ISSUE 03/14
March 2014

QUARTERLY JOURNAL FROM VIRGINIA ASSOCIATION OF CLINICAL COUNSELORS

VACC Headlines

Serving the needs of Virginia Clinical Counselors since 1980

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Don't Miss Out

An All In One Workshop

2 $1,000 Fellowship Opportunities by April 1st

Upcoming Conference

VACC Presents:
An All in One Workshop:
Supervision, Ethics, and DSM-5 Update

When: Friday, April 4, 2014
Where: Hampton Roads area, site to be announced

Get your CEUs and ethics requirements all in one workshop!

Visit www.vacc.org for information. For questions about the conference please contact one of our board members at VACC.ORG

Discount rates apply for VACC members

PRESIDENT'S CORNER

Dear Colleagues,

The Virginia Association of Clinical Counselors is requesting that its members (and all counselors) contact their federal Congressmen (not their Senators) and ask that they cosponsor HR 3662, which would include LPCs as Medicare providers. Medicare status will become extremely important as the ramifications of the Affordable Care Act unfold. Medicare and Medicaid will be shifting to an integrated delivery system that will exclude the services of licensed professional counselors unless we are eligible for payment. Accountable Care Organizations represent a critical service delivery model that will focus on quality of care and outcome status, while boosting clinical care coordination. Medicare exclusion is a major obstacle to the participation of LPCs in accountable care organizations.

You can find a sample email and further information about the bill on the website of the American Mental Health Counselors Association (www.amhca.org). Go to the "About" section and then to "Public Policy." You can find your Congressman by googling "Virginia Congressman." The second listing "Find Your Congressman" allows you to search by ZIP Code. I hope that you will pass this message on to all students, supervisees, and colleagues. **Please take action right away**.

On the home front (Virginia) there is no bill, as of this writing, that threatens our reimbursement or scope of practice. However, VACC will be monitoring legislation and coordinating with our sister organizations, the Virginia Association of Marriage and Family Therapists and the Virginia Society for Clinical Social Work.

VACC is also proud to offer our fifth annual Linda Heacock Memorial Fellowships for students and for counselors in residency. See our website (www.vacc.org) for further information. We are also in the final stages of planning a workshop in the Hampton Roads area for Friday, April 4th. And, by the way, if you are interested in serving on the Executive Board, please send your resume or CV to me with a brief statement about why you are interested in doing so (michaelnahl@cox.net).

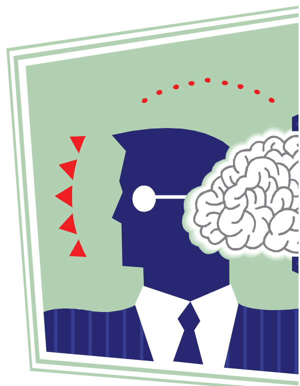
All the best to our wonderful VACC members!

Michael E. Nahl, LPC, LMFT

FACTS ABOUT LPC LICENSURE

Catherine Chappell, Virginia Board of Counseling

Did you know...



- ⇒ Virginia was the first state to offer licensure to professional counselors (starting in 1975)
- ⇒ To date, close to 7,000 LPCs have become licensed
- ⇒ Thirty percent of Virginia's LPCs live in Northern Virginia
- ⇒ 76 percent of LPCs are women, with a median age of 52
- ⇒ A master's degree is the highest degree held by 83% of Virginia LPCs
- ⇒ Virginia has an initiative to expedite applications for military spouses

(Source: Virginia Board of Counseling)

In order to ensure safe and competent care for Virginia residents, the Virginia Board of Counseling oversees the requirements for licensure of LPCs. This oversight includes, but is not limited to: education requirements, supervision requirements, and the LPC examination. The Board consists of 14 members and is overseen by executive director Catherine Chappell. Quarterly board meetings take place in Richmond and are open to the public. For further information, (email) coun@dhp.virginia.gov, (phone) 804-367-4610, or visit www.dhp.virginia.gov/counseling to read the requirements for education, internship, residency, and supervision of counselors in the state of Virginia.

