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POLICY AND ADVOCACY COMMITTEE MEETING NOTICE
January 30, 2015
9:00 a.m.

Department of Consumer Affairs
First Floor Hearing Room
1625 North Market Blvd
Sacramento, CA 95834

- I. Call to Order and Establishment of Quorum
- II. Introductions*
- III. Approval of the September 18, 2014 Committee Meeting Minutes
- IV. Discussion and Recommendations for Possible Action Regarding Telehealth:
 - a. Other States' Telehealth Laws, Regulations, and Policies
 - b. Inclusion of Trainees in the Board's Proposed Telehealth Regulations
 - c. Security and Confidentiality Requirements for Telehealth
 - d. Review of Proposed BBS Regulations for Telehealth
 - e. Supervision Via Telehealth
- V. Update and Possible Action on Text of Proposed Legislation for 2015: Crime Victims: Compensation for Reimbursement of Violence Peer Counseling Expenses
- VI. Update Regarding AB 2198: Suicide Prevention Training for Mental Health Professionals
- VII. Legislative Update
- VIII. Regulation Update
- IX. Suggestions for Future Agenda Items
- X. Public Comment for Items not on the Agenda
- XI. Adjournment



Governor
Edmund G. Brown Jr.
State of California

Business, Consumer Services
and Housing Agency
Department of
Consumer Affairs

**Introductions are voluntary for members of the public*

Public Comment on items of discussion will be taken during each item. Time limitations will be determined by the Chairperson. Times and order of items are approximate and subject to change. Action may be taken on any item listed on the Agenda.

THIS AGENDA AS WELL AS BOARD MEETING MINUTES CAN BE FOUND ON THE BOARD OF BEHAVIORAL SCIENCES WEBSITE AT www.bbs.ca.gov.

NOTICE: The meeting is accessible to persons with disabilities. A person who needs a disability-related accommodation or modification in order to participate in the meeting may make a request by contacting Christina Kitamura at (916) 574-7835 or send a written request to Board of Behavioral Sciences, 1625 N. Market Blvd., Suite S-200, Sacramento, CA 95834. Providing your request at least five (5) business days before the meeting will help ensure availability of the requested accommodation.



Policy and Advocacy Committee Minutes - *DRAFT*
September 18, 2014

Department of Consumer Affairs
2450 Del Paso Rd., #109
Sacramento, CA 95834

Members Present

Renee Lonner, Chair, LCSW Member
Deborah Brown, Public Member
Dr. Christine Wietlisbach, Public Member
Christina Wong, LCSW Member

Staff Present

Kim Madsen, Executive Officer
Steve Sodergren, Asst. Executive Officer
Rosanne Helms, Legislative Analyst
Christy Berger, Regulatory Analyst
Dianne Dobbs, Legal Counsel

Members Absent

None

Guest List

On file

I. Call to Order and Establishment of Quorum

Renee Lonner, Policy and Advocacy Committee (Committee) Chair, called the meeting to order at 9:17 a.m. Kim Madsen took roll, and a quorum was established.

II. Introductions

The Committee, Board staff, and meeting attendees introduced themselves.

III. Approval of the August 6, 2014 Committee Meeting Minutes

The following edits were suggested:

Renee Lonner moved to approve the Policy and Advocacy Committee meeting minutes. Christina Wong seconded. The Committee voted (3 yeas, 1 abstention) to pass the motion.

IV. Discussion and Recommendations for Possible Rulemaking Action Regarding Proposed 2015 Omnibus Bill Amending Business and Professions Code Sections 4980.43, 4984.01, 4996.2, 4996.28, 4999.45, 4999.46, and 4999.100

Rosanne Helms presented the suggested amendments to the Business and Professions Code (BPC):

- Amend BPC §4984.01, §4996.28, §4999.45, and §4999.100 – Prohibited Work Settings for a Subsequent Registration Number

1 Staff has expressed that some registrants with a subsequent registration number are
2 confused about the section in the law that prohibits them from working in a private
3 practice. Staff suggested clarifying language to these sections by stating the prohibition
4 more directly.

5
6 • Amend BPC §4996.2 – Qualifications for a License

7
8 BPC §4996.2 lists the requirements for an applicant, including being at least 21 years old,
9 having earned a master’s degree from an accredited school of social work, and having 2
10 years of supervised post-master’s degree experience. However, the section does not
11 specifically state whether these requirements pertain to an applicant for licensure or to an
12 applicant for registration.

13
14 Since the requirements are intended for applicants for licensure, staff recommends that
15 the section be amended to indicate so.

16
17 • Amend BPC §4980.43 and §4999.46 – 90-Day Rule for Intern Applicants

18
19 BPC §4999.46(d) allows an applicant for a PCI Intern registration to credit post-degree
20 hours of experience toward licensure experience requirements, as long as the applicant
21 applies for the intern registration within 90 days of the granting of the qualifying degree.

22
23 A stakeholder has pointed out that the current language is confusing. Currently, the
24 language allows the counting of the hours as long as the applicant applies for intern
25 registration “within 90 days of the granting of the qualifying degree and is registered as an
26 intern by the board.”

27
28 By definition, an applicant applying within 90 days of the degree being granted is not yet
29 registered as an intern by the Board. Staff recommends clarifying this language so that it
30 is similar to the language for MFT Interns in §4980.43(g)

31
32 Mr. Montgomery, California Association of Marriage and Family Therapists (CAMFT),
33 requested alternate language to the term “subsequent” in the first proposed amendment,
34 stating that the term could be misunderstood. Christy Berger referred to §4984.01(c), which
35 puts the term in good context. Dianne Dobbs agreed.

36
37 Ms. Madsen suggested using the term “a subsequent intern registration number.”

38
39 ***Christina Wong moved to direct staff to make any discussed changes, as well as any***
40 ***non-substantive changes to the proposed language and recommend that the Board***
41 ***sponsor legislation to make the proposed changes. Renee Lonner seconded. The***
42 ***Committee voted unanimously (4-0) to pass the motion.***

43
44 **V. Discussion and Recommendations for Possible Action Regarding Legislative**
45 **Amendments to Support Board’s Continuing Education Program**

46 The Board conducted an extensive committee process to revise its regulations related to
47 continuing education (CE). Those regulations were recently approved and will be effective on
48 January 1, 2015.

49
50 The regulations removed the Board’s authority to directly approve and license CE providers.
51 Instead, the Board proposes recognizing “approval agencies” that have already established
52 stringent requirements for CE providers.

53

1 The Board’s licensing law contains several references to the Board “approving” CE providers.
2 However, under the new CE regulations, the Board will no longer approve CE providers.
3 Therefore, this language is obsolete.
4

5 Staff proposed the following technical amendments to update the Board’s licensing law so it is
6 consistent with the CE regulations:

- 7 • Amend BPC §28 - Training for Child and Elder and Dependent Adult Abuse Assessment

8
9 This section discusses a need for the BBS and the Psychology Board (BOP) to establish
10 training in child and elder and dependent adult abuse assessment. The section states a
11 course is acceptable if it is from a CE provider approved by the BBS or BOP.
12

13 Both BBS and BOP no longer approve CE providers, and therefore staff suggests the
14 language be amended for consistency.
15

- 16 • Amend BPC §4980.399, §4980.54, §4989.34, §4992.09, §4996.22, §4999.55, and
17 §4999.76: Miscellaneous References to Approving CE Providers

18
19 These sections make several references to the Board approving CE providers. Staff
20 suggests changing the references as appropriate and stating that CE providers specified
21 by the Board in regulation are acceptable. Staff also recommends changing the
22 requirement of the Board to establish a procedure to approve CE providers, to instead
23 require the Board to establish a procedure to identify acceptable CE providers.
24

25 Dr. Christine Wietlisbach recognized former Board Member, Dr. Harry Douglas, for his work
26 on the CE program.
27

28 ***Renee Lonner moved to direct staff to make any discussed changes, and any non-***
29 ***substantive changes, and to bring to the Board for consideration as a legislative***
30 ***proposal. Dr. Christine Wietlisbach seconded. The Committee voted unanimously (4-0)***
31 ***to pass the motion.***
32

33 VI. Discussion and Recommendations for Possible Action to Sponsor Legislation to 34 Support the Board’s Enforcement Process

35 Staff is recommending consideration of two legislative amendments related to the Board’s
36 enforcement process:
37

- 38 • Requirements to Petition for Reinstatement or Modification of Penalty

39
40 As the Board’s licensing population increases, the Board’s Enforcement Unit is receiving
41 an increasing number of requests to petition for termination of probation or modify penalty
42 from licensees and registrants who are not in compliance with the terms of their probation.
43 These requests utilize the valuable time and resources of staff, attorneys, and Board
44 members, even though they will ultimately be rejected for noncompliance.
45

46 BPC §4990.30 sets the process by which a Board licensee or registrant may petition for
47 reinstatement or modification of penalty if his or her license or registration has been
48 revoked, suspended, or placed on probation.
49

50 Staff proposes to add BPC §4990.31, which outlines criteria under which the Board may
51 deny a request to petition to terminate probation or modify penalty:

- 52 ➤ Failure to comply with the terms/conditions of the disciplinary order;
- 53 ➤ Receipt of additional credible complaints against the petitioner while on probation;

- A subsequent arrest or conviction while on probation; and/or
- The petitioner’s probation is currently tolled.

Staff also recommends increasing waiting times to file a petition request, as follows:

- Two years to petition to terminate any probation period, regardless of its length.

Currently, a licensee/registrant must wait two years to petition to terminate any probation period of three years or more; and a licensee/registrant must wait one year to petition to terminate probation of less than three years.

- Two years to petition to modify a condition of probation.

Currently, a licensee/registrant must wait one year to petition to modify a condition of probation.

Discussion

Dr. Wietlisbach expressed that two years is a long period to wait, especially in terms of the expense for a licensee’s/registrant’s. She would prefer that the discretion remains with the Board.

Ms. Lonner agreed with Dr. Wietlisbach. She also added that there is no advantage in requiring to the licensee/registrant to wait two years to petition to terminate probation.

The Committee agreed that criteria need to be established for licensees/registrants petitioning to terminate or modify probation.

Ben Caldwell, American Association for Marriage and Family Therapy California Division (AAMFT-CA), agreed with the criteria; however, he does not agree with the waiting times to file a petition. Since only some of the petitions are granted, there is not a public protection need to require a two-year minimum waiting period. The two-year minimum waiting period will create an increased workload because probationers will remain on probation longer.

Mr. Montgomery, CAMFT, requested that the Board define “credible complaints.” To clarify this term, Ms. Madsen and Ms. Dobbs agreed to add language indicating that the Board “is conducting an investigation” against a probationer.

Ms. Helms summarized that the Committee does not want to amend BPC §4990.30. She further summarized that the Committee proposes to add BPC §4990.31 as suggested by staff.

- License or Registration Status Change

A new section is proposed to clarify that the Board has jurisdiction to investigate and/or take disciplinary action even if the status of a license or registration changes or the license or registration expires. This is being proposed for two reasons:

- Medical Board Case Ruling

The California Medical Board lost a court of appeal case where it was attempting to take disciplinary action against a licensee who held a retired license. The court ruled that a retired license status is not considered a licensee under the Medical Board’s jurisdiction, and that the disciplinary authority is valid “only if and when the retired

1 licensee seeks to return to the practice of medicine and files an application” with the
2 Medical Board.

3
4 Because of this ruling, the Medical Board sought an amendment to one of its statutes,
5 to add retired and inactive license statuses within that board’s authority to investigate
6 and take disciplinary action.

7
8 ➤ Deficiencies in BPC §118

9
10 BPC §118 is the statute that provides the Board with authority to continue a
11 disciplinary proceeding or take disciplinary action even if a license is expired,
12 suspended, or forfeited. However, there is a loophole in §118 that only allows this
13 authority during the period of time during which the license can be renewed, restored,
14 reissued, or reinstated.

15
16 The Board’s Enforcement Unit is experiencing difficulties in taking disciplinary action
17 on registrants with an expired or expiring registration number. Under the law, a
18 registration number is valid for six years. After six years, the registration expires and
19 cannot be renewed; therefore, the applicant must obtain a new registration number.
20 Technically, the registrant is continuing their registration, but since they must do this by
21 applying for a new registration number, §118 does not apply.

22
23 This is creating a situation where the Board cannot proceed with any disciplinary
24 action once a registrant needs a new registration number. The registrant can then wait
25 for the statute of limitations to run out on his or her violation and then apply for a new
26 number.

27
28 Staff is proposing to add §4990.33 so that the Board may take disciplinary action on its
29 licensees and registrants regardless of the status of a license or registration.

30
31 Discussion

32 Mr. Caldwell expressed that this is a good opportunity to take a look at the 6-year rule. In
33 Mr. Caldwell’s opinion, there seem to be a lot of interns who are exhausting the 6 years of
34 initial registration. The 6-year rule can be detrimental and could reduce a person’s chance
35 for becoming licensed. Mr. Caldwell would like a discussion in determining if 6 years is
36 adequate or not, and recommends looking at a structure in which an intern can operate
37 under one intern registration number.

38
39 Ms. Madsen recommends that the Supervision Committee lead the discussion on the 6-
40 year rule.

41
42 Ms. Helms summarized that the Committee made no changes to staff’s proposals.

43
44 ***Renee Lonner moved to direct staff to make any discussed changes, as well as any***
45 ***non-substantive changes to the proposed language and recommend that the Board***
46 ***sponsor legislation to make the proposed changes. Deborah Brown seconded. The***
47 ***Committee voted unanimously (4-0) to pass the motion.***
48

49 **VII. Discussion and Recommendations for Possible Action Regarding the Use of Telehealth**
50 **to Provide Psychotherapy**

51 As therapy via electronic means (telehealth) increases, Board staff continues to receive an
52 increasing number of inquiries regarding the lawful practice of telehealth. Frequently,
53 questions about telehealth focus on the issue of the practioner’s ability to continue counseling

1 his or her patient when the patient moves or travels to another jurisdiction, or vice versa.
2 Occasionally, other questions arise for which the law does not provide a clear answer.

3
4 Current law defines telehealth for all healing arts professions regulated by the Department of
5 Consumer Affairs (DCA), including the Board's licensees. It sets patient consent and
6 confidentiality standards, and it makes failure to comply with these standards unprofessional
7 conduct.

8
9 Staff has conducted research to examine the laws, regulations, and policies of several other
10 jurisdictions. Staff also researched codes of ethics or best practice guidelines from the
11 professional associations. Massachusetts, Arkansas and Ohio have well-defined telehealth
12 regulations or policies compared to other states. The professional associations outlined some
13 points of interest. Ms. Helms presented the common themes amongst the states and
14 professional associations.

15
16 Ms. Helms presented draft regulations. These regulations address specific issues related to
17 the practice of therapy where the law is unclear, and addresses issues which are commonly
18 addressed in other states or associations' guidelines.

19
20 Specific items that need further discussion are as follows:

- 21 1. How does the Board wish to define the location of the patient or client? Is it where the
22 patient is physically located, or where he or she is a resident?
- 23
24 2. Is it appropriate for interns and associates to provide services via telehealth? Current law
25 allows LMFT and LPCC applicants to count up to 375 hours of experience providing
26 personal psychotherapy, crisis counseling, or other counseling services via telehealth.
27 The law does not specify if LCSW applicants may perform or count telehealth hours.
28
- 29 3. Is it appropriate for trainees to provide services via telehealth? Current law allows LMFT
30 applicants to count some hours of experience earned as a trainee. A concern has been
31 raised to Board staff that BPC §2290.5 is written only for licensed individuals (a definition
32 which includes interns/associates, but not trainees, who are not yet under the jurisdiction
33 of the Board.)
34
- 35 4. Should supervision via telehealth be permitted? Currently, the law allows supervision via
36 telehealth if the intern or associate is working in an exempt setting. However, staff has
37 been asked why supervision via telehealth is not permitted for interns and associates who
38 are in rural settings where it is difficult to find a supervisor. In addition, questions about
39 supervision during military or charitable service in another jurisdiction are not uncommon.
40

41 Mr. Caldwell explained that Arizona wrote into their laws that people licensed in other states
42 can see clients located in Arizona for up to 30 days in the calendar year, as a way for the
43 client to transition. Mr. Caldwell expressed that, as a clinician, there is a struggle for balance
44 in respecting the boundaries of state lines and non-abandonment/continuity of care. Mr.
45 Caldwell provided examples of clients in situations when they are temporarily out-of-state due
46 to business or military. It is poor care to require these clients to find a therapist in each state
47 they travel, as opposed to staying with one practitioner.
48

49 Mr. Caldwell stated that AAMFT is revising its code of ethics, and will address in greater depth
50 the issues of telehealth and technology.

51
52 Mr. Caldwell provided answers to the questions outlined:

- 1 1. Jurisdiction takes place where the client is physically located. Using residency as
2 jurisdiction would work better for continuity of care; however, other state licensing boards
3 may have a problem with that.
- 4 2. It should be appropriate for interns and trainees to provide services via telehealth,
5 especially when considering the likely continued growth of telehealth. AAMFT-CA wants
6 interns and trainees to learn about providing services via telehealth while under
7 supervision.
- 8 3. Yes, this could open up opportunities to provide services in underserved areas. Also, if a
9 practitioner goes out-of-town for a week, the interns cannot count hours during that week.
10 If the practitioner can supervise by phone or video conference during that week, the intern
11 can count the hours. The supervisor can provide continuity of supervision.

12
13 Ms. Helms stated that she would look into the Arizona law.

14
15 Discussion took place; concerns mentioned during discussion were:

- 16 • Identity of the client
- 17 • Location of the client
- 18 • Confidentiality
- 19 • Support services available in other states

20
21 Ms. Madsen shared that telehealth is being discussed at the national level, and all the
22 interested entities are struggling with this issue.

23
24 Dianne Dobbs explained that the interstate compact issue in the medical arena is a huge
25 issue, and it is moving forward. There was federal legislation coming through that was
26 attempting to address national licensure issues. All of the state boards had issues with the
27 compact. Ms. Dobbs reported that the interstate compacts are close to being finalized.

28
29 Mr. Caldwell asked Ms. Dobbs if the interstate compacts were broad enough to capture
30 mental health. Ms. Dobbs responded that she doesn't believe so, but she will look into it
31 further.

32
33 Ms. Madsen stated that if California adopted language similar to Arizona's law, perhaps it will
34 attract attention from other state boards to do the same.

35
36 In response #1, Ms. Dobbs stated that there must be a method in identifying where the client
37 is located.

38
39 Mr. Caldwell referred to §1815.5(b) where it suggests that a licensee or registrant providing
40 services via telehealth shall exercise the same standard of care. He explained that there are
41 ways by which the standard of care when providing services by telehealth would be different,
42 or even higher. To suggest that the licensee or registrant provide the same standard of care
43 may be too low a standard as a non-distance provider.

44
45 In response to #3, Ms. Wong is hesitant to include trainees.

46
47 Mr. Caldwell expressed that trainees have a lot of supervision, and it would be ideal to allow
48 the trainee to provide services via telehealth when the trainee has so many watchful
49 supervisors. Ms. Madsen agreed with Mr. Caldwell.

50
51 Ms. Helms summarized the suggestions made during the discussion:

- 52 • Add language referencing registrants and trainees,
- 53 • Change §1815.5(b) to increase the standard of care;

- Add language that explains a method to verify the location of the client, and
- Draft language similar to Arizona’s law.

Mr. Montgomery referred to subsection (f) regarding encryption standards. CAMFT feels that this is overbroad, and it might hold a practitioner to a higher standard than is required by state or federal law.

Staff will incorporate suggestions in draft language and present the draft at the next meeting.

VIII. Legislative Update

Ms. Helms reported that the following Board-sponsored bills were signed by the Governor and will go into effect on January 1, 2015:

- AB 2213 - LMFT and LPCC Out-of-State Applicant Requirements
- SB 1466 - Omnibus Legislation
- AB 1843 - Child Custody Evaluations: Confidentiality

The following bills sponsored by CAMFT were signed by the Governor:

- AB 1775 Child Abuse and Neglect Reporting Act: Sexual Abuse
- SB 578 Marriage and Family Therapists: Records Retention

IX. Regulation Update

Ms. Berger reported:

- The Continuing Education regulations were approved.
- The Disciplinary Guidelines and SB 1441 regulations had its 15-day public comment period, which ended on September 17th.
- The Examination Restructure regulations have been submitted to OAL and will be published in its California Regulatory Notice Register on November 14th. The public hearing for this proposal will be held on December 29th.

X. Suggestions for Future Agenda Items

The suggestion to discuss the 6-year rule was mentioned earlier in the meeting.

Ms. Lonner suggested a discussion regarding continuing education. She briefly explained a situation. Within the last 60 days, for example, before a license expires, the next renewed license is received by the licensee. Continuing education (CE) taken during that 60 day period, does not count toward the current renewal. Ms. Lonner would like to discuss allowing the CE taken during that period to count towards the following renewal.

Mr. Caldwell suggested a discussion regarding a national LMFT exam and an update on the last review of the American Marital and Family Therapy Regulatory Boards’ (AMFTRB) examination.

XI. Public Comment for Items not on the Agenda

There were no public comments.

XII. Adjournment

The meeting was adjourned at 11:26 a.m.

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To: Committee Members
From: Rosanne Helms
Legislative Analyst
Date: January 21, 2015
Telephone: (916) 574-7897
Subject: Telehealth in Other States and Agencies

Laws, Regulations and Policies of Other Jurisdictions and Professional Associations

Staff has conducted research to examine the laws, regulations, and policies related to telehealth in several other jurisdictions.

There is a large volume of research regarding best practices of telehealth, and many states have adopted policies or rules, or are working on them, in order to regulate its practice. In addition, many professional associations have developed telehealth guidelines for their members.

Each set of rules or professional guidelines is quite different; however, there are some common themes that run through them. The chart in **Attachment A** summarizes some of these themes and compares them across states and professional associations.

Examination of States Providing Limited-Term Exemptions From Licensure: Arizona and Utah

The Policy and Advocacy Committee previously discussed telehealth at its September 18, 2014 meeting.

At that meeting, the Committee expressed a desire to examine the licensing law of other states which temporarily allow out-of-state licensees to practice in their state. The states of Arizona and Utah each have variations of such a clause.

State of Arizona

The Arizona Board of Behavioral Health Examiners licenses mental health professionals in that state.

According to the department, in Arizona, mental health services are assumed to take place in the jurisdiction where the client lives.

Arizona is unlike many other states in that it has an exemption to licensure that a behavioral health professional from another state may utilize. A non-resident is exempt from licensure if the following conditions are met (ARS Title 32, Chapter 33 §3271):

1. The practitioner performs the behavioral health services for no more than 90 days in any year;
2. The practitioner is licensed to perform those services in the state or country where he or she resides; and
3. The practitioner informs the client of the limited nature of the services and that he or she is not licensed in Arizona.

A practitioner performing services under this law is considered under the jurisdiction of the board and bound by the laws of Arizona.

Under this law, a licensee from another state could counsel a client located in Arizona via telehealth without an Arizona license if the duration of the counseling was less than 90 calendar days and the conditions listed above are met.

The complete text of this law can be found in **Attachment B**.

State of Utah

The Division of Occupational and Professional Licensing regulates mental health professionals in the state of Utah.

Utah has both laws and regulations governing the use of telehealth. In 2013, the state adopted an exemption to licensure for a mental health practitioner licensed in good standing in another state. The practitioner may provide short term, transitional mental health therapy remotely under the following conditions:

1. The practitioner must be present in the state in which he or she is licensed;
2. The client must have relocated to Utah; and
3. The client must be a client of the practitioner immediately before relocating to Utah.

