VACC Newsletter, Spring 2013

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VIRGINIA ASSOCIATION
OF CLINICAL
COUNSELORS

VACC Headlines

Serving the needs of Virginia Clinical Counselors since 1980

this issue

PRESIDENT'S CORNER

By Michael Jeffrey, LPC, LMFT

Spring is finally here, and during this period of renewal and positive energy, I want to talk about some of the things the VACC Board has been working on this year to bring about much-needed changes in our profession.

As part of a joint effort between VACC and the Northern Virginia Licensed Professional Counselors association, the two groups worked together to create an updated e-mail list of all licensed counselors in the state of Virginia. While VACC provided a portion of the funding, the work itself is being carried out and supervised by NVLPC. We look forward to receipt of the list, which will be instrumental in our membership recruitment and communication efforts. We expect to be able to use this list along with our regions, to distribute conference information, send out alerts about legislation, and keep in contact on a variety of other issues of interest to LPCs. This is a good example of how two organizations, working together, can accomplish more than either one alone.

NVLPC has already used portions of the list to contact LPCs in support of SB 1325, a bill was which was intended to increase the number of staff on the Virginia Board of Counseling so that the board could run more efficiently and could eliminate the backlog of applications that have resulted in waits for responses of up to six months or even a year.

Former VACC President Joan Normandy-Dolberg who is currently the chair of NVLPC's pre-licensure support group, gets the credit for the push and energy behind this effort. NVLPC President Donna C. Fortney was instrumental in developing the relationships and driving the efforts for this statewide email campaign.

Most of you received an email requesting your support, and although the bill passed in the Senate, and on February 18 the House passed an emergency version of the bill, unfortunately, last week Virginia Governor Robert McDonnell vetoed the bill and requested the Board of Counseling continue its work within the constraints of its current budget. It was noted that under the Callahan Act, the Board of Counseling can seek a fee increase in the future, if its current cash balance is depleted.

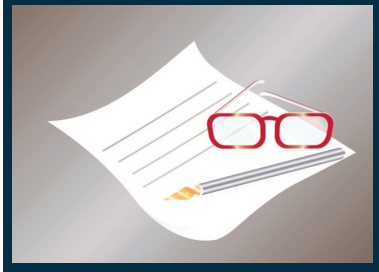
In Other News . . .

HB 1666. At our Board meeting in January, the VACC Board voted to support HB 1666 which gives the Board of Counseling the authority to create a registry of approved supervisors, and HB 2177 which changes the composition of the board.

Statewide Update. In other state news, we welcome the formation of a new regional chapter in Charlottesville, Virginia which calls itself the Central Virginia Licensed Professional Counselors. CVLPC was started through the efforts of VACC Board member Penny Norford.

CONTINUED

Virginia Association of Clinical Counselors has a long and proud tradition of protecting and advocating for the clinical counseling profession in Virginia. Much of the work of the organization is done by the Executive Board, a dozen or so members who serve as committee chairs and elected officers. We would welcome inquiries from all interested parties, and would like to include counselors from both private and public service. Racial, ethnic, and geographic diversity is valued as well. The rewards? Among others, camaraderie, leadership experience, a direct role in shaping the future of the counseling profession, credit (up to eight hours) toward your 20 hours of continuing education, and many intangibles.



DSM-5 Changes. The entire counseling profession is awaiting the release of new Diagnostic and Statistical Manual of Mental Disorders (DSM-5) from the American Psychiatric Association. See page 4 for a quick overview of what some of the major changes will be.

Fellowship Winners Announced. Also in the issue, the winners of the annual Linda Heacock Memorial Fellowship are announced.

Coming in 2013. . . VACC is developing two state wide trainings over the next year. Both trainings will specifically target LPCs as the audience. The first will be an overview of the changes in the new DSM-5. Many of the DSM training programs currently available are not specific to LPCs. They spend half a day discussing changes that we have little interest in and that do not affect us in our practice. Our training program will be specific to LPCs and only target those issues that impact our profession; such as substance abuse, depression, trauma and anxiety-related disorders, etc. The second training will focus on ethics issues, but, again, only those ethical issues that affect our practice. Our conference committee is working on this as I write. Stay tuned for specific details on time and place.

