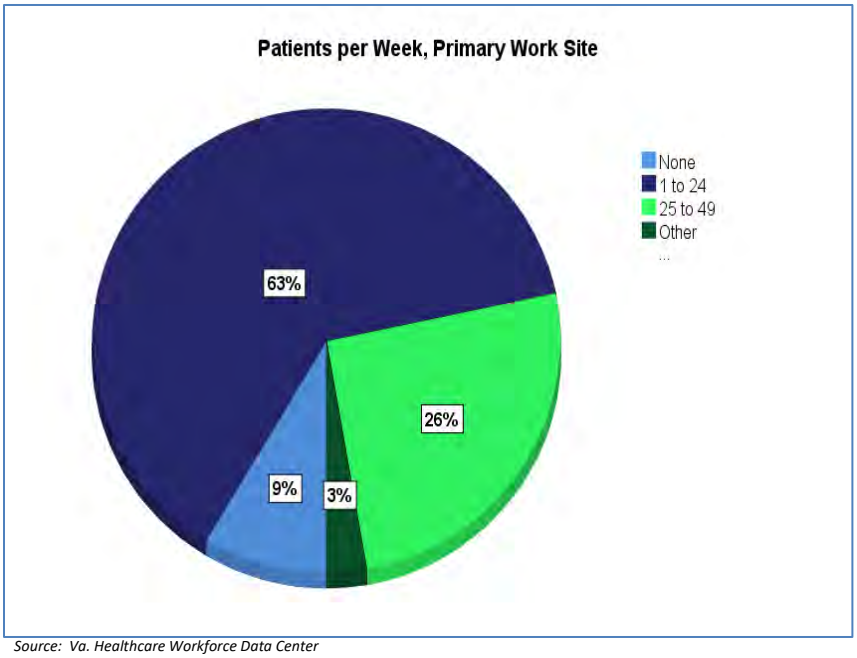
Primary Location: 1-24

Secondary Location: 1-24

Source: Va. Healthcare Workforce Data Center

Patients Per Week				
# of Patients	Primary Location		Secondary Location	
	#	%	#	%
None	341	9%	161	14%
1 to 24	2,504	63%	895	77%
25 to 49	1,014	26%	97	8%
50 to 74	54	1%	7	1%
75 or More	57	1%	3	0%
Total	**3,970**	**100%**	**1,163**	**100%**

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

63% of all LPCs treat between 1 and 24 patients per week at their primary work location. Among those LPCs who also have a secondary work location, 77% treat between 1 and 24 patients per week.

A Closer Look:

Retirement Expectations				
Expected Retirement Age	All LPCs		LPCs over 50	
	#	%	#	%
Under age 50	44	1%	0	0%
50 to 54	66	2%	6	0%
55 to 59	213	6%	41	2%
60 to 64	626	17%	190	11%
65 to 69	1,147	30%	498	29%
70 to 74	788	21%	455	27%
75 to 79	311	8%	205	12%
80 or over	108	3%	69	4%
I do not intend to retire	466	12%	247	14%
Total	**3,769**	**100%**	**1,711**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Retirement Expectations

All LPCs

Under 65: 25%
Under 60: 9%

LPCs 50 and over

Under 65: 14%
Under 60: 3%

Time until Retirement

Within 2 years: 5%
Within 10 years: 22%
Half the workforce: By 2044

Source: Va. Healthcare Workforce Data Center

9% of LPCs expect to retire no later than the age of 60, while 25% expect to retire by the age of 65. Among those LPCs who are ages 50 or over, 14% expect to retire by the age of 65.

Within the next two years, only 2% of Virginia's LPCs plan on leaving the state to practice elsewhere, while 1% plan on leaving the profession entirely. Meanwhile, 15% plan on increasing patient care hours, and 12% expect to pursue additional educational opportunities.

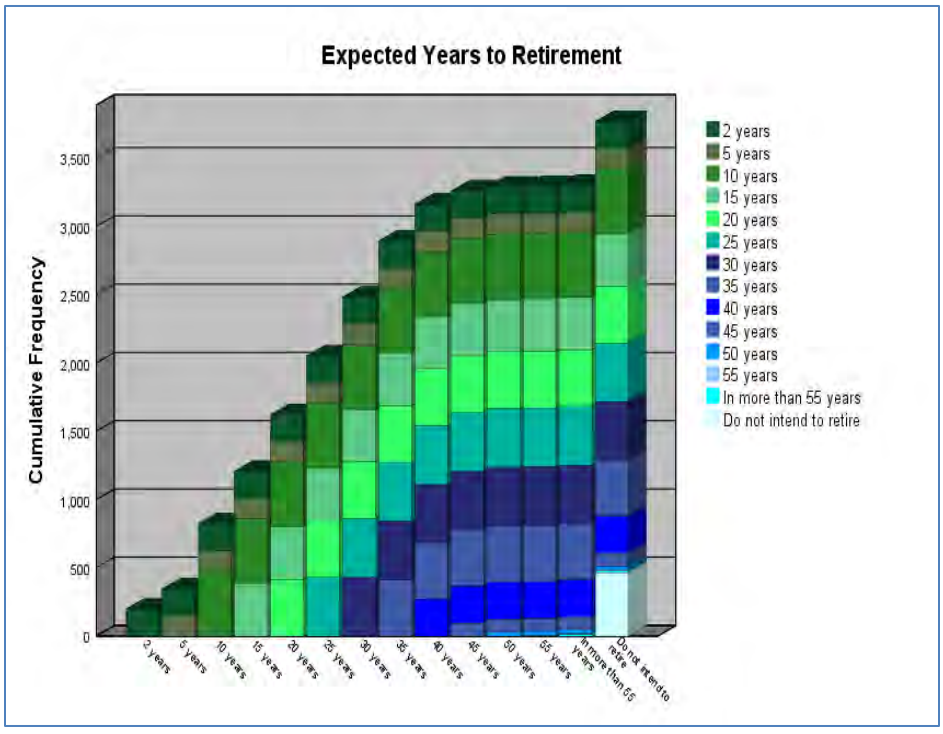
Future Plans		
2 Year Plans:	#	%
Decrease Participation		
Leave Profession	57	1%
Leave Virginia	117	2%
Decrease Patient Care Hours	424	8%
Decrease Teaching Hours	30	1%
Increase Participation		
Increase Patient Care Hours	792	15%
Increase Teaching Hours	369	7%
Pursue Additional Education	635	12%
Return to Virginia's Workforce	35	1%

Source: Va. Healthcare Workforce Data Center

By comparing retirement expectation to age, we can estimate the maximum years to retirement for LPCs. 5% of LPCs expect to retire in the next two years, while 22% plan on retiring in the next ten years. More than half of the current LPC workforce expects to retire by 2044.

Time to Retirement			
Expect to retire within. . .	#	%	Cumulative %
2 years	198	5%	5%
5 years	149	4%	9%
10 years	477	13%	22%
15 years	384	10%	32%
20 years	415	11%	43%
25 years	431	11%	54%
30 years	430	11%	66%
35 years	411	11%	77%
40 years	269	7%	84%
45 years	95	3%	86%
50 years	30	1%	87%
55 years	4	0%	87%
In more than 55 years	11	0%	88%
Do not intend to retire	466	12%	100%
Total	**3,769**	**100%**	

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

Using these estimates, retirements will begin to reach over 10% of the current workforce every five years by 2029. Retirements will peak at 13% of the current workforce around the same time period before declining to under 10% of the current workforce again around 2059.

At a Glance:

FTEs

Total:	4,402
FTEs/1,000 Residents[2]:	0.517
Average:	0.87

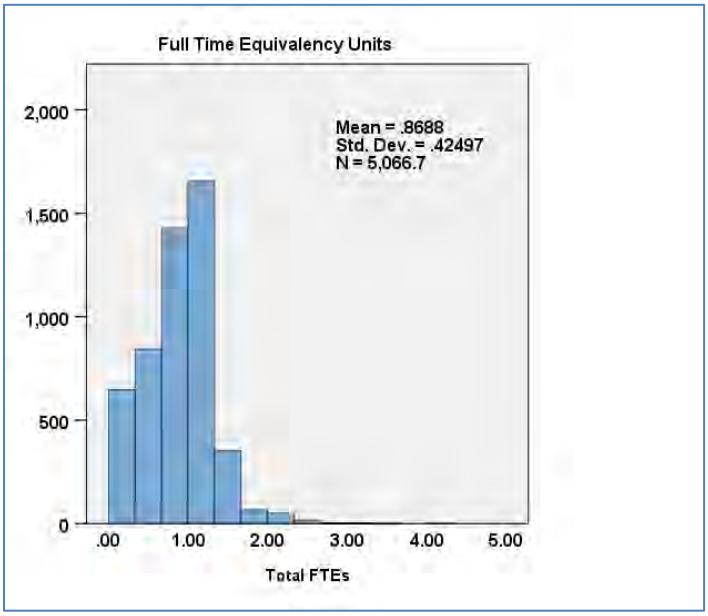
Age & Gender Effect

Age, Partial Eta[3]:	Medium
Gender, Partial Eta[3]:	Small

Partial Eta[3] Explained:
Partial Eta[3] is a statistical measure of effect size.

Source: Va. Healthcare Workforce Data Center

A Closer Look:

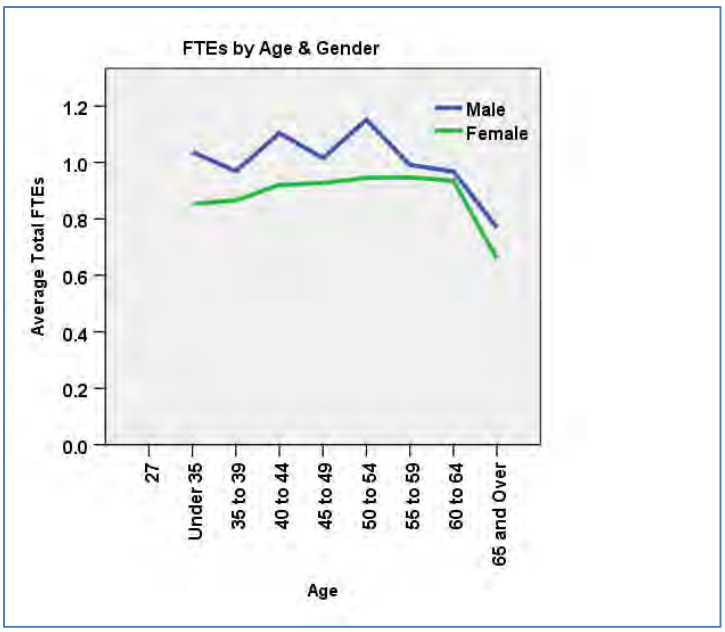


Source: Va. Healthcare Workforce Data Center

The typical (median) LPC provided 0.93 FTEs, or approximately 37 hours per week for 50 weeks. Although FTEs appear to vary by age and gender, statistical tests did not verify a difference exists.[3]

Full-Time Equivalency Units		
Age	**Average Age**	**Median Age**
Under 35	0.88	0.92
35 to 39	0.81	0.88
40 to 44	0.96	1.03
45 to 49	0.91	0.90
50 to 54	0.97	0.94
55 to 59	0.99	1.06
60 to 64	0.94	0.94
65 and Over	0.64	0.53
Gender		
Male	0.97	1.03
Female	0.87	0.93