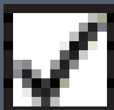
While the board is responsible for enforcing standards of practice and ensuring professional conduct and competency, the staff cannot provide legal advice. It is up to counselors to follow the standards of practice and the regulations relevant to being an LPC. The staff cannot advise counselors how to proceed if a complaint is filed against them.

Sometimes the guidelines leave room for interpretation. In those situations, professional associations can petition the Board of Counseling for

More at www.vacc.org Three Of The Top Issues Virginia Counselors Need to Know

CEUs

Ethics



Penny Norford, PhD, LPC will address issues related to "Ethics and Countertransference"

Michael F. Jeffrey, LPC, LMFT will present two one hour Presentations: "Psychopharmacology for Counselors" and "Supervision, Person and Practice Theory"

Lourie W. Reichenberg, LPC, author of DSM-5 Essentials: The Savvy Clinicians Guide will provide an update with the '"Changes that Every Counselor needs to know about DSM-5"

ETHICALLY SPEAKING

by Theresa Johnson-Sion, PhD, LPC

Our Influence and Our Capacity to Make a Difference

I recently read an interesting article that illustrated the influence we as Licensed Professional Counselors have on others. We have a powerful influence on the lives of people who come to us for guidance and direction in a lost, and often confusing and chaotic world. Jesus used the example of salt, a familiar household item that alters whatever it touches. Salt flavors and preserves food. When we sprinkle it on something flavorless the food becomes much more enjoyable. We can be that salt that flavors the life of others by using the right actions and motives when providing mental health services. But if our actions and motives contradict our ethical and moral responsibility to our clients, then we might worsen the wounds so many people attempt to manage on a daily basis.

Like many things in our diet, salt can also be damaging to human health if you add too much. In the worst case, it can be used as a way to inflict extreme pain if applied to an open wound. Salt doesn't change itself. Salt makes a difference in whatever it comes in contact with. Let's not forget that we have an influence on the lives of hurting, wounded people, good or bad. As Licensed Professional Counselors, our influence on others should be purposeful rather than haphazard.

Let's never forget The Virginia Code of Ethics "Standards of Practice," which states that our duty to protect 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 apply to the practice of counseling.

The complete Standards of Practice for Virginia LPCs can be found online at the Virginia Board of Counselors website: www.dhp.Virginia.gov/counselors

The American Counseling Association also states, that professional values are an important way of living out an ethical commitment. Values inform principles.

Inherently held values that guide our behaviors or exceed prescribed behaviors are deeply ingrained in the counselor and developed out of personal dedication, rather that the mandatory requirement of an external organization. As licensed professionals, we should be dedicated to the enhancement of human development throughout the life span. Let's never underestimate the scope and the powerful influence we can have when we are compliant to both Virginia Code of Ethics on the "Standard of Practice," and The American Counseling Association Code of Ethics.

Finally, when individuals who are depressed or deeply troubled over past and/or even current circumstances, we have an awesome opportunity to impact lives by chosen ethical decision making process and evaluation of the context of the situation. As licensed professionals, we are empowered to make decisions that expand the capacity of people to grow and develop. We have that kind of influence on others. Be wise in the way it's used; making the most out of every opportunity. Let our motives always be to encourage. Seasoned with salt so you will know how to build people up and not bring them down. The Virginia ethical code on standards of practice requires us to use our influences to be that salt that seasoned the life of others.