If the criteria above are met, then short term transitional mental health therapy may be provided remotely for a 45 day period, which begins on the day the client relocates to Utah. Within 10 days of the client's relocation, the practitioner must provide written notice to the state licensing agency of the intent to provide short term transitional mental health therapy.

Board staff contacted staff at Utah's licensing board to obtain additional information about this provision of law and its implementation. Utah staff clarified that the requirement that the client "relocate" to Utah does not mean that the client must permanently move to Utah. Instead, the client may be travelling or may be living there for a short period. They have not received any complaints against an out-of-state practitioner at this time. They also noted that the main purpose of this provision was to allow a practitioner relocating to Utah the ability to practice while they are seeking a Utah license.

Board staff asked how their department handling the requirement that a practitioner submit written notice to the board within 10 days of intent to provide short term transitional therapy. Utah staff indicated they have not received any such requests at this time. They also indicated that any such notices received would be used for enforcement purposes; if a complaint against an out-of-state practitioner were received, they would check to see if the practitioner had provided them with the required notification.

Utah's licensing board also has a regulation dedicated specifically to unprofessional conduct related to telehealth. It requires practitioners to adhere to professional standards when practicing telehealth, and to protect the security of confidential data and information.

The complete text of these laws can be found in **Attachment C**.

California Board of Psychology

The California Board of Psychology has a provision in law allowing a licensed psychologist from another state to practice temporarily for up to 30 days per year.

While this provision helps psychologists moving to CA to remain practicing while they are in the licensure process, the provision has raised some legal issues for that board, including the following:

- Issues with out-of-state psychologists wanting to advertise that they may practice in California due to the 30-day provision;
- Issues with federal agencies accepting psychological exams required in California that were performed by out-of-state practitioners;
- Difficulties with establishing whether or not a practitioner had practiced in this state for more than 30 days; and
- Concerns about inequity from licensees who had worked to become licensed in California

Other States and Professional Associations

Below are some highlights from the States of Massachusetts, Arkansas, and Ohio, which have well-defined telehealth regulations or policies compared to many other states. Also included are some points of interest from codes of ethics or best practice guidelines from the professional associations of the Board's license types:

State of Massachusetts Policy No. 07-03 (Policy on Distance, Online, and Other Electronic Assisted Counseling) (Attachment D)

- Therapy with patients located within the state fall under the jurisdiction of the Board, regardless of the location of the provider.
- Board licensees wishing to provide services to a client in another jurisdiction are urged to ensure they meet the requirements to practice in the jurisdiction where the client is located.
- Suggests licensees carefully consider confidentiality and its limitations
- Expects licensees to be prepared to refer for clients for whom electronic service is not appropriate.

State of Arkansas (Rules for Arkansas Code Annotated 17-27-101 Et Seq) (Attachment E)

- Requires licensees to hold a "Technology-assisted Distance Counseling" or "Marriage and Family Therapy Specialization License" to provide telehealth.
- States that any counseling via telehealth that occurs in that state is deemed to have occurred in Arkansas, and the provider must hold an Arkansas license.
- Incorporates the National Board for Certified Counselors (NBCC) document titled "The Practice of Internet Counseling" (2005) into their rules to extend and clarify telehealth standards for counselors and marriage and family therapists.

State of Ohio (Ohio Administrative Code; Chapter 4757-3-01 and 4757-5-13) (Attachment F)

- Requires practitioners providing therapy via telehealth to Ohio citizens to be licensed in Ohio. If providing services to clients outside the state, they must comply with the laws and rules of that jurisdiction.
- Requires an initial meeting to verify the client's identity and to take steps to establish ways to identify the client in the future. This initial meeting may be via video or audio.
- Requires licensees to identify an appropriately trained professional who can provide local assistance and crisis intervention. In addition, the licensee must give the client the local crisis hotline number and the local emergency mental health number.
- Requires the licensee to use encryption methods.

National Board for Certified Counselors (NBCC) "Policy Regarding the Provision of Distance Professional Services" (Approved July 31, 2012) (Attachment G)

- Requires practitioners to review legal regulations for both the counselor's state and the recipient's location prior to providing telehealth services.
- Requires practitioners to use encryption security and to inform clients of potential hazards of distance communications.
- Requires practitioners to screen potential telehealth clients for appropriateness of the service.
- Requires practitioners to provide telehealth patients with specific written emergency procedures.
- Requires practitioners to have procedures for verifying the identity of the patient.

California Association of Marriage and Family Therapists (CAMFT) Code of Ethics (May 2002, March 2011) (Attachment H)

- Requires LMFTs to consider the appropriateness of telehealth for the patient's needs.
- Requires LMFTs to inform patients of potential risks such as confidentiality, clinical limitations, and response to emergencies.
- Requires LMFTs to provide telehealth services in only in jurisdictions where they are permitted to by law.
- Requires LMFTs to be aware of limitations regarding confidentiality and to take care when transmitting or receiving confidential information.

American Association for Marriage and Family Therapy (July 1, 2012) (Attachment I)

- Prior to performing telehealth, requires LMFTs to ensure they are compliant with all relevant laws for performance of telehealth services.
- Requires LMFTs to determine whether therapy via telehealth is appropriate for each client based on his or her needs.
- Requires LMFTs to inform clients of the risks and benefits of telehealth.
- Requires LMFTs to ensure the security of their communication medium
- Requires LMFTs to advise clients in writing of the risks and responsibilities of telehealth.

National Association of Social Workers and Association of Social Work Boards “NASW & ASWB Standards for Technology and Social Work Practice” (2005) (Attachment J)

- Requires social workers utilizing telehealth to abide by the regulations in both his or her jurisdiction as well as those of the jurisdiction in which the client is located.
- Requires social workers utilizing telehealth to make efforts to verify client identity and contact information.
- Requires social workers using telehealth to be aware of privacy risks of telehealth and take steps to protect client privacy.
- Requires social workers to fully evaluate potential clients for appropriateness of using telehealth.

California Board of Occupational Therapy (Attachment K)

The Board’s current draft regulations are modeled after regulations recently adopted by the California Board of Occupational Therapy (**Attachment K**).

Recommendation

Conduct an open discussion of the telehealth laws, regulations and policies of other states and professional associations in order to determine if the Committee wishes to model any provisions in its proposed regulations.

Attachments

1. **Attachment A:** Key Provisions and Common Themes of Telehealth Law or Policy
2. **Attachment B:** State of Arizona Statutes Related to Telehealth (Title 32, Chapter 33)
3. **Attachment C:** State of Utah Laws and Regulations Related to Telehealth
4. **Attachment D:** State of Massachusetts Policy No. 07-03: Policy on Distance, Online, and Other Electronic-Assisted Counseling
5. **Attachment E:** State of Arkansas Code – Technology-Assisted Distance Counseling
6. **Attachment F:** State of Ohio Administrative Code – Electronic Service Delivery Provisions
7. **Attachment G:** National Board for Certified Counselors (NBCC) “Policy Regarding the Provision of Distance Professional Services” (Approved July 31, 2012)
8. **Attachment H:** Excerpts from CAMFT Code of Ethics Related to Telehealth
9. **Attachment I:** AAMFT-CA Code of Ethics Related to Telehealth
10. **Attachment J:** National Association of Social Workers and Association of Social Work Boards “NASW & ASWB Standards for Technology and Social Work Practice” (2005)
11. **Attachment K:** Telehealth Regulations Recently Adopted by the California Board of Occupational Therapy

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Attachment A

Key Provisions and Common Themes of Telehealth Law or Policy

Provision	PROPOSED State of California (Rules)	State of Arizona (Statutes)	State of Utah (Statutes &Rules)	State of Massachusetts (Policy)	State of Ohio (Rules)	State of Arkansas (Rules)	NBCC	CAMFT	AAMFT	NASW/ASWB
1) Awareness of and following the law in the location of the practitioner and the location of the client	X	X		X	X	<i>Incorporates NBCC guidelines (2005) by reference</i>	X	X	X	X
2) Consideration of confidentiality and its limitations in telehealth	X		X	X	X	<i>Incorporates NBCC guidelines (2005) by reference</i>	X	X	X	X
3) Require utilization of encryption methods	X				X	<i>Incorporates NBCC guidelines (2005) by reference</i>	X			
4) Require practitioner to inform client of risks and benefits of telehealth	X			X	X	<i>Incorporates NBCC guidelines (2005) by reference</i>	X	X	X	
5) Evaluation of clients to determine if telehealth is appropriate	X			X		<i>Incorporates NBCC guidelines (2005) by reference</i>	X	X	X	X
6) Requirement of a specialized license in order to practice telehealth						X				
7) Requirement to have a process in place to verify the client's identity	X			X	X	<i>Incorporates NBCC guidelines (2005) by reference</i>	X			X
8) Requirement of an initial meeting to establish client identity (may be via video/audio)					X					
9) Requirement that the licensee provide the client with the means to verify his or her license	X			X	X	<i>Incorporates NBCC guidelines (2005) by reference</i>	X			X
10) Requirement to provide the client with local resources/crisis hotlines for emergency situations.	X			X	X	<i>Incorporates NBCC guidelines (2005) by reference</i>	X			
11) Allows exemption from licensure to a practitioner licensed out-of-state for a limited time.		X	X							

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Attachment B
State of Arizona
Revised Statutes Related to Telehealth (Title 32, Chapter 33)

32-3251. Definitions

12. "Unprofessional conduct" includes the following, whether occurring in this state or elsewhere:

(dd) Failing to comply with the laws of the appropriate licensing or credentialing authority to provide behavioral health services by electronic means in all governmental jurisdictions where the client receiving these services resides.

32-3271. Exceptions to licensure; jurisdiction

A. This chapter does not apply to:

1. A person who is currently licensed, certified or regulated pursuant to another chapter of this title and who provides services within the person's scope of practice if the person does not claim to be licensed pursuant to this chapter.

2. A person who is not a resident of this state if the person:

(a) Performs behavioral health services in this state for not more than ninety days in any one calendar year as prescribed by board rule.

(b) Is authorized to perform these services pursuant to the laws of the state or country in which the person resides or pursuant to the laws of a federally recognized tribe.

(c) Informs the client of the limited nature of these services and that the person is not licensed in this state.

3. A rabbi, priest, minister or member of the clergy of any religious denomination or sect if the activities and services that person performs are within the scope of the performance of the regular or specialized ministerial duties of an established and legally recognizable church, denomination or sect and the person performing the services remains accountable to the established authority of the church, denomination or sect.

4. A member run self-help or self-growth group if no member of the group receives direct or indirect financial compensation.

5. A behavioral health technician or behavioral health paraprofessional who is employed by an agency licensed by the department of health services.

6. A person contracting with the supreme court or a person employed by or contracting with an agency under contract with the supreme court who is otherwise ineligible to be licensed or who is in the process of applying to be licensed under this chapter as long as that person is in compliance with the supreme court contract conditions regarding professional counseling services and practices only under supervision.

7. A person who is employed by the department of economic security and who practices social work, marriage and family therapy, substance abuse counseling, counseling and case management within the scope of the person's job duties and under direct supervision by the department of economic security.

8. A student, intern or trainee who is pursuing a course of study in social work, counseling, marriage and family therapy, substance abuse counseling or case management in a regionally accredited institution of higher education or training institution if the person's activities are

performed under qualified supervision and are part of the person's supervised course of study.

9. A person who is practicing social work, counseling and case management and who is employed by an agency licensed by the department of economic security.

10. A paraprofessional employed by the department of economic security or by an agency licensed by the department of economic security.

11. A christian science practitioner if all of the following are true:

(a) The person is not providing psychotherapy.

(b) The activities and services the person performs are within the scope of the performance of the regular or specialized duties of a christian science practitioner.

(c) The person remains accountable to the established authority of the practitioner's church.

12. A person who is not providing psychotherapy.

B. A person who provides services pursuant to subsection A, paragraph 2 is deemed to have agreed to the jurisdiction of the board and to be bound by the laws of this state.

Attachment C
State of Utah
Laws and Regulations Related to Telehealth

Utah Mental Health Professional Practice Act (Laws)

58-60-107. Exemptions from licensure.

(1) Except as modified in Section 58-60-103, the exemptions from licensure in Section 58-1-307 apply to this chapter.

(2) In addition to the exemptions from licensure in Section 58-1-307, the following may engage in acts included within the definition of practice as a mental health therapist, subject to the stated circumstances and limitations, without being licensed under this chapter:

(a) the following when practicing within the scope of the license held:

(i) a physician and surgeon or osteopathic physician and surgeon licensed under Chapter 67, Utah Medical Practice Act, or Chapter 68, Utah Osteopathic Medical Practice Act;

(ii) an advanced practice registered nurse, specializing in psychiatric mental health nursing, licensed under Chapter 31b, Nurse Practice Act; and

(iii) a psychologist licensed under Chapter 61, Psychologist Licensing Act;

(b) a recognized member of the clergy while functioning in a ministerial capacity as long as the member of the clergy does not represent that the member of the clergy is, or use the title of, a license classification in Subsection 58-60-102(5);

(c) an individual who is offering expert testimony in a proceeding before a court, administrative hearing, deposition upon the order of a court or other body having power to order the deposition, or a proceeding before a master, referee, or alternative dispute resolution provider;

(d) an individual engaged in performing hypnosis who is not licensed under this title in a profession which includes hypnosis in its scope of practice, and who:

(i) (A) induces a hypnotic state in a client for the purpose of increasing motivation or altering lifestyles or habits, such as eating or smoking, through hypnosis;

(B) consults with a client to determine current motivation and behavior patterns;

(C) prepares the client to enter hypnotic states by explaining how hypnosis works and what the client will experience;

(D) tests clients to determine degrees of suggestibility;

(E) applies hypnotic techniques based on interpretation of consultation results and analysis of client's motivation and behavior patterns; and

(F) trains clients in self-hypnosis conditioning;

(ii) may not:

(A) engage in the practice of mental health therapy;

(B) use the title of a license classification in Subsection 58-60-102(5); or

(C) use hypnosis with or treat a medical, psychological, or dental condition defined in generally recognized diagnostic and statistical manuals of medical, psychological, or dental disorders;

(e) an individual's exemption from licensure under Subsection 58-1-307(1)(b) terminates when the student's training is no longer supervised by qualified faculty or

- staff and the activities are no longer a defined part of the degree program;
- (f) an individual holding an earned doctoral degree or master's degree in social work, marriage and family therapy, or clinical mental health counseling, who is employed by an accredited institution of higher education and who conducts research and teaches in that individual's professional field, but only if the individual does not engage in providing or supervising professional services regulated under this chapter to individuals or groups regardless of whether there is compensation for the services;
 - (g) an individual in an on-the-job training program approved by the division while under the supervision of qualified persons;
 - (h) an individual providing general education in the subjects of alcohol, drug use, or substance use disorders, including prevention;
 - (i) an individual providing advice or counsel to another individual in a setting of their association as friends or relatives and in a nonprofessional and noncommercial relationship, if there is no compensation paid for the advice or counsel; and
 - (j) an individual who is licensed, in good standing, to practice mental health therapy or substance use disorder counseling in a state or territory of the United States outside of Utah may provide short term transitional mental health therapy remotely or short term transitional substance use disorder counseling remotely to a client in Utah only if:
 - (i) the individual is present in the state or territory where the individual is licensed to practice mental health therapy or substance use disorder counseling;
 - (ii) the client relocates to Utah;
 - (iii) the client is a client of the individual immediately before the client relocates to Utah;
 - (iv) the individual provides the short term transitional mental health therapy or substance use disorder counseling during the 45 day period beginning on the day on which the client relocates to Utah;
 - (v) within 10 days after the day on which the client relocates to Utah, the individual provides written notice to the division of the individual's intent to provide short term transitional mental health therapy or short term transitional substance use disorder counseling remotely to the client; and
 - (vi) the individual does not engage in unlawful conduct or unprofessional conduct.

Amended by Chapter 16, 2013 General Session

Utah Mental Health Professional Practice Act Rules (Regulation)

R156-60-502. Unprofessional Conduct.

"Unprofessional conduct" includes when providing services remotely:

- (1) failing to practice according to professional standards of care in the delivery of services remotely;
- (2) failing to protect the security of electronic, confidential data and information; or
- (3) failing to appropriately store and dispose of electronic, confidential data and information.

Attachment D
State of Massachusetts
Policy on Distance, Online, and Other Electronic-Assisted Counseling

The Board of Registration of Allied Mental Health and Human Services Professionals ("the Board") voted at its meeting on November 16, 2007 to adopt the following Policy Guideline. This policy guideline is intended as a recommended protocol for the profession to follow. The guideline set forth below does not have the full force and effect of law, as would a Massachusetts General Law or a Board rule or regulation. However, the Board uses policy guidelines as an internal management tool in formulating decisions that relate to issues in the practice of allied mental health and human services.

Policy No. 07-03

Purpose:

The Board acknowledges that therapy and counseling are increasingly being provided at a distance, making use of the internet, telephone and other electronic means of communication. The emergence of new clinical procedures is necessarily accompanied by uncertainty about legal and ethical obligations. The purpose of this policy statement is to offer guidance to Licensees regarding the ethical obligations and standards of conduct in the use of distance, on-line, and other electronic assisted counseling.

Policy:

The Board's policy with regard to all distance or electronic-assisted provision of clinical services is as follows:

1. The services offered by licensees of this Board across a distance by electronic means, fall within the jurisdiction of the Board just as traditional, face-to-face services do. Therefore all Board policies and regulations will apply to these services.
2. Distance delivery of counseling and therapy is considered to occur in two locations: where the client is located and where the clinician is located.
3. Therefore, the provision of counseling and/or therapy to individuals located within Massachusetts at the time services are occurring, are considered to fall under the jurisdiction of the Board, regardless of the location of the provider.

4. Mental health professionals licensed by any jurisdiction other than Massachusetts, and not licensed by any Massachusetts Board or not eligible for an exception to Massachusetts licensure, are considered unlicensed by this Board for practice in Massachusetts.

5. Mental health professionals licensed by other jurisdictions who wish to provide services to clients within Massachusetts, are encouraged to apply for Massachusetts licensure. Some, licensees may find the following helpful:

a. Mental Health Counselors: 262CMR 2.03, (1) Licensure for CCMHC's in good standing with NBCC

b. MFT's: 262 CMR 3.04 Licensure by Reciprocity for MFT's.

6. Board licensees who wish to provide services via electronic means to clients located outside of Massachusetts are urged to ensure that they meet the requirements for practice within the jurisdiction where the client is located.

7. Licensees are encouraged to carefully review the way in which the structure of their relationships with clients will be impacted by distance-therapy or counseling to ensure **compliance with** Board regulations and standards of practice.

8. The following are some areas of practice that **licensees should carefully consider**:

- a. Informed consent
- b. Confidentiality
- c. Basis for making clinical judgments
- d. Areas of competence
- e. Avoiding harm
- f. Fees and financial arrangements
- g. Advertising
- h. Abandonment of clients
- i. Handling requests for obtaining clinical records

9. The Board expects licensees to understand and overcome the significant challenges inherent in providing counseling and therapy without face-to-face contact with the client.

10. Some of the challenges **that licensees are expected to manage include, but are not limited to:**

- a. Full disclosure with regard to potential risks to confidentiality, including computer hacking and/or archiving of communications.
 - b. Full disclosure of the limits to confidentiality in the jurisdictions where the client, and where the clinician are located.
 - c. Full disclosure of mandated reporting requirements in the jurisdictions where the client, and where the clinician are located.
 - d. Full disclosure with regard to the potential disadvantages or limitations of electronic-assisted clinical services.
 - e. Redirection and/or referral of clients for whom electronic services will not be adequate or appropriate.
 - f. Full disclosure with regard to fees and billing practices.
 - g. Full disclosure with regard to licensing, credentials and areas of expertise.
 - h. Screening and local referral for critical and urgent problems.
 - i. Verification of the identity and age of the client.
 - j. Obtaining consent to provide services by a guardian for minors or other vulnerable clients.
 - k. Management of any misunderstanding or compensation for any missing information, resulting from the lack of visual or auditory cues.
 - l. Managing the problem of incomplete or inaccurate diagnoses that may result from electronic-assisted services.
 - m. Managing the potential for technology failure
 - n. Procedures for contacting the clinician when he/she is offline
11. The Board expects that licensees providing any form of distance counseling will comply with all of the guidelines of ethical practice that apply to traditional, face-to-face counseling.
12. The Board expects that licensees will practice distance counseling in a manner that is consistent with any existing guidelines provided by their professional associations.

13. The Board expects that licensees providing any form of distance counseling will ensure that they are properly trained to manage the specific challenges of this form of counseling and will regularly participate in sufficient continuing education activities that maintain and update the required skills.

14. Unlicensed providers of electronic-assisted counseling will be **treated** by the Board in the same manner as providers of unlicensed counseling in traditional settings.

Authority:

M.G.L. Chapter 13, Section 90; and 262 CMR 8.00 et seq

Attachment E
Arkansas Board of Examiners in Counseling
Rules for Arkansas Code Annotated 17-27-101 Et Seq

Section 1.9 (t) “Technology-Assisted Distance Counseling” (Electronic Counseling, Cyber Counseling) for Counseling or Marriage and Family Therapy means any form of services offered or rendered by electronic or technology-assisted approaches when the Counselor or Marriage and Family Therapist and the client are not located in the same place.

Technology-Assisted Distance Counseling may be synchronous or asynchronous. Only Counselors and Marriage and Family Therapists, licensed by the Arkansas Board of Examiners in Counseling, who also hold the Technology-assisted Distance Counseling or Marriage and Family Therapy Specialization License, may provide Technology Assisted Distance Counseling or Marriage and Family services.

Section 1.9 (w) “Technology” means electronically based hardware, software, video and related systems and telephone systems to deliver knowledge, skills, and tools for learning and communication processes. Technology for Counseling or Marriage and Family Therapy encompasses distance learning and distance counseling by any form of technology system /telephone system delivers of services. See section XII for the Technology-Assisted Distance Counseling definitions.

Section 3.5 (9) Technology-Assisted Distance Counseling or Marriage and Family Therapy Specialization license standards for issue for Counseling or Marriage and Family Therapy or Supervision being:

(A) A licensed LPC/LAC or LMFT/LAMFT in good standing with the Board must apply for the Technology-assisted Distance Counseling or Marriage Family Therapy specialization license and submit documentation of training for approval by the Board. As training sources are developed, the responsibility for seeking Board endorsement for the training rests with the provider of the training. The provider must submit a written request with materials documenting the training content for Board review and approval prior to endorsement of the training.

(B) The written submission of a detailed plan that delineates how the applicant will meet provisions of the 2005 American Counseling Association Code of Ethics and the Standards in Section XII regulating Technology-Assisted Distance Counseling or Marriage and Family Therapy for Board approval.

(C) Revised Statement of Intent (scope of practice) that includes a description of the Technology-Assisted Distance Counseling or Marriage and Family Therapy.

(D) The Board may require an oral examination if there are unresolved questions about requirements (9) (A-F).

(E) The submitted materials must be approved by the Board prior to the Technology-Assisted Distance Counseling or Marriage and Family Therapy Specialization license being issued.

(F) Any Technology-Assisted Distance Counseling or Marriage and Family Therapy that occurs within the State of Arkansas, whether by an Arkansas counselor or by an out of state Counselor or Marriage and Family Therapist, is deemed to have occurred in Arkansas. All

providers of services whether traditional or Technology-Assisted who may offer or provide Counseling or Marriage and Family Therapy services to individuals or groups must hold a valid Arkansas license to provide such services.

(e) Specialization requests not already specified will be reviewed by the Board and standards established as needed.