National News. . . We are excited that the 2013 AMHCA National Conference is going to be held in Virginia this year at the Renaissance Arlington Capital View Hotel in Crystal City. As the host state, VACC will open a hospitality suite for the leadership training and for Virginia LPCs to drop by and socialize. I encourage you to attend AMHCA and join us. So mark your calendars now for July 18-20

Get Involved. Join the VACC Board. . . One request I would ask you to think about is service to our profession. Why not join the VACC board? I personally believe that all professionals have the responsibility to serve the profession as a whole through service at the state, national, or local level. One way to do this is a term on the VACC board. Please visit our website www.vacc.org and take a look at our mission, our current board, and the by-laws. If you are interested in additional information, please contact Mike Nahl or myself. We'd be glad to hear from you.

Hope to see you at AMHCA this July, in Arlington!

Michael F. Jeffrey, LPC, LMFT
president@vacc.org

CARMICHAEL, RHODES WIN 2013 FELLOWSHIP AWARDS

Brad Carmichael (Old Dominion University) and Randall Rhodes (Regent University) each were awarded one of the $1000 Linda Heacock Memorial Fellowships offered by the Virginia Association of Clinical Counselors each year. They were the top two choices of each of the three judges. The essay topic for this year was that of "Your Therapy Style," and involved presenting a therapeutic model that addressed development of symptoms (past), treatment of symptoms (present), and future orientation.

Many of the other essays had some enlightening or interesting aspects, but they did not present their models as completely and cohesively as did those named the winners. Thanks to all who participated, and congratulations to our winners.

Ethically Speaking

by Theresa Johnson-Sion, PhD, LPC

Child Abuse Reporting Timeline
A report of suspected maltreatment is not an accusation! It is a request for the helping process to begin.

Child Abuse Laws Vary from State to State. Every state has a child abuse reporting law under which licensed mental health practitioners and others are required to report known or reasonably suspected child abuse. The laws vary from state to state. If neither the locality in which the child resides nor the location in which the abuse or neglect is believed to have occurred is known, then reports should be made to the local department of the county or city in which the abuse or neglect was discovered or to the Department's toll-free child abuse and neglect hotline.

Counselors are Mandated to Report. In Virginia, anyone may report abuse or neglect; however, under Virginia law certain professionals who work with children such as counselors, teachers and other health care professionals are mandated reporters. Any time you, as a mandated reporter, suspect that a child is being abused or neglected by a caregiver (or anyone else) you should immediately report your concerns to the local Department of Social Services. You need not "**prove**" that abuse or neglect has taken place; local Department of Social Services are responsible for making this determination. Non-caregiver abuse should be reported to the police.

Twenty-four Hours to Report. One essential aspect of the reporting law involves the time frame for making reports, which is usually rather short (not longer than 24 hours after having reason to suspect a reportable offense of child abuse or neglect). Failure to make a required report within the time frame specified usually constitutes a crime or, at minimum, unprofessional conduct. Virginia law states that a fine not more than $500 for the first failure to report, and not less than $1,000 for any subsequent failures. In cases evidencing acts of rape, sodomy, or object sexual penetration as defined in Article 7 of Chapter 4 of Title 18.2, a person who knowingly and intentionally fails to make the report required pursuant to this section shall be guilty of a Class 1 misdemeanor.

Virginia Code Protects Reporters. When making a report, it is helpful to provide as much information as possible. You may report anonymously if you choose, but you are encouraged to give your name so that Child Protective Services workers can contact you if additional information is needed. If the case is brought into court, the identity of the reporter may be revealed during the proceedings. It is important to point out, the code of Virginia provides protection from criminal and civil liability to any person making a report of child abuse or neglect unless it is proven that those persons acted with malicious intent.

Document the Actions You Take. In the eagerness to help clients, counseling professionals must be careful not to expose themselves to legal risks. The above information is a helpful reminder to protect yourself while providing clients with quality mental health services. And remember to document the conversation, advice given, and any follow-up with the client and family. You know what they say, "If it isn't written down . . . ". So, document, document, document. If you have questions, you should consult with a supervisor, with the local Department of Social Services child protection services unit, or call the Virginia Child Abuse and Neglect Hotline (1-800-552-7096).

