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BOARD MEETING NOTICE May 20-21, 2015

Embassy Suites Santa Ana – Orange County Airport North
1325 E. Dyer Road
Santa Ana, CA 92705
(714) 241-3800

While the Board intends to webcast this meeting, it may not be possible to webcast the entire open meeting due to limitations on resources.

**Wednesday, May 20th
8:30 a.m.**

FULL BOARD OPEN SESSION - Call to Order and Establishment of Quorum

- I. Petition for Early Termination of Probation for Kwamina Amonoo-Neizer, LCSW 26843
- II. Petition for Early Termination of Probation for Daniel Carr, LMFT 31037
- III. Petition for Early Termination of Probation for Jennifer Harris, IMF 68489
- IV. Petition for Early Termination of Probation for Kimberly Kupfer, LMFT 27299
- V. Petition for Early Termination of Probation for Cindy Plascencia, IMF 73371
- VI. Public Comment for Items not on the Agenda
- VII. Suggestions for Future Agenda Items



Governor
Edmund G. Brown Jr.
State of California

Business, Consumer Services
and Housing Agency

Department of
Consumer Affairs

FULL BOARD CLOSED SESSION

- VIII. Pursuant to Section 11126(c)(3) of the Government Code, the Board Will Meet in Closed Session for Discussion and to Take Action on Disciplinary Matters

- IX. Pursuant to Section 11126(a) of the Government Code, the Board Will Meet in Closed Session to Discuss the Performance of the Board's Executive Officer

FULL BOARD OPEN SESSION

- X. Adjournment

Thursday, May 21st
8:30 a.m.

FULL BOARD OPEN SESSION - Call to Order and Establishment of Quorum

- XI. Introductions*
- XII. Approval of the February 25-26, 2015 Board Meeting Minutes
- XIII. Chair Report
- XIV. Executive Officer's Report
 - a. Budget Report
 - b. Operations Report
 - c. Personnel Report
- XV. Strategic Plan Update
- XVI. Supervision Committee Update
- XVII. Examination Restructure Update
- XVIII. Policy and Advocacy Committee Report
 - a. Recommendation #1- Oppose, Assembly Bill 85 (Wilk)
 - b. Recommendation #2 – Support, Assembly Bill 250 (Olbernalte)
 - c. Recommendation #3 – Oppose Unless Amended, Assembly Bill 333 (Melendez)
 - d. Recommendation #4 – Support, Assembly Bill 690 (Wood)
 - e. Recommendation #5 – Neutral, Assembly Bill 796 (Nazarian)
 - f. Recommendation #6 – Support, Assembly Bill 832 (Garcia)
 - g. Recommendation #7 – Support, Assembly Bill 1001 (Maienschein)
 - h. Recommendation #8 – Neutral, Assembly Bill 1279 (Holden)
 - i. Recommendation #9 – Neutral, Assembly Bill 479 (Bates)
 - j. Recommendation #10 – Oppose Unless Amended, Senate Bill 614 (Leno)
 - k. Recommendation #11 – Oppose, Senate Bill 594 (Wieckowski)
- XIX. Update and Possible Action on Text of Proposed Legislation for 2015: Crime Victims: Compensation for Reimbursement of Violence Peer Counseling

- XX. Discussion and Possible Action Regarding Proposed Regulations for Telehealth
- XXI. Board Sponsored Legislation Update
- XXII. Regulation Update
- XXIII. Update on Suicide Prevention Training for Mental Health Professionals
- XXIV. Discussion and Possible Action Regarding English as a Second Language Accommodation for Examination Candidates
- XXV. Discussion and Possible Action Regarding Signatures on the Board's Licensed Wall Certificates
- XXVI. Election of Board Chair and Vice Chair
- XXVII. Discussion Regarding the Preparation of Sunset Review Report
- XXVIII. Public Comment for Items not on the Agenda
- XXIX. Suggestions for Future Agenda Items
- XXX. Adjournment

**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.

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1625 North Market Blvd., Suite S-200
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www.bbs.ca.gov

To: Board Members

Date: May 8, 2015

From: Christina Kitamura
Administrative Analyst

Telephone: (916) 574-7835

Subject: February 2015 Board Meeting Minutes

The February Board Meeting Minutes will be provided to the Board Members under separate cover prior to the meeting. The minutes will also be provided at the Board Meeting on May 21st.