(f) Licensed Counselors or Therapist who apply for a specialization license will be issued such license upon completion of the application for a specialization, documentation of a valid national or required credential (certificate, registry, or license), Pass on the oral examination (if required), payment of the specialization fee and approval by majority vote of the Board.+

SECTION XII. THE PRACTICE OF INTERNET OR TELEPHONE SERVICES

The Board adopts the National Board for Certified Counselors (NBCC) document titled The Practice of Internet Counseling, published in 2005. The NBCC document is adopted as part of Arkansas Rules to further extend and clarify Technology-Assisted Distance Counseling Ethics, Definitions and Standards for Counselors and Marriage and Family Therapist licensed in the state of Arkansas. The adoption of the document is to support and extend the American Counseling Code of Ethics, 2005 edition for the practice of Internet Counseling. *(Attachment Next Page)*

Attachment F

Ohio Administrative Code (OAC)

Chapter 4757-3-01 (EE) “Electronic service delivery” (electronic therapy, cyber therapy, e-therapy, etc.) means counseling, social work or marriage and family therapy in any form offered or rendered primarily by electronic or technology-assisted approaches when the counselor, social worker or marriage and family therapist and the client are not located in the same place during delivery of services.

[4757-5-13 Standards of practice and professional conduct: electronic service delivery \(internet, email, teleconference, etc.\).](#)

Electronic service delivery is defined in paragraph (EE) of rule [4757-3-01](#) of the Administrative Code. Licensees are reminded that standards of ethical practice and professional conduct rules [4757-5-01](#) to [4757-5-12](#) of the Administrative Code apply to electronic service delivery.

(A) These standards govern the practice of electronic service delivery and address practices that are unique to electronic service delivery and electronic service delivery practitioners.

(1) All practitioners providing counseling, social work or marriage and family therapy via electronic service delivery to Ohio citizens shall be licensed in Ohio.

(2) All licensees of this board providing services to clients outside the state of Ohio shall comply with the laws and rules of that jurisdiction.

(3) Electronic service delivery shall require an initial face-to-face meeting, which may be via video/audio electronically, to verify the identity of the electronic service delivery client. At that meeting steps shall be taken to address impostor concerns, such as by using passwords to identify the client in future electronic contacts.

(4) Informed consent shall include information defining electronic service delivery as practiced by the licensee and the potential risks and ethical considerations per paragraph (B) of rule [4757-5-02](#) of the Administrative Code.

(a) Licensees shall obtain written informed consent.

(b) Licensees shall not provide services without client signed informed consent.

(5) Licensees shall provide links to websites for all of their certification bodies and licensure boards to facilitate consumer protection.

(6) Licensees shall identify an appropriately trained professional who can provide local assistance, including crisis intervention, if needed. Licensees shall provide electronic service delivery clients the local crisis hotline telephone number and the local emergency mental health telephone number.

(7) Licensees shall provide a link to the board's online license verification site on their web page. They shall also have a copy of the professional disclosure statement available on their web site per rule [4757-5-12](#) of the Administrative Code.

(B) Confidentiality in electronic service delivery shall be maintained by the licensee:

(1) Licensees shall use encryption methods for electronic service delivery; and

(2) Shall inform electronic service delivery clients details of data record storage.

Effective: 10/18/2009

R.C. [119.032](#) review dates: 09/20/2012

Promulgated Under: [119.03](#)

Statutory Authority: 4757.11

Rule Amplifies: 4757.11



NATIONAL BOARD FOR CERTIFIED COUNSELORS (NBCC) POLICY REGARDING THE PROVISION OF DISTANCE PROFESSIONAL SERVICES

INTRODUCTION

The National Board for Certified Counselors (NBCC) is a not-for-profit organization dedicated to the identification of counselors who have voluntarily met national standards based on research in the profession. NBCC's mission also includes the promotion of quality assurance and professionalism in counseling practice.

In connection with the mission to promote quality assurance, NBCC recognized the potential impact of computers on the counseling profession decades ago. After conducting research with experts in the field, NBCC adopted the *Standards for the Ethical Practice of WebCounseling* in 1997, the first of such standards in the mental health profession. Given the evolution of the technology in this area, the NBCC Board of Directors has regularly reviewed these standards and adopted revised policies such as *The Practice of Internet Counseling*.

The most recent review of the practice of Internet counseling supports a revision in the standards, and the resulting information demonstrated the following fundamental concepts:

1. Counseling through distance means presents unique ethical dilemmas to professional counselors.
2. Related technology continues to advance and be used more by increasing numbers of professional counselors.
3. Use of technology by counselors continues to evolve.

In light of this information, the policy regarding Internet counseling has been revised, and this document, the *NBCC Policy Regarding the Provision of Distance Professional Services*, replaces previous editions.

One of the most recognizable differences in this policy is the use of the term "distance professional services." Rather than focusing only on the provision of "Internet counseling," this policy expands the terminology to include other types of professional services that are starting to be used more in distance formats.

Other key terms with regard to this policy include:

Face-to-face refers to services that involve the synchronous interaction between an individual or groups of people using what is seen and heard in person to communicate.

Distance professional services involve the use of electronic or other means (e.g., telephones or computers) to provide services such as counseling, supervision, consultation or education.

Counseling is a professional relationship that empowers diverse individuals, families and groups to accomplish mental health, wellness, education and career goals.

Supervision is a contracted, hierarchical relationship between two or more professionals. The intended focus of supervision is on the augmentation of a supervisee's professional services.

Consultation is a deliberate agreement between two or more professionals to work together to increase the effectiveness of professional services in relation to a specific individual (client, student or supervisee).

Common methods for the provision of distance professional services include the following:

- *Telephone-based* refers to the synchronous distance interaction in which information is received only through audio means.
- *E-mail-based* refers to the asynchronous distance interaction in which information is received through written text messages or e-mail.
- *Chat-based* refers to the synchronous distance interaction in which information is received through written messages.
- *Video-based* refers to the synchronous distance interaction in which information is received via video and audio mechanisms.
- *Social network-based* refers to the synchronous or asynchronous distance interaction in which information is exchanged through social networking mechanisms.

All of the above-mentioned examples of distance professional services may be conducted with individuals, couples, families or group members.

The NBCC Policy Regarding the Provision of Distance Professional Services identifies specific actions National Certified Counselors (NCCs) must take when providing distance services. NBCC recognizes that some counselors provide a combination of face-to-face and distance services even in the context of one particular client or supervisee; therefore, the standards described in this policy supplement the directives identified in the National Board for Certified Counselors (NBCC) *Code of Ethics*.

STANDARDS FOR DISTANCE PROFESSIONAL SERVICES

1. NCCs shall adhere to all NBCC policies and procedures, including the *Code of Ethics*.
2. NCCs shall provide only those services for which they are qualified by education and experience. NCCs shall also consider their qualifications to offer such service via distance means.
3. NCCs shall carefully adhere to legal regulations before providing distance services. This review shall include legal regulations from the state in which the counselor is located as well as those from the recipient's location. Given that NCCs may be offering distance services to individuals in different states at any one time, the NCC shall document relevant state regulations in the respective record(s).
4. NCCs shall ensure that any electronic means used in distance service provision are in compliance with current regulatory standards.
5. NCCs shall use encryption security for all digital technology communications of a therapeutic type. Information regarding security should be communicated to individuals who receive distance services. Despite the use of precautions, distance service recipients shall be informed of the potential hazards of distance communications. Not the least of these considerations is the warning about entering private information when using a public access or computer that is on a shared network. NCCs shall caution recipients of distance services against using "auto-remember" user names and passwords. NCCs shall also inform recipients of distance services to consider employers' policies relating to the use of work computers for personal communications.
6. To prevent the loss of digital communications or records, NCCs who provide distance services shall maintain secure backup systems. If the backup system is also a digital mechanism, this too shall offer encryption-level security. This information shall be provided to the recipient of professional services.

7. NCCs shall screen potential distance service recipients for appropriateness to receive services via distance methods. These considerations shall be documented in the records.
8. During the screening or intake process, NCCs shall provide potential recipients with a detailed written description of the distance counseling process and service provision. This information shall be specific to the identified service delivery type and include considerations for that particular individual. These considerations shall include the appropriateness of distance counseling in relation to the specific goal, the format of service delivery, the associated needs (i.e., computer with certain capabilities, etc.), the limitations of confidentiality, the possibility of technological failure, anticipated response time to electronic communication, and any additional considerations necessary to assist the potential recipient in reaching a determination about the appropriateness of this service delivery format for their need(s).
9. Because of the ease in which digital communications can inadvertently be sent to other individuals, NCCs shall adopt behaviors to prevent the distribution of confidential information to unauthorized individuals. NCCs shall discuss actions the recipient may take to reduce the possibility that they will send information to other individuals by mistake.
10. NCCs shall provide recipients of distance professional services with information concerning their professional credentials and links to the respective credentialing organization Web sites.
11. NCCs, either prior to or during the initial session, shall inform recipients of the purposes, goals, procedures, limitations, potential risks, and benefits of services and techniques. NCCs also shall provide information about rights and responsibilities as appropriate to the counseling setting. As a part of this type of service provision, NCCs shall discuss with recipients the associated challenges that may occur when communicating through distance means.
12. In the event that the recipient of distance services is a minor or is unable to provide legal consent, the NCC shall obtain a legal guardian's consent prior to the provision of distance services. Furthermore, NCCs shall retain copies of documentation indicating the legal guardian's identity in the recipient's file.
13. NCCs shall avoid the use of public social media sources (e.g., tweets, blogs, etc.) to provide confidential information. To facilitate the secure provision of information, NCCs shall provide in writing the appropriate ways to contact them.
14. NCCs shall provide recipients of distance services with specific written procedures regarding emergency situations. This information shall include emergency responders near the recipient's home location. Given the increased dangers intrinsic to providing certain distance professional services, NCCs shall take reasonable steps to secure reasonable referrals for recipients when needed.
15. NCCs shall develop written procedures for verifying the identity of the recipient at each instance of receiving distance services. Examples of verification means include the use of code words or phrases.
16. NCCs shall limit use of information obtained through social media sources (e.g., Facebook, LinkedIn, Twitter, etc.) in accordance with established practice procedures provided to the recipient at the initiation of services.
17. NCCs shall provide information concerning locations where members of the public may access the internet free of charge or provide information regarding the location of complimentary Web communication services.
18. NCCs shall retain copies of all written communications with distance service recipients. Examples of written communications include e-mail/text messages, instant messages and histories of chat-based discussions even if they are related to housekeeping issues such as change of contact information or scheduling appointments.

19. At a minimum, NCCs shall retain distance service records for a minimum of five years unless state laws require additional time. Due to the nature of most distance services, it may be convenient for NCCs to retain records for longer durations, and thus may be considered useful for research or other professional activities. NCCs shall limit the use of records to those permitted by law, professional standards and as specified by the agreement with the respective recipient of distance services.
20. In recognition of the inherent ethical implications which may arise, NCCs shall develop written procedures for the use of social media and other related digital technology with current and former recipients. These written procedures shall, at a minimum, provide appropriate protections against the disclosure of confidential information and the creation of multiple relationships. These procedures shall also stipulate that personal accounts be distinct from any used for professional purposes.

Approved by the NBCC Board of Directors: July 31, 2012

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Attachment H
Excerpts from CAMFT Codes of Ethics Related to Telehealth

California Association of Marriage and Family Therapists (CAMFT) Code of Ethics (May 2002, March 2011)

1.4.2 ELECTRONIC THERAPY: When patients are not physically present (e.g., therapy by telephone or Internet) during the provision of therapy, marriage and family therapists take extra precautions to meet their responsibilities to patients. Prior to utilizing electronic therapy, marriage and family therapists consider the appropriateness and suitability of this therapeutic modality to the patient's needs. When therapy occurs by electronic means, marriage and family therapists inform patients of the potential risks, consequences, and benefits, including but not limited to, issues of confidentiality, clinical limitations, transmission difficulties, and ability to respond to emergencies. Marriage and family therapists ensure that such therapy complies with the informed consent requirements of the California Telemedicine Act.

2.3 ELECTRONIC MEDIA: Marriage and family therapists are aware of the possible adverse effects of technological changes with respect to the dissemination of patient information, and take care when disclosing such information. Marriage and family therapists are also aware of the limitations regarding confidential transmission by Internet or electronic media and take care when transmitting or receiving such information via these mediums.

3.11 ELECTRONIC SERVICES: Marriage and family therapists provide services by Internet or other electronic media to patients located only in jurisdictions where the therapist may lawfully provide such services.

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PREAMBLE

The Board of Directors of the American Association for Marriage and Family Therapy (AAMFT) hereby promulgates, pursuant to Article 2, Section 2.01.3 of the Association's Bylaws, the Revised AAMFT Code of Ethics, effective January 1, 2015.

Honoring Public Trust

The AAMFT strives to honor the public trust in marriage and family therapists by setting standards for ethical practice as described in this Code. The ethical standards define professional expectations and are enforced by the AAMFT Ethics Committee.

Commitment to Service, Advocacy and Public Participation

Marriage and family therapists are defined by an enduring dedication to professional and ethical excellence, as well as the commitment to service, advocacy, and public participation. The areas of service, advocacy, and public participation are recognized as responsibilities to the profession equal in importance to all other aspects. Marriage and family therapists embody these aspirations by participating in activities that contribute to a better community and society, including devoting a portion of their professional activity to services for which there is little or no financial return. Additionally, marriage and family therapists are concerned with developing laws and regulations pertaining to marriage and family therapy that serve the public interest, and with altering such laws and regulations that are not in the public interest. Marriage and family therapists also encourage public participation in the design and delivery of professional services and in the regulation of practitioners. Professional competence in these areas is essential to the

character of the field, and to the well-being of clients and their communities.

Seeking Consultation

The absence of an explicit reference to a specific behavior or situation in the Code does not mean that the behavior is ethical or unethical. The standards are not exhaustive. Marriage and family therapists who are uncertain about the ethics of a particular course of action are encouraged to seek counsel from consultants, attorneys, supervisors, colleagues, or other appropriate authorities.

Ethical Decision-Making

Both law and ethics govern the practice of marriage and family therapy. When making decisions regarding professional behavior, marriage and family therapists must consider the AAMFT Code of Ethics and applicable laws and regulations. If the AAMFT Code of Ethics prescribes a standard higher than that required by law, marriage and family therapists must meet the higher standard of the AAMFT Code of Ethics. Marriage and family therapists comply with the mandates of law, but make known their commitment to the AAMFT Code of Ethics and take steps to resolve the conflict in a responsible manner. The AAMFT supports legal mandates for reporting of alleged unethical conduct.

Marriage and family therapists remain accountable to the AAMFT Code of Ethics when acting as members or employees of organizations. If the mandates of an organization with which a marriage and family therapist is affiliated, through employment, contract or otherwise, conflict with the AAMFT Code of Ethics, marriage and family therapists make known to the organization their commitment to the

inducements for research participation, marriage and family therapists make reasonable efforts to avoid offering inappropriate or excessive inducements when such inducements are likely to coerce participation.

5.5 Confidentiality of Research Data.

Information obtained about a research participant during the course of an investigation is confidential unless there is a waiver previously obtained in writing. When the possibility exists that others, including family members, may obtain access to such information, this possibility, together with the plan for protecting confidentiality, is explained as part of the procedure for obtaining informed consent.

5.6 Publication. Marriage and family therapists do not fabricate research results. Marriage and family therapists disclose potential conflicts of interest and take authorship credit only for work they have performed or to which they have contributed. Publication credits accurately reflect the relative contributions of the individual involved.

5.7 Authorship of Student Work.

Marriage and family therapists do not accept or require authorship credit for a publication based from student's research, unless the marriage and family therapist made a substantial contribution beyond being a faculty advisor or research committee member. Co-authorship on student research should be determined in accordance with principles of fairness and justice.

5.8 Plagiarism. Marriage and family therapists who are the authors of books or other materials that are published or distributed do not plagiarize or fail to cite persons to whom credit for original ideas or work is due.

5.9 Accuracy in Publication. Marriage and family therapists who are authors of books or other materials published or

distributed by an organization take reasonable precautions to ensure that the published materials are accurate and factual.

**STANDARD VI
TECHNOLOGY-ASSISTED
PROFESSIONAL SERVICES**

Therapy, supervision, and other professional services engaged in by marriage and family therapists take place over an increasing number of technological platforms. There are great benefits and responsibilities inherent in both the traditional therapeutic and supervision contexts, as well as in the utilization of technologically-assisted professional services. This standard addresses basic ethical requirements of offering therapy, supervision, and related professional services using electronic means.

6.1 Technology Assisted Services.

Prior to commencing therapy or supervision services through electronic means (including but not limited to phone and Internet), marriage and family therapists ensure that they are compliant with all relevant laws for the delivery of such services. Additionally, marriage and family therapists must: (a) determine that technologically-assisted services or supervision are appropriate for clients or supervisees, considering professional, intellectual, emotional, and physical needs; (b) inform clients or supervisees of the potential risks and benefits associated with technologically-assisted services; (c) ensure the security of their communication medium; and (d) only commence electronic therapy or supervision after appropriate education, training, or supervised experience using the relevant technology.

6.2 Consent to Treat or Supervise.

Clients and supervisees, whether contracting for services as individuals, dyads, families, or groups, must be

made aware of the risks and responsibilities associated with technology-assisted services. Therapists are to advise clients and supervisees in writing of these risks, and of both the therapist's and clients'/supervisees' responsibilities for minimizing such risks.

6.3 Confidentiality and Professional Responsibilities. It is the therapist's or supervisor's responsibility to choose technological platforms that adhere to standards of best practices related to confidentiality and quality of services, and that meet applicable laws. Clients and supervisees are to be made aware in writing of the limitations and protections offered by the therapist's or supervisor's technology.

6.4 Technology and Documentation. Therapists and supervisors are to ensure that all documentation containing identifying or otherwise sensitive information which is electronically stored and/or transferred is done using technology that adhere to standards of best practices related to confidentiality and quality of services, and that meet applicable laws. Clients and supervisees are to be made aware in writing of the limitations and protections offered by the therapist's or supervisor's technology.

6.5 Location of Services and Practice. Therapists and supervisors follow all applicable laws regarding location of practice and services, and do not use technologically-assisted means for practicing outside of their allowed jurisdictions.

6.6 Training and Use of Current Technology. Marriage and family therapists ensure that they are well trained and competent in the use of all chosen technology-assisted professional services. Careful choices of audio, video, and other options are

made in order to optimize quality and security of services, and to adhere to standards of best practices for technology-assisted services. Furthermore, such choices of technology are to be suitably advanced and current so as to best serve the professional needs of clients and supervisees.

STANDARD VII PROFESSIONAL EVALUATIONS

Marriage and family therapists aspire to the highest of standards in providing testimony in various contexts within the legal system.

7.1 Performance of Forensic Services. Marriage and family therapists may perform forensic services which may include interviews, consultations, evaluations, reports, and assessments both formal and informal, in keeping with applicable laws and competencies.

7.2 Testimony in Legal Proceedings. Marriage and family therapists who provide expert or fact witness testimony in legal proceedings avoid misleading judgments, base conclusions and opinions on appropriate data, and avoid inaccuracies insofar as possible. When offering testimony, as marriage and family therapy experts, they shall strive to be accurate, objective, fair, and independent.

7.3 Competence. Marriage and family therapists demonstrate competence via education and experience in providing testimony in legal systems.

7.4 Informed Consent. Marriage and family therapists provide written notice and make reasonable efforts to obtain written consents of persons who are the subject(s) of evaluations and inform clients about the evaluation process, use of information and recommendations, financial

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NATIONAL ASSOCIATION OF SOCIAL WORKERS
ASSOCIATION OF SOCIAL WORK BOARDS

NASW & ASWB Standards for

Technology

and Social Work Practice



2005

NASW & ASWB Standards for

Technology

and Social Work Practice

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About the Associations

The **National Association of Social Workers (NASW)** is the largest membership organization of professional social workers in the world. Membership in NASW includes over 150,000 social workers from 50 states, the District of Columbia, New York City, the U.S. Virgin Islands, Guam, Puerto Rico, and U.S. social workers practicing abroad. The mission of NASW is to enhance the professional growth and development of its members, to create and maintain professional standards, and to advance sound social policies.

The **Association of Social Work Boards (ASWB)** is the association of jurisdictional boards that regulate social work. Membership in ASWB includes 49 states, the District of Columbia, the U.S. Virgin Islands, and the Canadian provinces of Alberta, British Columbia, Manitoba, New Brunswick, Nova Scotia, Quebec, and Saskatchewan. The mission of ASWB is to assist social work regulatory bodies in carrying out their legislated mandates and to encourage jurisdictional efforts to protect a diverse public served by social workers who are regulated through common values, ethics, and practice standards.

Preface

The **National Association of Social Workers (NASW)** and **Association of Social Work Boards (ASWB)** have developed *Standards for Technology and Social Work Practice* to create a uniform document for the profession. Technology has changed social work practice offering new ways to perform services and obtain information. The challenges that it brings require a special set of skills and knowledge to provide the best practice available.

The standards apply to the use of technology as an adjunct to practice, as well as practice that is exclusively conducted with technology. The *NASW Code of Ethics* and the *ASWB Model Social Work Practice Act* served as foundation documents in developing these standards, along with a variety of other sources. The standards use a humanistic values framework to ensure that ethical social work practice can be enhanced by the appropriate use of technology.

The specific goals of the standards are:

- to maintain and improve the quality of technology-related services provided by social workers
- to serve as a guide to social workers incorporating technology into their services
- to help social workers monitor and evaluate the ways technology is used in their services
- to inform clients, government regulatory bodies, insurance carriers, and others about the professional standards for the use of technology in the provision of social work services.

Special Note: The order in which the standards appear does NOT reflect their order of importance.

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3	Introduction
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Technology and social work practice, when used in these standards, is defined as any electronically mediated activity used in the conduct of competent and ethical delivery of social work services.

The past two decades have witnessed an immense expansion of the use of information technology in social work practice. This expansion has affected nearly every area of the profession: At the individual practitioner level, e-mail and the Web make Internet-mediated direct practice possible on a global scale; social workers and clients can uncover vast Web-based sources for information that can enhance the likelihood of effective interventions; support groups for people at risk can be easily created and moderated. At the agency level, case management programs can generate reports, track personnel, automate billing, forecast budgets, and greatly assist service planning and delivery; global-level consultation and conference abilities are at hand; emerging geographic information systems can pinpoint community assets and needs. The future promises even more changes: automated interventions that do not require the direct involvement of the worker are emerging, and wireless technologies are facilitating social work in the field. These current and near-future technologies are changing the nature of professional social work practice in countless ways.

As a result, the roles for social workers are changing and they may need to adjust to the new demands for practice in the information

age. Social workers should acquire adequate skills that use technology appropriately, and adapt traditional practice protocols to ensure competent and ethical practice.

Several critical issues need to be addressed: many technologies are powerful but fragile; crucial information can be lost or intercepted; not all Web sites providing information are reliable; service providers can easily misrepresent themselves and their credentials online; confidentiality in an electronic medium can quickly evaporate; jurisdiction, liability and malpractice issues blur when state lines and national boundaries are crossed electronically; numerous digital divides can thwart access and success; and clients and social workers alike may have unrealistic expectations for what a technology can actually provide.

Standards for Professional Practice

Standard 1. Ethics and Values

Social workers providing services via the telephone or other electronic means shall act ethically, ensure professional competence, protect clients, and uphold the values of the profession.