Source: Va. Healthcare Workforce Data Center

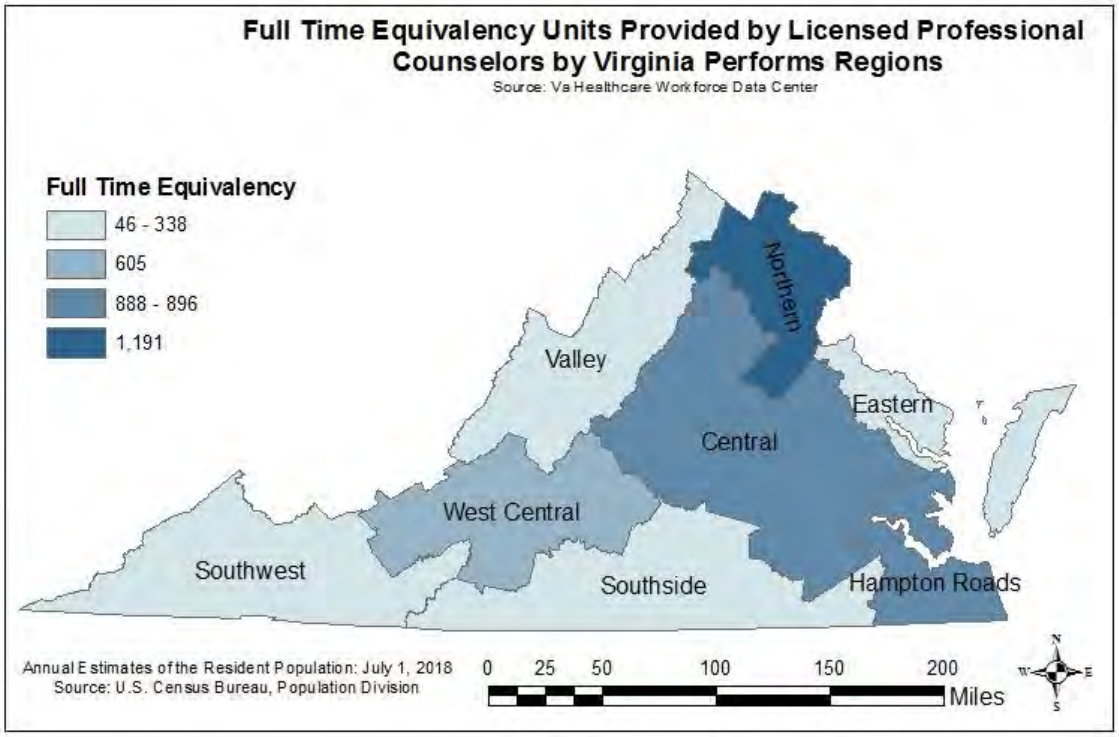


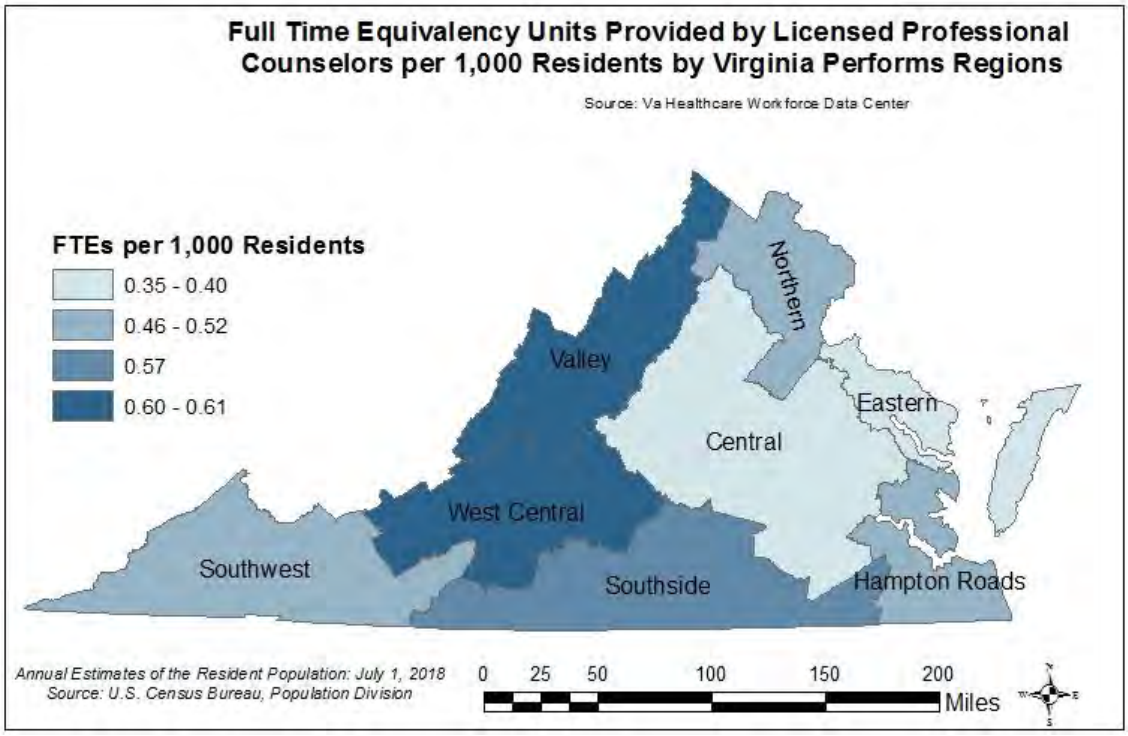
Source: Va. Healthcare Workforce Data Center

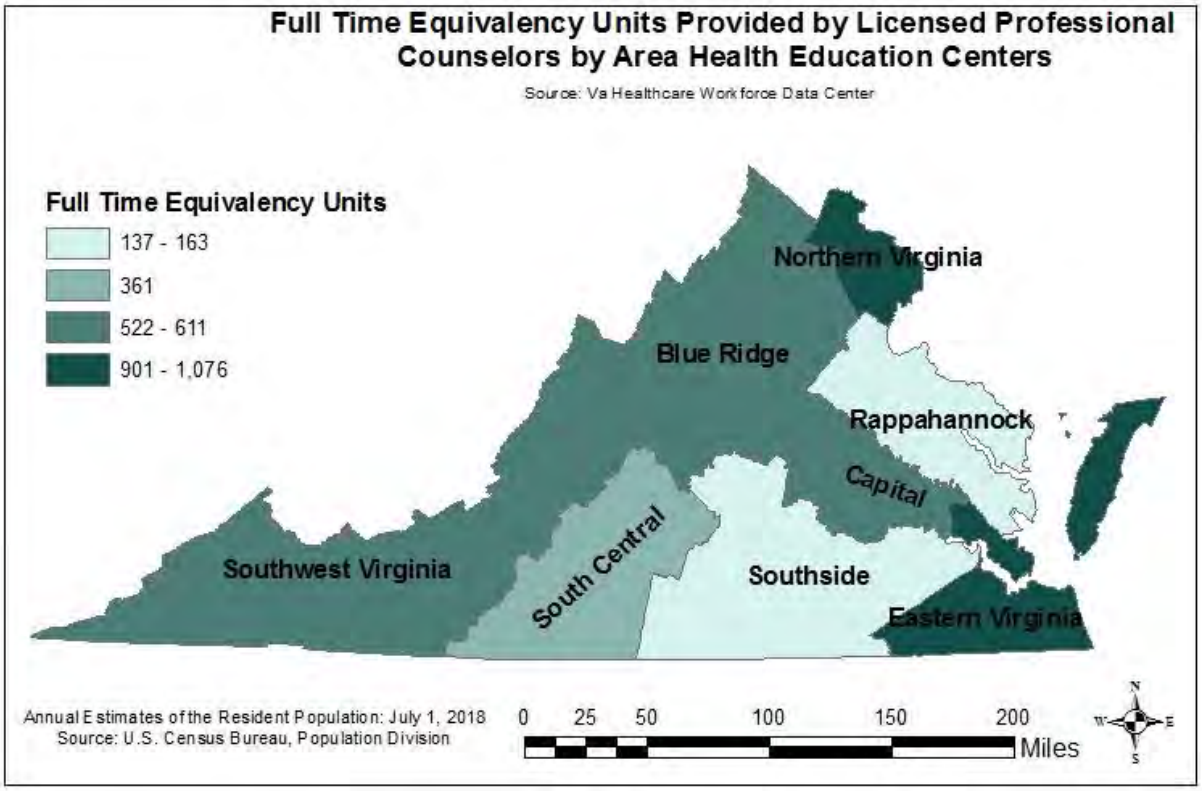
[2] Number of residents in 2018 was used as the denominator.
[3] Due to assumption violations in Mixed between-within ANOVA (Levene's Test is significant)