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2014/2015 Budget

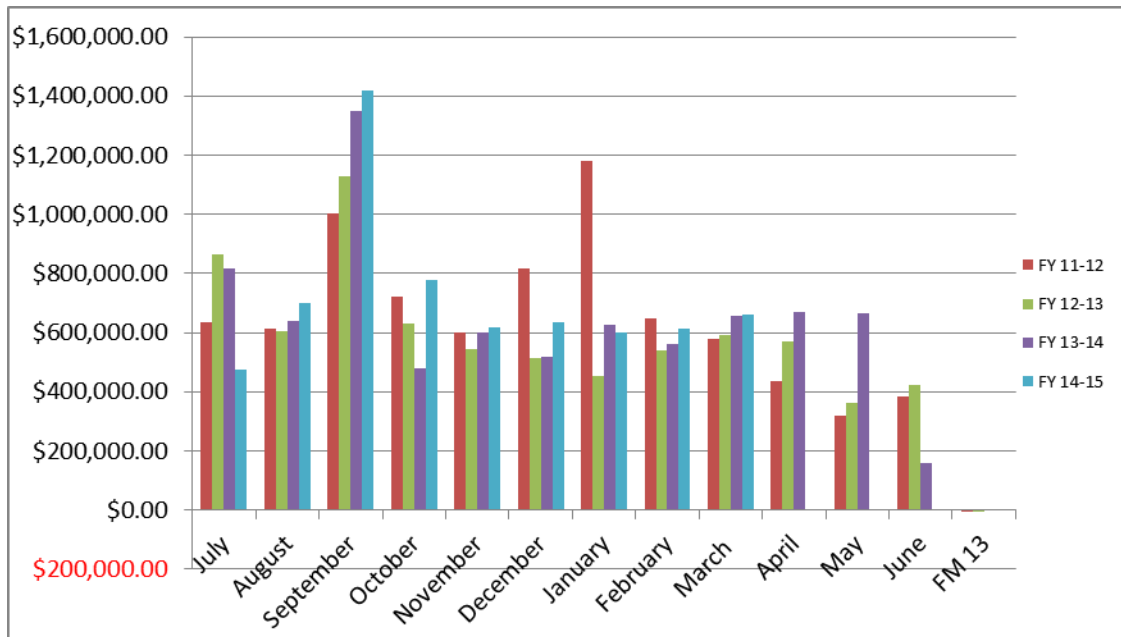
The 2014/2015 budget for the Board is \$9,139,000. As of March 31, 2015, the Board has spent \$ 6,365,218 reflecting 68% of the total budget. The chart below provides a breakdown of expense categories and percentages.

Expense Category	Amount	Percentage
Personnel	\$2,726,039	29%
OE&E	\$2,324,276	25 %
Enforcement	\$ 975,663	10 %
Minor Equipment <i>Includes LPCC exp</i>	\$ 339,240	4%
Total Expenses	\$ 6,365,218	68%

As of March 31, 2015, the Board had collected \$ 6,502,055 in total revenue.