Interpretation

Social workers should ensure that services conform to all practice and regulatory standards addressing ethical conduct and protection of the public. The NASW *Code of Ethics*, licensing laws, and regulations from licensing boards set forth principles and standards to guide the conduct of social

workers, establish basic competencies, and allow for the evaluation of both. The NASW *Code of Ethics* also sets forth explicit standards for social work conduct in all practice arenas. Social workers providing services through electronic means should know about the codes, standards, practices, and values and incorporate them into their practices.

The potential for harm or abuse of vulnerable people can be increased because of the lack of a face-to-face relationship with the social worker. Therefore, the social worker should make every effort to ensure that the use of technology conforms to all practice and regulatory standards addressing ethical conduct and protection of the public.

Standard 2. Access

Social workers shall have access to technology and appropriate support systems to ensure competent practice, and shall take action to ensure client access to technology.

Interpretation

Many “digital divides” can limit access for social workers and clients. Unavailable or obsolete equipment or software can make access difficult, while use of policies, privacy and security features, language issues, and the reading comprehension levels required may thwart access entirely. Even when such issues are adequately addressed, people with disabilities often have additional support needs. Social workers should advocate for both themselves and for clients to resolve access problems.

Social workers should ensure that adequate risk-reducing precautions are in place that will protect clients. All communications directed toward clients need to be written at a level and in a manner that is culturally competent and easily understood. Access for people with disabilities should conform to standards.

Standard 3. Cultural Competence and Vulnerable Populations

Social workers shall select and develop appropriate online methods, skills, and techniques that are attuned to their clients' cultural, bicultural, or marginalized experiences in their environments. In striving for cultural competence, social workers shall have the skills to work with a wide range of people who are culturally different or who may be considered a member of a vulnerable population, such as people with disabilities and racial, ethnic, and sexual minority status, and those whose primary language may not be English.

Interpretation

The social work profession has espoused a commitment to diversity, inclusion, and affirmative action. Social workers possess specialized knowledge regarding the influence of social and cultural discrimination for people of racial, ethnic, religious, sexual minority status, and people with physical and mental disabilities. Electronic communication can provide access to information, referral, advocacy services, and interpersonal communication; however, social workers should be aware of the cultural contexts of global social work services. This requires the continuous development of specialized

knowledge and understanding of the history, traditions, values, family systems, and artistic expressions of major client groups served through technology. Geographical barriers are inherently absent on the Internet. Client perspectives of therapy and service delivery via technology may differ. Because of the social isolation often experienced by people in vulnerable populations, social workers should be aware of the potential for exploitation and misuse of electronic methods with these individuals and families. In addition, culturally competent social workers should know the strengths and limitations of current electronic modalities, process and practice models, to provide services that are applicable and relevant to the needs of culturally and geographically diverse clients and members of vulnerable populations.

Standard 4. Technical Competencies

Social workers shall be responsible for becoming proficient in the technological skills and tools required for competent and ethical practice and for seeking appropriate training and consultation to stay current with emerging technologies.

Interpretation

Numerous technologies are available to social workers to establish, enhance, and deliver services; conduct research; and circulate information. They represent a new method of agency administration and service delivery. Computer-based software helps social workers track client services and outcomes. Technical systems are increasingly available to support ongoing routines and standard operating procedures vital for agency functioning and

efficiency. These technologies include tools such as budget planning, assessment, client record keeping, reimbursement, delivery of information to the community, research, and service delivery.

Standard 5. Regulatory Competencies

Social workers who use telephonic or other electronic means to provide services shall abide by all regulation of their professional practice with the understanding that their practice may be subject to regulation in both the jurisdiction in which the client receives services as well as the jurisdiction in which the social worker provides services.

Interpretation

The practice of professional social work is regulated in some manner in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Canada, and other countries. Social workers should be aware of the laws, rules or other regulations that govern their work. They should comply with applicable regulation in all jurisdictions in which they practice. Social workers should understand that in some jurisdictions, the delivery of social work services is deemed to take place at the location of the client. It is the social worker's responsibility to contact the regulatory board(s) of intent to provide services and find out what requirements are necessary to provide services legally in those jurisdictions.

Standard 6. Identification and Verification

Social workers who use electronic means to provide services shall represent themselves to the public with accuracy and make efforts to verify client identity and contact information.

Interpretation

Social workers should advertise and perform only those services they are licensed, certified, and trained to provide. The anonymity of electronic communication makes misrepresentation possible for both social workers and consumers of social work services. Because of the potential misuse by unqualified individuals, it is essential that information be readily verifiable to ensure client protection. Web sites should provide links to all appropriate certification bodies and licensing boards to facilitate verification. Social workers need to provide their full name, credentials, licensure information, office address and phone number, and e-mail address. In addition, each party should plan for technology failures by providing alternate ways of making contact.

Standard 7. Privacy, Confidentiality, Documentation, and Security

Social workers shall protect client privacy when using technology in their practice and document all services, taking special safeguards to protect client information in the electronic record.

Interpretation

During the initial session, social workers should provide clients with information on the use of technology in service delivery. Social workers should obtain client confirmation of

notice of privacy practices and any authorizations for information disclosure and consents for treatment or services. Social workers should be aware of privacy risks involved when using wireless devices and other future technological innovations and take proper steps to protect client privacy.

Social workers should adhere to the privacy and security standards of applicable laws such as the Health Insurance Portability and Accountability Act (HIPAA) and other jurisdictional laws when performing services electronically. These laws address electronic transactions, patient rights, and allowable disclosure and include requirements regarding data protection, firewalls, password protection, and audit trails.

Social workers should give special attention to documenting services performed via the Internet and other technologies. They should be familiar with applicable laws that may dictate documentation standards in addition to licensure boards, third-party payers, and accreditation bodies. All practice activities should be documented and maintained in a safe, secure file with safeguards for electronic records.

Standard 8. Risk Management

Social workers providing services through the use of the telephone or other electronic means shall ensure high-quality practices and procedures that are legally sound and ethical to protect clients and safeguard against litigation.

Interpretation

Social workers shall provide a standard of care that is consistent with the NASW *Code of Ethics*, licensing laws, applicable organization policies and procedures, relevant criminal laws, and regulations for businesses and the practice of fair trade. Records should be accurate and reflect the standard of care provided. It is particularly important when providing services using electronic means to document client authorization for disclosure and informed consent. Key issues such as communication guidelines (timing and length of e-mails), security mechanisms (encryption, firewalls and pass codes), and actions to ensure fair and equitable fees should be addressed.

Adequate technical and policy supports including privacy and security procedures, protocols, and technologies should be in place to ensure protection of the clients, social workers, and the organization.

Standard 9. Practice Competencies

9-1. Advocacy and Social Action

Social workers shall use technology to inform and mobilize communities about policies that will benefit individuals and groups and seek to provide tools, opportunities, and information so that clients are able to advocate directly for their own interests.

Interpretation

Social work has a rich tradition of both collective advocacy for social change and case advocacy to improve the services provided to an individual, family, group, organization, or community. Various technologies are increasingly being used to monitor legislative

and regulatory activities, to communicate political messages, and to mobilize citizens to take action. The Internet has become a powerful tool to access information about public policy and to communicate quickly to large numbers of coalition partners and individual activists. Citizens can communicate instantaneously with elected officials through e-mail and FAX. Voter registration is now offered on many Web sites, including NASW's, to promote civic participation. On an individual case advocacy level, a social worker, using Internet resources, can more easily assist clients in navigating systems of care. In addition to informational resources, social workers can assist clients by using online application processes and services, and by providing access to support networks.

9-2. Community Practice

Social workers shall advocate for the adoption and use of relevant technologies that will enhance the well-being of communities.

Interpretation

Social workers are in a unique position to ensure that technological innovations are culturally sensitive and attuned to the characteristics and needs of the specific community. Technologies such as e-mail groups, resource-rich Web sites, databases, and geographic information systems can assist practice within real and virtual communities. It is the social worker's responsibility to be aware of technology that may facilitate community well-being and to advocate for adoption of innovative systems when appropriate. If resources are not available, the social worker should advocate for securing

them. When technical support is not forthcoming, the social worker should work to see that this support is made available and that there are systems in place that will foster consistency and permanency. Social workers should strive to ensure access to technology and the benefits of technology for all members of the community.

9-3. Administrative Practice

Social workers shall keep themselves informed about technology that will advance quality program operations and service delivery, invest in and maintain such systems, and establish policies to ensure access, appropriate security, and privacy in agency information systems.

Interpretation

Technology is the backbone of agency administration. Electronic systems are essential for routine operations as well as applications designed to enhance forecasting, long-range planning, and project management. Major tasks, vital routines, ongoing communications, and agency outreach can be facilitated and enhanced through the use of databases, the Internet, and other technologies. When used appropriately, technology can help an agency accomplish its mission in a cost-effective way.

Access to adequate technology can be problematic for underfunded organizations, yet it is important that appropriate use of technology be an integral part of short- and long-term organizational goals. Although the costs of hardware, software, personnel, and training can be daunting, technical systems

planning and maintenance should be a routine part of the regular budgeting process.

The agency administrator should be attentive to related issues of information security and confidentiality. The provision of ethical and safe practice should be the driving force behind security and confidentiality policies that carefully address elements ranging from information exchange with third parties, to collaboration, fiscal transactions, and even the physical layout of workstations and other office equipment.

A risk-management plan is highly recommended, and should include protocols and policies for all technologies used by the agency for all administrative, managerial, and social worker–related purposes.

9-4. Clinical Competencies

Social workers shall strive to become and remain knowledgeable about the dynamics of online relationships, the advantages and drawbacks of non-face-to-face interactions, and the ways in which technology-based social work practice can be safely and appropriately conducted.

Interpretation

The Internet has become a means for providing individual, group, and family therapy. Social workers should be aware, however, that the possibility of a client suffering harm or loss remains present in any therapeutic encounter. Social workers should fully evaluate potential clients for appropriateness for online social work interventions, and if it is determined that such

methods would be appropriate, the social worker should provide the best online assessments and interventions possible.

The process of assessment for online therapy may be similar to assessment for in-person therapy. It is critical to obtain client background, history of presenting problem and previous records if necessary (with confirmation of the client's consent). Social workers should take responsibility for keeping current with emerging knowledge, review professional literature, and participate in continuing education relevant to technology-based clinical practice. The social worker should provide a contingency plan for clinical emergencies or technology failures.

Assessment is the key to appropriate intervention in all social work areas. Information technology allows assessments to be more complex and informed. Social workers should use only assessment instruments that are valid, reliable, and free from cultural bias.

Social workers should be aware of the special protection given to psychotherapy notes by HIPAA.

9-5. Research

Social workers conducting, evaluating, disseminating, or implementing research using technological approaches shall do so in a manner that ensures ethical credibility and ensures the informed consent of the participant.

Interpretation

The NASW *Code of Ethics* is a statement of values and guidelines for conducting, evaluating, disseminating and implementing research in practice. When engaging in electronically mediated research such as survey research on the Web or other electronic inquiries, participant-related safeguards should be applied. Human subjects review procedures should be followed rigorously to protect participants from harm and to monitor informed consent protocols.

When using research gained from electronic sources, the social worker has the obligation to evaluate the credibility and limitations of the research. This includes establishing and verifying authorship and sponsorship; the credentials and competencies of the researchers; the reliability, validity, and limitations of the research; and the accuracy of the reported findings or results. Social workers should carefully consider research based on these dimensions, and if doubt arises on any of them, then the social worker should use the information with caution, if at all.

9-6. Supervision

When using or providing supervision and consultation by technological means, social work supervisors and supervisees shall follow the standards that would be applied to a face-to-face supervisory relationship and shall be competent in the technologies used.

Interpretation

Social workers should follow applicable laws regarding direct services, case, or clinical supervision requirements and the use of

technology for the purposes of licensure. Supervision for purposes of licensure is governed by regulatory boards that may have specific definitions and requirements pertaining to the use of technology in supervision. Social workers receiving supervision for the purposes of licensure have a responsibility to become familiar with these definitions and meet the requirements. Third-party payers and professional entities may have additional requirements that need to be followed.

Social workers should retain a qualified supervisor or consultant for technology concerns that may arise. When using technology for client services, proper training should be obtained to become familiar with the technologies being used. As with all supervisor–supervisee relationships, the supervisor may share the responsibility for services provided and may be held liable for negligent or inadequate practice by a supervisee.

Standard 10. Continuing Education

Social workers shall adhere to the NASW *Standards for Continuing Professional Education* and follow applicable licensing laws regarding continuing education delivered via electronic means.

Interpretation

Continuing education represents learning opportunities beyond the entry-level degree to enable social workers to increase their skill proficiency and level of knowledge. Typically, social work continuing education is a self-directed process in which social workers

should assume responsibility for their own professional development. Examples of technology-based continuing education can include any courses, lectures, seminars, etc., mediated by technology, including, but not limited to computer-based training, online courses, Web-based or satellite televised workshops/seminars. In taking or instructing continuing education programs via technology, access issues demand particular attention: Participants should be able to access technical support services as well as social work professionals who can answer content questions. Online scoring systems should provide feedback to the participant. It is also essential to maintain course records as a backup in case of technology failure. Providers should develop a method to authenticate users with professional license number or NASW membership number.

Glossary of Terms

Client

The individual, group, family, organization, or community that seeks or is provided with professional social work services.

Confidentiality

A basic principle of social work intervention and counseling. It ensures the client system that the social worker client–relationship and information provided by the client will remain private unless the client gives written authorization to the social worker for its release.

Electronic

A mode of communication and information acquisition, transmission, and storage, such as used in computers, telephones, cell phones, personal digital assistants, facsimile machines, etc.

HIPAA (Health Insurance Portability and Accountability Act of 1996)

A set of standards that protects electronic health information through the implementation of privacy and security rules and the establishment of electronic transactions and code sets. It also ensures the continuity of health insurance coverage and increases federal and state governments' enforcement authority over protected health information.

Information Technology (IT)

The overarching term to describe technologies that process information, most often in electronic form.

Internet

A worldwide network of computer networks that share information.

Online

A mode of communication where the user is in direct contact with the computer network to the extent that the network responds rapidly to user commands.

Privacy

The right of an individual to withhold her/his information from public scrutiny or unwanted publicity.

Risk Management

The practice of competent social work services and accurate documentation of practice decisions and interventions to avoid litigation.

Security

The protection of hardware, software, and data by locks, doors, and other electronic barriers such as passwords, firewalls, and encryption.

Technology

A set of prescribed events that are embedded in hardware, software, or telecommunications and that direct activities, decisions, or choices. Sometimes technology is divided into hard technologies, such as switches and electronics, and soft technology such as the processes and procedures associated with accounting or risk assessment.

World Wide Web (WWW or Web)

A subset of the Internet that allows access using a standard graphical protocol.

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ATTACHMENT K

Board of Occupational Therapy Telehealth Regulations

California Board of Occupational Therapy
Department of Consumer Affairs

Title 16, Division 39, California Code of Regulations

ORDER OF ADOPTION

Proposed new text is underlined.

ARTICLE 8. Ethical Standards of Practice

Add section 4172 - Standards of Practice for Telehealth

§ 4172. Standards of Practice for Telehealth.

(a) In order to provide occupational therapy services via telehealth as defined in Section 2290.5 of the Code, an occupational therapist or occupational therapy assistant providing services to a patient or client in this State must have a valid and current license issued by the Board.

(b) An occupational therapist shall obtain informed consent from the patient or client prior to delivering occupational therapy services via telehealth consistent with Section 2290.5 of the Code.

(c) Prior to providing occupational therapy services via telehealth:

(1) an occupational therapist shall determine whether an in-person evaluation is necessary and ensure that a therapist must be available if an onsite visit is required and;

(2) an occupational therapist shall determine whether in-person interventions are necessary. If it is determined that in-person interventions are necessary, an on-site occupational therapist or occupational therapy assistant shall provide the appropriate interventions.

(d) In making the determination whether an in-person evaluation or in-person interventions are necessary, an occupational therapist shall consider: the complexity of the patient's/client's condition; his or her own knowledge, skills, and abilities; the nature and complexity of the intervention; the requirements of the practice setting; and the patient's/client's context and environment.

(e) An occupational therapist or occupational therapy assistant providing occupational therapy services via telehealth must:

(1) Exercise the same standard of care when providing occupational therapy services via telehealth as with any other mode of delivery of occupational therapy services;

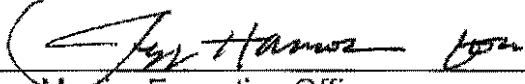
(2) Provide services consistent with section 2570.2(k) of the Code; and

(3) Comply with all other provisions of the Occupational Therapy Practice Act and its attending regulations, including the ethical standards of practice set forth in section 4170, as well as any other applicable provisions of law.

(f) Failure to comply with these regulations shall be considered unprofessional conduct as set forth in the Occupational Therapy Practice Act.

Note: Authority Cited: Business and Professions Code section 2570.20. Reference: Business and Professions Code sections 2290.5 and 2570.20.

DATE: December 30, 2013



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To: Committee Members

Date: January 21, 2015

From: Rosanne Helms
Legislative Analyst

Telephone: (916) 574-7897

Subject: Trainees and Telehealth

Background

The Board's licensing law defines marriage and family therapist and professional clinical counselor trainees as individuals who are currently enrolled in a qualifying master's degree program and have completed at least 12 semester or 18 quarter units in that program. (Business and Professions Code (BPC) §§4980.03(c) and 4999.12(g))

The law specifies that trainees may not provide services in a private practice. (BPC §§4980.43(d) and 4999.34(c))

It is the responsibility of the trainee's school to coordinate the trainee's services with the site at which he or she is providing services. The school must approve the site and have a written agreement with the site detailing each party's responsibilities and outlining supervision methods. (BPC §§4980.42 and 4999.36))

Licensing law for clinical social workers does not specifically define trainees or specify any requirements of them. It does recognize them as being exempt from licensure (BPC §4996.15).

Because trainees are practicing in exempt settings, the Board does not have authority to regulate their practice. This includes their use of telehealth.

However, applicants for licensure as a marriage and family therapist (LMFT) are allowed to count some pre-degree hours of trainee experience. Because the Board accepts some of those hours as experience toward licensure, the Board may specify the conditions under which those hours are gained.

Telehealth Statute and MFT Trainees

BPC §2290.5 is the statute that defines telehealth and sets provisions for the practice of telehealth for healing arts licensees.

A stakeholder has raised concern that BPC §2290.5 is written only for licensed individuals (a definition which includes interns/associates, but not trainees, who are not yet under the jurisdiction of the Board.)

However, BPC §4980.43 allows trainees count some of their experience gained as a trainee toward licensure, and allows some of this experience to be via telehealth. This is causing concern that trainees and their supervisors may be vulnerable to liability for providing telehealth services, as §2290.5 does not include trainees.

Because BPC §2290.5 affects all healing arts boards with a variety of license, registration, and other provider statuses, it is therefore unlikely that the Board would be successful in getting a Board-specific definition amended in. Therefore, staff has worked with DCA Legal to propose a solution via amendment to the LMFT statute, clarifying that trainees are permitted to perform telehealth (**Attachment B**):

BPC §4980.43(i): (i) Trainees, interns, and applicants shall only perform services at the place where their employers regularly conduct business, which may include performing services at other locations, so long as the services are performed under the direction and control of their employer and supervisor, and in compliance with the laws and regulations pertaining to supervision. For purposes of section 2290.5, trainees may provide services via telehealth within the scope authorized by this chapter and in accordance with any regulations governing the use of telehealth promulgated by the board. Trainees and interns shall have no proprietary interest in their employers' businesses and shall not lease or rent space, pay for furnishings, equipment, or supplies, or in any other way pay for the obligations of their employers.

Draft Telehealth Regulations

Provided that the above statutory amendment is made, Legal does not advise including trainees in the telehealth regulations, as they are working in exempt setting that are not under Board jurisdiction.

Recommendation

Conduct an open discussion about the issue of trainees and telehealth.

Attachments

Attachment A: BPC §2290.5

Attachment B: Proposed Amendment to LMFT Statute

Attachment A
Business and Professions Code Section 2290.5 – Telehealth

§2290.5.

(a) For purposes of this division, the following definitions shall apply:

(1) “Asynchronous store and forward” means the transmission of a patient’s medical information from an originating site to the health care provider at a distant site without the presence of the patient.

(2) “Distant site” means a site where a health care provider who provides health care services is located while providing these services via a telecommunications system.

(3) “Health care provider” means a person who is licensed under this division.

(4) “Originating site” means a site where a patient is located at the time health care services are provided via a telecommunications system or where the asynchronous store and forward service originates.

(5) “Synchronous interaction” means a real-time interaction between a patient and a health care provider located at a distant site.

(6) “Telehealth” means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient’s health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

(b) Prior to the delivery of health care via telehealth, the health care provider initiating the use of telehealth shall inform the patient about the use of telehealth and obtain verbal or written consent from the patient for the use of telehealth as an acceptable mode of delivering health care services and public health. The consent shall be documented.

(c) Nothing in this section shall preclude a patient from receiving in-person health care delivery services during a specified course of health care and treatment after agreeing to receive services via telehealth.

(d) The failure of a health care provider to comply with this section shall constitute unprofessional conduct. Section 2314 shall not apply to this section.

(e) This section shall not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law.

(f) All laws regarding the confidentiality of health care information and a patient’s rights to his or her medical information shall apply to telehealth interactions.

(g) This section shall not apply to a patient under the jurisdiction of the Department of Corrections and Rehabilitation or any other correctional facility.

(h) (1) Notwithstanding any other provision of law and for purposes of this section, the governing body of the hospital whose patients are receiving the telehealth services may grant privileges to, and verify and approve credentials for, providers of telehealth services based on its medical staff recommendations that rely on information provided by the distant-site hospital or telehealth

entity, as described in Sections 482.12, 482.22, and 485.616 of Title 42 of the Code of Federal Regulations.

(2) By enacting this subdivision, it is the intent of the Legislature to authorize a hospital to grant privileges to, and verify and approve credentials for, providers of telehealth services as described in paragraph (1).

(3) For the purposes of this subdivision, “telehealth” shall include “telemedicine” as the term is referenced in Sections 482.12, 482.22, and 485.616 of Title 42 of the Code of Federal Regulations.

ATTACHMENT B

Proposed Amendment to LMFT Statute

§4980.43. PROFESSIONAL EXPERIENCE; INTERNS OR TRAINEES

(a) Prior to applying for licensure examinations, each applicant shall complete experience that shall comply with the following:

- (1) A minimum of 3,000 hours completed during a period of at least 104 weeks.
- (2) Not more than 40 hours in any seven consecutive days.
- (3) Not less than 1,700 hours of supervised experience completed subsequent to the granting of the qualifying master's or doctoral degree.
- (4) Not more than 1,300 hours of supervised experience obtained prior to completing a master's or doctoral degree.

The applicant shall not be credited with more than 750 hours of counseling and direct supervisor contact prior to completing the master's or doctoral degree.

(5) No hours of experience may be gained prior to completing either 12 semester units or 18 quarter units of graduate instruction and becoming a trainee except for personal psychotherapy.

(6) No hours of experience may be gained more than six years prior to the date the application for examination eligibility was filed, except that up to 500 hours of clinical experience gained in the supervised practicum required by subdivision (c) of Section 4980.37 and subparagraph (B) of paragraph (1) of subdivision (d) of Section 4980.36 shall be exempt from this six-year requirement.

(7) Not more than a combined total of 1,000 hours of experience in the following:

(A) Direct supervisor contact.

(B) Professional enrichment activities. For purposes of this chapter, "professional enrichment activities" include the following:

(i) Workshops, seminars, training sessions, or conferences directly related to marriage and family therapy attended by the applicant that are approved by the applicant's supervisor. An applicant shall have no more than 250 hours of verified attendance at these workshops, seminars, training sessions, or conferences.