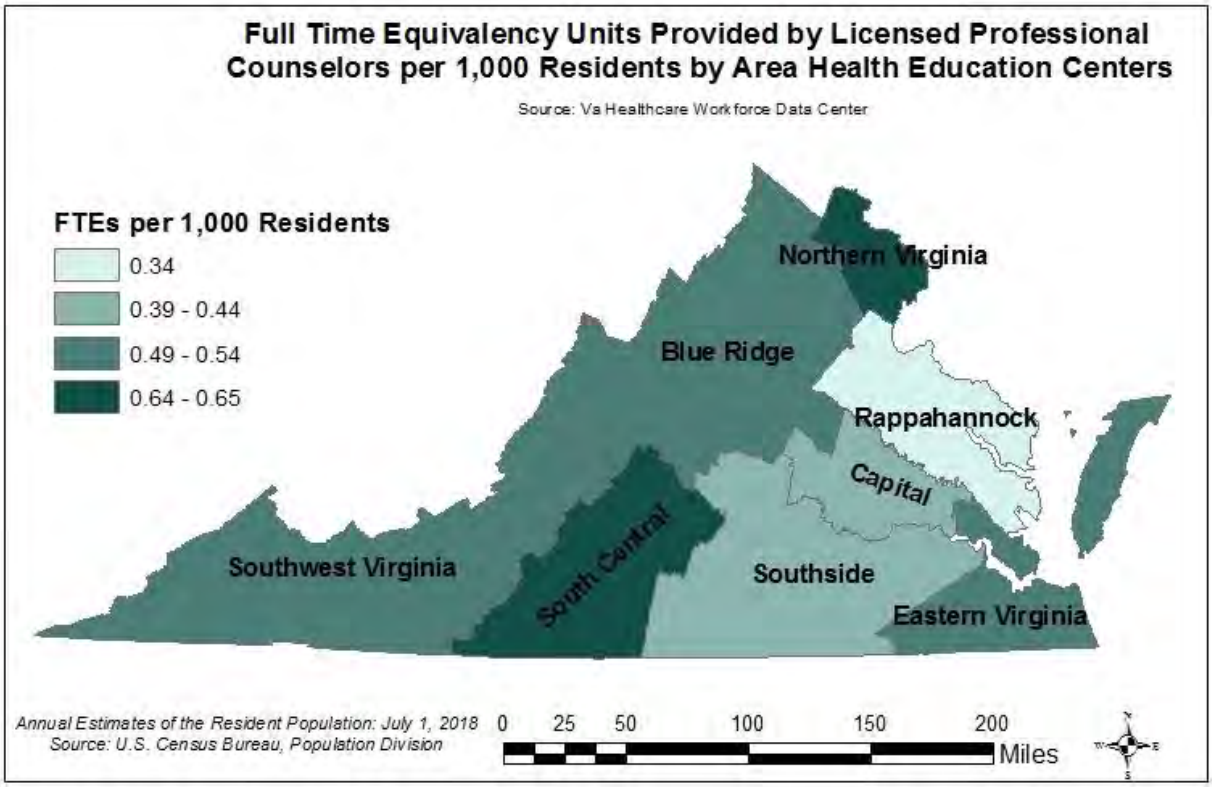
Maps

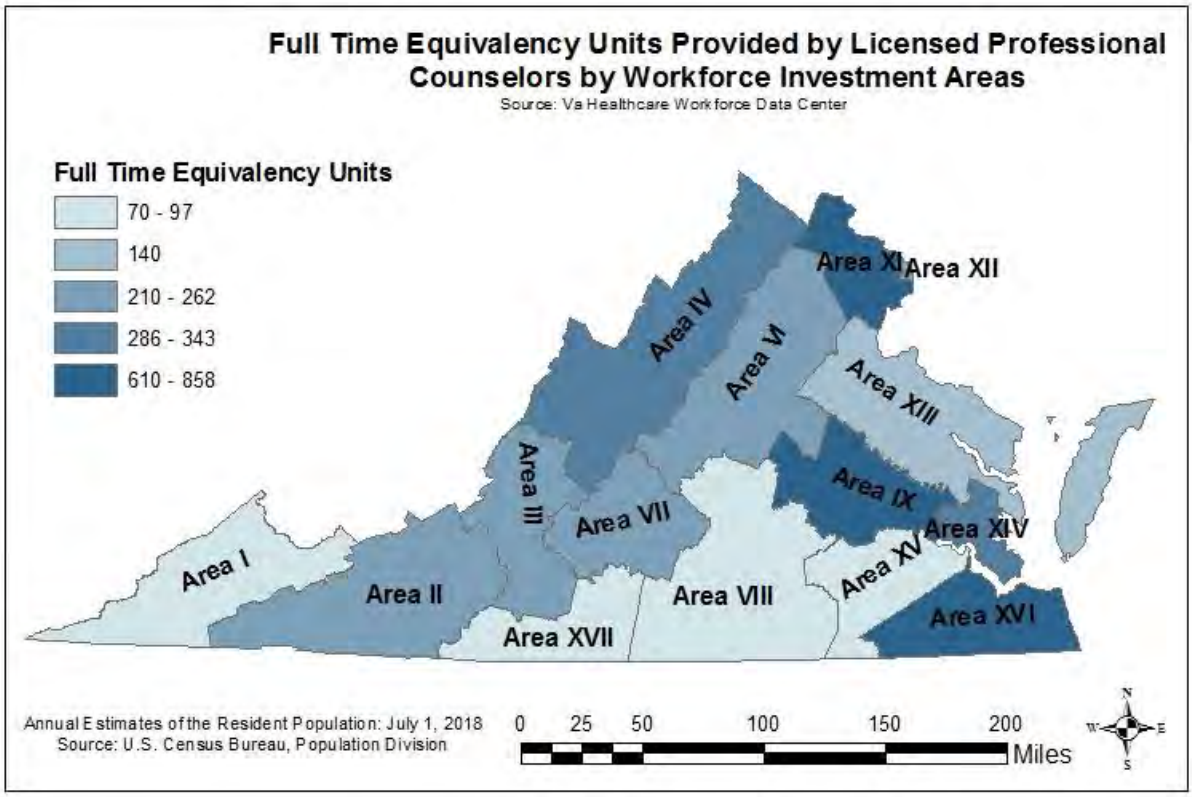
Virginia Performs Regions

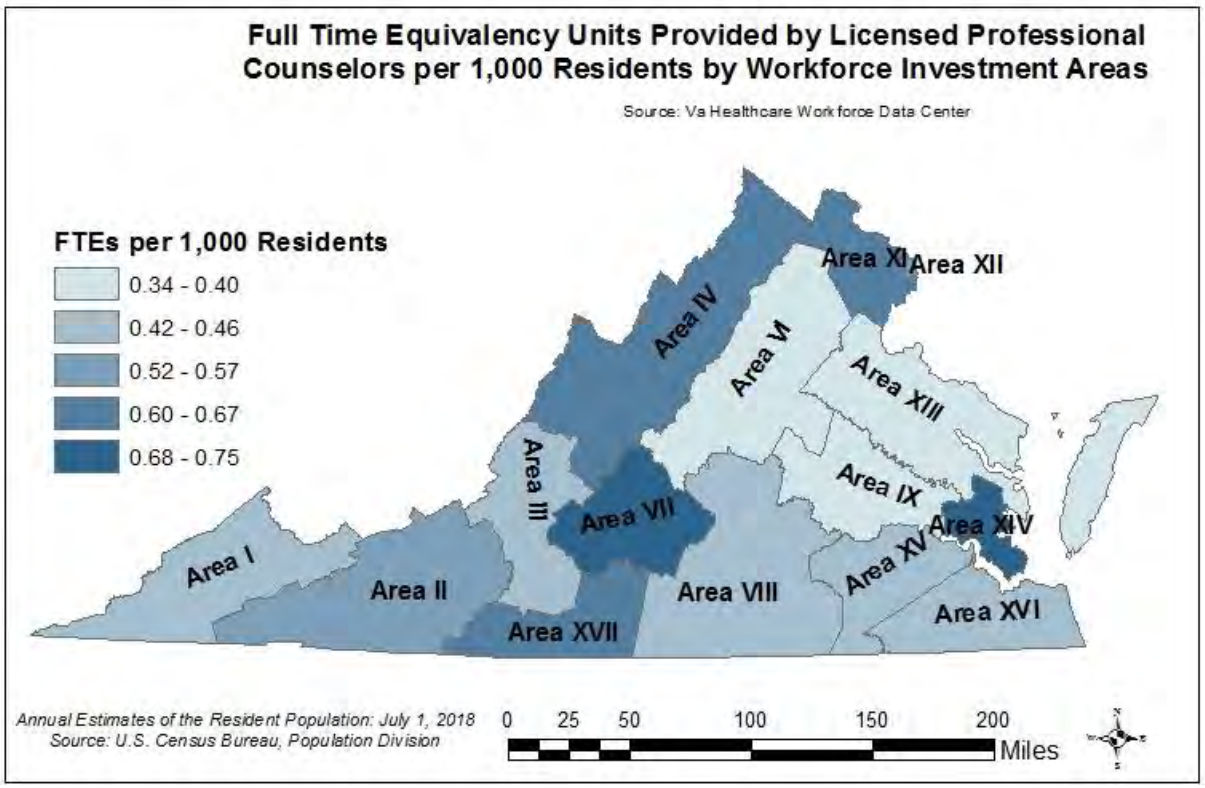


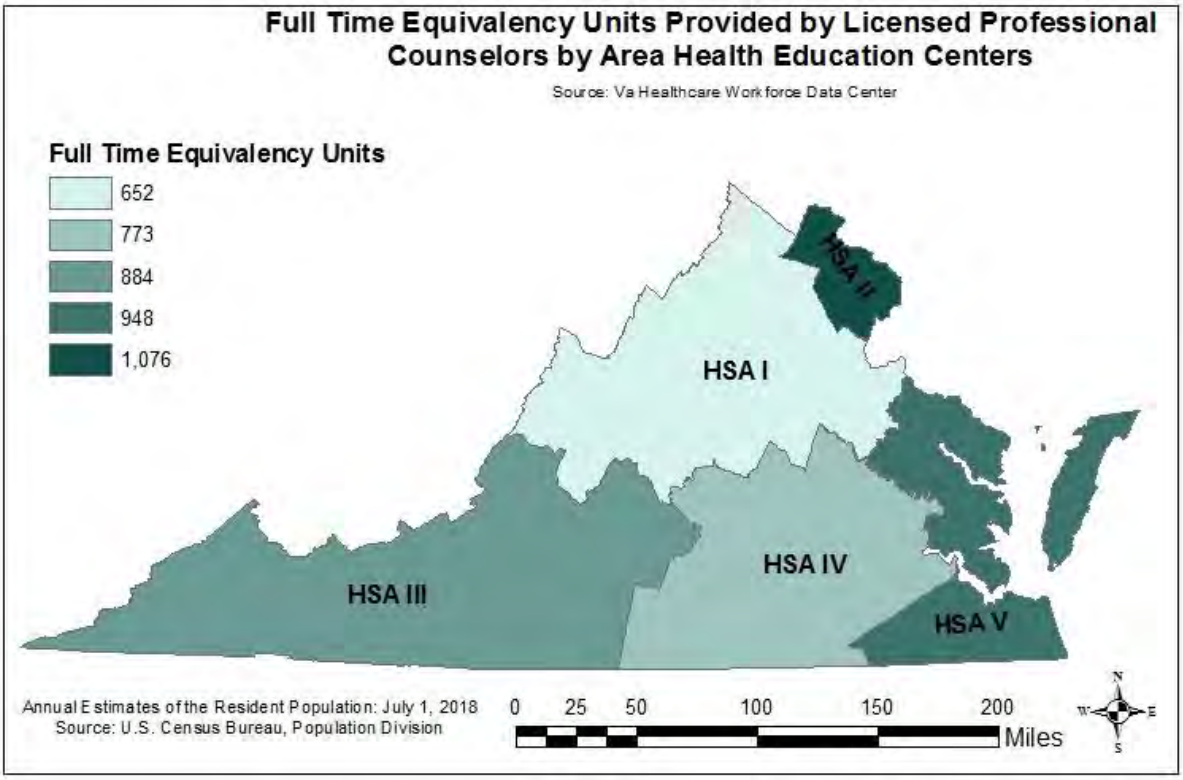


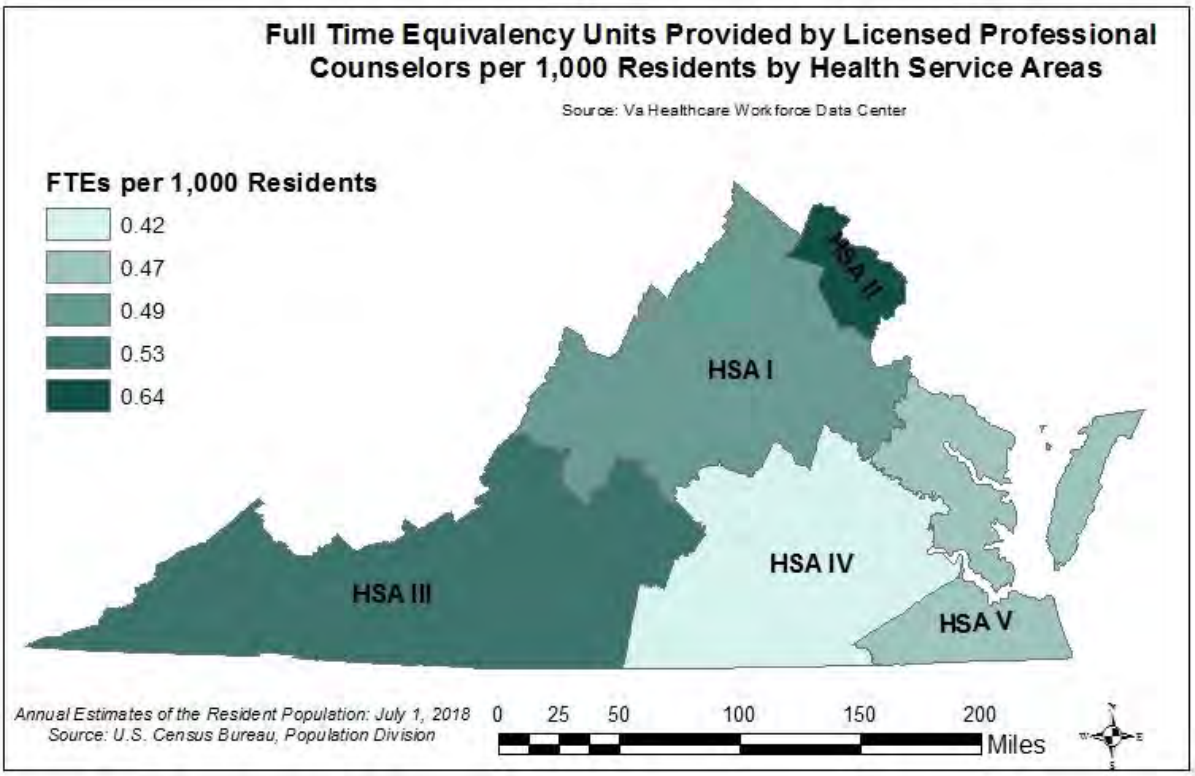

Full Time Equivalency Units Provided by Licensed Professional Counselors by Area Health Education Centers
Source: Va Healthcare Workforce Data Center
Full Time Equivalency Units
137 - 163
361
522 - 611
901 - 1,076
Northern Virginia
Blue Ridge
Rappahannock
Capital
Southwest Virginia
South Central
Southside
Eastern Virginia
Annual Estimates of the Resident Population: July 1, 2018
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S

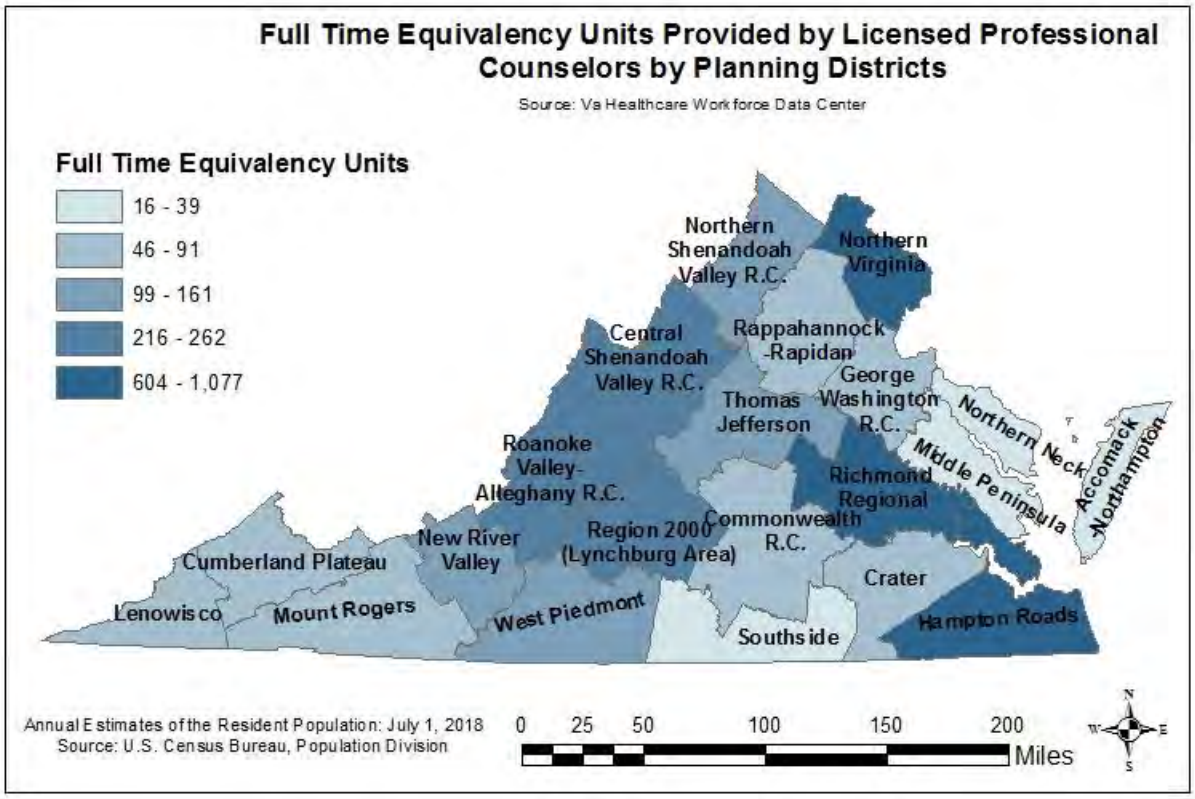

Full Time Equivalency Units Provided by Licensed Professional Counselors per 1,000 Residents by Area Health Education Centers
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.34
0.39 - 0.44
0.49 - 0.54
0.64 - 0.65
Northern Virginia
Blue Ridge
Rappahannock
Capital
Southwest Virginia
South Central
Southside
Eastern Virginia
Annual Estimates of the Resident Population: July 1, 2018
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S

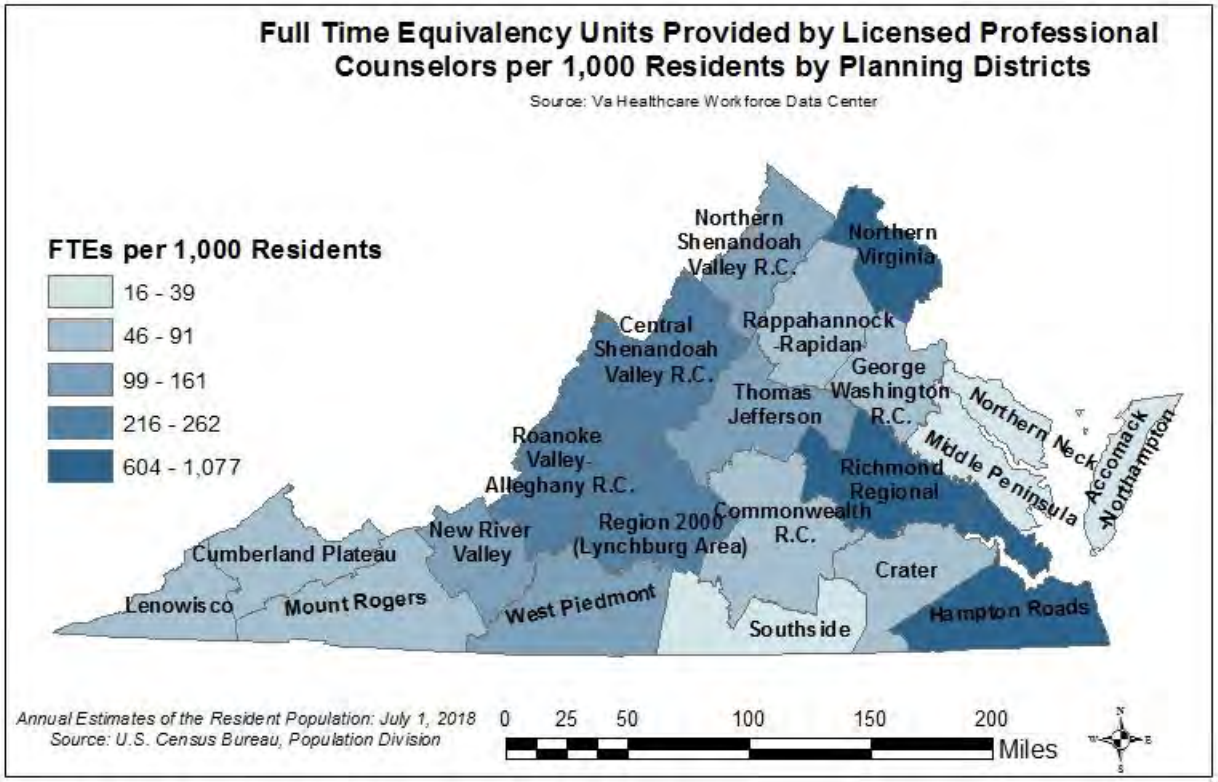

Full Time Equivalency Units Provided by Licensed Professional Counselors by Workforce Investment Areas
Source: Va Healthcare Workforce Data Center
Full Time Equivalency Units
70 - 97
140
210 - 262
286 - 343
610 - 858
Area I
Area II
Area III
Area IV
Area VI
Area VII
Area VIII
Area IX
Area XI
Area XII
Area XIII
Area XIV
Area XV
Area XVI
Area XVII
Annual Estimates of the Resident Population: July 1, 2018
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles


Full Time Equivalency Units Provided by Licensed Professional Counselors per 1,000 Residents by Workforce Investment Areas
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.34 - 0.40
0.42 - 0.46
0.52 - 0.57
0.60 - 0.67
0.68 - 0.75
Area I
Area II
Area III
Area IV
Area VI
Area VII
Area VIII
Area IX
Area XI
Area XII
Area XIII
Area XIV
Area XV
Area XVI
Area XVII
Annual Estimates of the Resident Population: July 1, 2018
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles


Full Time Equivalency Units Provided by Licensed Professional Counselors by Area Health Education Centers
Source: Va Healthcare Workforce Data Center
Full Time Equivalency Units
652
773
884
948
1,076
HSA I
HSA II
HSA III
HSA IV
HSA V
Annual Estimates of the Resident Population: July 1, 2018
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full Time Equivalency Units Provided by Licensed Professional Counselors per 1,000 Residents by Health Service Areas
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.42
0.47
0.49
0.53
0.64
HSA I
HSA II
HSA III
HSA IV
HSA V
Annual Estimates of the Resident Population: July 1, 2018
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full Time Equivalency Units Provided by Licensed Professional Counselors by Planning Districts
Source: Va Healthcare Workforce Data Center
Full Time Equivalency Units
16 - 39
46 - 91
99 - 161
216 - 262
604 - 1,077
Northern Shenandoah Valley R.C.
Northern Virginia
Central Shenandoah Valley R.C.
Rappahannock -Rapidan
George Washington R.C.
Thomas Jefferson
Northern Neck
Middle Peninsula
Accomack Northampton
Roanoke Valley-Alleghany R.C.
Richmond Regional
Commonwealth R.C.
Region 2000 (Lynchburg Area)
New River Valley
Cumberland Plateau
Crater
Lenowisco
Mount Rogers
West Piedmont
Southside
Hampton Roads
Annual Estimates of the Resident Population: July 1, 2018
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full Time Equivalency Units Provided by Licensed Professional Counselors per 1,000 Residents by Planning Districts
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FTEs per 1,000 Residents
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Northern Shenandoah Valley R.C.
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Crater
Lenowisco
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West Piedmont
Southside
Hampton Roads
Annual Estimates of the Resident Population: July 1, 2018
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S

Appendix A: Weights

Rural Status	Location Weight			Total Weight	
	#	Rate	Weight	Min	Max
Metro, 1 million+	3395	86.98%	1.1497	1.0813	1.3068
Metro, 250,000 to 1 million	628	89.17%	1.1214	1.0547	1.2747
Metro, 250,000 or less	708	89.41%	1.1185	1.0519	1.2714
Urban pop 20,000+, Metro adj	64	87.50%	1.1429	1.0749	1.2991
Urban pop 20,000+, nonadj	0	NA	NA	NA	NA
Urban pop, 2,500-19,999, Metro adj	168	86.31%	1.1586	1.0897	1.3170
Urban pop, 2,500-19,999, nonadj	114	87.72%	1.1400	1.0722	1.2958
Rural, Metro adj	72	90.28%	1.1077	1.0418	1.2591
Rural, nonadj	28	89.29%	1.1200	1.0636	1.2731
Virginia border state/DC	450	83.78%	1.1936	1.1226	1.3568
Other US State	345	80.58%	1.2410	1.1672	1.4107

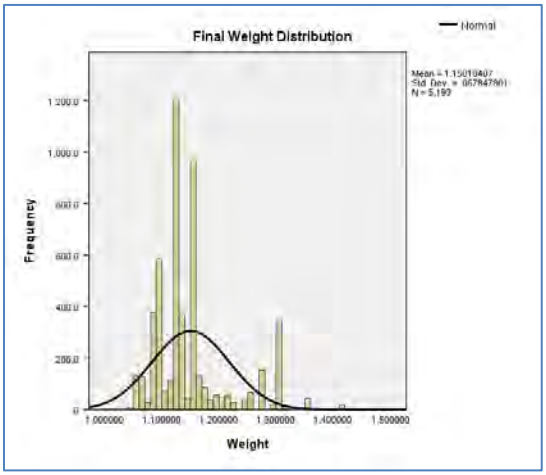
Source: Va. Healthcare Workforce Data Center

See the Methods section on the HWDC website for details on HWDC Methods: www.dhp.virginia.gov/hwdc/

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

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

Overall Response Rate: 0.869412



Source: Va. Healthcare Workforce Data Center

Age	Age Weight			Total Weight	
	#	Rate	Weight	Min	Max
Under 35	791	76.49%	1.307438	1.259117	1.410656
35 to 39	836	86.72%	1.153103	1.110486	1.244137
40 to 44	758	88.65%	1.127976	1.086288	1.217027
45 to 49	704	88.78%	1.1264	1.08477	1.215326
50 to 54	635	92.44%	1.081772	1.041791	1.167174
55 to 59	579	87.74%	1.139764	1.09764	1.229745
60 to 64	568	91.55%	1.092308	1.051938	1.178542
65 and Over	1102	86.30%	1.15878	1.115953	1.250262

Source: Va. Healthcare Workforce Data Center

Executive Director’s Report

	109 Counseling
Board Cash Balance as June 30, 2019	$ 1,825,713
YTD FY20 Revenue	191,795
Less: YTD FY20 Direct and Allocated Expenditures	494,151
Board Cash Balance as September 30, 2019	$ 1,523,356

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 10900 - Counseling

For the Period Beginning July 1, 2019 and Ending September 30, 2019

Account Number	Account Description	Amount	Budget	Amount Under/(Over) Budget	% of Budget
4002400	Fee Revenue				
4002401	Application Fee	126,180.00	444,600.00	318,420.00	28.38%
4002406	License & Renewal Fee	36,820.00	1,206,610.00	1,169,790.00	3.05%
4002407	Dup. License Certificate Fee	850.00	825.00	(25.00)	103.03%
4002409	Board Endorsement - Out	1,470.00	1,740.00	270.00	84.48%
4002421	Monetary Penalty & Late Fees	16,280.00	13,960.00	(2,320.00)	116.62%
4002430	Board Changes Fee	9,390.00	-	(9,390.00)	0.00%
4002432	Misc. Fee (Bad Check Fee)	210.00	140.00	(70.00)	150.00%
	Total Fee Revenue	191,200.00	1,667,875.00	1,476,675.00	11.46%
4003000	Sales of Prop. & Commodities				
4003020	Misc. Sales-Dishonored Payments	595.00	-	(595.00)	0.00%
	Total Sales of Prop. & Commodities	595.00	-	(595.00)	0.00%
	Total Revenue	191,795.00	1,667,875.00	1,476,080.00	11.50%
5011110	Employer Retirement Contrib.	4,347.87	15,891.00	11,543.13	27.36%
5011120	Fed Old-Age Ins- Sal St Emp	3,209.33	8,993.00	5,783.67	35.69%
5011140	Group Insurance	497.26	1,540.00	1,042.74	32.29%
5011150	Medical/Hospitalization Ins.	4,809.00	16,488.00	11,679.00	29.17%
5011160	Retiree Medical/Hospitalizatn	444.06	1,376.00	931.94	32.27%
5011170	Long term Disability Ins	235.41	729.00	493.59	32.29%
	Total Employee Benefits	13,542.93	45,017.00	31,474.07	30.08%
5011200	Salaries				
5011230	Salaries, Classified	38,104.22	117,537.00	79,432.78	32.42%
5011250	Salaries, Overtime	4,686.86	-	(4,686.86)	0.00%
	Total Salaries	42,791.08	117,537.00	74,745.92	36.41%
5011300	Special Payments				
5011310	Bonuses and Incentives	-	1,000.00	1,000.00	0.00%
5011340	Specified Per Diem Payment	600.00	3,000.00	2,400.00	20.00%
5011380	Deferred Compnstn Match Pmts	140.00	1,288.00	1,148.00	10.87%
	Total Special Payments	740.00	5,288.00	4,548.00	13.99%
5011600	Terminatn Personal Svce Costs				
5011660	Defined Contribution Match - Hy	784.13	-	(784.13)	0.00%
	Total Terminatn Personal Svce Costs	784.13	-	(784.13)	0.00%
5011930	Turnover/Vacancy Benefits		-	-	0.00%
	Total Personal Services	57,858.14	167,842.00	109,983.86	34.47%
5012000	Contractual Svs				
5012100	Communication Services				
5012110	Express Services	-	295.00	295.00	0.00%
5012120	Outbound Freight Services	27.45	-	(27.45)	0.00%
5012140	Postal Services	11,387.52	8,232.00	(3,155.52)	138.33%
5012150	Printing Services	11.75	120.00	108.25	9.79%
5012160	Telecommunications Svcs (VITA)	156.44	900.00	743.56	17.38%

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 10900 - Counseling

For the Period Beginning July 1, 2019 and Ending September 30, 2019

Account Number	Account Description	Amount	Budget	Amount Under/(Over) Budget	% of Budget
5012190	Inbound Freight Services	641.81	-	(641.81)	0.00%
	Total Communication Services	12,224.97	9,547.00	(2,677.97)	128.05%
5012200	Employee Development Services				
5012210	Organization Memberships	900.00	500.00	(400.00)	180.00%
5012240	Employee Trainng/Workshop/Conf	1,425.00	-	(1,425.00)	0.00%
	Total Employee Development Services	2,325.00	500.00	(1,825.00)	465.00%
5012300	Health Services				
5012360	X-ray and Laboratory Services	2,400.00	140.00	(2,260.00)	1714.29%
	Total Health Services	2,400.00	140.00	(2,260.00)	1714.29%
5012400	Mgmnt and Informational Svcs	-			
5012420	Fiscal Services	23,373.69	9,280.00	(14,093.69)	251.87%
5012440	Management Services	137.41	134.00	(3.41)	102.54%
5012460	Public Infrmtnl & Relatn Svcs	42.00	5.00	(37.00)	840.00%
5012470	Legal Services	-	475.00	475.00	0.00%
	Total Mgmnt and Informational Svcs	23,553.10	9,894.00	(13,659.10)	238.05%
5012500	Repair and Maintenance Svcs				
5012520	Electrical Repair & Maint Srvc	97.50	-	(97.50)	0.00%
5012560	Mechanical Repair & Maint Srvc	-	34.00	34.00	0.00%
	Total Repair and Maintenance Svcs	97.50	34.00	(63.50)	286.76%
5012600	Support Services				
5012630	Clerical Services	30,669.68	110,551.00	79,881.32	27.74%
5012640	Food & Dietary Services	678.03	1,075.00	396.97	63.07%
5012660	Manual Labor Services	380.09	1,170.00	789.91	32.49%
5012670	Production Services	2,440.05	5,380.00	2,939.95	45.35%
5012680	Skilled Services	4,012.38	16,764.00	12,751.62	23.93%
	Total Support Services	38,180.23	134,940.00	96,759.77	28.29%
5012800	Transportation Services				
5012820	Travel, Personal Vehicle	1,535.84	4,979.00	3,443.16	30.85%
5012830	Travel, Public Carriers	522.71	-	(522.71)	0.00%
5012850	Travel, Subsistence & Lodging	2,844.01	1,950.00	(894.01)	145.85%
5012880	Trvl, Meal Reimb- Not Rprtble	732.50	988.00	255.50	74.14%
	Total Transportation Services	5,635.06	7,917.00	2,281.94	71.18%
	Total Contractual Svs	84,415.86	162,972.00	78,556.14	51.80%
5013000	Supplies And Materials				
5013100	Administrative Supplies				
5013120	Office Supplies	1,153.21	597.00	(556.21)	193.17%
5013130	Stationery and Forms	89.07	-	(89.07)	0.00%
	Total Administrative Supplies	1,242.28	597.00	(645.28)	208.09%
5013600	Residential Supplies				
5013630	Food Service Supplies	-	183.00	183.00	0.00%
	Total Residential Supplies	-	183.00	183.00	0.00%
	Total Supplies And Materials	1,242.28	780.00	(462.28)	159.27%