Month	FY 11-12	FY 12-13	FY 13-14	FY 14-15
July	\$636,305.00	\$865,553.99	\$817,394.34	\$475,567.98
August	\$614,882.97	\$605,609.87	\$641,178.70	\$698,635.93
September	\$1,002,602.57	\$1,130,230.37	\$1,349,479.66	\$1,419,736.29
October	\$723,621.83	\$631,685.86	\$480,531.87	\$779,134.95
November	\$601,895.03	\$545,880.97	\$600,316.56	\$617,891.41
December	\$816,772.93	\$514,784.93	\$516,264.24	\$635,199.34
January	\$1,180,871.34	\$452,850.71	\$625,528.05	\$601,512.09
February	\$646,040.15	\$541,115.50	\$559,755.55	\$612,208.93
March	\$576,972.25	\$593,123.75	\$655,619.38	\$662,167.83
April	\$437,016.67	\$569,381.90	\$670,839.44	
May	\$317,204.07	\$360,131.06	\$663,732.55	
June	\$383,326.67	\$421,329.60	\$158,802.68	
FM 13	(\$1,375.78)	(\$266.97)	\$388.71	

The chart below provides a fiscal year comparison of the Board's monthly revenue.



The Board is projecting an unencumbered balance of \$13,091 at the end of this fiscal year. This amount is significantly lower than in previous budget years. The lower balance is due to a few unanticipated expenses in personnel and examinations.

Board staff believed that the expenses for the staff reassigned to the Board from DCA was being paid each fiscal year. However, Board staff was recently informed that none of these payments have been made since the Board began using this staff in 2012. Therefore, the Board owes approximately \$160,000 which must be paid this fiscal year. Board staff will ensure these expenditures will be paid annually to avoid this situation in the future.

Additionally, the Board had a large increase in the number of examinations administered in October 2014, November 2014, and December 2014. A total of 3731 examinations were administered during this time period. This figure represents a 73% increase when comparing these months to the same period of time in 2013.

Further, from October 2014 to November 2014, the number of examinations administered increased by a 36% (345 examinations). Board staff believes the increased volume is attributed to candidates wishing to test prior to the implementation of questions related to the DSM V. Due to the unanticipated increase in the volume of examinations administered, the Board's examination budget must be augmented by \$100,000.

Board Fund Condition

The Board's fund condition reflects 2.7 months in reserve.

General Fund Loans

The current outstanding balance of loans to the General Fund is \$10.9 million. The Board is scheduled to receive a repayment of \$1 million in fiscal year 2014/2015.

2015/2016 Budget

The Board's budget for fiscal year 2015/2016 will be \$9,039,000 and includes two limited term positions and full time position authority for two existing half time positions. The Board's cost for the BreEZe system will increase significantly in 2015/2016. The increase in cost is attributed to the amended BreEZe contract.

The amended contract revises the scope of the BreEZe project and redistributes the cost of BreEZe among the Boards and Bureaus. The redistribution of costs is based upon the contract revisions that allow DCA to fully implement Release 1 and 2 using the current vendor. Release 3 will not be implemented with the current vendor.

Under the revision, all DCA Boards and Bureaus will continue to pay for the design and other components related to the initial purchase of the BreEZe system. However, Release 1 and 2 Boards and Bureaus will also incur costs related to implementation and maintenance of the BreEZe data system. Under the new amendments, the Board's BreEZe costs will increase 94%; rising from \$482,249 in 2014/2015 to \$938,109 in 2015/2016, and increasing to \$990,811 in 2016/2017.

The Board is scheduled to receive a \$1.2 million General Fund Loan repayment in 2015/2016. The Board anticipates that this repayment will help to offset the increased BreEZe costs. However, despite the repayment, the Board's fund condition is projected to be a 1.1 month reserve. This figure is below the 3 month reserve that in recent years, has been considered sufficient by the Department of Finance. Business and Professions Code section 128.5 specifies that the Board's surplus fund may not exceed 24 months. However, neither this statute nor any other statute specifies a minimum number of months that the Board must have in its reserve.