(ii) Participation by the applicant in personal psychotherapy, which includes group, marital or conjoint, family, or individual psychotherapy by an appropriately licensed professional. An applicant shall have no more than 100 hours of participation in personal psychotherapy. The applicant shall be credited with three hours of experience for each hour of personal psychotherapy.

(8) Not more than 500 hours of experience providing group therapy or group counseling.

(9) For all hours gained on or after January 1, 2012, not more than 500 hours of experience in the following:

(A) Experience administering and evaluating psychological tests, writing clinical reports, writing progress notes, or writing process notes.

(B) Client centered advocacy.

(10) Not less than 500 total hours of experience in diagnosing and treating couples, families, and children. For up to 150 hours of treating couples and families in conjoint therapy, the applicant shall be credited with two hours of experience for each hour of therapy provided.

(11) Not more than 375 hours of experience providing personal psychotherapy, crisis counseling, or other counseling services via telehealth in accordance with Section 2290.5.

(12) It is anticipated and encouraged that hours of experience will include working with elders and dependent adults who have physical or mental limitations that restrict their ability to carry out normal activities or protect their rights.

This subdivision shall only apply to hours gained on and after January 1, 2010.

(b) All applicants, trainees, and registrants shall be at all times under the supervision of a supervisor who shall be responsible for ensuring that the extent, kind, and quality of counseling performed is consistent with the training and experience of the person being supervised, and who shall be responsible to the board for compliance with all laws, rules, and regulations governing the practice of marriage and family therapy. Supervised experience shall be gained by interns and trainees only as an employee or as a volunteer. The requirements of this chapter regarding gaining hours of experience and supervision are applicable equally to employees and volunteers. Experience shall not be gained by interns or trainees as an independent contractor.

(1) If employed, an intern shall provide the board with copies of the corresponding W-2 tax forms for each year of experience claimed upon application for licensure.

(2) If volunteering, an intern shall provide the board with a letter from his or her employer verifying the intern's employment as a volunteer upon application for licensure.

(c) Except for experience gained pursuant to subparagraph (B) of paragraph (7) of subdivision (a), supervision shall include at least one hour of direct supervisor contact in each week for which experience is credited in each work setting, as specified:

(1) A trainee shall receive an average of at least one hour of direct supervisor contact for every five hours of client contact in each setting. No more than six hours of supervision, whether individual or group, shall be credited during any single week.

(2) An individual supervised after being granted a qualifying degree shall receive at least one additional hour of direct supervisor contact for every week in which more than 10 hours of client contact is gained in each setting. No more than six hours of supervision, whether individual or group, shall be credited during any single week.

(3) For purposes of this section, “one hour of direct supervisor contact” means one hour per week of face-to-face contact on an individual basis or two hours per week of face-to-face contact in a group.

(4) Direct supervisor contact shall occur within the same week as the hours claimed.

(5) Direct supervisor contact provided in a group shall be provided in a group of not more than eight supervisees and in segments lasting no less than one continuous hour.

(6) Notwithstanding paragraph (3), an intern working in a governmental entity, a school, a college, or a university, or an institution that is both nonprofit and charitable may obtain the required weekly direct supervisor contact via two-way, real-time videoconferencing. The supervisor shall be responsible for ensuring that client confidentiality is upheld.

(7) All experience gained by a trainee shall be monitored by the supervisor as specified by regulation.

(8) The six hours of supervision that may be credited during any single week pursuant to paragraphs (1) and (2) shall apply to supervision hours gained on or after January 1, 2009.

(d) (1) A trainee may be credited with supervised experience completed in any setting that meets all of the following:

(A) Lawfully and regularly provides mental health counseling or psychotherapy.

(B) Provides oversight to ensure that the trainee’s work at the setting meets the experience and supervision requirements set forth in this chapter and is within the scope of practice for the profession as defined in Section 4980.02.

(C) Is not a private practice owned by a licensed marriage and family therapist, a licensed professional clinical counselor, a licensed psychologist, a licensed clinical social worker, a licensed physician and surgeon, or a professional corporation of any of those licensed professions.

(2) Experience may be gained by the trainee solely as part of the position for which the trainee volunteers or is employed.

(e) (1) An intern may be credited with supervised experience completed in any setting that meets both of the following:

(A) Lawfully and regularly provides mental health counseling or psychotherapy.

(B) Provides oversight to ensure that the intern’s work at the setting meets the experience and supervision requirements set forth in this chapter and is within the scope of practice for the profession as defined in Section 4980.02.

(2) An applicant shall not be employed or volunteer in a private practice, as defined in subparagraph (C) of paragraph (1) of subdivision (d), until registered as an intern.

(3) While an intern may be either a paid employee or a volunteer, employers are encouraged to provide fair remuneration to interns.

(4) Except for periods of time during a supervisor's vacation or sick leave, an intern who is employed or volunteering in private practice shall be under the direct supervision of a licensee that has satisfied the requirements of subdivision (g) of Section 4980.03. The supervising licensee shall either be employed by and practice at the same site as the intern's employer, or shall be an owner or shareholder of the private practice. Alternative supervision may be arranged during a supervisor's vacation or sick leave if the supervision meets the requirements of this section.

(5) Experience may be gained by the intern solely as part of the position for which the intern volunteers or is employed.

(f) Except as provided in subdivision (g), all persons shall register with the board as an intern in order to be credited for postdegree hours of supervised experience gained toward licensure.

(g) Except when employed in a private practice setting, all postdegree hours of experience shall be credited toward licensure so long as the applicant applies for the intern registration within 90 days of the granting of the qualifying master's or doctoral degree and is thereafter granted the intern registration by the board.

(h) Trainees, interns, and applicants shall not receive any remuneration from patients or clients, and shall only be paid by their employers.

(i) Trainees, interns, and applicants shall only perform services at the place where their employers regularly conduct business, which may include performing services at other locations, so long as the services are performed under the direction and control of their employer and supervisor, and in compliance with the laws and regulations pertaining to supervision. [For purposes of section 2290.5, trainees may provide services via telehealth within the scope authorized by this chapter and in accordance with any regulations governing the use of telehealth promulgated by the board.](#) Trainees and interns shall have no proprietary interest in their employers' businesses and shall not lease or rent space, pay for furnishings, equipment, or supplies, or in any other way pay for the obligations of their employers.

(j) Trainees, interns, or applicants who provide volunteered services or other services, and who receive no more than a total, from all work settings, of five hundred dollars (\$500) per month as reimbursement for expenses actually incurred by those trainees, interns, or applicants for services rendered in any lawful work setting other than a private practice shall be considered an employee and not an independent contractor. The board may audit applicants who receive reimbursement for expenses, and the applicants shall have the burden of demonstrating that the payments received were for reimbursement of expenses actually incurred.

(k) Each educational institution preparing applicants for licensure pursuant to this chapter shall consider requiring, and shall encourage, its students to undergo individual, marital or conjoint, family, or group counseling or psychotherapy, as appropriate. Each supervisor shall consider, advise, and encourage his or her interns and trainees regarding the advisability of undertaking individual, marital or conjoint, family, or group counseling or psychotherapy, as appropriate. Insofar as it is deemed appropriate and is desired by the applicant, the educational institution and supervisors are encouraged to assist the applicant in locating that counseling or psychotherapy at a reasonable cost.

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To: Committee Members
From: Rosanne Helms
Legislative Analyst
Date: January 21, 2015
Telephone: (916) 574-7897
Subject: Security and Encryption in Telehealth

Background

Several jurisdictions and professional associations have regulations or guidelines requiring that mental health practitioners take steps to ensure the confidentiality of services performed via telehealth. Some organizations make that requirement even more specific, requiring telehealth services to be encrypted.

HIPAA defines encryption as “the use of an algorithmic process to transform data into a form in which there is a low probability of assigning meaning without use of a confidential process or key.” (U.S. Department of Health and Human Services, *HIPAA Administrative Simplification Regulation Text*, March 2013).
(Attachment A)

Proposed Language

The Board’s current draft of the telehealth regulations, as considered at the September 18, 2014 Policy and Advocacy Committee Meeting, stated the following:

“A licensee or registrant shall take steps to ensure the confidentiality of all telehealth services provided to the patient or client. This includes, but is not limited to, utilizing encryption security for the delivery of services.”

However, the Committee had some concerns about requiring licensees to use encryption, and so asked for further discussion of this matter.

Sample Language

Some entities discuss encryption directly:

- “NCCs shall use encryption security for all digital technology communications of a therapeutic type.”
(National Board for Certified Counselors (NBCC) “Policy Regarding the Provision of Distance Professional Services” (Approved July 31, 2012)

- “Licensees shall use encryption methods for electronic service delivery.” (*State of Ohio Administrative Code Chapter 4757-5-13(B)(1)*)

Other entities have more general requirements that telehealth services be safeguarded:

- “Marriage and family therapists are also aware of the limitations regarding confidential transmissions by Internet or electronic media and take care when transmitting or receiving such information via these mediums” (*CAMFT Code of Ethics, May 2002, March 2011, Section 2.3*)
- “Prior to commencing therapy or supervision services through electronic means...marriage and family therapists must (c) ensure the security of their communication medium...” (*AAMFT Board Approved Revised Code of Ethics, Effective January 1, 2015, Section 6.1*)

Consideration of Language Appropriate for California

HIPAA does not explicitly require encryption for telehealth. However, there are several products that therapists may utilize that provide an encrypted platform. Google Helpouts, Mytherapynet.com, and CloudVisit are examples of these types of services. **Attachments B** and **C** contain information about the services of Mytherapynet.com and CloudVisit, respectively.

Stakeholders have offered precautions about utilizing language specifically requiring encryption. For example, it may not be possible to require encryption for services conducted via telephone. In addition, there may be differing opinions about the definition of encryption and its appropriate utilization.

Recommendation

Conduct an open discussion regarding the security and confidentiality requirements that should be incorporated into the Board’s telehealth regulations.

Attachments

Attachment A: U.S. Department of Health and Human Services, “*HIPAA Administrative Simplification Regulation Text*,” March 2013 (Partial)

Attachment B: Online Therapy: Mytherapynet.com

Attachment C: Online Therapy: CloudVisit

U.S. Department of Health and Human Services
Office for Civil Rights



HIPAA Administrative Simplification

Regulation Text

**45 CFR Parts 160, 162, and 164
(Unofficial Version, as amended through March 26, 2013)**

for 6 years from the date of its creation or the date when it last was in effect, whichever is later.

[68 FR 8375, Feb. 20, 2003, as amended at 78 FR 5692, Jan. 25, 2013]

§ 164.106 Relationship to other parts.

In complying with the requirements of this part, covered entities and, where provided, business associates, are required to comply with the applicable provisions of parts 160 and 162 of this subchapter.

[78 FR 5693, Jan. 25, 2013]

Subpart B [Reserved]

Subpart C—Security Standards for the Protection of Electronic Protected Health Information

AUTHORITY: 42 U.S.C. 1320d-2 and 1320d-4; sec. 13401, Pub. L. 111-5, 123 Stat. 260.

SOURCE: 68 FR 8376, Feb. 20, 2003, unless otherwise noted.

§ 164.302 Applicability.

A covered entity or business associate must comply with the applicable standards, implementation specifications, and requirements of this subpart with respect to electronic protected health information of a covered entity.

[78 FR 5693, Jan. 25, 2013]

§ 164.304 Definitions.

As used in this subpart, the following terms have the following meanings:

Access means the ability or the means necessary to read, write, modify, or communicate data/information or otherwise use any system resource. (This definition applies to “access” as used in this subpart, not as used in subparts D or E of this part.)

Administrative safeguards are administrative actions, and policies and procedures, to manage the selection, development, implementation, and maintenance of security measures to protect electronic protected health information and to manage the conduct of the covered entity's or business associate's workforce in relation to the protection of that information.

Authentication means the corroboration that a person is the one claimed.

Availability means the property that data or information is accessible and useable upon demand by an authorized person.

Confidentiality means the property that data or information is not made available or disclosed to unauthorized persons or processes.

* *Encryption* means the use of an algorithmic process to transform data into a form in which there is a low probability of assigning meaning without use of a confidential process or key.

Facility means the physical premises and the interior and exterior of a building(s).

Information system means an interconnected set of information resources under the same direct management control

that shares common functionality. A system normally includes hardware, software, information, data, applications, communications, and people.

Integrity means the property that data or information have not been altered or destroyed in an unauthorized manner.

Malicious software means software, for example, a virus, designed to damage or disrupt a system.

Password means confidential authentication information composed of a string of characters.

Physical safeguards are physical measures, policies, and procedures to protect a covered entity's or business associate's electronic information systems and related buildings and equipment, from natural and environmental hazards, and unauthorized intrusion.

Security or Security measures encompass all of the administrative, physical, and technical safeguards in an information system.

Security incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

Technical safeguards means the technology and the policy and procedures for its use that protect electronic protected health information and control access to it.

User means a person or entity with authorized access.

Workstation means an electronic computing device, for example, a laptop or desktop computer, or any other device that performs similar functions, and electronic media stored in its immediate environment.

[68 FR 8376, Feb. 20, 2003, as amended at 74 FR 42767, Aug. 24, 2009; 78 FR 5693, Jan. 25, 2013]

§ 164.306 Security standards: General rules.

(a) General requirements.

Covered entities and business associates must do the following:

✱ (1) Ensure the confidentiality, integrity, and availability of all electronic protected health information the covered entity or business associate creates, receives, maintains, or transmits.

(2) Protect against any reasonably anticipated threats or hazards to the security or integrity of such information.

(3) Protect against any reasonably anticipated uses or disclosures of such information that are not permitted or required under subpart E of this part.

(4) Ensure compliance with this subpart by its workforce.

(b) Flexibility of approach.

(1) Covered entities and business associates may use any security measures that allow the covered entity or business associate to reasonably and appropriately implement the standards and implementation

specifications as specified in this subpart.

(2) In deciding which security measures to use, a covered entity or business associate must take into account the following factors:

(i) The size, complexity, and capabilities of the covered entity or business associate.

(ii) The covered entity's or the business associate's technical infrastructure, hardware, and software security capabilities.

(iii) The costs of security measures.

(iv) The probability and criticality of potential risks to electronic protected health information.

(c) *Standards.* A covered entity or business associate must comply with the applicable standards as provided in this section and in § 164.308, § 164.310, § 164.312, § 164.314 and § 164.316 with respect to all electronic protected health information.

(d) *Implementation specifications.* In this subpart:

(1) Implementation specifications are required or addressable. If an implementation specification is required, the word "Required" appears in parentheses after the title of the implementation specification. If an implementation specification is addressable, the word "Addressable" appears in parentheses after the title of the implementation specification.

(2) When a standard adopted in § 164.308, § 164.310, § 164.312, § 164.314, or § 164.316 includes required implementation specifications, a covered entity or business associate must implement the implementation specifications.

(3) When a standard adopted in § 164.308, § 164.310, § 164.312, § 164.314, or § 164.316 includes addressable implementation specifications, a covered entity or business associate must—

(i) Assess whether each implementation specification is a reasonable and appropriate safeguard in its environment, when analyzed with reference to the likely contribution to protecting electronic protected health information; and

(ii) As applicable to the covered entity or business associate—

(A) Implement the implementation specification if reasonable and appropriate; or

(B) If implementing the implementation specification is not reasonable and appropriate—

(1) Document why it would not be reasonable and appropriate to implement the implementation specification; and

(2) Implement an equivalent alternative measure if reasonable and appropriate.

(e) *Maintenance.* A covered entity or business associate must review and modify the security measures implemented under this subpart as needed to continue provision of reasonable and appropriate protection of

electronic protected health information, and update documentation of such security measures in accordance with § 164.316(b)(2)(iii).

[68 FR 8376, Feb. 20, 2003; 68 FR 17153, Apr. 8, 2003; 78 FR 5693, Jan. 25, 2013]

§ 164.308 Administrative safeguards.

(a) A covered entity or business associate must, in accordance with § 164.306:

(1)(i) *Standard: Security management process.* Implement policies and procedures to prevent, detect, contain, and correct security violations.

(ii) *Implementation specifications:*

(A) *Risk analysis (Required).* Conduct an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information held by the covered entity or business associate.

(B) *Risk management (Required).* Implement security measures sufficient to reduce risks and vulnerabilities to a reasonable and appropriate level to comply with § 164.306(a).

(C) *Sanction policy (Required).* Apply appropriate sanctions against workforce members who fail to comply with the security policies and procedures of the covered entity or business associate.

(D) *Information system activity review (Required).* Implement procedures to regularly review records of information system activity, such as audit logs, access reports, and security incident tracking reports.

(2) *Standard: Assigned security responsibility.* Identify the security official who is responsible for the development and implementation of the policies and procedures required by this subpart for the covered entity or business associate.

(3)(i) *Standard: Workforce security.* Implement policies and procedures to ensure that all members of its workforce have appropriate access to electronic protected health information, as provided under paragraph (a)(4) of this section, and to prevent those workforce members who do not have access under paragraph (a)(4) of this section from obtaining access to electronic protected health information.

(ii) *Implementation specifications:*

(A) *Authorization and/or supervision (Addressable).* Implement procedures for the authorization and/or supervision of workforce members who work with electronic protected health information or in locations where it might be accessed.

(B) *Workforce clearance procedure (Addressable).* Implement procedures to determine that the access of a workforce member to electronic protected health information is appropriate.

(C) *Termination procedures (Addressable).* Implement procedures for terminating access to electronic protected health information when the employment of, or other arrangement with, a workforce member ends or as required by determinations made as specified in paragraph (a)(3)(ii)(B) of this section.

(4)(i) *Standard: Information access management.* Implement policies and procedures for authorizing access to electronic protected health information that are consistent with the applicable requirements of subpart E of this part.

(ii) *Implementation specifications:*

(A) *Isolating health care clearinghouse functions (Required).* If a health care clearinghouse is part of a larger organization, the clearinghouse must implement policies and procedures that protect the electronic protected health information of the clearinghouse from unauthorized access by the larger organization.

(B) *Access authorization (Addressable).* Implement policies and procedures for granting access to electronic protected health information, for example, through access to a workstation, transaction, program, process, or other mechanism.

(C) *Access establishment and modification (Addressable).* Implement policies and procedures that, based upon the covered entity's or the business associate's access authorization policies, establish, document, review, and modify a user's right

of access to a workstation, transaction, program, or process.

(5)(i) *Standard: Security awareness and training.*

Implement a security awareness and training program for all members of its workforce (including management).

(ii) *Implementation specifications.* Implement:

(A) *Security reminders (Addressable).* Periodic security updates.

(B) *Protection from malicious software (Addressable).* Procedures for guarding against, detecting, and reporting malicious software.

(C) *Log-in monitoring (Addressable).* Procedures for monitoring log-in attempts and reporting discrepancies.

(D) *Password management (Addressable).* Procedures for creating, changing, and safeguarding passwords.

(6)(i) *Standard: Security incident procedures.* Implement policies and procedures to address security incidents.

(ii) *Implementation specification: Response and reporting (Required).* Identify and respond to suspected or known security incidents; mitigate, to the extent practicable, harmful effects of security incidents that are known to the covered entity or business associate; and document security incidents and their outcomes.

(7)(i) *Standard: Contingency plan.* Establish (and implement as needed) policies and procedures for responding to an emergency or other occurrence (for example, fire, vandalism, system failure, and natural disaster) that damages systems that contain electronic protected health information.

(ii) *Implementation specifications:*

(A) *Data backup plan (Required).* Establish and implement procedures to create and maintain retrievable exact copies of electronic protected health information.

(B) *Disaster recovery plan (Required).* Establish (and implement as needed) procedures to restore any loss of data.

(C) *Emergency mode operation plan (Required).* Establish (and implement as needed) procedures to enable continuation of critical business processes for protection of the security of electronic protected health information while operating in emergency mode.

(D) *Testing and revision procedures (Addressable).* Implement procedures for periodic testing and revision of contingency plans.

(E) *Applications and data criticality analysis (Addressable).* Assess the relative criticality of specific applications and data in support of other contingency plan components.

(8) *Standard: Evaluation.* Perform a periodic technical and nontechnical evaluation, based

initially upon the standards implemented under this rule and, subsequently, in response to environmental or operational changes affecting the security of electronic protected health information, that establishes the extent to which a covered entity's or business associate's security policies and procedures meet the requirements of this subpart.

(b)(1) *Business associate contracts and other arrangements.* A covered entity may permit a business associate to create, receive, maintain, or transmit electronic protected health information on the covered entity's behalf only if the covered entity obtains satisfactory assurances, in accordance with § 164.314(a), that the business associate will appropriately safeguard the information. A covered entity is not required to obtain such satisfactory assurances from a business associate that is a subcontractor.

(2) A business associate may permit a business associate that is a subcontractor to create, receive, maintain, or transmit electronic protected health information on its behalf only if the business associate obtains satisfactory assurances, in accordance with § 164.314(a), that the subcontractor will appropriately safeguard the information.

(3) *Implementation specifications: Written contract or other arrangement (Required).* Document the satisfactory assurances required by paragraph (b)(1) or (b)(2) of this section through a written contract or other arrangement with the business associate that

meets the applicable requirements of § 164.314(a).

[68 FR 8376, Feb. 20, 2003, as amended at 78 FR 5694, Jan. 25, 2013]

§ 164.310 Physical safeguards.

A covered entity or business associate must, in accordance with § 164.306:

(a)(1) *Standard: Facility access controls.* Implement policies and procedures to limit physical access to its electronic information systems and the facility or facilities in which they are housed, while ensuring that properly authorized access is allowed.

(2) Implementation specifications:

(i) *Contingency operations (Addressable).* Establish (and implement as needed) procedures that allow facility access in support of restoration of lost data under the disaster recovery plan and emergency mode operations plan in the event of an emergency.

(ii) *Facility security plan (Addressable).* Implement policies and procedures to safeguard the facility and the equipment therein from unauthorized physical access, tampering, and theft.

(iii) *Access control and validation procedures (Addressable).* Implement procedures to control and validate a person's access to facilities based on their role or function, including visitor control, and control of access to

software programs for testing and revision.

(iv) *Maintenance records (Addressable).* Implement policies and procedures to document repairs and modifications to the physical components of a facility which are related to security (for example, hardware, walls, doors, and locks).

(b) *Standard: Workstation use.* Implement policies and procedures that specify the proper functions to be performed, the manner in which those functions are to be performed, and the physical attributes of the surroundings of a specific workstation or class of workstation that can access electronic protected health information.

(c) *Standard: Workstation security.* Implement physical safeguards for all workstations that access electronic protected health information, to restrict access to authorized users.

(d)(1) *Standard: Device and media controls.* Implement policies and procedures that govern the receipt and removal of hardware and electronic media that contain electronic protected health information into and out of a facility, and the movement of these items within the facility.

(2) Implementation specifications:

(i) *Disposal (Required).* Implement policies and procedures to address the final disposition of electronic protected health information, and/or the hardware or electronic media on which it is stored.

(ii) *Media re-use (Required).* Implement procedures for removal of electronic protected health information from electronic media before the media are made available for re-use.

(iii) *Accountability (Addressable).* Maintain a record of the movements of hardware and electronic media and any person responsible therefore.

(iv) *Data backup and storage (Addressable).* Create a retrievable, exact copy of electronic protected health information, when needed, before movement of equipment.

[68 FR 8376, Feb. 20, 2003, as amended at 78 FR 5694, Jan. 25, 2013]

§ 164.312 Technical safeguards.

A covered entity or business associate must, in accordance with § 164.306:

(a)(1) *Standard: Access control.* Implement technical policies and procedures for electronic information systems that maintain electronic protected health information to allow access only to those persons or software programs that have been granted access rights as specified in § 164.308(a)(4).