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 10900 - Counseling

For the Period Beginning July 1, 2019 and Ending September 30, 2019

Account Number	Account Description	Amount	Budget	Amount Under/(Over) Budget	% of Budget
5015000	Continuous Charges				
5015100	Insurance-Fixed Assets				
5015160	Property Insurance	54.87	46.00	(8.87)	119.28%
	Total Insurance-Fixed Assets	54.87	46.00	(8.87)	119.28%
5015300	Operating Lease Payments				
5015340	Equipment Rentals	114.17	540.00	425.83	21.14%
5015350	Building Rentals	22.80	-	(22.80)	0.00%
5015360	Land Rentals	-	60.00	60.00	0.00%
5015390	Building Rentals - Non State	2,924.31	12,584.00	9,659.69	23.24%
	Total Operating Lease Payments	3,061.28	13,184.00	10,122.72	23.22%
5015500	Insurance-Operations				
5015510	General Liability Insurance	196.94	170.00	(26.94)	115.85%
5015540	Surety Bonds	11.62	11.00	(0.62)	105.64%
	Total Insurance-Operations	208.56	181.00	(27.56)	115.23%
	Total Continuous Charges	3,324.71	13,411.00	10,086.29	24.79%
5022000	Equipment				
5022200	Educational & Cultural Equip				
5022240	Reference Equipment	-	77.00	77.00	0.00%
	Total Educational & Cultural Equip	-	77.00	77.00	0.00%
5022600	Office Equipment				
5022610	Office Appurtenances	-	42.00	42.00	0.00%
5022620	Office Furniture	6,396.53	-	(6,396.53)	0.00%
	Total Office Equipment	6,396.53	42.00	(6,354.53)	15229.83%
5022700	Specific Use Equipment				
5022710	Household Equipment	20.37	-	(20.37)	0.00%
	Total Specific Use Equipment	20.37	-	(20.37)	0.00%
	Total Equipment	6,416.90	119.00	(6,297.90)	5392.35%
	Total Expenditures	153,257.89	345,124.00	191,866.11	44.41%
	Net Revenue in Excess (Shortfall) of Expenditures Before Allocated Expenditures	$ 38,537.11	$ 1,322,751.00	$ 1,284,213.89	2.91%
	Allocated Expenditures				
20100	Behavioral Science Exec	59,084.39	231,276.00	172,191.62	25.55%
30100	Data Center	70,071.82	280,114.83	210,043.00	25.02%
30200	Human Resources	1,631.71	8,928.42	7,296.71	18.28%
30300	Finance	33,990.55	106,278.12	72,287.57	31.98%
30400	Director's Office	15,165.00	42,280.20	27,115.20	35.87%
30500	Enforcement	100,422.63	196,848.63	96,426.00	51.02%
30600	Administrative Proceedings	42,195.83	54,754.55	12,558.71	77.06%
30700	Impaired Practitioners	151.07	347.15	196.08	43.52%
30800	Attorney General	-	13,080.11	13,080.11	0.00%

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 10900 - Counseling

For the Period Beginning July 1, 2019 and Ending September 30, 2019

Account Number	Account Description	Amount	Budget	Amount Under/(Over) Budget	% of Budget
30900	Board of Health Professions	11,216.60	30,765.02	19,548.42	36.46%
31100	Maintenance and Repairs	-	1,602.96	1,602.96	0.00%
31300	Emp. Recognition Program	3.69	404.02	400.32	0.91%
31400	Conference Center	29.73	384.16	354.43	7.74%
31500	Pgm Devlpmnt & Implmentn	6,930.41	18,094.59	11,164.18	38.30%
	Total Allocated Expenditures	340,893.43	985,158.75	644,265.32	34.60%
	Net Revenue in Excess (Shortfall) of Expenditures	$ (302,356.32)	$ 337,592.25	$ 639,948.57	89.56%

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 10900 - Counseling

For the Period Beginning July 1, 2019 and Ending September 30, 2019

Account Number	Account Description	July	August	September	Total
4002400	Fee Revenue				
4002401	Application Fee	45,000.00	40,795.00	40,385.00	126,180.00
4002406	License & Renewal Fee	28,860.00	5,665.00	2,295.00	36,820.00
4002407	Dup. License Certificate Fee	280.00	300.00	270.00	850.00
4002409	Board Endorsement - Out	510.00	450.00	510.00	1,470.00
4002421	Monetary Penalty & Late Fees	12,715.00	2,355.00	1,210.00	16,280.00
4002430	Board Changes Fee	3,150.00	3,265.00	2,975.00	9,390.00
4002432	Misc. Fee (Bad Check Fee)	105.00	105.00	-	210.00
	Total Fee Revenue	90,620.00	52,935.00	47,645.00	191,200.00
4003000	Sales of Prop. & Commodities				
4003020	Misc. Sales-Dishonored Payments	115.00	350.00	130.00	595.00
	Total Sales of Prop. & Commodities	115.00	350.00	130.00	595.00
	Total Revenue	90,735.00	53,285.00	47,775.00	191,795.00
5011000	Personal Services				
5011100	Employee Benefits				
5011110	Employer Retirement Contrib.	1,853.83	1,247.02	1,247.02	4,347.87
5011120	Fed Old-Age Ins- Sal St Emp	1,359.98	954.74	894.61	3,209.33
5011140	Group Insurance	212.02	142.62	142.62	497.26
5011150	Medical/Hospitalization Ins.	2,061.00	1,374.00	1,374.00	4,809.00
5011160	Retiree Medical/Hospitalizatn	189.34	127.36	127.36	444.06
5011170	Long term Disability Ins	100.37	67.52	67.52	235.41
	Total Employee Benefits	5,776.54	3,913.26	3,853.13	13,542.93
5011200	Salaries				
5011230	Salaries, Classified	16,330.38	10,886.92	10,886.92	38,104.22
5011250	Salaries, Overtime	1,815.37	1,828.62	1,042.87	4,686.86
	Total Salaries	18,145.75	12,715.54	11,929.79	42,791.08
5011340	Specified Per Diem Payment	150.00	400.00	50.00	600.00
5011380	Deferred Compnstn Match Pmts	60.00	40.00	40.00	140.00
	Total Special Payments	210.00	440.00	90.00	740.00
5011600	Terminatn Personal Svce Costs				
5011660	Defined Contribution Match - Hy	334.33	224.90	224.90	784.13
	Total Terminatn Personal Svce Costs	334.33	224.90	224.90	784.13
	Total Personal Services	24,466.62	17,293.70	16,097.82	57,858.14
5012000	Contractual Svs				-
5012100	Communication Services				-
5012120	Outbound Freight Services	22.39	5.06	-	27.45
5012140	Postal Services	3,103.22	5,364.73	2,919.57	11,387.52
5012150	Printing Services	11.75	-	-	11.75
5012160	Telecommunications Svcs (VITA)	54.84	50.70	50.90	156.44

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 10900 - Counseling

For the Period Beginning July 1, 2019 and Ending September 30, 2019

Account Number	Account Description	July	August	September	Total
5012190	Inbound Freight Services	2.16	639.65	-	641.81
	Total Communication Services	3,194.36	6,060.14	2,970.47	12,224.97
5012200	Employee Development Services				
5012210	Organization Memberships	900.00	-	-	900.00
5012240	Employee Trainng/Workshop/Conf	1,425.00	-	-	1,425.00
	Total Employee Development Services	2,325.00	-	-	2,325.00
5012300	Health Services				
5012360	X-ray and Laboratory Services	-	2,400.00	-	2,400.00
	Total Health Services	-	2,400.00	-	2,400.00
5012400	Mgmnt and Informational Svcs				
5012420	Fiscal Services	522.65	22,654.57	196.47	23,373.69
5012440	Management Services	-	45.26	92.15	137.41
5012460	Public Infrmtnl & Relatn Svcs	18.00	16.00	8.00	42.00
	Total Mgmnt and Informational Svcs	540.65	22,715.83	296.62	23,553.10
5012500	Repair and Maintenance Svcs				
5012520	Electrical Repair & Maint Srvc	97.50	-	-	97.50
	Total Repair and Maintenance Svcs	97.50	-	-	97.50
5012600	Support Services				
5012630	Clerical Services	9,595.00	12,541.24	8,533.44	30,669.68
5012640	Food & Dietary Services	84.70	55.75	537.58	678.03
5012660	Manual Labor Services	55.76	140.43	183.90	380.09
5012670	Production Services	260.85	558.60	1,620.60	2,440.05
5012680	Skilled Services	1,495.81	1,137.45	1,379.12	4,012.38
	Total Support Services	11,492.12	14,433.47	12,254.64	38,180.23
5012800	Transportation Services				
5012820	Travel, Personal Vehicle	315.52	1,106.64	113.68	1,535.84
5012830	Travel, Public Carriers	-	-	522.71	522.71
5012850	Travel, Subsistence & Lodging	213.00	1,346.53	1,284.48	2,844.01
5012880	Trvl, Meal Reimb- Not Rprtble	124.50	344.50	263.50	732.50
	Total Transportation Services	653.02	2,797.67	2,184.37	5,635.06
	Total Contractual Svs	18,302.65	48,407.11	17,706.10	84,415.86
5013000	Supplies And Materials				
5013100	Administrative Supplies				-
5013120	Office Supplies	161.76	277.28	714.17	1,153.21
5013130	Stationery and Forms	-	89.07	-	89.07
	Total Administrative Supplies	161.76	366.35	714.17	1,242.28
	Total Supplies And Materials	161.76	366.35	714.17	1,242.28

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 10900 - Counseling

For the Period Beginning July 1, 2019 and Ending September 30, 2019

Account Number	Account Description	July	August	September	Total
5015000	Continuous Charges				
5015100	Insurance-Fixed Assets				-
5015160	Property Insurance	54.87	-	-	54.87
	Total Insurance-Fixed Assets	54.87	-	-	54.87
5015300	Operating Lease Payments				
5015340	Equipment Rentals	-	65.47	48.70	114.17
5015350	Building Rentals	22.80	-	-	22.80
5015390	Building Rentals - Non State	937.73	1,061.93	924.65	2,924.31
	Total Operating Lease Payments	960.53	1,127.40	973.35	3,061.28
5015500	Insurance-Operations				
5015510	General Liability Insurance	196.94	-	-	196.94
5015540	Surety Bonds	11.62	-	-	11.62
	Total Insurance-Operations	208.56	-	-	208.56
	Total Continuous Charges	1,223.96	1,127.40	973.35	3,324.71
5022000	Equipment				
5022620	Office Furniture	-	6,396.53	-	6,396.53
	Total Office Equipment	-	6,396.53	-	6,396.53
5022710	Household Equipment	-	20.37	-	20.37
	Total Specific Use Equipment	-	20.37	-	20.37
	Total Equipment	-	6,416.90	-	6,416.90
5023000	Plant and Improvements				
5023200	Construction of Plant and Improvements				
5023280	Construction, Buildings Improvements	-	-	-	-
	Total Construction of Plant and Improvements	-	-	-	-
	Total Plant and Improvements	-	-	-	-
	Total Expenditures	44,154.99	73,611.46	35,491.44	153,257.89
	Allocated Expenditures				
20100	Behavioral Science Exec	24,657.34	17,093.89	17,333.16	59,084.39
20200	Opt\Vet-Med\ASLP Executive Dir	-	-	-	-
20400	Nursing / Nurse Aid	-	-	-	-
20600	Funeral\LTCA\PT	-	-	-	-
30100	Data Center	30,215.98	30,068.40	9,787.44	70,071.82
30200	Human Resources	1,410.32	135.16	86.23	1,631.71
30300	Finance	13,279.94	10,810.33	9,900.28	33,990.55
30400	Director's Office	6,355.78	4,430.35	4,378.87	15,165.00
30500	Enforcement	40,177.09	29,127.01	31,118.53	100,422.63

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 10900 - Counseling

For the Period Beginning July 1, 2019 and Ending September 30, 2019

Account Number	Account Description	July	August	September	Total
30600	Administrative Proceedings	19,354.37	17,402.37	5,439.10	42,195.83
30700	Impaired Practitioners	37.50	45.98	67.58	151.07
30800	Attorney General	-	-	-	-
30900	Board of Health Professions	4,570.51	3,784.19	2,861.90	11,216.60
31000	SRTA	-	-	-	-
31100	Maintenance and Repairs	-	-	-	-
31300	Emp. Recognition Program	3.69	-	-	3.69
31400	Conference Center	10.45	24.44	(5.16)	29.73
31500	Pgm Devlpmnt & Implmentn	2,706.00	2,228.27	1,996.14	6,930.41
98700	Cash Transfers	-	-	-	-
	Total Allocated Expenditures	142,778.96	115,150.39	82,964.08	340,893.43
	Net Revenue in Excess (Shortfall) of Expenditures	$ (96,198.95)	$ (135,476.85)	$ (70,680.52)	$ (302,356.32)

Discipline Report

Virginia Department of Health Professions
Board of Counseling

Discipline Reports

07/26/2019 - 10/03/2019

NEW CASES RECEIVED IN BOARD 07/26/2019 - 10/03/2019				
	Counseling	Psychology	Social Work	BSU Total
Cases Received for Board review	59	39	19	***117***

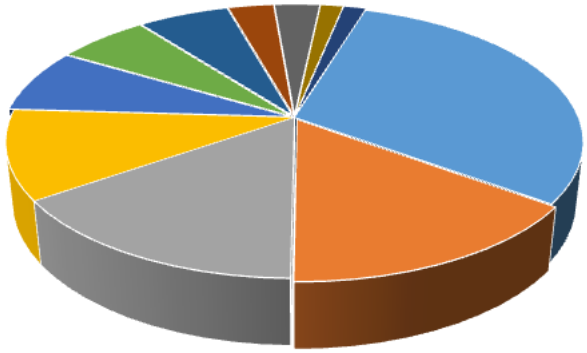
OPEN CASES (as of 10/03/2019)				
Open Case Stage	Counseling	Psychology	Social Work	BSU Total
Probable Cause Review	46	41	58	
Scheduled for Informal Conferences	27	6	3	
Scheduled for Formal Hearings	1	1	0	
Other (pending CCA, PHCO, hold, etc.)	12	6	1	
Cases with APD for processing (IFC, FH, Consent Order)	8	1	0	
TOTAL CASES AT BOARD LEVEL	94	55	62	***211***
OPEN INVESTIGATIONS	93	43	26	***162***
TOTAL OPEN CASES	187	98	88	***373***

UPCOMING CONFERENCES AND HEARINGS	
Informal Conferences	January 10, 2020 February 28, 2020 May 8, 2020 June 19, 2020
Formal Hearings	Following scheduled board meetings, as necessary

Virginia Department of
Health Professions
Board of Counseling

CASES CLOSED (07/26/2019 - 10/03/2019)	
Closed – no violation	45
Closed – undetermined	7
Closed – violation	8
Credentials/Reinstatement – Denied	4
Credentials/Reinstatement – Approved	2
TOTAL CASES CLOSED	66

Closed Case Categories



- No jurisdiction (20)
- Application (10)
- Diagnosis/Treatment (10)
- Inability Safely Practice (7)
- Inappropriate Relationship (5)
- Abuse/Abandonment/Neglect (4)
- Business Practice Issues (4)
- Dishonored Check (2)
- Fraud, Patient Care (2)
- Confidentiality (1)
- Drug Related, Patient Care (1)

AVERAGE CASE PROCESSING TIMES (counted on closed cases)	
Average time for case closures	160
Avg. time in Enforcement (investigations)	80
Avg. time in APD (IFC/FH preparation)	101
Avg. time in Board (includes hearings, reviews, etc).	69
Avg. time with board member (probable cause review)	7

Virginia Department of Health Professions

AGENCY REPORTS

CASES RECEIVED, OPEN, & CLOSED REPORT
SUMMARY BY BOARD
FISCAL YEAR 2019, QUARTER ENDING JUNE 30, 2019

The "Received, Open, Closed" table below shows the number of received and closed cases during the quarters specified and a "snapshot" of the cases still open at the end of the quarter.