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BBS EXPENDITURE REPORT FY 2014/15

OBJECT DESCRIPTION	FY 2013/2014	FY 2014/2015			
	ACTUAL EXPENDITURES	BUDGET ALLOTMENT	CURRENT AS OF 3/31/2015	PROJECTIONS	UNENCUMBERED BALANCE
PERSONAL SERVICES					
Salary & Wages (Civ Svc Perm)	1,867,358	2,459,901	1,630,786	2,361,277	98,624
Salary & Wages (Stat Exempt)	93,888	93,888	67,332	98,389	(4,501)
Temp Help (907)(Seasonals)	62,564	60,000	54,908	100,000	(40,000)
Temp Help (915)(Proctors)	0	444	0	0	444
Board Memb (Per Diem)	16,400	12,900	11,400	20,000	(7,100)
Overtime	18,025	1,500	20,969	30,000	(28,500)
Totals Staff Benefits	1,026,090	1,378,745	940,644	1,422,000	(43,255)
Salary Savings		0			0
TOTALS, PERSONAL SERVICES	3,084,325	4,007,378	2,726,039	4,031,666	(24,288)
OPERATING EXP & EQUIP					
Fingerprint Reports	9,743	14,827	10,481	15,000	(173)
General Expense	79,829	113,428	72,514	100,000	13,428
Printing	88,968	53,000	77,293	130,000	(77,000)
Communication	14,311	31,513	10,774	15,000	16,513
Insurance	0	325	0	0	325
Postage	48,855	24,767	31,075	50,000	(25,233)
Travel, In State	84,066	67,684	66,890	95,000	(27,316)
Travel, Out-of-State	17,835	82,000	1,237	10,000	72,000
Training	450	30,463	2,496	4,000	26,463
Facilities Operations	353,176	227,925	156,637	225,000	2,925
Utilities	0	9,330	140	200	9,130
C&P Services - Interdept.	0	14,939	0	0	14,939
C&P Services-External Contracts	40	245,516	3,473	5,000	240,516
DEPARTMENTAL PRORATA					
DP Billing (424.03)	851,283	875,310	644,595	875,310	0
Indirect Distribution Costs (427)	432,543	485,759	350,541	485,759	0
Public Affairs (427.34)	16,010	14,852	10,707	14,852	0
D of I Prorata (427.30)	13,864	23,133	10,989	23,133	0
Consumer Relations Division (427.3)	15,797	16,098	11,706	16,098	0
OPP Support Services (427.01)	0	490	0	490	0
Interagency Services (OER IACs)	175,868	325,065	113,773	325,065	0
Consolidated Data Services (428)	685	24,096	23	500	23,596
Data Proc (Maint,Supplies,Cont) (43)	16,785	14,448	18,920	28,000	(13,552)
Statewide Pro Rata (438)	361,763	388,161	291,120	388,161	0
EXAM EXPENSES					
Exam Site Rental	27,949	99,630	17,528	70,000	29,630
Exam Contract (PSI) (404.00)	280,488	358,659	299,151	448,800	(90,141)
C/P Svs - Expert Examiners (404.01)	0	45,000	0	0	45,000
C/P Svs - External Subj Matter (404)	126,202	365,260	122,215	172,000	193,260
ENFORCEMENT					
Attorney General	739,028	801,588	663,802	850,000	(48,412)
Office of Admin. Hearing	131,616	154,926	126,836	203,000	(48,074)
Court Reporters	9,223	0	6,251	10,000	(10,000)
Evidence/Witness Fees	22,564	94,955	17,022	25,000	69,955
Division of Investigation	60,756	215,669	161,751	215,669	0
<i>LPCC</i>	<i>482,348</i>		<i>284,310</i>	<i>390,000</i>	<i>(390,000)</i>
Minor Equipment (226)	63,162	16,000	46,166	80,000	(64,000)
Equipment, Replacement (452)	0	0	6,846	10,000	(10,000)
Equipment, Additional (472)	0	69,600	1,918	5,000	64,600
Vehicle Operations	0	19,000	0	0	19,000
TOTAL, OE&E	4,525,207	5,323,416	3,639,179	5,286,037	37,379
TOTAL EXPENDITURES	\$7,609,532	\$9,330,794	\$6,365,218	\$9,317,703	\$13,091

	FY 13/14 FM 13	Budget Alotment	Current as of 3/31/15
Reimbursements			
Fingerprints	(11,040)	(24,000)	(9,539)
Other Reimbursements	(9,685)	(26,000)	(5,405)
Unscheduled Reimbursements	(140,234)		(146,796)
Total Reimbursements	(160,959)	(50,000)	(161,740)

BLUE PRINT INDICATES THE ITEMS ARE SOMEWHAT DISCRETIONARY.