MARK YOUR CALENDARS

APA Will Release New DSM-5 Next Month

by Lourie W. Reichenberg, LPC

In the words of the old Sam Cooke classic: *"It's been a long time coming, but I know a change is gonna come . . . oh yes it will"*

To be sure, the new *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) *has* been a long time coming. More than 14 years to be exact, from the first conversations between NIH and the American Psychiatric Association in 1999, until the APA Board of Trustees gave its final approval in December, 2012. And we still won't know the exact details of the approved changes until the published version is released at the APA annual convention in San Francisco May 18-23, 2013. Rather than speculate on the specific criteria for each disorder, we will have to wait and see exactly what the final changes will be. Until then, we can focus on what the APA has announced will be in *DSM-5*:

Name Change. Future editions of the DSM will replace the Roman numerals (e.g., DSM-IV) with Arabic numerals (DSM-5) to facilitate ease of revision of future editions (e.g., DSM-5.2).

Elimination of the Multi-axial System. The five-axis system has been eliminated from DSM-5, reportedly due to a lack of scientific evidence to support it. Axis I, II, III, IV, and V (the GAF score), will be no more. Neither will therapists list contributing factors.

Reorganization of Chapters. The first four editions of the DSM organized disorders by frequency of diagnosis. *DSM-5* will put similar disorders near each other on a continuum of severity and will more closely align with ICD-11 codes put out by the World Health Organization.

Dimensional Assessments. Many, if not most, disorders in *DSM-5* will take a dimensional approach. In many cases, dimensional assessments will help clinicians to determine not only the presence of symptoms, but their degree of severity (e.g., mild, moderate, severe). This could be helpful in diagnosis, and will provide a means to monitor progress over the course of treatment.

A Few New Disorders. According to an American Psychiatric Association press release, new disorders included in *DSM-5* will include: Excoriation (skin-picking), and disruptive mood dysregulation disorder (DMDD), among others. DMDD will address extreme childhood irritability and emotion dysregulation. Research indicates that most children with a history of extreme emotions do not generally develop bipolar disorder as adults. It is hoped that the new DMDD diagnosis may reduce the number of children who are being diagnosed with (and prescribed medication for) bipolar disorder.

Major Changes in Some Areas. Autism and substance abuse disorders are expected to include major changes, some of which have already received widespread attention in the media. For example, *DSM-5* will incorporate Asperger's disorder into the broader umbrella of autism spectrum disorders. Substance abuse and substance dependence will be combined into one category: Substance Use Disorder. And, in a somewhat controversial decision, the bereavement exclusion for depression will be removed.

What Will Not Be in *DSM-5*. APA's Board of Trustees decided not to include the following disorders at this time: mixed anxiety and depression, hypersexual disorder, parental alienation syndrome, and sensory processing disorder.

Section 3 Disorders. As in DSM-IV, the newest edition of the DSM will include disorders that are deserving of future research. Section 3 Disorders will include: attenuated psychosis syndrome, Internet use gaming disorder, non-suicidal self-injury, and suicidal behavioral disorder. A new trait-specific methodology for diagnosing personality disorders will be included in Section 3 to encourage further study.

It has been more than 10 years since the DSM has had anything other than text revisions, and DSM-5 promises to provide a decade's worth of changes. As did the first four editions that preceded it, *DSM-5* will provide a much-needed diagnostic tool, albeit a tool that continues to evolve. All insurance companies require a diagnosis before they will agree to payment for medical or behavioral health treatment. The DSM provides a concise tool that we can use to identify symptoms and diagnose disorders. It's not perfect, but in many ways, it will include much of what we already do, anyway. For example, binge eating disorder and premenstrual dysphoric disorder (both listed in the Appendix of DSM-IV) are expected to be classified as full blown disorders in their own right. Hoarding, once considered a symptom, is also expected to become a disorder onto itself.

So, yes, change is hard and it can sometimes feel uncomfortable to unlearn what we already "know." But it's clear that the APA did not enter into any of these changes lightly. They came after years of research, expert opinion, committee input, comment periods, and even more research. Whichever specific changes are included in the DSM-5, we can pretty much be assured they are moving forward in keeping with the evolution of our knowledge about mental health, and will help us ultimately to provide better services, care, and treatment to the millions of people who rely on us every day.

Stay tuned for the publication in May of DSM-5. Oh, yeah, a change is gonna come . . . yes, it is.

Lourie W. Reichenberg is co-author of *Selecting Effective Treatments: A Guide to Diagnosing and Treating Mental Disorders, 4th Ed.* An addendum reflecting DSM-5 revisions will be released in Summer, 2013.

Newsletter Update

by Lourie W. Reichenberg, LPC

In his President's Report, Michael Jeffrey encouraged members to get involved by volunteering for a committee, serving on the Board, or taking advantage of networking and socializing opportunities at the AMHCA Conference in Arlington this summer.