COUNSELING	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019
Number of Cases Received	27	17	40	35	28	37	31	45	56	54	76	72
Number of Cases Open	98	69	58	56	61	72	84	102	124	150	176	144
Number of Cases Closed	44	43	60	42	26	29	23	33	29	28	51	103

PSYCHOLOGY	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019
Number of Cases Received	18	26	13	22	23	23	28	26	20	31	38	27
Number of Cases Open	76	87	49	34	46	44	52	57	64	83	75	75
Number of Cases Closed	9	17	52	38	16	24	19	24	13	11	46	29

SOCIAL WORK	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019
Number of Cases Received	19	12	28	21	14	27	15	34	35	25	33	39
Number of Cases Open	78	70	54	39	39	48	52	71	93	95	97	90
Number of Cases Closed	62	17	46	39	15	19	11	18	13	23	31	48

Virginia Department of Health Professions

AGENCY REPORTS

AVERAGE TIME TO CLOSE A CASE (IN DAYS) PER QUARTER

FISCAL YEAR 2019, QUARTER ENDING JUNE 30, 2019

*The average age of cases closed is a measurement of how long it takes, on average, for a case to be processed from entry to closure. These calculations include only cases closed within the quarter specified.

BOARD	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019
Counseling	375.5	292.8	247.9	106.1	251.5	128.2	153.7	185	164.2	161.3	251	279
Psychology	380	291.7	357.7	252.7	119.5	183.3	118.8	175.2	170.4	228.6	225	153
Social Work	469.7	407.6	366.2	228.8	292.7	123.6	277.5	237.2	113.8	200.7	263	211
Agency Totals	202.7	207.7	222.8	194.1	255.7	186.5	196.4	201.1	173.8	169.2	258	204

PERCENTAGE OF CASES OF ALL TYPES CLOSED WITHIN 365 CALENDAR DAYS*

FISCAL YEAR 2019, QUARTER ENDING JUNE 30, 2019

*The percent of cases closed in fewer than 365 days shows, from the total of all cases closed during the specified period, the percent of cases that were closed in less than one year.

BOARD	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019
Counseling	45.5%	78.6%	84.7%	97.5%	76.9%	97.0%	91.3%	84.8%	89.7%	89.3%	73.8%	68.0%
Psychology	44.4%	50.0%	44.2%	81.6%	92.9%	85.2%	100.0 %	90.5%	92.3%	81.8%	86.4%	93.1%
Social Work	30.7%	62.5%	41.3%	92.3%	73.3%	100.0 %	81.8%	66.7%	84.2%	78.3%	50.9%	70.8%
Agency Totals	82.0%	85.1%	81.7%	86.7%	82.2%	86.7%	87.6%	80.6%	85.5%	84.0%	76.4%	82.3%

Licensing Report

Virginia Department of
Health Professions

Applicant Satisfaction Survey

Quarterly Summary

Quarter 1 - Fiscal Year 2020

Application Satisfaction Survey are sent to all applicants, and includes seven categories for which applicants rate their satisfaction on a scale from one to four, one and two being degrees of satisfaction, three and four being degrees of dissatisfaction. This report calculates the percentage of total responses falling into the approval range. "N/A" indicates that no response was received for that board during the specified timeframe.

Quarter Date Ranges	
Quarter 1	July 1 - September 30
Quarter 2	October 1- December 31
Quarter 3	January 1 - March 31
Quarter 4	April 1 - June 30

BOARD	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020
Counseling	81.7%	88.7%	94.0%	92.0%	85.9%	87.7%	98.3%	92.7%	93.5%	91.6%	90.0%	89.9%
Agency Average	**86%**	**85%**	**90%**	**89%**	**90%**	91%	**91%**	**89%**	90%	93%	90%	87%

Virginia Department of
Health Professions

Quarter Date Ranges	
Quarter 1	July 1 - September 30
Quarter 2	October 1- December 31
Quarter 3	January 1 - March 31
Quarter 4	April 1 - June 30

Board	Occupation	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019	CURRENT Q1 2020
Counseling	Certified Substance Abuse Counselor	7	33	24	32	57	48	31	39	28	29	35	27	34
	Licensed Marriage and Family Therapist	11	17	15	10	15	10	11	10	17	21	10	16	15
	Licensed Professional Counselor	113	128	142	112	119	137	152	173	185	168	159	134	210
	Marriage and Family Therapist Resident	3	5	10	10	22	10	23	18	23	36	41	14	32
	Resident in Counseling	-	-	-	-	-	-	-	-	-	509	556	367	586
	Qualified Mental Health Prof-Adult	-	-	-	-	-	-	676	1544	1306	2401	1408	168	293
	Qualified Mental Health Prof-Child	-	-	-	-	-	-	671	1227	1117	2268	1355	170	266
	Registered Peer Recovery Specialist	-	-	-	-	-	-	57	29	53	40	34	27	23
	Registration of Supervision	91	182	189	131	440	154	503	510	444	-	-	-	-
	Rehabilitation Provider	2	1	0	0	2	0	2	2	1	2	10	2	1
	Substance Abuse Counseling Assistant	12	10	11	28	14	12	10	18	18	6	0	7	12
	Substance Abuse Trainee	-	-	-	61	63	48	52	73	40	48	57	35	62
	Substance Abuse Treatment Practitioner	12	0	48	0	1	14	23	14	9	15	17	8	17
	Substance Abuse Treatment Resident	3	51	4	0	1	1	45	1	0	0	0	0	1
	Trainee for Qualified Mental Health Prof	-	-	-	-	-	-	-	-	-	455	822	339	516
	Total	254	427	443	384	734	434	2256	3798	3447	5998	4504	1314	2068

Quarter Date Ranges	
Quarter 1	July 1 - September 30
Quarter 2	October 1- December 31
Quarter 3	January 1 - March 31
Quarter 4	April 1 - June 30

BOARD

BOARD	Occupation	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019	CURRENT Q1 2020
Counseling	Certified Substance Abuse Counselor	1712	1745	1784	1776	1837	1870	1911	1836	1867	1915	1965	1899
	Licensed Marriage and Family Therapist	856	872	885	854	864	876	889	874	895	906	930	894
	Licensed Professional Counselor	4653	4803	4932	4915	5062	5218	5394	5417	5590	5754	5970	6004
	Marriage & Family Therapist Resident	131	140	148	166	205	225	239	252	282	313	320	344
	Resident in Counseling	-	-	-	-	-	-	-	-	-	8454	8749	9030
	Qualified Mental Health Prof-Adult**	-	-	-	-	-	-	2220	3501	5927	7331	7586	7316
	Qualified Mental Health Prof-Child**	-	-	-	-	-	-	1897	3012	5278	6628	6895	6501
	Registered Peer Recovery Specialist**	-	-	-	-	-	-	86	139	179	212	246	253
	Registration of Supervision	5632	5747	5831	6220	6660	7095	7445	7706	8076	-	-	-
	Rehabilitation Provider	273	250	252	258	260	235	237	239	243	222	226	228
	Substance Abuse Counseling Assistant	174	188	218	203	217	232	252	231	238	251	0	241
	Substance Abuse Trainee	-	-	1563	1609	1654	1691	1748	1765	1791	1832	1841	1892
	Substance Abuse Treatment Practitioner	171	176	177	171	185	208	223	216	231	249	258	265
	Substance Abuse Treatment Residents	1	1	1	3	4	4	5	5	5	5	5	6
	Trainee for Qualified Mental Health Prof**	-	-	-	-	-	-	185	391	846	1660	2193	2715
	Total	13603	13922	15791	16175	16948	17654	22731	25584	31448	35732	37449	37588

Virginia Department of Health Professions

Quarter Date Ranges	
Quarter 1	July 1 - September 30
Quarter 2	October 1- December 31
Quarter 3	January 1 - March 31
Quarter 4	April 1 - June 30

BOARD	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020
Audiology/Speech Pathology	150	156	69	62	159	165	61	86	181	177	92	137	269
Counseling	175	254	427	443	384	734	434	2256	3798	3447	4504	1314	2068
Dentistry	364	237	138	145	401	268	103	130	335	400	113	134	269
Funeral Directing	37	40	33	37	41	52	25	42	43	51	40	28	53
Long-Term Care Administrators	85	79	69	66	99	80	78	78	91	107	81	56	108
Medicine	2406	1719	897	1237	2335	1656	939	1391	2495	1630	1217	1382	1786
Nurse Aide	2016	1625	1273	1111	1576	1520	1689	1656	2560	2060	1517	1824	2260
Nursing	2842	4344	2586	3293	3350	4369	2353	3152	3146	4532	3194	1535	4870
Optometry	34	26	15	16	51	25	17	20	53	23	31	30	28
Pharmacy	1135	1357	742	1207	1060	1367	841	1045	923	1316	196	656	1326
Physical Therapy	444	431	182	176	406	459	164	196	392	457	934	282	414
Psychology	95	107	112	99	88	245	105	118	109	100	171	61	130
Social Work	207	277	353	352	343	388	335	360	360	399	430	353	525
Veterinary Medicine	246	106	62	79	244	95	76	92	328	222	106	175	134
Total	10236	10758	6958	8323	10537	11423	7220	10622	14814	14921	12626	7967	14240

Virginia Department of
Health Professions

Current Count of Licenses

Quarterly Summary

Quarter 1 - Fiscal Year 2020

Current licenses by board and occupation as of the last day of the quarter.

** New Occupation

*** Veterinary Establishments are now grouped together, as the board works on designating existing establishments as "Ambulatory" or "Stationary", instead of "Full Service" or "Restricted Service".

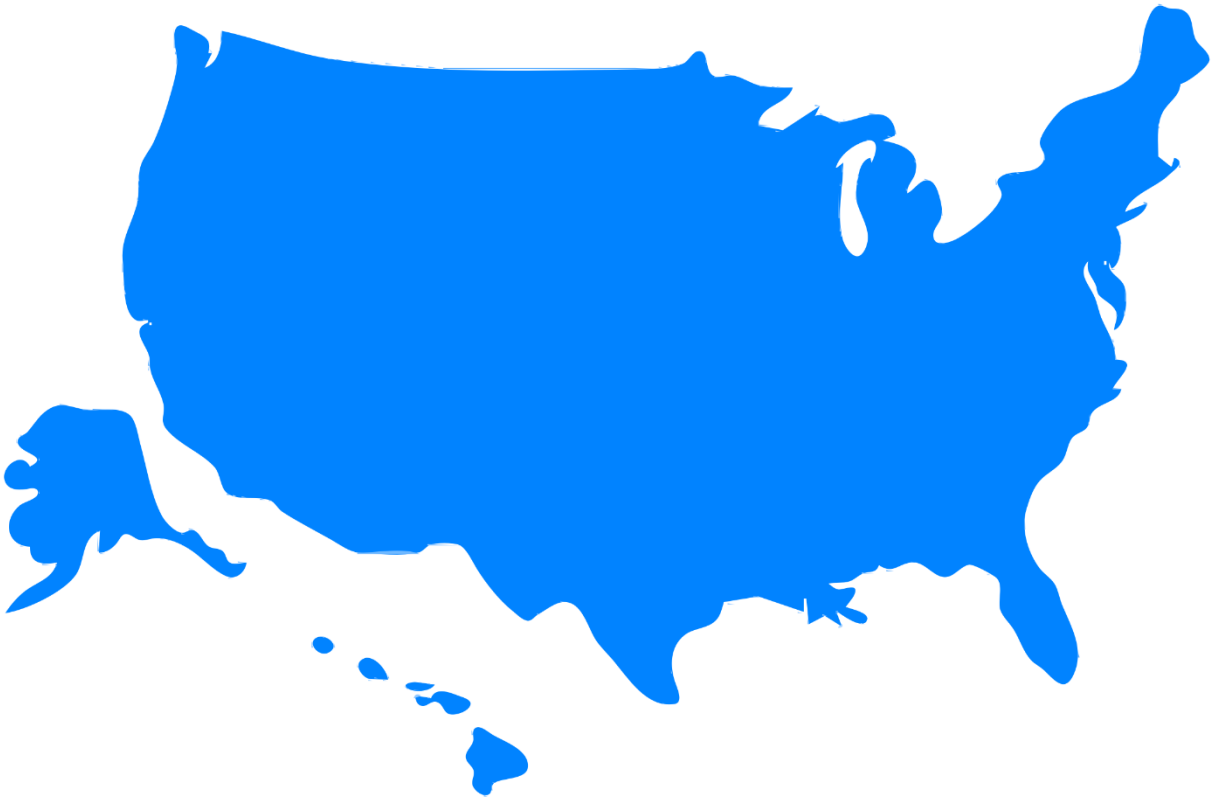
Quarter Date Ranges	
Quarter 1	July 1 - September 30
Quarter 2	October 1- December 31
Quarter 3	January 1 - March 31
Quarter 4	April 1 - June 30