0773 - Behavioral Science

Analysis of Fund Condition

(Dollars in Thousands)

2015-16 Governor's Budget w/ BreZE SPR 3.1

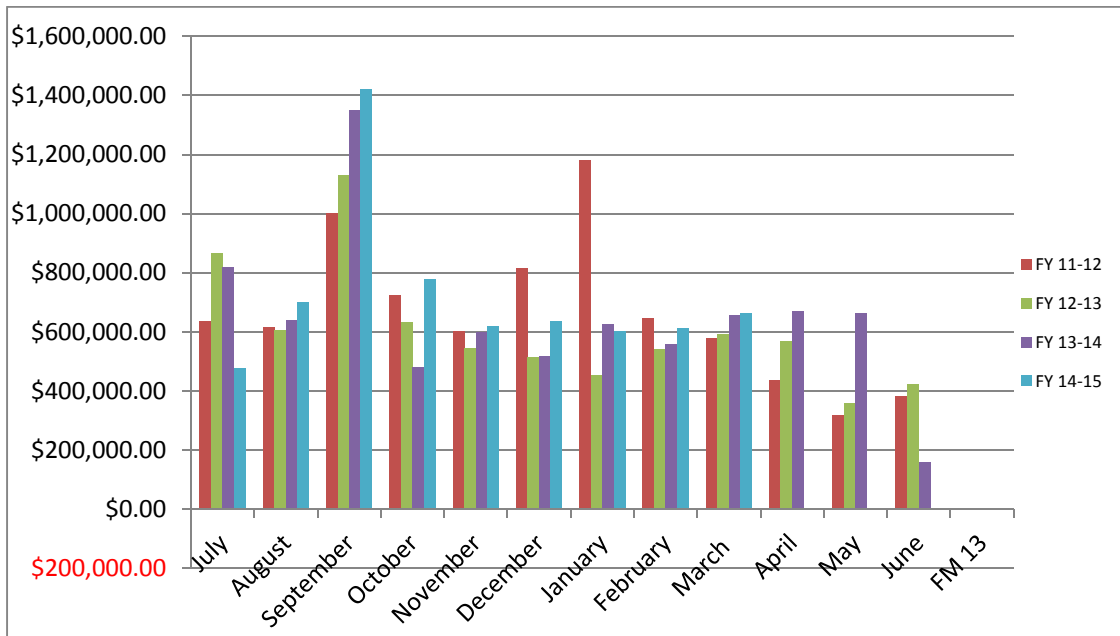
	ACTUAL 2013-14	CY 2014-15	BY 2015-16	BY +1 2016-17
BEGINNING BALANCE	\$ 1,468	\$ 3,309	\$ 2,258	\$ 962
Prior Year Adjustment	\$ 215	\$ -	\$ -	\$ -
Adjusted Beginning Balance	\$ 1,683	\$ 3,309	\$ 2,258	\$ 962
REVENUES AND TRANSFERS				
Revenues:				
125600 Other regulatory fees	\$ 81	\$ 78	\$ 83	\$ 83
125700 Other regulatory licenses and permits	\$ 2,339	\$ 2,309	\$ 2,388	\$ 2,388
125800 Renewal fees	\$ 5,071	\$ 4,845	\$ 4,996	\$ 4,996
125900 Delinquent fees	\$ 75	\$ 69	\$ 72	\$ 72
141200 Sales of documents	\$ -	\$ -	\$ -	\$ -
142500 Miscellaneous services to the public	\$ 1	\$ 2	\$ 2	\$ 2
150300 Income from surplus money investments	\$ 5	\$ 4	\$ 2	\$ -
150500 Interest interest from Interfund loans	\$ 415	\$ -	\$ -	\$ -
160400 Sale of fixed assets	\$ -	\$ -	\$ -	\$ -
161000 Escheat of unclaimed checks and warrants	\$ 3	\$ 3	\$ 3	\$ 3
161400 Miscellaneous revenues	\$ 4	\$ 4	\$ 4	\$ 4
Totals, Revenues	\$ 7,994	\$ 7,314	\$ 7,550	\$ 7,548
Transfers from Other Funds				
F00683 Teale Data Center (CS 15.00, Bud Act of 2005)	\$ -	\$ -	\$ -	\$ -
F00001 GF loan repayment per item 1170-011-0773 BA of 2002	\$ 1,400	\$ 1,000	\$ 1,200	\$ 2,400
F00001 GF loan repayment per item 1110-011-0773 BA of 2008	\$ -	\$ -	\$ -	\$ -
F00001 GF loan repayment per item 1110-011-0773 BA of 2011	\$ -	\$ -	\$ -	\$ -
Totals, Revenues and Transfers	\$ 9,394	\$ 8,314	\$ 8,750	\$ 9,948
Totals, Resources	\$ 11,077	\$ 11,623	\$ 11,008	\$ 10,910
EXPENDITURES				
Disbursements:				
8860 FSCU (State Operations)	\$ -	\$ -	\$ -	\$ -
8880 Financial Information System for California	\$ 37	\$ 7	\$ 17	\$ -
1110 Program Expenditures (State Operations)	\$ 7,731	\$ 9,281	\$ 8,989	\$ 9,150
2015-16 BreZE SFL	\$ -	\$ 77	\$ 1,040	\$ 1,092
Total Disbursements	\$ 7,768	\$ 9,365	\$ 10,046	\$ 10,242
FUND BALANCE				
Reserve for economic uncertainties	\$ 3,309	\$ 2,258	\$ 962	\$ 668
Months in Reserve	4.2	2.7	1.1	0.9