WHAT YOU DON'T KNOW COULD HURT YOUR PRACTICE AND YOUR CLIENTS

Elaine Johnson, Larry Epp, Courtenay Culp, Midge Williams & David McAllister

Are you a mental health counselor? If so, you may be only vaguely aware of the ways in which CACREP (Council for Accreditation of Counseling and Related Educational Programs)-only language in hiring, credentialing and reimbursement policies could impact your practice. As practicing mental health counselors and board members of the Maryland and Massachusetts chapters of the American Mental Health Counselors Association, we have watched recent developments with increasing alarm. Our practices and livelihoods are under serious threat, and the public faces greatly reduced access to care, by growing efforts to restrict the practice of mental health counseling to those who attended CACREP-approved graduate programs. It is imperative that professional counselors everywhere understand these developments and take action to protect what we have worked so hard

The hidden threats to practice

TRICARE is the health care program for all active-duty and retired military personnel and their families. Licensed mental health counselors have served this population for many years but could do so only with physician referral and supervision. "Interim" regulations issued in 2011, based on a study by the Institute of Medicine (IOM), created a new classification of TRICARE providers (TRICARE certified mental health counselors, or CMHCs) who are allowed to practice independently. An interim period was created, during which current providers could ostensibly move to independent status by taking the National Clinical Mental Health Counseling Examination (NCMHCE) and meeting supervision requirements. The goal of the change, according to its announcement in the December 2011 *Federal Register*, was to increase access to mental health care by eliminating the physician-referral/supervision requirement. *Yet, the result is quite the opposite*.

TRICARE supervision rules: A major problem lies with the supervision requirement in the interim rule, which states that all of one's post-master's supervision hours must have been obtained under a licensed professional counselor. (It has come to our attention that this rule is not being applied consistently. This may be relieving for some, but haphazard enforcement is not a solution to an overly restrictive rule.) If we follow the rule, it prohibits most of the board members of the Maryland and Massachusetts AMHCA chapters from TRICARE participation because at the time we graduated, there were virtually no counselors who could have supervised us (since licensure laws were relatively new). Thus, *this rule disqualifies the most-seasoned counselors in many states from becoming CMHCs*. The American Counseling Association has requested the removal of this stipulation (for example, in a letter from ACA Executive Director Richard Yep to the assistant secretary of defense for health affairs in February 2012), but it remains on the TRICARE application. We do not believe the IOM intended to create a profound roadblock to CMHC status, but efforts so far to change the regulation have been unsuccessful.

It is also critical to recognize that at the conclusion of the interim period in December 2014, providers who cannot achieve CMHC status *will no longer be able to participate in TRICARE at all* because the physician-referral provider status will be eliminated. If you are currently a TRICARE provider who cannot meet this supervision requirement, you will either terminate your military clients or go unreimbursed — unless the regulations are changed.

CACREP restriction in TRICARE: The second problem with the TRICARE rules is that once the interim period expires, *all graduates from programs not approved by CACREP will be permanently excluded from participation in TRICARE even when duly licensed by their own states.* After December 2014, if you did not graduate from a CACREP-approved program, you *cannot and will not ever* be able to join the TRICARE network.

The CACREP-only rule, in combination with the supervision rule, will disqualify thousands of currently licensed practitioners. For example, ACA's own 2011 study found

that only 13 percent of licensed mental health counselors in New York graduated from CACREP-approved programs. In addition, because only 32 percent of U.S. master's programs in counseling and only 11 percent of 60-credit mental health counseling programs are accredited by CACREP (see the 2010 text *Ethical, Legal and Professional Issues in Counseling* by Theodore Remley and Barbara Herlihy), there are undoubtedly thousands of current counseling students in the country who will be permanently excluded. Again, as an example, in Massachusetts and Maryland, 32 programs train mental health counselors. Two (one in each state) are accredited by CACREP.

Our country faces a critical shortage of mental health counselors to serve legions of our veterans, including those from the recent wars. It is a travesty that the majority of current and future mental health counselors will be excluded from providing services to these veterans. They deserve more and better, as opposed to more restricted, access to therapists.