BOARD	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019	CURRENT Q1 2020
Audiology/Speech Pathology	5056	4855	4971	5142	4770	4991	5085	5272	5384	5106	5249	5458
Counseling	13603	13922	15791	16175	16948	17654	22731	25584	31448	35732	37449	37588
Dentistry	14522	14657	14338	14601	14665	14835	14544	14885	15018	15144	14654	14911
Funeral Directing	2561	2609	2513	2554	2579	2620	2532	2564	2603	3198	3087	3135
Long-Term Care Administrators	2188	2235	2065	2138	2198	2258	2114	2192	2248	2303	2140	2217
Medicine	66733	67320	69206	69092	69230	69628	70959	69687	70076	70573	72819	72747
Nurse Aide	53681	53434	53066	52653	52160	52888	53276	52466	53241	53241	53758	53898
Nursing	166039	166796	167953	170125	169465	171385	171964	1722989	173905	174537	174518	176647
Optometry	1955	1867	1921	1949	1805	1859	1913	1933	1954	1895	1970	2008
Pharmacy	37844	35289	36441	37608	34789	35995	36967	38002	36034	36034	37265	38388
Physical Therapy	11751	11652	1278	12556	12735	12939	13341	13797	38001	12611	13022	13447
Psychology	5128	5227	5335	5368	5470	5582	5690	5497	5583	5852	5939	5787
Social Work	9144	9340	9559	9089	9326	9468	9671	9350	9810	10113	10346	10243
Veterinary Medicine	7565	7320	7587	7703	7105	7448	7767	7994	8097	7789	8073	8210
Agency Total	397810	396523	402824	406753	403245	409550	418554	422212	432338	434128	440289	444684

National Counselor Licensure Endorsement (NCLEP) Information

A TOOLKIT FOR STATE COUNSELING BOARDS

PORTABILITY STANDARDS FOR COUNSELORS



SEPTEMBER 2019

Authored by: THE NATIONAL PORTABILITY TASKFORCE

AASCB AMERICAN ASSOCIATION OF STATE COUNSELING BOARDS

A·C·E·S ASSOCIATION FOR COUNSELOR EDUCATION AND SUPERVISION

AMHCA

NATIONAL BOARD FOR CERTIFIED COUNSELORS®

Table of Contents

EXECUTIVE SUMMARY

Counseling regulatory boards will determine the **future** of license portability for counselors. With the recent progress toward a counseling interstate compact, creating uniform standards across state lines has never been **more important** or **more possible**. The four organizations which comprise the National Portability Taskforce, AASCB, ACES, AMHCA, and NBCC are dedicated to serving licensing boards by continuing to seek an endorsement process that protects the public and increases access to care.

In April of 2017, the National Portability Taskforce released NCLEP 1.0 and received a positive response. Since that time, the taskforce has continued its work to ensure portability of licensure is a reality for all counselors. **By listening to feedback from state boards**, practicing counselors, and legislators, we understand that the challenges surrounding portability have changed. Consequently, we have worked together to create NCLEP 2.0.

State Counseling Board laws and regulations are aimed at aimed at protecting the public by setting basic standards of qualification, education, training, experience, and professional competence for persons who engage in the practice of these professional services. We recognize that no portability process is a "silver bullet" that resolves all concerns related to portability. Each state has different needs and we believe NCLEP 2.0 can be a starting point to address these needs, limit administrative overhead, and protect the public. Our portability process will significantly benefit mental health consumers by increasing access to services and by creating a vibrant workforce of licensed counselors during a time of changing regulatory standards and an increasing need for united advocacy efforts.

Taking the steps to improve portability will protect the public and add to the strategies through which licensed professional counselors across the country may provide critical services, while at the same time creating a network of reciprocal relationships across the country. Our hope is that NCLEP 2.0 is reflective of the new portability landscape in a way that best meets the needs of state boards. We remain committed to listening to the wishes and concerns of state boards to ensure true licensure portability becomes a reality.

This tool kit provides key documents that explain the evolution of the NCLEP process and resource material, including:

- Background of NCLEP
- NCLEP 1.0
- A press release associated with the NCLEP 1.0 plan released in June 2017
- NCLEP 2.0
- Key changes between NCLEP 1.0 and NCLEP 2.0
- Frequently Asked Questions (FAQs) about state portability issues
- Information on Interstate Compacts
- Recent Articles on Portability

Background on the National Counselor Licensure Endorsement (NCLEP) Process

*****

Four organizations adopted the National Counselor Licensure Endorsement Process (NCLEP) 2.0 in September of 2018—the American Association of State Counseling Boards (AASCB), the Association of Counselor Education and Supervision (ACES), the American Mental Health Counselors Association (AMHCA), and the National Board for Certified Counselors (NBCC). This plan was a revision to NCLEP 1.0, adopted in April of 2017.

The organizations believe that a uniform licensure endorsement process will:

- Significantly increase public access to qualified care.
- Establish minimum standards for safe practice.
- Reduce administrative burdens for state regulatory boards and licensees.
- Create consistency in licensure standards across state lines.
- Ensure protection of the public and the continued development of the profession.

An overarching goal of the initiative is to move the mental health counseling profession toward unified education standards, exam requirements, and years of post-graduate experience. Portability of licensure is a need that the mental health counseling profession must address to improve access to care.

The four sponsoring organizations believe the new united portability process will significantly benefit mental health consumers by increasing access to needed care and services and will help create a vibrant workforce of licensed counselors. Moreover, we believe a secure, mental health counselor portability licensure process will ensure that consumer protections are in place.

In an era of a mobile workforce, which is increasingly receptive to innovative service delivery such as tele-mental health services and military-friendly licensure processes, a national portability process is more vital than ever. To be a counselor *must hold the same meaning* to a citizen as it does to a policy maker from state to state.

The Portability Task Force that created the NCLEP 1.0 and 2.0 plans agreed on the importance of honoring the work and practices already adopted by state regulatory boards while developing a portability process. We understand and appreciate that such a change will require rule and possibly even statutory changes for many state regulatory boards.

National Counselor Licensure Endorsement Process (NCLEP) 1.0

(Adopted April 2017)

Any counselor licensed at the highest level of licensure for independent practice available in his or her state may obtain licensure in any other state or territory of the United States if all of the following criteria are met:

(1) The licensee has engaged in ethical practice, with no disciplinary sanctions, for at least 5 years from the date of application for licensure endorsement.

(2) The licensee has possessed the highest level of counselor licensure for independent practice for at least 3 years from the date of application for licensure endorsement.

(3) The licensee has completed a jurisprudence or equivalent exam if required by the state regulatory body.

(4) The licensee complies with ONE of the following:

> (a) Meets all academic, exam, and post-graduate supervised experience standards as adopted by the state counseling licensure board.
>
> (b) Holds the National Certified Counselor (NCC) credential, in good standing, as issued by the National Board for Certified Counselors (NBCC).
>
> (c) Holds a graduate-level degree from a program accredited by the Council for Accreditation of Counseling & Related Educational Programs (CACREP).

Press Release

FOR IMMEDIATE RELEASE: OCTOBER 1, 2019

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COUNSELING ORGANIZATIONS PROPOSE NEW PORTABILITY PROCESS TO INCREASE ACCESS TO CARE

WASHINGTON, DC – A new collaborative effort of four major professional counseling organizations aimed at improving access to quality mental health care nationwide has resulted in a proposed uniform portability plan called the – National Counselor Licensure Endorsement Process - or "NCLEP 2.0."

The four organizations – the American Association of State Counseling Boards (AASCB), the Association of Counselor Education and Supervision (ACES), the American Mental Health Counselors Association (AMHCA), and the National Board for Certified Counselors (NBCC) – believe that a uniform licensure endorsement process will:

- Significantly increase public access to qualified care.
- Establish minimum standards for safe practice.

- Reduce administrative burdens for state regulatory boards and licensees.
- Create consistency in licensure standards across state lines.
- Ensure protection of the public and the continued development of the profession.

An overarching goal of the initiative is to move the counseling profession toward unified education standards, exam requirements and years of post-graduate experience. To see the overall National Counselor Licensure Endorsement Process, please go to:

https://www.amhca.org/advocacy/portability/portability2019

President of AASCB, Ryan Pickut, said, "Portability of licensure is a need that the counseling profession must address to improve access to care. Taking the steps to improve portability will protect the public and add to the strategies through which licensed professional counselors across the country may provide critical services, while at the same time creating a network of reciprocal relationships across the country. AASCB will be requesting that its member boards carefully consider the provisions outlined in the joint statement."

President of ACES, Kristopher Goodrich, said, "We believe our united portability process will significantly benefit mental health consumers by increasing access to needed care and services, and it will help create a vibrant workforce of licensed counselors in terms of changing regulatory standards. Moreover, we believe a secure, counselor portability licensure process will ensure that consumer protections are in place."

President of AMHCA, Eric Beeson, said, "Having the leading organizations representing the counselor licensing boards, counselor educators, mental health counselors, and board certified counselors jointly agree to a collaborative portability process, creates a way for states to pave a path forward for highly qualified current and future counselors to improve client access to services. This proposal represents the best chance to accomplish this crucial need for quality services around the country."

President of NBCC, Kylie Dotson-Blake, said, "We recognize that no portability process is a "silver bullet" that resolves all concerns related to portability. Each state has different needs and NCLEP 2.0 is intended to be a starting point to address these needs, limit administrative overhead, and protect the public. We hope by reducing variability in the counselor licensure process and requirements, we will facilitate cross-state practice and movement, and provide a major shot in the arm for needed rule and statutory changes."

The officers of the four counseling organizations said the portability plan is built on principles of quality assurance and national standards.

The plan will promote acceptance of a license from another state if the applicant meets current standards adopted by the receiving state counseling licensure board. Another option provided to states for accepting applicants includes if the individual holds a degree from a clinically focused counselor preparation program accredited by the Council for Accreditation of Counseling & Related Educational Programs (CACREP), or holds certification as a National Certified

Counselor. It also requires that a counselor possess the highest level of licensure for independent practice for at least three years before licensure endorsement in a given state.

https://www.amhca.org/advocacy/portability/portability2019

In an era of a mobile workforce, which is increasingly receptive to innovative service delivery such as tele-mental health services, a national, uniform portability process is more vital than ever. We believe the time has come to pave a path forward for highly qualified current and future counselors to improve client access to services. This new portability statement provides that roadmap.

The four counseling organizations are part of a Portability Task Force that worked on the proposal over the last year. The task force principals said the leadership and collaboration that went into the effort demonstrates the critical importance of professional unification and portability of licensure.

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National Counselor Licensure Endorsement Process NCLEP 2.0

Endorsed by the American Association of State Counseling Boards (AASCB), Association for Counselor Education and Supervision (ACES), American Mental Health Counselors Association (AMHCA), & the National Board for Certified Counselors (NBCC)

(Adopted October 2019)

Counseling regulatory boards will determine the future of license portability for mental health counselors. Creating uniform standards across state lines has never been more important or more possible. The four organizations that comprise the National Portability Taskforce – AASCB, ACES, AMHCA, and NBCC – are dedicated to serving licensing boards by continuing to seek an endorsement process that meets your needs.

In April of 2017, the National Portability Taskforce released the National Counselor Licensure Endorsement Process (also called NCLEP 1.0) and received a positive response from licensure boards and professional organizations. Additionally, the taskforce received feedback regarding revisions that would align NCLEP even more strongly with state licensure requirements and board administrative processes. This feedback from state boards, practicing mental health counselors, and stakeholders, was integrated into NCLEP, resulting in a revised version that is even better positioned to meet the needs of the counseling regulatory community and public.

State Counseling Board laws and regulations are aimed at protecting the public by setting basic standards of qualification, education, training, experience, and professional competence for persons who engage in the practice of these professional services. We recognize that no portability process is a "silver bullet" that resolves all concerns related to portability. Each state has different needs and NCLEP 2.0 is intended to be a starting point to address these needs, limit administrative overhead, and protect the public.

The implementation of NCLEP 2.0 to facilitate the portability process will significantly benefit mental health consumers by increasing access to services and by creating a vibrant workforce of licensed counselors. The benefits offered by NCLEP are particularly powerful during a time of changing regulatory standards and an increasing need for united advocacy efforts.

NCLEP 2.0 is designed with the intent of honoring the work and practices already adopted by state regulatory boards while developing a portability process that may be applied to facilitate efficient review of licensure requirements and the mobility of licensed professionals. Thus, there are two pathway options articulated within NCLEP 2.0.

Option 1 supports the continuation of the complete review process currently utilized by a state.

Option 2 offers a streamlined version of review, accepting evidence of required experience previously reviewed by another licensure board and educational requirements previously

reviewed by another recognized professional organization. With Option 2, regulatory boards are assured that the experience and education requirements have already been subject to stringent review by another responsible party, providing critical protections for the public. Additionally, Option 2 clearly indicates that applicants through the streamlined process are still subject to any jurisprudence assessment and/or criminal background check requirements a state may require.

With either option, the goal of encouraging and supporting the mobility of counselors and the work of the regulatory boards may be achieved.

The National Portability Taskforce intends that NCLEP 2.0 is reflective of the new portability landscape in a way that best meets the needs of state boards. We ask your state counseling boards to consider adopting NCLEP 2.0, and we remain committed to listening to the wishes and concerns of state boards to ensure licensure portability becomes a reality.