NOTES:

- A. ASSUMES WORKLOAD AND REVENUE PROJECTIONS ARE REALIZED IN BY+1 AND ON-GOING.
- B. ASSUMES APPROPRIATION GROWTH OF 2% PER YEAR IN BY+1 AND ON-GOING.
- C. ASSUMES INTEREST RATE AT 0.3%.

BBS Revenue Analysis

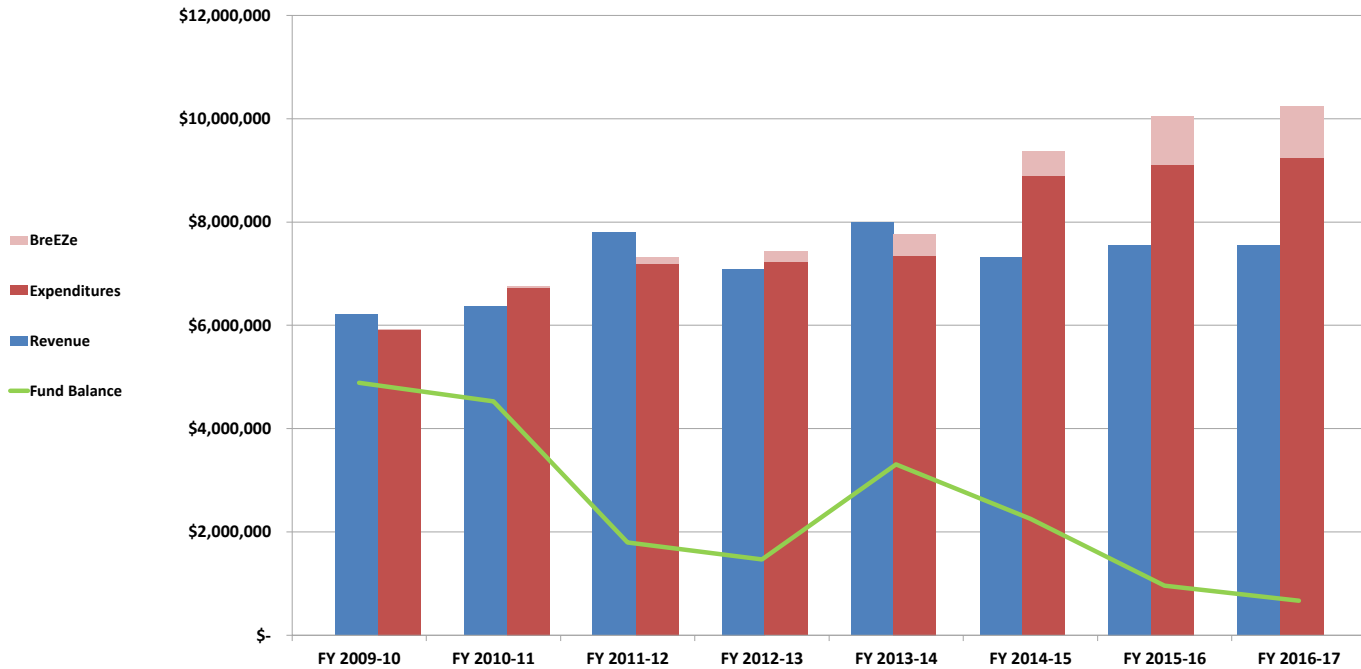
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July	\$636,305.00	\$865,553.99	\$817,394.34	\$475,567.98
August	\$614,882.97	\$605,609.87	\$641,178.70	\$698,635.93
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June	\$383,326.67	\$421,329.60	\$158,802.68	
FM 13	(\$1,375.78)	(\$266.97)	\$388.71	



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Board of Behavioral Sciences
Fund Analysis: Governor's Budget w/BreEZe SPR 3.1
Release 1

	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17
	Actual					Projected*		
Beginning Fund Balance (Incl. Prior Year Adj.)	\$ 4,600,000	\$ 4,925,000	\$ 4,627,000	\$ 1,818,000	\$ 1,683,000	\$ 3,309,000	\$ 2,258,000	\$ 962,000