I would like to plant an additional seed in your mind—why not share some of your professional expertise with other LPCs by submitting an article to this newsletter? Whether it's a book you've recently read that was professionally inspiring, an announcement of a job vacancy or office for rent, or a suggestion of articles or information we can provide to help meet your needs as a Virginia counselor, we would be glad to hear from you. Please send newsletter articles or suggestions to me at: Editor@VACC.org.

The VACC newsletter is published four times a year and distributed by mail and via website with the mission of making information that is relevant and timely to our profession available to therapists across the Commonwealth of Virginia. The Virginia Association of Clinical Counselors is the state chapter of the American Mental Health Counselors Association.

Psychotherapy Billing Code Changes Went into Effect January 1, 2013

by Deborah Legge, PhD, CPC, LMHC

The following information about the new CPT procedure codes and regulations is excerpted, with permission of the author, from The Advocate, published by the American Mental Health Counselors Association. Please be aware that this information is subject to change.

Whether or not you do your own billing, if you are in private practice YOU need to be in charge of your money. Knowing what has been billed and what has (or has not) been collected is just the tip of that iceberg. In addition to having a good handle on your receivables, you need to know the rules. The insurance companies you bill generate some of those rules--things like authorization requirements, session limits, billing procedures, etc. Other rules have their roots in the CMS (Centers for Medicare & Medicaid Services) guidelines.

On January 1, 2013, the CMS instituted a revision of the codes that mental health professionals use to bill for mental health services. Effective January 1, 2013, if you are still billing under the old CPT codes, your claims will likely be rejected and you will be required to resubmit your bills using the new CPT codes. (Note: Services provided in 2012 must still be billed using the 2012 codes.)

Here is a brief overview of the changes you'll see for the codes most commonly used by Counselors:

Service	Old Code	New Code
Psychiatric Diagnostic Evaluation	90801	90791
Outpatient Psychotherapy (45-50 min)	90806	90834 (45 min)
Outpatient Psychotherapy (75-80 min)	90808	90837 (60 min)
Group Psychotherapy	90857	90853

New to the CPT coding system in 2013 are the Crisis Code (90839 for 60 min and 90840 add-on for additional 30 minutes), and the interactive complexity add-on code (90785) for use when the delivery of services is more complex. Remember that not all insurance companies reimburse all providers for all of the available codes. Therefore, you should always look to the insurance companies for which you are a provider for a complete listing of approved codes and new coding regulations.
Stay informed; knowing the rules will help keep you in compliance, and will decrease rejected claims and unpaid invoices.

Deborah Legge, PhD CRC LMHC is a private practice mentor who helps counselors establish, build, or revitalize a private practice. She can be reached at DrLegge@influentialtherapist.com