(2) Implementation specifications:

(i) *Unique user identification (Required).* Assign a unique name and/or number for identifying and tracking user identity.

(ii) *Emergency access procedure (Required)*. Establish (and implement as needed) procedures for obtaining necessary electronic protected health information during an emergency.

(iii) *Automatic logoff (Addressable)*. Implement electronic procedures that terminate an electronic session after a predetermined time of inactivity.

(iv) *Encryption and decryption (Addressable)*. Implement a mechanism to encrypt and decrypt electronic protected health information.

(b) *Standard: Audit controls*. Implement hardware, software, and/or procedural mechanisms that record and examine activity in information systems that contain or use electronic protected health information.

(c)(1) *Standard: Integrity*. Implement policies and procedures to protect electronic protected health information from improper alteration or destruction.

(2) *Implementation specification: Mechanism to authenticate electronic protected health information (Addressable)*. Implement electronic mechanisms to corroborate that electronic protected health information has not been altered or destroyed in an unauthorized manner.

(d) *Standard: Person or entity authentication*. Implement procedures to verify that a person or entity seeking access to electronic protected health information is the one claimed.

(e)(1) *Standard: Transmission security*. Implement technical security measures to guard against unauthorized access to electronic protected health information that is being transmitted over an electronic communications network.

(2) *Implementation specifications:*

(i) *Integrity controls (Addressable)*. Implement security measures to ensure that electronically transmitted electronic protected health information is not improperly modified without detection until disposed of.

(ii) *Encryption (Addressable)*. Implement a mechanism to encrypt electronic protected health information whenever deemed appropriate.

[68 FR 8376, Feb. 20, 2003, as amended at 78 FR 5694, Jan. 25, 2013]

§ 164.314 Organizational requirements.

(a)(1) *Standard: Business associate contracts or other arrangements*. The contract or other arrangement required by § 164.308(b)(3) must meet the requirements of paragraph (a)(2)(i), (a)(2)(ii), or (a)(2)(iii) of this section, as applicable.

(2) *Implementation specifications (Required)*.

(i) *Business associate contracts*. The contract must provide that the business associate will—

(A) Comply with the applicable requirements of this subpart;

(B) In accordance with § 164.308(b)(2), ensure that any subcontractors that create, receive, maintain, or transmit electronic protected health information on behalf of the business associate agree to comply with the applicable requirements of this subpart by entering into a contract or other arrangement that complies with this section; and

(C) Report to the covered entity any security incident of which it becomes aware, including breaches of unsecured protected health information as required by § 164.410.

(ii) *Other arrangements*. The covered entity is in compliance with paragraph (a)(1) of this section if it has another arrangement in place that meets the requirements of § 164.504(e)(3).

(iii) *Business associate contracts with subcontractors*. The requirements of paragraphs (a)(2)(i) and (a)(2)(ii) of this section apply to the contract or other arrangement between a business associate and a subcontractor required by § 164.308(b)(4) in the same manner as such requirements apply to contracts or other arrangements between a covered entity and business associate.

(b)(1) *Standard: Requirements for group health plans*. Except when the only electronic protected health information disclosed to a plan sponsor is disclosed pursuant to § 164.504(f)(1)(ii) or (iii), or as authorized under § 164.508, a group health plan must ensure that its plan documents provide that the plan sponsor will reasonably and appropriately safeguard electronic protected

health information created, received, maintained, or transmitted to or by the plan sponsor on behalf of the group health plan.

(2) *Implementation specifications (Required)*. The plan documents of the group health plan must be amended to incorporate provisions to require the plan sponsor to—

(i) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the group health plan;

(ii) Ensure that the adequate separation required by § 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

(iii) Ensure that any agent to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and

(iv) Report to the group health plan any security incident of which it becomes aware.

[68 FR 8376, Feb. 20, 2003, as amended at 78 FR 5694, Jan. 25, 2013]

§ 164.316 Policies and procedures and documentation requirements.

A covered entity or business associate must, in accordance with § 164.306:

(a) *Standard: Policies and procedures*. Implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications, or other requirements of this subpart, taking into account those factors specified in § 164.306(b)(2)(i), (ii), (iii), and (iv). This standard is not to be construed to permit or excuse an action that violates any other standard, implementation specification, or other requirements of this subpart. A covered entity or business associate may change its policies and procedures at any time, provided that the changes are documented and are implemented in accordance with this subpart.

(b)(1) *Standard: Documentation*. (i) Maintain the policies and procedures implemented to comply with this subpart in written (which may be electronic) form; and

(ii) If an action, activity or assessment is required by this subpart to be documented, maintain a written (which may be electronic) record of the action, activity, or assessment.

(2) *Implementation specifications*:

(i) *Time limit (Required)*. Retain the documentation required by paragraph (b)(1) of this section for 6 years from the date of its creation or the date when it last was in effect, whichever is later.

(ii) *Availability (Required)*. Make documentation available to those persons responsible for implementing the procedures to

which the documentation pertains.

(iii) *Updates (Required)*. Review documentation periodically, and update as needed, in response to environmental or operational changes affecting the security of the electronic protected health information.

[68 FR 8376, Feb. 20, 2003, as amended at 78 FR 5695, Jan. 25, 2013]

§ 164.318 Compliance dates for the initial implementation of the security standards.

(a) *Health plan*. (1) A health plan that is not a small health plan must comply with the applicable requirements of this subpart no later than April 20, 2005.

(2) A small health plan must comply with the applicable requirements of this subpart no later than April 20, 2006.

(b) *Health care clearinghouse*. A health care clearinghouse must comply with the applicable requirements of this subpart no later than April 20, 2005.

(c) *Health care provider*. A covered health care provider must comply with the applicable requirements of this subpart no later than April 20, 2005.

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2) Scroll down to view our Featured Therapists, and scroll further down for a list of categories.

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3) Use the Search Box that says "Therapist Name or Issue" located near the top left corner of the page. Type the name of

a therapist, if you are looking for someone in particular, or type in the name of the issue you are experiencing – such as “depression”.

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5) If you have a question, or want to see if a therapist is a good match for you, you may use the “SecureMessage” feature by clicking on “more info” and then “SecureMessage” for the therapist with whom you would like to communicate.

5) Once you have decided upon a Therapist to meet with online, click on “Book An Appointment” to schedule and pay for your appointment. Therapists set their own fees.

6) At your appointment time, log into your Therapist’s Online Therapy Office and click “Enter Session Room”. If you are doing Chat therapy, all you need is a keyboard and an internet connection. If you are using audio and video, make sure you have a microphone and webcam attached to your computer.

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MyTherapyNet.com Security

MyTherapyNet.com is the original Online Therapy Service, and launched to the public in April of 2000. MTN recognized and understood the very specific needs of mental health, and that in order to provide a viable service the foundation had to be based upon a solid security protocol. The Mental Health field’s HIPAA (Health Insurance Portability and Accountability Act) regulations and individual state laws governing patient rights and treatments have to be taken into consideration for an Online Therapy service to provide the mandated level of service.

This is why “Skype” therapy is a bad idea. Skype was not built for use with therapy. Skype communications are not secured in a fashion mandated by law for use with therapy and counseling.

MyTherapyNet’s Online Communications System is specifically designed for therapy. You can rest assured that your communications are truly private. In fact, MyTherapyNet employs multiple security protocols to cover data and communications – each protocol with at least one redundancy and fail-safe.

MyTherapyNet Therapists

All MyTherapyNet.com Therapists are licensed, insured and have therapy experience in the “real world”. Think of MyTherapyNet.com as an online “office building” that only rents “offices” to Mental Health providers. Therefore MyTherapyNet.com does not have anything to do with the individual therapists’ practices. However, as a landlord that only

rents to Mental Health Providers, we want our website visitors to be assured that therapists listed at the service are of exceptional quality. MyTherapyNet.com's Therapist Quality Assurance Protocol (TQAP) takes into consideration complaints, and therapists who fail to comply with the standards of our protocol are removed from the MyTherapyNet.com service.

MyTherapyNet.com Technology

Log in, click "Enter Session Room" and get started! Online Therapy is meant to make life EASIER! No travel time to and from "real world" appointments. Appointment times that are convenient for your schedule. The last thing you want is a complicated Online Therapy System.

MyTherapyNet.com makes taking care of what matters most – your mental health – easy, fun and convenient.

Welcome to the future of therapy – Online Therapy at MyTherapyNet.com!

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Security Measures



Security and patient privacy are top priorities in the CloudVisit Telemedicine platform. Following is a broad look at the safety precautions in place.

[Data Encryption \(in transmission\)](#)

[Data Encryption \(at rest\)](#)

[Audio/Video Encryption](#)

[Distributed Servers](#)

[HIPAA-Compliant Webhosting](#)

[HIPAA-Compliant Business Standards](#)

Security is our priority

We built CloudVisit Telemedicine from the ground up with your security in mind.



Encryption

Encryption is a technique used to protect your data and it takes many forms. Imagine if you were to take your digital information and put it through a virtual paper shredder, jumble it up, and then lock it away in a safe. Even if someone could break into that safe and look at your bits of information they would be meaningless to them. That's encryption in a nutshell.



Data Encryption (in transmission)

Industry standard AES 256-bit encryption is used at all points where patient information is transmitted between a user and our servers. This includes full encryption for information shared by providers and patients, as well as encrypted transmission of uploaded/downloaded documents and images.



Data Encryption (at rest)

All patient data and billing information is stored in encrypted database tables using standard AES 256-bit. All documents and images uploaded by a patient or provider are stored encrypted, as well. Full drive encryption is in place for all hard drives storing patient information and website operation data using SHA-512 encryption standards.



Audio/Video Encryption

Audio and video for all sessions are transmitted over an encrypted channel using industry standard cryptographic primitives. Audio and video streams are decoded as received by a participating provider or patient.



Distributed Servers

Multiple servers are used to handle specific tasks, such as webhosting, data storage, and video session management.

Each server is uniquely configured with separate access details, software decryption keys, permissions, and safeguards. Access to systems containing sensitive information is restricted to an internal network structure.



HIPAA-Compliant Webhosting

We use an enterprise-class hosting solution that provides all necessary tools for maintaining HIPAA-compliant security measures and patient privacy.

Our encryption standards ensure that our hosting solution has no access to sensitive patient information at any time.



HIPAA-Compliant Business Standards

In accordance with the newly-announced 2013 HIPAA guidelines and regulations, suppliers of telemedicine software solutions are required to maintain HIPAA-compliant security and business practices. Further, healthcare providers are required to enter a Business Associates Agreement (BAA) with their telemedicine software supplier. We maintain HIPAA standards and enter into a mutual BAA with each CloudVisit Telemedicine subscriber.

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Questions? Call 888-503-3009

CloudVisit Telemedicine is committed to providing our clients with easy-to-use telemedicine & telepsychiatry software services and solutions. For more information on how we can help grow your practice please call us at: **888-503-3009**.

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At the September meeting, staff presented draft regulations to the Committee. Discussion points focused on the following:

- The location of the patient is critical. The location of the patient must be verified, and the practitioner must be aware of applicable local laws as well as local resources in case referral is necessary.
- The regulations should be revised so that it is clear that the Board's laws and regulations apply to services via telehealth just as they apply to face-to-face services. However, it is possible that the standard of care may be higher for telehealth in certain instances.
- The Committee expressed a desire to examine a clause in the State of Arizona's law that allows licensed out-of-state practitioners to practice unlicensed in that state for up to 90 days.

Draft regulations are provided in **Attachment A**. New changes, which were made after the discussion at the September 2014 Policy and Advocacy Committee meeting, are shown in red underline and strikeout.

In addition, the California Association of Marriage and Family Therapists (CAMFT) has provided written comments for the September 18th draft of the regulations. These comments are shown in **Attachment B**.

Recommendation

Conduct an open discussion regarding the issues related to telehealth for Board licensees, as well the draft regulations and the items for discussion listed above.

Attachments

Attachment A: Draft Telehealth Regulations

Attachment B: CAMFT Written Comments Regarding Proposed Regulations on Telehealth

Attachment C: California Business and Professions Code Section 2290.5: Definition of Telehealth

Attachment A
Draft Telehealth Regulations
Title 16, Division 18, California Code of Regulations

ARTICLE 1. GENERAL PROVISIONS

ADD §1815.5. Standards of Practice for Telehealth

- (a) All persons engaging in the practice of marriage and family therapy, educational psychology, clinical social work, or professional clinical counseling via telehealth, as defined in Section 2290.5 of the Code, with a ~~patient or~~ client who is physically located in this State must have a valid and current license ~~or registration~~ issued by the Board.
- ~~(b) A licensee (or registrant?) providing services via telehealth shall exercise the same standard of care when providing services via telehealth as with any other mode of delivery of services.~~
- ~~(b) All psychotherapy services offered by board licensees and registrants via telehealth fall within the jurisdiction of the board just as traditional face-to-face services do. Therefore, all psychotherapy services offered via telehealth are subject to the board's statutes and regulations.~~
- (c) A licensee ~~or registrant~~ shall obtain informed consent from the ~~patient or~~ client prior to the delivery of services via telehealth consistent with Section 2290.5 of the Code.
- (d) Prior to the delivery of services via telehealth, the licensee ~~or registrant~~ shall do the following:
- a. Determine whether an in-person evaluation is necessary. If it is determined that an in-person evaluation is necessary, an on-site licensee ~~or registrant~~ shall provide an evaluation.
 - b. Determine whether an in-person intervention is necessary. If it is determined that an in-person intervention is necessary, an on-site licensee ~~or registrant~~ shall provide the appropriate intervention.
- (e) In making a determination whether an in-person evaluation or an in-person intervention is necessary, a licensee ~~or registrant~~ shall consider the following:
- a. The complexity of the ~~patient or~~ client's condition;
 - b. His or her own knowledge, skills, and abilities;
 - c. The nature and complexity of the intervention;

- d. The ~~patient or~~ client's context and environment.
- (f) A licensee ~~or registrant~~ shall ~~take steps to~~ ensure the confidentiality of all telehealth services provided to the ~~patient or~~ client according to industry best practices related to client confidentiality. ~~This includes, but is not limited to, utilizing encryption security for the delivery of services.~~
- (g) When performing services via telehealth, a licensee ~~or registrant~~ shall inform the ~~patient or~~ client of the potential risks of receiving treatment via telehealth, including the following:
- a. Issues of confidentiality;
 - b. Clinical limitations;
 - c. The possibility of transmission difficulties; and
 - d. Ability to respond to emergencies.
- (h) A licensee ~~or registrant~~ providing services via telehealth shall provide the ~~patient or~~ client with the board's online license verification site, as well as his or her license or registration number and type.
- (i) A licensee ~~or registrant~~ providing services via telehealth shall provide the ~~patient or~~ client with specific written procedures to follow in an emergency situation. This shall include contact information for emergency services near the ~~patient or~~ client's home location.
- (j) A licensee ~~or registrant~~ providing services via telehealth shall ~~be familiar with~~ follow the mandated reporting requirements in the jurisdiction where the ~~patient or~~ client is located, and shall be prepared to refer the ~~patient or~~ client to local services in that jurisdiction, and to make a report to the appropriate local authorities in that jurisdiction.
- (k) A licensee ~~or registrant~~ shall ~~develop and follow written procedures for verifying~~ verify and document the identity of and the physical location of the ~~patient or~~ client prior to beginning each telehealth session. Examples of verification may include the use of code words or phrases.
- (l) A licensee ~~or registrant~~ of this state may only provide telehealth services to ~~patients or~~ clients located in another jurisdiction if they meet the requirements to lawfully provide services in that jurisdiction.
- (m) Failure to comply with these ~~regulations~~ provisions shall be considered unprofessional conduct.



October 17, 2014

VIA EMAIL

Rosanne Helms
Board of Behavioral Sciences
1625 N. Market Blvd., Suite S-200
Sacramento, CA 95834
Rosanne.Helms@dca.ca.gov

RE: Proposed Regulations on Telehealth

Dear Ms. Helms:

CAMFT would like to thank the Board of Behavioral Sciences (BBS) for giving thoughtful attention to this very important topic. We also would like to thank the BBS for allowing CAMFT to provide informal thoughts and concerns about the proposed regulations before it goes to the Board of Directors for formal consideration. In addition to the thoughts shared in this letter, CAMFT anticipates the open period for public comment on these proposed regulations and will provide more formal comments during that time. Our thoughts regarding the proposed regulations on telehealth are discussed below:

Adding "Registrants" to the proposed regulations

Since Registered Interns, as well as Trainees are currently allowed to gain up to 375 hours toward licensure, CAMFT proposes both Interns and Trainees be permitted to provide telehealth services. Registered Interns and Trainees are also commonly found working in rural areas where in-person mental health counseling services are difficult to obtain. Giving Registered Interns and Trainees who are under proper supervision the ability to provide services via telehealth would ensure individuals who are in need of mental health services receive the necessary care.

Section 1815.5(d)

Such language is unnecessary, because a clinician is expected to determine, in the exercise of his or her professional judgment, whether the treatment being considered is clinically appropriate for his or her patient. The fact that telehealth is involved does not, in itself, necessitate a regulation which reminds therapists of the need to evaluate the patient and consider whether a particular treatment modality may or may not be appropriate for that person. The proposed language concerns clinical decisions that should be left to the judgment of the therapist, based upon his or her impression of the individual's needs at the time in question.

In addition, the proposed language suggests a therapist must determine whether an in- person evaluation is necessary, prior to offering any services to his or her patient via telehealth. Such

language is inflexible and interferes with the ability of a clinician to exercise his or her clinical judgment. In some instances, a therapist may consider it appropriate, or necessary, to begin to provide telehealth to a patient, while continuing to evaluate whether that person may be better served by a face-to-face contact. The therapist must be free to exercise his or her professional judgment under the circumstances, and to develop, or amend, the elements of his or her patient's treatment plan, based upon the information that is then-available to the therapist.

Section 1815.5(e)

This proposed regulatory language is too prescriptive and attempts to define a clinical standard by delineating the specific areas of content a therapist must consider in the process of conducting a clinical assessment of his or her patient or client. The proposed language concerns clinical decisions that should be left to the judgment of the therapist, based upon his or her impression of the patient's needs at the time in question. We are concerned the regulations attempts to dictate the manner in which a therapist exercises his or her clinical judgment, or, which prescribes how the therapist should construct a treatment plan for his or her patient. The therapist must be free to exercise his or her professional judgment under the circumstances, and to develop, or amend, the elements of a treatment plan, based upon the information that is then-available concerning the patient.

Section 1815.5(f)

Therapists are currently required to take steps to reasonably maintain confidentiality of patient information in accordance with state and HIPPA laws. Furthermore, CAMFT members must abide by CAMFT's Code of Ethics, which also addresses confidentiality standards. We are concerned the proposed language places an extra burden on therapists providing telehealth services since state and HIPPA laws do not currently require encryption security for electronic transmission of clinical information. Also, the term "encryption security" is vague. Therapists may not know what "encryption security" program/software is sufficient.

Section 1815.5(g)

We agree therapists should inform patients of the potential risks associated with providing telehealth services, such as issues of confidentiality, clinical limitations, and the ability to respond to emergencies. However, the term "transmission difficulties" is vague. How could therapists be expected to inform patients of *all* potential transmission difficulties associated with the technology used for telehealth?

Section 1815.5(h)

Licenses are currently required to disclose their license number in public communications pertaining to professional services. Registrants and Trainees have to disclose their unlicensed status and registration numbers in public communications, as well as prior to rendering services. The fact that telehealth is involved does not, in itself, generate a particular need to inform the patient of the BBS's online license verification site. The patient may or may not, have an interest in verifying the therapist's licensure/registration status. The location of the therapy has no bearing on the ability of a patient to locate the desired information. Should a therapist be asked for such information, the therapist would be expected to assist the individual, regardless of the mode of treatment or the location of his or her patient.

Section 1815.5(i)

The proposed language is unnecessarily burdensome. It is possible an emergency may arise when working with any patient, regardless of whether the person is being treated in the therapist's office, or via telehealth. The therapist should be given discretion to use his or her professional judgment consistent with the applicable standard of care, to determine whether there is a need for emergency procedures, or, if it is necessary to identify particular resources in the vicinity of the patient.

Section 1815.5(j)

We are concerned about the broad scope of the proposed language. What is the intent behind requiring verification of the identity of the patient prior to beginning telehealth services? There is little reason to believe telehealth patients are likely to misrepresent their identities to a therapist. The fact that services are being provided via telehealth does not make this issue any different than it would be with a patient in the therapist's office. In an office setting, if the patient elected to use his or her health insurance, the therapist would expect the patient to provide the identifying information from the patient's insurance policy. The therapist would not, as a general rule, ask the patient for any additional identification. Similarly, if the patient was paying out-of-pocket for services, the therapist would not ordinarily ask him or her for "proof" of his or her identity, and doing-so would be inappropriate.

Section 1815.6

We are concerned the proposed language does not take into account situations where a patient is in another location temporarily due to vacation, work, or for any other reason. Further, there are situations where a patient moves out of the state but may be in need of one or more supportive, transitional therapeutic contacts while he or she locates a new source of help. We believe it is reasonable for therapists to be expected to diligently investigate the requirements to lawfully provide therapeutic services in the jurisdiction in question and to facilitate a referral in a timely manner when necessary.

Thank you for your consideration of our thoughts on the proposed regulations regarding telehealth. If you have any questions about our thoughts, please do not hesitate to contact us.

Sincerely,



Michael Griffin, J.D., LCSW
Staff Attorney



Jill Epstein, J.D.
Executive Director

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Attachment C
Business and Professions Code Section 2290.5 – Telehealth

§2290.5.

(a) For purposes of this division, the following definitions shall apply:

(1) “Asynchronous store and forward” means the transmission of a patient’s medical information from an originating site to the health care provider at a distant site without the presence of the patient.

(2) “Distant site” means a site where a health care provider who provides health care services is located while providing these services via a telecommunications system.

(3) “Health care provider” means a person who is licensed under this division.

(4) “Originating site” means a site where a patient is located at the time health care services are provided via a telecommunications system or where the asynchronous store and forward service originates.

(5) “Synchronous interaction” means a real-time interaction between a patient and a health care provider located at a distant site.

(6) “Telehealth” means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient’s health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

(b) Prior to the delivery of health care via telehealth, the health care provider initiating the use of telehealth shall inform the patient about the use of telehealth and obtain verbal or written consent from the patient for the use of telehealth as an acceptable mode of delivering health care services and public health. The consent shall be documented.

(c) Nothing in this section shall preclude a patient from receiving in-person health care delivery services during a specified course of health care and treatment after agreeing to receive services via telehealth.

(d) The failure of a health care provider to comply with this section shall constitute unprofessional conduct. Section 2314 shall not apply to this section.

(e) This section shall not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law.

(f) All laws regarding the confidentiality of health care information and a patient’s rights to his or her medical information shall apply to telehealth interactions.

(g) This section shall not apply to a patient under the jurisdiction of the Department of Corrections and Rehabilitation or any other correctional facility.

(h) (1) Notwithstanding any other provision of law and for purposes of this section, the governing body of the hospital whose patients are receiving the telehealth services may grant privileges to, and verify and approve credentials for, providers of telehealth services based on its medical staff recommendations that rely on information provided by the distant-site hospital or telehealth entity, as described in Sections 482.12, 482.22, and 485.616 of Title 42 of the Code of Federal Regulations.

(2) By enacting this subdivision, it is the intent of the Legislature to authorize a hospital to grant privileges to, and verify and approve credentials for, providers of telehealth services as described in paragraph (1).

(3) For the purposes of this subdivision, "telehealth" shall include "telemedicine" as the term is referenced in Sections 482.12, 482.22, and 485.616 of Title 42 of the Code of Federal Regulations.