CACREP-only language has moved into regulations in other important areas:
1) The Department of Veterans Affairs (VA) recently created a new job classification for professional counselors. These jobs are open only to graduates of CACREP-approved programs.
2) No state currently requires graduation from a CACREP-accredited program for licensure. Yet, CACREP's stated goal (see, for example, Barry Mascari and Jane Webber's article, "CACREP Accreditation: A Solution to License Portability and Counselor Identity Problems," in the January 2013 *Journal of Counseling & Development*) is to restrict state licensure to graduates of CACREP-approved programs. Under regulations adopted in New Jersey in 2006 (and ultimately reversed by the grass-roots efforts of licensed counselors and educators), *graduation from a CACREP-accredited program would have become a requirement for all new counselors in the state and any counselor moving into New Jersey*. State counseling boards are continually lobbied by CACREP to restrict licensure to graduates of programs bearing their accreditation.
3) A bill recently introduced in the U.S. Senate (S. 562) would, if passed, extend Medicare eligibility to licensed professional counselors. Although there are no restrictions by type/accreditation of degree program in this bill, we are very concerned by the precedent that has been set in the regulations we have already described. If a CACREP-only restriction were to be inserted into Medicare regulations, we believe that Medicaid and private insurers would quickly follow suit, and in relatively short order, the practices of all graduates of programs not affiliated with CACREP would be obliterated.

These challenges to the majority of practicing professionals and counseling students in the country need a vigorous response. The rules need to be changed, and further restrictions must be prevented.

What is happening now

Practicing professionals, for whom CACREP may have seemed an "academic" issue, may not be aware that it serves only one slice of master's- and doctoral-level training programs. The only programs eligible for CACREP accreditation are those in "counseling" or "counselor education." CACREP does not serve programs that grant degrees with "psychology" in the name (for example, a master's in counseling psychology) or whose core faculty have degrees in psychology, identify as psychologists or are otherwise interdisciplinary, despite the fact that these graduates are license holders and license eligible in all 50 states.

Ironically, if Carl Rogers wished to hold a core faculty position in a CACREP program today, he would be prohibited due to the requirement that only counselor educators may occupy such positions. Many of us received excellent education and training from psychologists and others whose training was in other disciplines. We do not believe that national certification and reimbursement should be restricted to those who were trained solely or primarily by counselor educators, thus excluding qualified license holders in every state.

We applaud and support the educational standards that CACREP has developed and the efforts to promote these standards nationally. However, other accrediting bodies with equally impressive standards exist that accredit the programs that CACREP does not. Many of our members are graduates of or students in these programs. A notable example is the Council on Rehabilitation Education (CORE).

All accrediting bodies share the same mission — to train and graduate counseling professionals of the highest caliber. We can coexist peacefully and strengthen each other by supporting strong common core training and diversity in faculty background as well as programs' specialty areas of expertise.

What needs to be done

1) We believe that CACREP-only restrictions should be removed from hiring and credentialing processes for TRICARE and the VA and should *not* be included in any future regulations (for example, state licensure laws, Medicare and private insurance regulations). Restrictive supervision rules in the TRICARE regulations must also be removed. ACA has consistently requested TRICARE policymakers to expand the original, restrictive criteria, and we ask the leadership to redouble efforts to press for those changes. The TRICARE rules are "interim final rules" and can be changed. Because ACA's requests of regulators have not been effective to date, we ask the ACA membership to join us in lobbying our congressional delegations to change the rules. Please send an email to your representatives in Congress and urge them to oppose the restrictive TRICARE and VA regulations on your behalf.

2) Until CACREP-only language and the restrictive supervision rule are removed from TRICARE regulations, the current interim rules for transition to CMHC status in TRICARE should remain open. Established and emerging professionals who can meet the supervision requirement should be allowed to move into independent CMHC status.

3) The requirement for CMHC applicants to pass the NCMHCE (the clinical counseling exam) should commence in 2017, giving states that do not currently use this exam a chance to move to it in a reasonable way.

4) Please write (emails are more effective than letters) to your senators and congressional representatives and ask them to support S. 562, which would allow professional counselors to participate in Medicare. We believe it is very important that regulations are written to allow *all currently licensed professional counselors* to participate. This is a matter of honoring the right of states to determine the qualifications for professional practice and to provide much-needed services to citizens in every state.