NCLEP 2.0

Any counselor licensed as a mental health counselor at the highest level of licensure for independent practice available in his or her state may obtain licensure in any other state or territory of the U.S. if the applicant **meets the requirements of Option 1 OR Option 2 below:**

Option 1

The applicant meets current standards for endorsement adopted by the receiving state counseling licensure board.

Option 2

The applicant has been actively licensed as a mental health counselor for **at least three (3) years** prior to the date of application for licensure endorsement, is currently in good standing with no pending disciplinary action, and has completed a jurisprudence or equivalent exam and background checks as required by the state regulatory body (if required by the originating state).

In addition, the applicant **must comply** with **ONE** of the following under Option 2:

(a) Has maintained a license to practice independently that was awarded on or before December 31, 2014.

(b) Possesses the National Certified Counselor (NCC) credential as issued by the National Board for Certified Counselors (NBCC).

(c) Possesses a graduate-level degree in counseling from a regionally accredited program (if the degree is awarded on or after January 1, 2025, then possesses a graduate level degree from a program accredited by the Council for Accreditation of Counseling & Related Educational Programs (CACREP).

Key Changes between NCLEP 1.0 and NCLEP 2.0

Based on feedback from state board members and staff, the National Portability Taskforce edited NCLEP 1.0 to reflect the changing portability landscape. The most significant change was helping experienced, qualified counselors seeking licensure endorsement by adding a provision whereby an individual must have maintained a license that was awarded on or before December 31st, 2014. Additional revisions included editing Section 1 for clarification, changing "licensee" to "applicant", and making all requirements based on three (3) years *prior to the date of application* for licensure endorsement (rather than three (3) *and* five (5) years).

- ✓ **Clarification of Language: Section 1**

The applicant meets current standards for endorsement adopted by the receiving state counseling licensure board.

- ✓ **Using "Applicant" instead of "Licensee"**

Broader language should create more flexibility for regulatory boards with varying terms.

- ✓ **Recognizing Counselor Experience: Section 2(a)**

The applicant has been actively licensed at the highest level of counselor licensure for independent practice for at least three (3) years prior to the date of application for licensure endorsement AND complies with ONE of the following:

(a) Has maintained a license to practice independently that was awarded on or before December 31, 2014.

- ✓ **Creating Consistent Language: Three (3) Years for all Requirements**

… and who has no pending investigations or disciplinary sanctions **for at least three (3) years** prior to the date of application for licensure endorsement…"

FAQ'S on State Portability & the National Counselor Licensure Endorsement Process (NCLEP)

What is portability?

Portability, also known as licensure endorsement, is what allows a person with a license in one state to be recognized to practice in another.

Why is a uniform licensure endorsement process important?

A uniform process for portability accomplishes several key things, including:

- It allows Counseling Professionals to practice in new states when relocating or work in nearby states.
- It assures there is significantly increased public access to qualified care.
- It establishes minimum standards for safe practice.
- It creates consistency in licensure standards across state lines.
- It ensures protection of the public and the continued development of the profession.

Is this a proposal or will states be using this new process?

The National Counselor Licensure Endorsement Process proposed in October 2019 by four organizations—the American Association of State Counseling Boards (AASCB), the Association for Counselor Education and Supervision (ACES), the American Mental Health Counselors Association (AMHCA) and the National Board for Certified Counselors (NBCC)—is not yet a new law.

It is a proposal that will be presented to licensing boards as a service to Professional Counselors across the United States for consideration over the next few months and years. It is ultimately up to each state to determine if it would like to adopt the proposal.

The 2019 NCLEP proposal replaces a similar document that the 4 organizations developed in 2017. The newer version lays out additional pathways for mental health counselors to achieve portability.

Is this proposal different from others in the past?

This proposal is the result of a groundbreaking, long-planned collaborative of four major professional counseling organizations and as such, has a better chance of approval by state licensing agencies.

In fact, because the organization representing state licensing boards, AASCB, was part of the proposal to create this plan, there has been input to formulate a proposal that will, in particular, address concerns that licensing boards have expressed in the past. For example, this proposal would require that counselors who seek licensure in another state possess the highest level of counselor licensure for independent practice, with no disciplinary sanctions, for at least three years from the

date of application for licensure endorsement. Some state licensing boards have previously expressed concerns about proposals that fail to require past experience.

What makes this proposal important?

Having the leading organizations representing the counselor licensing boards, counselor educators, mental health counselors, and board certified counselors jointly agree to a collaborative portability process creates a way for states to pave a path forward for highly qualified current and future counselors to improve client access to services.

This proposal represents the best chance to accomplish this crucial need for quality services around the country. The four organizations were able to capitalize upon their knowledge of the history of state regulatory standards in crafting this proposal. This proposal also will move the profession toward the future goal of unified education standards, examination requirements, and years of postgraduate experience.

What happens next to move the approval process forward?

The four organizations proposing the National Counselor Licensure Endorsement Process 2.0 will work through their advocacy arms and/or government affairs departments—and with the assistance of counselors willing to lend their time and support—to encourage state licensing boards and legislative bodies to adopt the proposal.

The four organizations have already approved two presentations to large meetings of licensure boards. This is a high priority of all four organizations.

How quickly might states adopt the endorsement process?

There is no way to determine when an individual state will adopt the National Counselor Licensure Endorsement Process. Each state must independently take this step; there is no national implementation process possible by the federal government. The adoption process may require new legislation or regulations—each state has its own rules governing licensing board regulations—and this takes time and organization.

How can I stay abreast of the approval process?

NBCC will provide regular updates and news about the National Counselor Licensure Endorsement Process through its new monthly newsletter, NBCC Visions, as well as on the NBCC website, and the NBCC Facebook page. News may occasionally also be disseminated through e-mail to board certified NCCs. AASCB will also maintain updated information for all Member Boards on the AASCB website.

How can I help efforts to support the National Counselor Licensure Endorsement Process?

Counselors interested in contributing to efforts on behalf of this proposal should contact their state licensing board and encourage adoption of the National Counselor Licensure Endorsement Process.

Portability Resources

Council of State Governments—National Center for Interstate Compacts

Understanding Interstate Compacts

Interstate compacts represent an opportunity for multistate cooperation, reinforcing state sovereignty and avoiding federal intervention. The emergence of broad public policy issues that cross jurisdictional boundaries present new governing challenges to state authorities.

Compacts enable the states – in their sovereign capacity – to act jointly and collectively, generally outside the confines of the federal legislative or regulatory process while respecting the view of Congress on the appropriateness of joint action.

Unlike federal actions that impose unilateral, rigid mandates, compacts afford states the opportunity to develop dynamic, self-regulatory systems over which the party states can maintain control through a coordinated legislative and administrative process.

Compacts enable the states to develop adaptive structures that can evolve to meet new and increased challenges that naturally arise over time.

What is an Interstate Compact?

Interstate compacts are contracts between two or more states creating an agreement on a particular policy issue, adopting a certain standard or cooperating on regional or national matters. Interstate compacts are the most powerful, durable, and adaptive tools for ensuring cooperative action among the states. Unlike federally imposed mandates that often dictate unfunded and rigid requirements, interstate compacts provide a state developed structure for collaborative and dynamic action, while building consensus among the states and evolving to meet new and increased demands over time.

General purposes for creating an interstate compact include:

- Establish a formal, legal relationship among states to address common problems or promote a common agenda.
- Create independent, multistate governmental authorities (e.g., commissions) that can address issues more effectively than a state agency acting independently, or when no state has the authority to act unilaterally.
- Establish uniform guidelines, standards, or procedures for agencies in the compact's member states.
- Create economies of scale to reduce administrative and other costs.
- Respond to national priorities in consultation or in partnership with the federal government.

- Retain state sovereignty in matters traditionally reserved for the states.
- Settle interstate disputes.

It should be noted that an interstate compact is not a uniform state law. In fact, an interstate compact differs from a uniform state law in several ways, most notably that a uniform law does not depend on contractual obligations and a state can therefore change any portion of the law, thus losing any degree of uniformity initially intended.

Second, courts of different states may interpret the provisions of a uniform state law differently and since the highest court in a state is the final arbiter on legal issues within that state, there is no satisfactory way to achieve a reconciliation of divergent interpretations.

Compacts are created when an offer is made by one state, usually by statute that adopts the terms of a compact requiring approval by one or more other states to become effective. Other states accept the offer by adopting identical compact language.

Once the required number of states has adopted the pact, the "contract" among them is valid and becomes effective as provided.

How prevalent are Interstate Compacts?

Compacts were seldom used until the 20th century. Between 1783 and 1920, states approved just 36 compacts, most of which were used to settle boundary disputes. But in the last 75 years, more than 150 compacts have been created, most since the end of World War II.

On average, a state today belongs to 25 interstate compacts. Although there are many types of interstate compacts, they can generally be divided into three camps:

- Border Compacts: agreements between two or more states that establish or alter the boundaries of a state.
- Advisory Compacts: agreements between two or more states that create study commissions. The purpose of the commission is to examine a problem and report to the respective states on their findings.
- Regulatory Compacts: broadest and largest category of interstate compacts may be called "regulatory" or "administrative" compacts. Regulatory compacts create ongoing administrative agencies whose rules and regulations may be binding on the states to the extent authorized by the compact.

Compacts Today

The purpose of interstate compacts ranges from implementing common laws to exchanging information about similar problems. They apply to everything from conservation and resource management to civil defense, emergency management, law enforcement, transportation, and taxes. Other compact subjects include education, energy, mental health, workers compensation and low-level radioactive waste.

Some compacts authorize the establishment of multistate regulatory bodies. The first and most famous of these is the New York-New Jersey Port Authority, which arose from a 1921 compact between the two states. But other agreements are simply intended to establish uniform regulations without creating new agencies.

In recent years, compacts have grown in scope and number. Today, many are designed for regional or national participation, whereas the compacts of old were usually bi-state agreements. Recent efforts include the Emergency Management Assistance Compact, the Interstate Insurance Product Regulation Compact, National Crime Prevention & Privacy Compact, and the Wildlife Violator Compact.

Other examples of compact activity include the revision of existing interstate agreements; updating agreements that maintain relevance, but which require a modernization of their structures. Recent examples include the Interstate Compact for Adult Offender Supervision and the Interstate Compact for Juveniles.

Congressional Consent

Article I, Section 10, Clause III of the U.S. Constitution provides in part that "no state shall, without the consent of Congress, enter into any agreement or compact with another state."

Historically, this clause generally meant all compacts must receive congressional consent. However, it has been found in a number of instances, notably the 1893 US Supreme Court case Virginia v. Tennessee that not all compacts require congressional consent. It is well established today that only those compacts that affect a power delegated to the federal government or alter the political balance within the federal system, require the consent of Congress.

Fortunately, even though congressional consent may be needed, it is not particularly burdensome to acquire. Though usually satisfied by means of a congressional resolution granting the states the authority to create a compact, the Constitution specifies neither the means nor the timing of the required consent. Over the years, the Supreme Court has held that congressional consent may be expressed or implied and may be obtained either before or after a compact is enacted.

http://www.gsgp.org/media/1313/understanding_interstate_compacts-csgncic.pdf

Streamlining Licensing Across State Lines: Initiatives to Enhance Occupational License Portability

(ABRIDGED VERSION)

EVENT DESCRIPTION

On July 27, 2017, the Federal Trade Commission's Economic Liberty Task Force hosted a roundtable to examine ways to mitigate the effects of state-based occupational licensing requirements that make it difficult for license holders to obtain licenses in other states. License portability restrictions often prevent otherwise qualified people from marketing their services across state lines or when they move to a new state. These types of restrictions are especially hard on military families who often face the financial and administrative burdens of applying for a new license with each move across state lines. This public event supported the Task Force's consideration of how occupational licensing reform could reduce barriers to entry, enhance competition, and promote economic opportunity.

State licensing rules, by their very nature, inhibit one's ability to provide services in a given state. Even in situations where licensing serves a legitimate health and safety purpose, licensing requirements restrict the labor supply and reduce competition, and therefore may increase the price consumers pay for services. Licensing restrictions also may limit employment opportunities for qualified providers.

In addition, because licensing rules are almost always state-based, it may be difficult for someone licensed in one state to become licensed in another state. For some occupations, state licensing standards vary considerably, so that applicants licensed in one state may need additional education or training to qualify for another state's license. Even when a profession's underlying standards are national and state licensing requirements are similar throughout the United States, the process of obtaining a license in another state is often slow, burdensome, and costly.

The need to obtain a license in multiple states can reduce interstate mobility and practice, and may even lead licensees to exit their occupations when they move to another state. The need for multi-state licensure also affects consumers' access to services. It may prevent qualified service providers from addressing time-sensitive emergency situations near state lines, limit the ability of health care providers to supply telehealth services to consumers in rural and underserved locations, or otherwise reduce the availability of any service for which providers are in short supply.

Recognizing the costs to both consumers and licensees of multistate licensing requirements, a variety of initiatives have sought to enhance occupational license portability. Three types of models have emerged thus far.

- A number of nationwide organizations of state licensing boards for individual professions have developed interstate licensing compacts. These binding contracts are enacted by states to define licensing standards and processes, and to share applicants' records and disciplinary information among states participating in the compact.
- Other occupational organizations have developed agreements, model laws, and model rules that serve many of the same purposes as compacts.
- With the encouragement of the Department of Defense's State Liaison Office, many states have adopted legislation that enhances military spouse license portability for multiple occupations.

The July 27 roundtable explored options for enhancing the portability of occupational licenses by bringing together various experts, including: experts on the law of interstate compacts; representatives of organizations that have developed or administer compacts or model laws for specific professions; and government officials who have facilitated the adoption of state legislation aimed at improving the portability of licenses for military spouses.

https://www.ftc.gov/news-events/events-calendar/2017/07/streamlining-licensing-across-state-lines-initiatives-enhance

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