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www.bbs.ca.gov

To: Committee Members

Date: January 21, 2015

From: Rosanne Helms
Legislative Analyst

Telephone: (916) 574-7897

Subject: Supervision via Telehealth

Background

The Board's statutes currently only allow supervision via videoconferencing if the intern or associate is working in an exempt setting (Business and Professions Code (BPC) §§4980.43, 4996.23, and 4999.46).

As the use of telehealth in therapy becomes more common, the Board is increasingly being asked to consider allowing supervision via telehealth in all settings. Proponents of such an allowance reason that this would increase the availability of supervision in rural settings, which often have supervisor shortages. This would increase access to care in such areas.

Supervision via Telehealth in Other States

Last summer, staff conducted a survey of 10 other states to examine their supervised experience requirements. Two of the states examined explicitly allowed some supervision via telehealth:

1. Texas

- LMFT applicants may obtain a maximum of 50 hours of supervision via telephone or electronic media (Out of a total of 200 supervision hours required).
- LPCC applicants may obtain up to 50 percent of their required supervision via live internet webcam.

2. Oregon

LMFT and LPCC applicants may obtain up to 75 percent of their required individual supervision hours via electronic communication.

Recommendation

Conduct an open discussion about the advantages and disadvantages of allowing supervision via telehealth, and discuss which electronic media would be acceptable.

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To: Committee Members

Date: January 21, 2015

From: Rosanne Helms
Legislative Analyst

Telephone: (916) 574-7897

Subject: AB 1629 Update

Background

AB 1629 (Chapter 535, Statutes of 2014) makes costs incurred for certain services provided by violence peer counselors reimbursable to crime victims through the California Victim Compensation Board. It was signed into law by the Governor in late September, and became effective on January 1, 2015.

This bill was amended late in last year's legislative session to require a violence peer counselor to be supervised by a Board licensee in order to be eligible for reimbursable services. The Board was supportive of the concept of the bill, and indicated that requiring violence peer counselors to be supervised by Board licensees was a step in the right direction to achieve public protection. However, the Board had several concerns about the bill's language. At its August 28, 2014 meeting, the Board took an "oppose unless amended" position on the bill, citing the following concerns:

- 1. Scope of Practice:** Board members voiced concerns that violence peer counselors may not have enough education or experience to know where their scope of practice ends, making it possible that they may unknowingly perform unlicensed practice.
- 2. Liability of Board Licensees:** The language, as written, contains very broad language defining the types of counseling that a peer counselor may perform, and the setting it may be performed in. This could mislead a board licensee who is supervising a violence peer counselor, into believing that his or her supervisee does not need to be licensed or registered, even if providing clinical services. However, in a non-exempt setting, this would be grounds for both the supervisor and supervisee to receive disciplinary action for violating the Board's licensing law.
- 3. Supervision Requirements:** The Board asked whether licensees supervising violence peer counselors should be required to have some education and experience providing supervision.
- 4. Cost to Service Organizations for Victims of Violent Crime:** Questions were raised about the cost to service organizations for victims of violent crime to employ a Board licensee as a supervisor.
- 5. LEPs as Supervisors:** The language includes LEPs as acceptable supervisors for violence peer counselors; however, LEPs do not typically perform clinical supervision services.

Upon learning of the Board's concerns, the author's office attempted to make amendments to address some of the concerns, but it was too late in the legislative session to do so. Therefore, they have committed to making clarifying amendments in this year's legislative session. They have worked with Legislative Counsel to draft amendments, which they have provided for the Committee's review (**Attachment A**). The proposed language is drafted as an urgency measure, meaning it would become effective immediately upon signature by the Governor.

Unclear Language

While several of the underlying issues raised by the Board are important topics, some of those issues may be best resolved with future legislation or in the Board's upcoming exempt setting committee. From conversations with the author's office, staff believes it is most likely that they will agree to amending language which is unclear about violence peer counselors' practice scope and settings.

The following language is of particular concern:

- Government Code (GC) §13957.9(c)(1) defines a "service organization for victims of violent crime" as a nongovernmental organization. (This implies it could be a private practice setting).
- GC §13957.9(c)(3) defines a "violence peer counselor" as a provider of formal or informal counseling services. (It is unclear if "formal" counseling services would rise to a clinical level where a license is needed.)

Proposed Amendments

Currently, the proposed amendments drafted by Legislative Counsel, and provided by the author's office clarify the following:

- A "service organization for victims of violent crime" in which violence peer counselors perform services eligible for reimbursement must be both nonprofit and charitable.
- Violence peer counseling services that fall under the scope of practice of any of the professions the Board regulates must either take place in an exempt setting, or be performed by an appropriately licensed professions.

Recommendation

Conduct an open discussion regarding the proposed amendments.

Attachments

Attachment A: Proposed Amendments from Legislative Counsel to Address Board Concerns

Attachment B: AB 1629 Board Analysis

Attachment C: AB 1629 Chaptered Language (effective January 1, 2015)

**OFFICE OF LEGISLATIVE COUNSEL
DRAFT BILL**

RN: 1425268

This request was prepared for you in accordance with instructions provided to us by Amy Alley.

LCB Deputy Contact:Ms. Amanda Mattson at 341-8352.

The boxes checked below, if any, apply to this request:

- Cover letter:** This request is accompanied by a cover letter, to bring to your attention legal or practical issues that may be raised by this bill, if introduced.
- Unbacked bill:** The attached bill draft has **not** been backed for introduction. When a Member has decided to introduce this bill draft, the draft should be returned to the Office of Legislative Counsel as soon as possible so that it can be prepared for introduction by that Member.
- Spot bill:** This bill, if introduced, may not be qualified for referral to a committee, if it is deemed a bill that makes no substantive change in or addition to existing law, or that would not otherwise affect the ongoing operations of state or local government (see, for example, Assembly Rule 51.5).
- Bill related to the budget:** In order for this measure to be deemed a bill “providing for appropriations related to the budget” within the meaning of Section 12 of Article IV of the California Constitution, thereby allowing the measure to be passed by a majority vote and to take effect immediately upon enactment, it is necessary that this measure contain an appropriation and be identified in the Budget Bill as a measure related to the state budget.
- Reintroduced bill:** This bill, if introduced, may violate the rule that, except as specified, a Member may not author a bill during a session that would have substantially the same effect as a bill he or she previously introduced during that session (Joint Rule 54(c)).

An act to amend Section 13957.9 of the Government Code, relating to crime victims, and declaring the urgency thereof, to take effect immediately.



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THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 13957.9 of the Government Code, as added by Section 1 of Chapter 535 of the Statutes of 2014, is amended to read:

13957.9. (a) In addition to the authorization provided in Section 13957 and subject to the limitations set forth in Section 13957.2, the board may grant for pecuniary loss, when the board determines it will best aid the person seeking compensation, reimbursement of the amount of outpatient psychiatric, psychological, or other mental health counseling-related expenses incurred by the victim or derivative victim, including peer counseling services provided by violence peer counseling services provided by a service organization for victims of violent crime, and including family psychiatric, psychological, or mental health counseling for the successful treatment of the victim provided to family members of the victim in the presence of the victim, whether or not the family member relationship existed at the time of the crime, that became necessary as a direct result of the crime, subject to the following conditions:

(1) The following persons may be reimbursed for the expense of their outpatient mental health counseling in an amount not to exceed ten thousand dollars (\$10,000):

(A) A victim.

(B) A derivative victim who is the surviving parent, sibling, child, spouse, fiancé, or fiancée of a victim of a crime that directly resulted in the death of the victim.

(C) A derivative victim, as described in paragraphs (1) to (4), inclusive, of subdivision (c) of Section 13955, who is the primary caretaker of a minor victim whose claim is not denied or reduced pursuant to Section 13956 in a total amount not to exceed ten thousand dollars (\$10,000) for not more than two derivative victims.



(2) The following persons may be reimbursed for the expense of their outpatient mental health counseling in an amount not to exceed five thousand dollars (\$5,000):

(A) A derivative victim not eligible for reimbursement pursuant to paragraph (1), provided that mental health counseling of a derivative victim described in paragraph (5) of subdivision (c) of Section 13955, shall be reimbursed only if that counseling is necessary for the treatment of the victim.

(B) A victim of a crime of unlawful sexual intercourse with a minor committed in violation of subdivision (d) of Section 261.5 of the Penal Code. A derivative victim of a crime committed in violation of subdivision (d) of Section 261.5 of the Penal Code shall not be eligible for reimbursement of mental health counseling expenses.

(C) A minor who suffers emotional injury as a direct result of witnessing a violent crime and who is not eligible for reimbursement of the costs of outpatient mental health counseling under any other provision of this chapter. To be eligible for reimbursement under this clause, the minor must have been in close proximity to the victim when he or she witnessed the crime.

(3) The board may reimburse a victim or derivative victim for outpatient mental health counseling in excess of that authorized by paragraph (1) or (2) or for inpatient psychiatric, psychological, or other mental health counseling if the claim is based on dire or exceptional circumstances that require more extensive treatment, as approved by the board.

(4) Expenses for psychiatric, psychological, or other mental health counseling-related services may be reimbursed only if the services were provided by either of the following individuals:



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(A) A person who would have been authorized to provide those services pursuant to former Article 1 (commencing with Section 13959) as it read on January 1, 2002.

(B) A person who is licensed by the state to provide those services, or who is properly supervised by a person who is so licensed, subject to the board's approval and subject to the limitations and restrictions the board may impose.

(b) The total award to or on behalf of each victim or derivative victim may not exceed thirty-five thousand dollars (\$35,000), except that this amount may be increased to seventy thousand dollars (\$70,000) if federal funds for that increase are available.

(c) For the purposes of this section, the following definitions shall apply:

(1) "Service organization for victims of violent crime" means a ~~nongovernmental~~ nonprofit and charitable organization that meets both of the following criteria:

(A) Its primary mission is to provide services to victims of violent crime.

(B) It provides programs or services to victims of violent crime and their families, and other programs, whether or not a similar program exists in an agency that provides additional services.

(2) "Violence peer counseling services" means counseling by a violence peer counselor for the purpose of rendering advice or assistance for victims of violent crime and their families. Any violence peer counseling services that fall under the scope of practice of the Licensed Marriage and Family Therapist Act (Chapter 13 (commencing with Section 4980), the Educational Psychologist Practice Act (Chapter 13.5 (commencing with Section 4989.10), the Clinical Social Worker Practice Act (Chapter 14 (commencing with Section 4991), and the Licensed Professional Clinical Counselor Act (Chapter 16 (commencing with Section 4999.10) of Division 2 of the Business



and Professions Code, which are not performed in an exempt setting as defined in Sections 4980.01, 4996.14, and 4999.22 of the Business and Professions Code, shall only be performed by a licensee or a registrant of the Board of Behavioral Sciences or other appropriately licensed professional, such as a licensed psychologist or board certified psychiatrist.

(3) “Violence peer counselor” means a provider of formal or informal counseling services who is employed by a service organization for victims of violent crime, whether financially compensated or not, and who meets all of the following requirements:

(A) Possesses at least six months of full-time equivalent experience in providing peer support services acquired through employment, volunteer work, or as part of an internship experience.

(B) Completed a training program aimed at preparing an individual who was once a mental health services consumer to use his or her life experience with mental health treatment, combined with other strengths and skills, to promote the mental health recovery of other mental health services consumers who are in need of peer-based services relating to recovery as a victim of a violent crime.

(C) Possesses 40 hours of training on all of the following:

(i) The profound neurological, biological, psychological, and social effects of trauma and violence.

(ii) Peace-building and violence prevention strategies, including, but not limited to, conflict mediation and retaliation prevention related to gangs and gang-related violence.



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(iii) Post-traumatic stress disorder and vicarious trauma, especially as related to gangs and gang-related violence.

(iv) Case management practices, including, but not limited to, ethics and victim compensation advocacy.

(D) When providing violence peer counseling services, is supervised by a marriage and family therapist licensed pursuant to Chapter 13 (commencing with Section 4980) of Division 2 of the Business and Professions Code, a licensed educational psychologist licensed pursuant to Chapter 13.5 (commencing with Section 4989.10) of Division 2 of the Business and Professions Code, a clinical social worker licensed pursuant to Chapter 14 (commencing with Section 4991) of Division 2 of the Business and Professions Code, or a licensed professional clinical counselor licensed pursuant to Chapter 16 (commencing with Section 4999.10) of Division 2 of the Business and Professions Code. For the purposes of this subparagraph, a licensed marriage and family therapist, licensed educational psychologist, licensed clinical social worker, or licensed professional clinical counselor shall be employed by the same service organization as the violence peer counselor.

(d) This section shall remain in effect only until January 1, 2017, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2017, deletes or extends that date.

SEC. 2. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:



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In order to ensure that an unlicensed violence peer counselor is not practicing outside of his or her scope of practice, it is necessary for this act to take effect immediately.

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LEGISLATIVE COUNSEL'S DIGEST

Bill No.

as introduced, _____.

General Subject: Crime victims: reimbursement of violence peer counseling expenses.

Existing law provides for the compensation of victims and derivative victims of specified types of crimes by the California Victim Compensation and Government Claims Board from the Restitution Fund, a continuously appropriated fund, for specified losses suffered as a result of those crimes. Existing law sets forth eligibility requirements and specified limits on the amount of compensation the board may award. Existing law, effective January 1, 2015, authorizes the board to reimburse a crime victim or derivative victim for the amount of outpatient violence peer counseling-related expenses incurred by the victim or derivative victim from, among others, a service organization for victims of violent crime, as specified.

This bill would specify that a service organization for victims of violent crime is a nonprofit and charitable organization instead of a nongovernmental organization. The bill would also require that any peer counseling services that fall under the scope



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of practice of certain acts, including the Clinical Social Worker Practice Act, be performed by a licensee or a registrant of the Board of Behavioral Sciences or other appropriately licensed professional unless in an exempt setting.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: 2/3. Appropriation: no. Fiscal committee: no. State-mandated local program: no.



14252680528BILL

CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES

BILL ANALYSIS

BILL NUMBER: AB 1629 **VERSION:** AMENDED AUGUST 21, 2014

AUTHOR: BONTA **SPONSOR:** YOUTH ALIVE

BOARD POSITION: OPPOSE UNLESS AMENDED

SUBJECT: CRIME VICTIMS: COMPENSATION: REIMBURSEMENT OF VIOLENCE PEER
COUNSELING EXPENSES

Overview: This bill would make costs incurred for certain services provided by violence peer counselors reimbursable to crime victims through the California Victim Compensation Board.

Existing Law:

- 1) Sets forth a procedure for the state to assist crime victims in obtaining compensation for certain losses suffered as a direct result of a criminal act. (Government Code (GC) §13950)
- 2) Defines “peer counseling” as counseling offered by a provider of mental health counseling services who does the following (GC §13951(f)):
 - a. Has completed a course in rape crisis counseling skills development;
 - b. Participates in continuing education in rape crisis counseling skills development; and
 - c. Provides rape crisis counseling in California.
- 3) Permits the California Victim Compensation and Government Claims Board (CA Victim Compensation Board) to reimburse certain medical, outpatient psychiatric, psychological, or other mental-health counseling-related expenses incurred by a crime victim. This includes peer counseling services provided by a rape crisis center. (GC §13957(a))
- 4) Allows psychiatric, psychological, or other mental health counseling services to be reimbursed only if the services were provided as follows (GC §13957(a)):
 - a. By a person who was authorized to provide the services pursuant to GC §13959 as it read on January 1, 2002;
 - b. By a person licensed by the state to provide the services; or
 - c. By a person properly supervised by a licensed person.
- 5) States that payments by the CA Victim Compensation Board for peer counseling provided by a rape crisis center may not exceed \$15 per hour of service. (GC §13957.7(d))

This Bill:

- 1) Includes peer counseling services provided by a violence peer counselor at a service organization for victims of violent crime, as one of the services for which the California Victim Compensation Board is permitted to reimburse a victim. (GC §13957.9(a)(2))

- 2) Defines a “service organization for victims of violent crime” as a nongovernmental organization with a primary mission to provide services to victims of violent crime, and which provides such services to these victims and their families. (GC §13957.9(c)(1))
- 3) Defines “violence peer counseling services” as counseling by a violence peer counselor in order to render advice to a violent crime victim and his or her family. (GC §13957.9(c)(1)(2))
- 4) Defines a “violence peer counselor” as a provider of formal or informal counseling services who is employed by a service organization for victims of violent crime, whether or not they are financially compensated. The violence peer counselor must meet the following criteria: (GC §13957.9(c)(3))
 - a. Has at least six months full-time equivalent experience providing peer support services, acquired through employment, volunteering, or an internship;
 - b. Has completed a training program to prepare an individual who was once a mental health services consumer to use his or her life experience with mental health treatment to promote the mental health recovery of others who were victims of a violent crime;
 - c. Possess 40 hours of training in the following areas:
 - i. The neurological, biological, psychological, and social effects of trauma and violence;
 - ii. Peace-building and violence prevention strategies; and
 - iii. Post-traumatic stress disorder and vicarious trauma.
 - d. Requires a violence peer counselor to be supervised by a licensee of the Board of Behavioral Sciences when providing violence peer counseling services. The licensee must be employed by the same service organization as the violence peer counselor. (GC §13957.9(c)(3)(D))

Comment:

- 1) **Existing Law.** Under the Board’s current licensing law, a license is required to practice marriage and family therapy, educational psychology, clinical social work, and professional clinical counseling in this state. The only exception is for employees working in an exempt setting, which must be one of the following:
 - i. A governmental entity;
 - ii. A school, college, or university;
 - iii. An institution that is both nonprofit and charitable.
- 2) **Definition Unclear.** This bill defines a “violence peer counselor” who is eligible for reimbursement from the CA Victim Compensation Board as a provider of formal or informal counseling services, who is employed by a service organization for victims of violent crime. The violence peer counselor must have six months experience, complete specified training programs, and be supervised by a Board licensee.

This bill also defines a “service organization for victims of violent crime” as a nongovernmental organization with a primary mission of providing services to victims of violent crime, and which provides these services to both victims and their families.

Staff has two primary concerns with these definitions:

- a. The bill permits a “violence peer counselor” to receive reimbursement for providing formal or informal counseling services. This definition is very broad. The term “formal counseling services” is not defined. It is unclear whether formal counseling services would rise to the level of psychotherapy or clinical practice for which a Board license would be required. In addition, the education and experience required for a violence peer counselor does not come close to the education and experience required for an associate or intern registration for any of the Board’s license types.

If the formal counseling services do rise to the level where a license would be required, the language seems to create an exemption from licensure, permitting only a minimal amount of training and experience, as well as supervision by a Board licensee, in order to obtain reimbursement for practice.

- b. The definition of “service organization for victims of violent crime” is overly broad and does not specify that the service organization must be nonprofit and charitable. It simply states that it may be any nongovernmental organization that meets certain criteria. Under Board licensing law, psychotherapeutic or clinical services may only be performed by unlicensed practitioners if the entity is both nonprofit and charitable.

The consequences of the unclear language are twofold. First, it is misleading because it could imply to an unlicensed violence peer counselor that he or she may practice psychotherapy in a private practice setting without a license, even though that is a violation of the Board’s practice acts. Second, it could also mislead a Board licensee, who is supervising a violence peer counselor, into believing that his or her violence peer counselor supervisee does not need to be licensed or registered, even if they are in a non-exempt setting. If the violence peer counselor then provides clinical or psychotherapeutic services in a non-exempt setting, this would be grounds for the supervising licensee to receive disciplinary action for violating the Board’s licensing law.

- 3) Recommended Amendment.** Staff recommends that definitions of a “violence peer counselor,” “violence peer counseling services,” and “service organization for victims of violent crime” be amended to clarify that services falling under the scope of practice of the Board’s licensing acts, conducted in a non-exempt setting, require licensure or registration with the Board.
- 4) Board Position.** At its August 28, 2014 meeting, the Board took an “Oppose Unless Amended” position on this bill. The Board’s members were supportive of the concept of the bill. They also noted that the August 19, 2014 amendment requiring violence peer counselors to be supervised by the Board’s licensees has merit and is a step in the right direction to achieve public protection.

However, the Board was concerned that the addition of its licensees as supervisors raised a number of important questions, and that the language in this bill needs further vetting to avoid possible unintended consequences.

5) Support and Opposition.

Support:

- Youth Alive (sponsor)
- AFSCME
- California Catholic Conference
- California Equity Leaders Network
- California Pan-Ethnic Health Network
- Californians for Safety and Justice

- Children's Defense Fund-California
- City of Oakland
- Crime Victims United of California
- National Network of Hospital-based Violence Intervention Programs
- PolicyLink
- San Francisco Wraparound Project
- Wellspace Health

Opposition:

- Taxpayers for Improving Public Safety

6) History.

2014

09/25/14 Chaptered by Secretary of State - Chapter 535, Statutes of 2014.

09/25/14 Approved by the Governor.

09/10/14 Enrolled and presented to the Governor at 4 p.m.

08/28/14 Senate amendments concurred in. To Engrossing and Enrolling. (Ayes 79. Noes 0. Page 6628.).

08/28/14 Assembly Rule 77 suspended. (Page 6616.)

08/27/14 In Assembly. Concurrence in Senate amendments pending. May be considered on or after August 29 pursuant to Assembly Rule 77.

08/27/14 Read third time. Passed. Ordered to the Assembly. (Ayes 36. Noes 0. Page 4897.).

08/22/14 Read second time. Ordered to third reading.

08/21/14 Read third time and amended. Ordered to second reading.

08/19/14 Read second time and amended. Ordered to third reading.

08/18/14 From committee: Do pass as amended. (Ayes 5. Noes 0.) (August 14).

08/04/14 In committee: Placed on APPR. suspense file.

06/24/14 In committee: Set, first hearing. Hearing canceled at the request of author.

06/17/14 From committee: Do pass and re-refer to Com. on APPR. (Ayes 5. Noes 0.) (June 17). Re-referred to Com. on APPR.

06/05/14 Referred to Com. on PUB. S.

05/28/14 In Senate. Read first time. To Com. on RLS. for assignment.

05/28/14 Read third time. Passed. Ordered to the Senate. (Ayes 79. Noes 0. Page 5242.)

05/27/14 Read second time. Ordered to third reading.

05/23/14 Read second time and amended. Ordered to second reading.

05/23/14 From committee: Do pass as amended. (Ayes 17. Noes 0.) (May 23).

04/09/14 In committee: Set, first hearing. Referred to APPR. suspense file.

03/26/14 From committee: Do pass and re-refer to Com. on APPR. (Ayes 7. Noes 0.) (March 25). Re-referred to Com. on APPR.

02/20/14 Referred to Com. on PUB. S.

02/11/14 From printer. May be heard in committee March 13.

02/10/14 Read first time. To print.

Assembly Bill No. 1629

CHAPTER 535

An act to add and repeal Section 13957.9 of the Government Code, relating to crime victims, and making an appropriation therefor.

[Approved by Governor September 25, 2014. Filed with Secretary of State September 25, 2014.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1629, Bonta. Crime victims: compensation: reimbursement of violence peer counseling expenses.

Existing law provides for the compensation of victims and derivative victims of specified types of crimes by the California Victim Compensation and Government Claims Board from the Restitution Fund, a continuously appropriated fund, for specified losses suffered as a result of those crimes. Existing law sets forth eligibility requirements and specified limits on the amount of compensation the board may award. Existing law authorizes the board to reimburse a crime victim or derivative victim for the amount of outpatient mental health counseling-related expenses incurred by the victim or derivative victim, including peer counseling services provided by a rape crisis center, as specified.