5) Regarding training standards, the profession of mental health counseling stands at a historic moment. Importantly, delegates to the 20/20: A Vision for the Future of Counseling initiative did *not* reach agreement that graduation from a CACREP-accredited mental health counseling or clinical mental health counseling program should be included in model licensure language. We believe that a more inclusive endorsement of educational standards is needed and should be part of all future federal and state credentialing processes. Please join with us in calling on the leadership of ACA and its divisions to recognize and affirm the value that CORE has long brought to the training of professional counselors and that other accrediting bodies bring in providing an alternate route to accreditation for counseling programs in related academic departments. Future initiatives and regulations should recognize and incorporate these accrediting bodies alongside CACREP. In doing so, ACA will affirm and continue its rich and diverse intellectual history and serve the best interests of *all* of its professional counseling members.

MEMBERSHIP COMMITTEE NEWS

by Penny A. Norford, PhD, LPC, CSAT-S

VACC added a Central Virginia chapter in Charlottesville in 2013. The chapter has hosted 3 professional education workshops as well as providing networking opportunities for licensed professional counselors, both at meetings and through group emails.

Chapters will have the opportunity to host workshops, some provided by VACC board members, while utilizing the VACC CEU provider number.

If you are interested in spearheading a local chapter in your region, please contact VACC's Membership Committee Chairperson Penny Norford at pennor4d@aol.com.

KNOW WHEN TO HOLD 'EM...

by Penny A. Norford, PhD, LPC, CSAT-S

As a certified sex addiction supervisor, I am often asked by colleagues how they can know when to refer their client to a sex addiction therapist. It's a great question and unfortunately one that is not being asked often enough by therapists around our Commonwealth. I am now treating several individuals who spent years and much money in therapy having their compulsive behaviors minimized, deflected to couple's work, and eventually being blamed for not improving.

In this article, I provide an overview, a few suggestions, and then give a brief screening tool you can use when referring to a certified sexual addiction therapist. You can find these therapists online at recoveryzone.com or by contacting the International Institute of Trauma and Addiction Professionals at www.IITAP.com (phone: 480-575-6853).

Suggestions

If you are treating a couple, please be sure to inquire about their sexual practices. In David Schnarch's book, *Passionate Marriage* (1999), he suggests that a couple's sexual practices will describe the power and control dynamics within the relationship. As therapists, we are trained to focus on the emotional relationship of the couple, however like any addiction, the addict is often lying to him or herself and will talk a good game in therapy. In fact, much of the pain caused to the addict's spouse or partner stems from the addict's compulsive dishonesty coupled with the suggestion that the partner is being paranoid, exaggerating, etc. This term is known as "gaslighting," stemming from the movie by the same name.

Please rethink your original ideas about pornography. While many couples can share pornography to enhance their sexual experience together, many more marriages are being destroyed by online affairs, hookups, and voyeurism. Compulsive use of pornography begins long before the partners in a couple meet and has little or nothing to do with the amount of sex that the couple is having. Many therapists erroneously attempt to improve this aspect of the relationship.

Also consider that a sex addict, much like a drug addict or alcoholic, is often emotionally immature and regressed to the age of onset of addiction. So, if a client appears immature when discussing relational issues or seems preoccupied with sex, explore! Sexual addiction stems from early trauma.

Screening

The *PATHOS screening tool is used as a preliminary evaluation for assessing sexual addiction. If a client confirms the existence of at least three of six of the following criteria, then referral should be made to a certified sex addiction therapist.

Preoccupation. Do you often find yourself preoccupied with sexual thoughts?

Ashamed. Do you hide some of your sexual behavior from others?

Treatment. Have you ever sought therapy for sexual behavior you did not like?

Hurt others. Has anyone been hurt emotionally because of your sexual behavior?

Out of control. Do you feel controlled by your sexual desire?

Sad. When you have sex do you feel depressed afterwards?

If you want to read more about this screening instrument please refer to "PATHOS: A brief screening application for assessing sexual addiction." Carnes, P., Green, B., Merlo, L., Polles, A., Carnes, S., and Gold, M. (2011) *Addictive Medicine V* 00, #00