TRICARE UPDATE

by Jim Finley

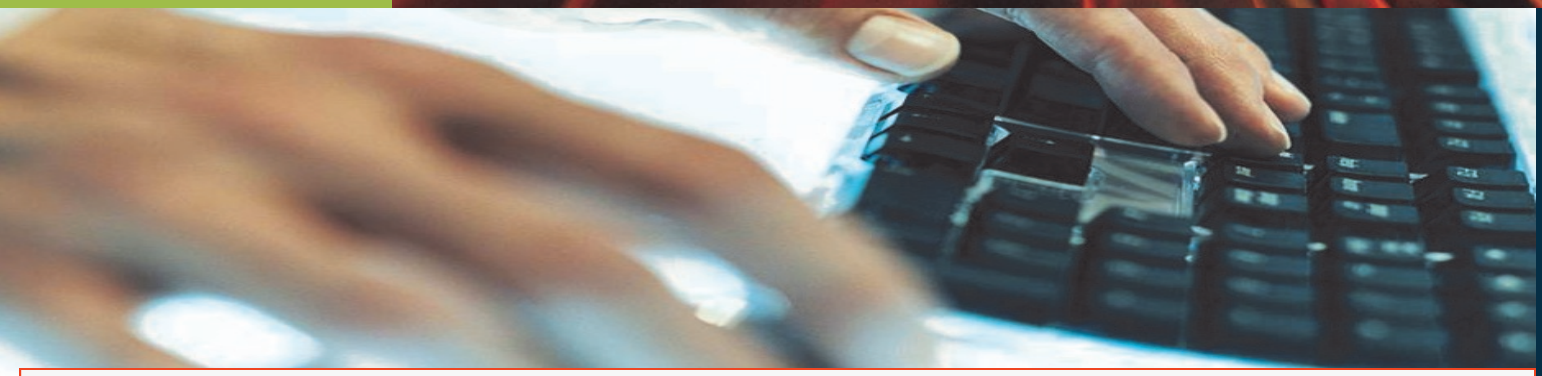
AMHCA Associate Executive Director

The following update appeared in the Advocate, published by the American Mental Health Counselors Association. It is reprinted here with permission. VACC members who wish to keep abreast of changes as they become available are encouraged to visit AMHCA online at www.amhca.org or on Facebook.

AMHCA continues to receive a trickle of member requests seeking help obtaining TRICARE certification for independent practice. We are pleased that many mental health counselors around the country have received certified provider status. However, key deficiencies in TRICARE's December 2011 rules remain. During much of 2012 TRICARE administrators worked on revised program rules; however there has been no sign of recent activity by the agency. AMHCA continues to seek a more inclusive grandfather provision that will enable all demonstrably well-qualified practitioners to participate in the program. Specifically, we seek an inclusive grandfather that will open a time-limited alternative to the CACREP accreditation requirement. Beginning this month AMHCA has joined its coalition partners in meeting with potential Senate supporters to assess whether new grandfather rules will be forthcoming or to seek congressional intervention. We are currently exploring strategies for congressional intervention should improved rules not be forthcoming.

Similar to the situation with TRICARE, AMHCA is also upping pressure on the Veterans Administration (VA) to hire more mental health counselors. We continue regular meetings with top VA leadership to advocate for increased hiring of the profession, but we encounter great resistance. In late February we resumed making rounds of House and Senate VA committee members to seek traineeship funding for mental health counselors. Such traineeships are an important starting point to employing more mental health counselors in the VA. We are also urging congressional offices to examine the very slow pace of mental health counselor hiring, including considering how barriers to mental health counselor hiring compound broader congressional concerns about the pace of VA hiring of mental health professionals. An important item on our congressional list is seeking support for bill language that would add a grandfather provision to mental health counselor position requirements. Such a provision is essential to allow more mental health counselor to qualify for VA employment.

For both TRICARE and the VA, AMHCA leaders have set a high priority on securing more inclusive grandfather language in the agencies' professional standards. AMHCA recognizes the need for national (CACREP) accreditation standards of our training programs, but we also urge adoption of an inclusive grandfather provision so that prior graduates of state or regionally accredited programs may participate. AMHCA expects that Medicare administrators will lean heavily on TRICARE and VA professional standards when Medicare provider status legislation is finally enacted. AMHCA strategy is to seek an inclusive grandfather provision under TRICARE and the VA, thereby creating an inclusive professional certification model for Medicare administrators to consider in the future.



Web Site

by Michael Nahl, Communications Committee Chair

Have you looked at our website (www.vacc.org) lately? We have some great links to the most important information LPCs need to stay abreast of recent developments in the profession. At www.vacc.org you can link to:

- Virginia Board of Counseling,
- Department of Health Professions,
- Nearby state clinical counseling associations,
- AMHCA,
- Virginia graduate counseling programs,
- Insurance companies, and
- your state and federal legislators.

Our website is a handy site for connecting to many of the places licensed professional counselors need to go.

Students, too, will find a separate page that includes links to state counseling programs, Board mentors, and a list of clinical supervisors. By the way, any VACC member who provides supervision can list themselves on our site at no charge.

Get the Latest Legislative Updates for LPCs. Updates on federal and state legislation affecting LPCs can be found on the home page and the You Can Help sections of the website.

Find & Post Job Openings. Looking for a job? Want to advertise a job position you have available? Need or want to rent office space? We can help. Look for the Job Opportunities section.

Renew Your Membership. Want to renew your membership or become a member? You can do that online, too. You can also register for our conferences and pay for them over the website.

Track Information. Read the history of our profession, get a concise print out of what LPCs do, find recent VACC newsletter content, and information about VACC, including our bylaws, all on the website.

Connect with us on Facebook and Twitter. That's right! You can now visit us on Facebook and Twitter for the latest news, announcements, events, and membership information. Connect with us on Facebook and Twitter to instantly share your comments, ideas, videos, pictures, and links.

There's much, much more. So, don't forget to check it out, and be sure to tell a colleague about us!

www.vacc.org