This bill would additionally, until January 1, 2017, authorize the board to reimburse a crime victim or derivative victim for the amount of outpatient violence peer counseling-related expenses incurred by the victim or derivative victim, as specified. By expanding the authorization for the use of moneys in a continuously appropriated fund, this bill would make an appropriation.

Appropriation: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 13957.9 is added to the Government Code, to read:
13957.9. (a) In addition to the authorization provided in Section 13957 and subject to the limitations set forth in Section 13957.2, the board may grant for pecuniary loss, when the board determines it will best aid the person seeking compensation, reimbursement of the amount of outpatient psychiatric, psychological, or other mental health counseling-related expenses incurred by the victim or derivative victim, including peer counseling services provided by violence peer counseling services provided by a service organization for victims of violent crime, and including family psychiatric, psychological, or mental health counseling for the successful treatment of the victim provided to family members of the victim in the

presence of the victim, whether or not the family member relationship existed at the time of the crime, that became necessary as a direct result of the crime, subject to the following conditions:

(1) The following persons may be reimbursed for the expense of their outpatient mental health counseling in an amount not to exceed ten thousand dollars (\$10,000):

(A) A victim.

(B) A derivative victim who is the surviving parent, sibling, child, spouse, fiancé, or fiancée of a victim of a crime that directly resulted in the death of the victim.

(C) A derivative victim, as described in paragraphs (1) to (4), inclusive, of subdivision (c) of Section 13955, who is the primary caretaker of a minor victim whose claim is not denied or reduced pursuant to Section 13956 in a total amount not to exceed ten thousand dollars (\$10,000) for not more than two derivative victims.

(2) The following persons may be reimbursed for the expense of their outpatient mental health counseling in an amount not to exceed five thousand dollars (\$5,000):

(A) A derivative victim not eligible for reimbursement pursuant to paragraph (1), provided that mental health counseling of a derivative victim described in paragraph (5) of subdivision (c) of Section 13955, shall be reimbursed only if that counseling is necessary for the treatment of the victim.

(B) A victim of a crime of unlawful sexual intercourse with a minor committed in violation of subdivision (d) of Section 261.5 of the Penal Code. A derivative victim of a crime committed in violation of subdivision (d) of Section 261.5 of the Penal Code shall not be eligible for reimbursement of mental health counseling expenses.

(C) A minor who suffers emotional injury as a direct result of witnessing a violent crime and who is not eligible for reimbursement of the costs of outpatient mental health counseling under any other provision of this chapter. To be eligible for reimbursement under this clause, the minor must have been in close proximity to the victim when he or she witnessed the crime.

(3) The board may reimburse a victim or derivative victim for outpatient mental health counseling in excess of that authorized by paragraph (1) or (2) or for inpatient psychiatric, psychological, or other mental health counseling if the claim is based on dire or exceptional circumstances that require more extensive treatment, as approved by the board.

(4) Expenses for psychiatric, psychological, or other mental health counseling-related services may be reimbursed only if the services were provided by either of the following individuals:

(A) A person who would have been authorized to provide those services pursuant to former Article 1 (commencing with Section 13959) as it read on January 1, 2002.

(B) A person who is licensed by the state to provide those services, or who is properly supervised by a person who is so licensed, subject to the

board's approval and subject to the limitations and restrictions the board may impose.

(b) The total award to or on behalf of each victim or derivative victim may not exceed thirty-five thousand dollars (\$35,000), except that this amount may be increased to seventy thousand dollars (\$70,000) if federal funds for that increase are available.

(c) For the purposes of this section, the following definitions shall apply:

(1) "Service organization for victims of violent crime" means a nongovernmental organization that meets both of the following criteria:

(A) Its primary mission is to provide services to victims of violent crime.

(B) It provides programs or services to victims of violent crime and their families, and other programs, whether or not a similar program exists in an agency that provides additional services.

(2) "Violence peer counseling services" means counseling by a violence peer counselor for the purpose of rendering advice or assistance for victims of violent crime and their families.

(3) "Violence peer counselor" means a provider of formal or informal counseling services who is employed by a service organization for victims of violent crime, whether financially compensated or not, and who meets all of the following requirements:

(A) Possesses at least six months of full-time equivalent experience in providing peer support services acquired through employment, volunteer work, or as part of an internship experience.

(B) Completed a training program aimed at preparing an individual who was once a mental health services consumer to use his or her life experience with mental health treatment, combined with other strengths and skills, to promote the mental health recovery of other mental health services consumers who are in need of peer-based services relating to recovery as a victim of a violent crime.

(C) Possesses 40 hours of training on all of the following:

(i) The profound neurological, biological, psychological, and social effects of trauma and violence.

(ii) Peace-building and violence prevention strategies, including, but not limited to, conflict mediation and retaliation prevention related to gangs and gang-related violence.

(iii) Post-traumatic stress disorder and vicarious trauma, especially as related to gangs and gang-related violence.

(iv) Case management practices, including, but not limited to, ethics and victim compensation advocacy.

(D) When providing violence peer counseling services, is supervised by a marriage and family therapist licensed pursuant to Chapter 13 (commencing with Section 4980) of Division 2 of the Business and Professions Code, a licensed educational psychologist licensed pursuant to Chapter 13.5 (commencing with Section 4989.10) of Division 2 of the Business and Professions Code, a clinical social worker licensed pursuant to Chapter 14 (commencing with Section 4991) of Division 2 of the Business and Professions Code, or a licensed professional clinical counselor licensed

pursuant to Chapter 16 (commencing with Section 4999.10) of Division 2 of the Business and Professions Code. For the purposes of this subparagraph, a licensed marriage and family therapist, licensed educational psychologist, licensed clinical social worker, or licensed professional clinical counselor shall be employed by the same service organization as the violence peer counselor.

(d) This section shall remain in effect only until January 1, 2017, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2017, deletes or extends that date.

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To: Committee Members
Date: January 21, 2015
From: Rosanne Helms
Legislative Analyst
Telephone: (916) 574-7897
Subject: Update on Suicide Prevention Training for Mental Health Professionals

Background

AB 2198 (Levine, 2014) proposed requiring Board licensees to complete a six-hour training course in suicide assessment, treatment, and management. It also proposed requiring new applicants graduating after January 1, 2016 to take a 15-hour course on the subject.

This bill was prompted by the author's desire to ensure mental health professionals have concentrated training in suicide assessment, treatment, and management. Several organizations, including the U.S. Department of Human Services and the Institute of Medicine, have indicated a need for improved education and training in suicide assessment.

There is currently no requirement in law that Board licensees have specific coursework devoted to suicide assessment in his or her degree. According to schools and stakeholders, this content is interwoven throughout the degree programs.

Citing a need for further discussion and information from experts on the topic, the Board took an "oppose unless amended" position on AB 2198 and asked that it be amended to form a task force on the subject.

The Governor vetoed AB 2198 last fall, and in his veto message asked the licensing boards to evaluate the issues raised by the bill and to take appropriate action as needed.

Survey of Master's Degree Programs

In an effort to gain specific information about the content suicide assessment training currently being offered in degree programs leading to Board licensure, staff created a survey. The survey asks the Master's degree programs to do the following:

- Name the required courses in its program covering suicide assessment;
- Estimate the number of hours each course spends on the topic; and
- Provide a description of the type of suicide assessment coverage for each course.

The survey was sent to the Board's contacts at degree programs leading to Board licensure in late November. Staff is still in the process of receiving responses. Responses that have been returned are summarized in **Attachment A**.

Governor's Office Meeting

In mid-January, Board staff, as well as staff from the Board of Psychology and the Medical Board was asked to meet with the Governor's office. The Governor is anticipating a similar bill authored by Assemblymember Levine this year, and is seeking additional information and potential solutions. The attending boards were asked to continue to pursue survey data and to work to develop a menu of options to address the issues raised by AB 2198.

Recommendation

Conduct an open discussion of the issues raised by AB 2198 and the survey results to determine what further action is needed.

Attachments

Attachment A: Survey Results: Schools' Coverage of Suicide Assessment, Treatment, and Management

Attachment B: AB 2198 Text

Attachment A
BBS Master's Degree Programs Survey Results
Coverage of Suicide Assessment, Treatment, and Management

Required Courses in Degree Covering Topic	Units or Hours Courses Spend on Topic	Topic Areas Covered	Additional Elective Courses (Not Required)
Alliant International University - Couple and Family Therapy Program [1]			
PSY 6310 Law & Ethics	3 hours	Patient rights and responsibilities when patient is danger to self. Voluntary and involuntary hospitalization (5150 holds).	
PSY 6325 Crisis & Trauma	3 hours	Principles & processes of crisis intervention and treatment. Clinical management and treatment of suicidality.	
PSY 6322 MFT Theory and Technique II	2 hours	Clinical assessment of suicidality.	
PSY 6323 MFT Theory and Technique II Lab	2 hours	Students role-play to practice skills at clinical assessment and intervention in suicide.	
PSY 6360 Preparation for Community Practice	3 hours	Community resources for suicidal clients.	
PSY 7314 MFT Assessment	2 hours	Assessment instruments for depression and suicide risk.	
CSU Fullerton - Clinical Psychology Program			
501 - Professional & Legal Issues	3 hours	Duty to warn and danger to self.	
561 - Advanced Psychological Assessment	1.5 hours	Assessment of suicide risk.	
545 - Advanced Psychopathology	.5 hours	General assessment and hospitalization.	
549 - Marriage, Family, and Child Therapy	2-3 hours	Topic addressed generally in this course in the context of addiction.	
CSU Northridge - MS in Counseling - MFT [1]			
659B - Practicum	Approx. 3 hours	These courses cover examples, case studies, intervention techniques, and warning signs.	
672 - Diagnosis	Approx. 3 hours		
Fuller Theological Seminary - Master of Science in Marital and Family Therapy			
FT 530B Clinical Foundations II	3.5 hours	The use of anti-depressants and their risk of suicidal tendencies in consumers.	
FT 522 Assessment of Individuals/Couples/Families	2.5 hours		
FT 502 Legal & Ethical Issues in Family Practice	2 hours		
FT 549 Psychopharmacology	0.5 to 1 hour		
Phillips Graduate Institute - MA in Psychology, Emphasis Marriage and Family Therapy [2]			
PSY 520A Abnormal Psychology	2 unit course	Suicidal gestures, self harming behavior, and aggression. Crisis intervention and other levels of counseling intervention are discussed.	
PSY 503 Developmental Psychology	3 unit course	Suicide risk covered with developmental issues.	
PSY 539 Legal, Ethical, & Professional Issues	3 unit course	Managing confidentiality when clients are dangerous to themselves.	
PSY 531A and 531B Applied Therapeutic Methodology	1 unit each	Common clinical emergencies, including assessment and treatment of suicidality and self-harm.	
PSY 533A and 533B Practicum	2 units each	Case discussions, which usually involve experience with crisis situation such as suicide	
USC School of Social Work - Master of Social Work			
SOWK 543 Social Work Practice With Individuals	4 hours	assessing suicide across the lifespan. Suicide viewed from a micro, mezzo and macro level.	-SOWK 631 Advanced Theories and Clinical Interventions in Health Care (Approx. 1 hr. covering suicide ideation, assessment, & resources) -SOWK 612 Psychopathology and Diagnosis of Mental Disorders (Approx. 4 hrs.) -SOWK 615 Brief Therapy and Crisis Intervention (Approx. 4 hrs.) -SOWK 617 Substance Abuse w/ Consideration of Other Addictive Disorders (Approx. 4 hrs.) -SOWK 618 Systems of Recovery from Mental Illness in Adults (Approx. 4 hrs.) SOWK 645 Clinical Practice in Mental Health Settings (Approx. 4 hrs.)

[1] These programs note that the topic is covered in other elective courses as well, for example, suicidality in specific populations.

[2] This program also offers an emphasis in Art Therapy and School Counseling along with the Marriage and Family Therapy emphasis. All of these programs are required to complete the courses shown.

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AMENDED IN SENATE AUGUST 4, 2014

AMENDED IN ASSEMBLY APRIL 21, 2014

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL

No. 2198

Introduced by Assembly Member Levine

(Principal coauthor: *Senator* coauthors: *Senators Hill and Steinberg*)

February 20, 2014

An act to add Sections 2915.3, 2915.4, 4980.393, 4980.394, 4989.21, 4989.35, 4996.27, 4996.275, 4999.37, and 4999.77 to the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 2198, as amended, Levine. Mental health professionals: suicide prevention training.

Existing law provides for the licensure and regulation of various professionals who provide mental health-related services, including psychologists, marriage and family therapists, educational psychologists, professional clinical counselors, and clinical social workers. Under existing law, an applicant for licensure in these professions is required to complete certain coursework or training in order to be eligible for a license. Existing law also requires these professionals to participate in continuing education as a prerequisite for renewing their license.

This bill would require a psychologist, marriage and family therapist, educational psychologist, professional clinical counselor, and clinical social worker who began graduate study on or after January 1, 2016, to complete a minimum of 15 contact hours of coursework in suicide assessment, treatment, and management before he or she may be issued a license. The bill would also require, commencing January 1, 2016, a

person licensed in these professions *or any applicant for licensure* who began graduate study prior to January 1, 2016, to take a six-hour continuing education course in suicide assessment, treatment, and management in order to renew his or her license.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. Section 2915.3 is added to the Business and
2 Professions Code, to read:

3 2915.3. (a) Any applicant for licensure as a psychologist who
4 began graduate study on or after January 1, 2016, shall complete,
5 as a condition of licensure, a minimum of 15 contact hours of
6 coursework in suicide assessment, treatment, and management.

7 (b) The board shall not issue a license to the applicant until the
8 applicant has met the requirements of this section.

9 SEC. 2. Section 2915.4 is added to the Business and Professions
10 Code, to read:

11 2915.4. (a) A licensee *or any applicant for licensure* who
12 began graduate study prior to January 1, 2016, shall complete a
13 six-hour continuing education course in best practices for suicide
14 assessment, treatment, and management during his or her first
15 renewal period after the operative date of this section, and shall
16 submit to the board evidence acceptable to the board of the person's
17 satisfactory completion of that course.

18 (b) The board shall not issue a license to the applicant until the
19 applicant has met the requirements of this section.

20 (c) Continuing education courses taken pursuant to this section
21 shall be applied to the 36 hours of approved continuing education
22 required by Section 2915.

23 (d) This section shall become operative on January 1, 2016.

24 SEC. 3. Section 4980.393 is added to the Business and
25 Professions Code, immediately following Section 4980.39, to read:

26 4980.393. (a) An applicant for licensure who began graduate
27 study on or after January 1, 2016, and whose education qualifie
28 him or her under Section 4980.36 or ~~4980.37~~ 4980.37, shall
29 complete, as a condition of licensure, a minimum of 15 contact
30 hours of coursework in suicide assessment, treatment, and
31 management.

1 SEC. 4. Section 4980.394 is added to the Business and
2 Professions Code, to read:

3 4980.394. (a) A licensee *or any applicant for licensure* who
4 began graduate study before January 1, 2016, shall complete a
5 six-hour continuing education course in best practices for suicide
6 assessment, treatment, and management, during his or her first
7 renewal period after the operative date of this section and shall
8 submit to the board evidence, acceptable to the board, of the
9 person's satisfactory completion of the course.

10 (b) Continuing education courses taken pursuant to this section
11 shall be applied to the 36 hours of approved continuing education
12 required by Section 4980.54.

13 (c) This section shall become operative on January 1, 2016.

14 SEC. 5. Section 4989.21 is added to the Business and
15 Professions Code, to read:

16 4989.21. (a) Any applicant for licensure as an educational
17 psychologist who began graduate study on or after January 1, 2016,
18 shall complete, as a condition of licensure, a minimum of 15
19 contact hours of coursework in suicide assessment, treatment, and
20 management.

21 (b) The board shall not issue a license to the applicant until the
22 applicant has met the requirements of this section.

23 SEC. 6. Section 4989.35 is added to the Business and
24 Professions Code, to read:

25 4989.35. (a) A licensee *or any applicant for licensure* who
26 began graduate study before January 1, 2016, shall complete a
27 six-hour continuing education course in best practices for suicide
28 assessment, treatment, and management, during his or her first
29 renewal period after the operative date of this section and shall
30 submit to the board evidence, acceptable to the board, of the
31 person's satisfactory completion of the course.

32 (b) Continuing education courses taken pursuant to this section
33 shall be applied to the 36 hours of approved continuing education
34 required by Section 4989.34.

35 (c) This section shall become operative on January 1, 2016.

36 SEC. 7. Section 4996.27 is added to the Business and
37 Professions Code, immediately following Section 4996.26, to read:

38 4996.27. (a) Any applicant for licensure as a licensed clinical
39 social worker who began graduate study on or after January 1,
40 2016, shall complete, as a condition of licensure, a minimum of

1 15 contact hours of coursework in suicide assessment, treatment,
2 and management.

3 (b) The board shall not issue a license to the applicant until the
4 applicant has met the requirements of this section.

5 SEC. 8. Section 4996.275 is added to the Business and
6 Professions Code, immediately following Section 4996.27, to read:

7 4996.275. (a) A licensee *or any applicant for licensure* who
8 began graduate study prior to January 1, 2016, shall complete a
9 six-hour continuing education course in best practices for suicide
10 assessment, treatment, and management, during his or her first
11 renewal period after the operative date of this section, and shall
12 submit to the board evidence, acceptable to the board, of the
13 person’s satisfactory completion of the course.

14 (b) Continuing education courses taken pursuant to this section
15 shall be applied to the 36 hours of approved continuing education
16 required in Section 4996.22.

17 (c) This section shall become operative on January 1, 2016.

18 SEC. 9. Section 4999.37 is added to the Business and
19 Professions Code, to read:

20 4999.37. An applicant for examination eligibility or registration
21 who began graduate study on or after January 1, 2016, and whose
22 education qualifies him or her under Section 4999.32 ~~or 4999.33~~
23 4999.33, shall complete, as a condition of licensure, a minimum
24 of 15 contact hours of coursework in suicide assessment, treatment,
25 and management.

26 SEC. 10. Section 4999.77 is added to the Business and
27 Professions Code, to read:

28 4999.77. (a) A licensee *or any applicant for licensure* who
29 began graduate study prior to January 1, 2016, shall complete a
30 six-hour continuing education course in best practices for suicide
31 assessment, treatment, and management, during his or her first
32 renewal period after the operative date of this section, and shall
33 submit to the board evidence, acceptable to the board, of the
34 person’s satisfactory completion of the course.

35 (b) Continuing education courses taken pursuant to this section
36 shall be applied to the 36 hours of approved continuing education
37 required in Section 4999.76.

38 (c) This section shall become operative on January 1, 2016.

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To: Committee Members

Date: January 8, 2015

From: Rosanne Helms
Legislative Analyst

Telephone: (916) 574-7897

Subject: Legislative Update

Board staff is currently pursuing the following legislative proposals:

1. **Supervised Work Experience Requirements (No Bill Number Assigned at This Time)**

This bill streamlines the experience requirements for LMFT and LPCC applicants. It eliminates the complex assortment of minimum and maximum hours of differing types of experience required for licensure (also known as the “buckets” of experience) and instead requires 1,750 hours of the experience to be direct clinical counseling hours. The remaining required 1,250 hours may be non-clinical experience.

The bill also makes amendments to LCSW law to allow LCSW applicants to count some direct supervisor contact hours, as well as some hours spent attending workshops, trainings, conferences, and seminars, toward their required experience.

This bill proposal was approved by the Board at its November 20, 2014 meeting.

2. **Enforcement Process (No Bill Number Assigned at This Time)**

This bill makes two separate amendments to the law governing the enforcement process:

- a) It modifies the Board’s requirements for an individual to petition for a termination of probation or modification of penalty. Under the proposal, the Board may deny a petition without hearing if the petitioner is not in compliance with the terms of his or her probation.
- b) It clarifies that the Board has jurisdiction to investigate and take disciplinary action even if the status of a license or registration changes or if the license or registration expires.

The goal of these changes is to increase the efficiency of the enforcement process. This bill proposal was approved by the Board at its November 20, 2014 meeting.

3. **Omnibus Legislation (Senate Business, Professions, and Economic Development Committee) (No Bill Number Assigned at This Time)**

This bill proposal, approved by the Board at its November 20, 2014 meeting, makes minor, technical, and non-substantive amendments to add clarity and consistency to current licensing law.

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To: Committee Members
Date: January 14, 2015
From: Christy Berger
Regulatory Analyst
Telephone: (916) 574-7817
Subject: Rulemaking Update

APPROVED REGULATORY PROPOSALS

Continuing Education

The Continuing Education regulations have been finalized and are scheduled to take effect on the following dates:

- **Effective January 1, 2015:**
 1. The new regulations will officially become part of the Board's regulations
 2. An entity who would like to become recognized by the Board as an approval agency may submit documentation of compliance with the new requirements
 3. The board will cease accepting applications for board-approved CE providers
- **Effective July 1, 2015**

As of this date, all Board-approved CE providers will no longer be renewed. Board-approved providers with a current Board-approved CE provider number may continue to offer CE courses until their provider number expires. This means that the number of providers with Board approval will phase-out gradually, until the last expire on June 30, 2017.

CURRENT REGULATORY PROPOSALS

Disciplinary Guidelines and SB 1441: Uniform Standards for Substance Abuse: Amend Title 16, CCR Section 1888

This is a regulatory proposal that the Department of Consumer Affairs (DCA) and the state Legislature have asked all healing arts licensing boards to pursue. It creates uniform standards for discipline that the boards must follow in cases of licensee or registrant substance abuse. This proposal was prompted by a concern at the Legislature that there is a lack of a consistent policy across DCA's healing arts boards for handling cases that involve licensees or registrants who abuse drugs or alcohol.

Disciplinary Guidelines and SB 1441 (continued)

This proposal was initially approved by the Board at its meeting in November 2012. A revised proposal was approved by the Board in March 2014. The public comment period has ended, and the proposal has been submitted to DCA and the State and Consumer Services Agency (SCSA) for review. Once approved by these entities, staff will submit it to OAL for final approval.

Implementation of SB 704 (Examination Restructure): Amend Title 16, CCR Sections 1805, 1806, 1816, 1816.2, 1816.3, 1816.4, 1816.5, 1816.6, 1816.7, 1829, 1877; Add Sections 1805.01, 1822.5, 1822.6, 1830, 1878

This proposal would revise Board regulations for consistency with statutory changes made by SB 704¹, which restructures the examination process for LMFT, LCSW, and LPCC applicants effective January 1, 2016.

This proposal was originally approved by the Board at its meeting in February 2013, and published in its California Regulatory Notice Register on March 15, 2013. However, the proposal was withdrawn in May 2013, as staff learned of implementation conflicts with the new BreEZe database system. For this reason, the effective date of the restructure was delayed until 2016².

The final proposal was approved by the Board at its meeting in August 2014. It was published in its California Regulatory Notice Register on November 14, 2014. The public hearing was held on December 29, 2014, and the 45-day public comment period has ended. This proposal is now under review by the Department of Consumer Affairs.

Requirements for Licensed Professional Clinical Counselors to Treat Couples or Families: Amend Title 16, CCR Sections 1820.5 and 1822; Add Sections 1820.6 and 1820.7

This proposal clarifies requirements for LPCCs to treat couples and families, and outlines a process by which LPCCs and PCC Interns would receive Board confirmation that they have met the requirements to treat couples and families.

The final proposal was approved by the Board at its meeting in May 2014. Staff is developing materials that are required for submission of the proposal to OAL for publication, which will begin the 45-day public comment period.

¹ Chapter 387, Statutes of 2011

² SB 821 (Chapter 473, Statutes of 2013)