Total Revenue	\$ 6,211,000	\$ 6,366,000	\$ 7,791,000	\$ 7,088,000	\$ 7,994,000	\$ 7,314,000	\$ 7,550,000	\$ 7,548,000
Transfers/General Fund Loans	\$ -	\$ -	\$ -3,300,000	\$ -	\$ 1,400,000	\$ 1,000,000	\$ 1,200,000	\$ 2,400,000
Total Expenditures	\$ 5,922,000	\$ 6,763,000	\$ 7,320,000	\$ 7,438,000	\$ 7,768,000	\$ 9,365,000	\$ 10,046,000	\$ 10,242,000
BreEZe Cost	\$ 9,920	\$ 34,021	\$ 128,641	\$ 203,974	\$ 422,298	\$ 482,429	\$ 938,109	\$ 990,811
Expenditures (less BreEZe)	\$ 5,912,080	\$ 6,728,979	\$ 7,191,359	\$ 7,234,026	\$ 7,345,702	\$ 8,882,571	\$ 9,107,891	\$ 9,251,189
Ending Fund Balance	\$ 4,889,000	\$ 4,528,000	\$ 1,798,000	\$ 1,468,000	\$ 3,309,000	\$ 2,258,000	\$ 962,000	\$ 668,000
Months in Reserve	8.7	7.4	2.9	2.3	4.2	2.7	1.1	0.9



* Projected years assume full budget appropriation is expended

Highlights

- o \$6.3 million loan to the General Fund after FY 2016-17
- o Budget Augmentations:
 - o FY 2010-11 - Consumer Protection Enforcement Initiative (CPEI): 1.5 positions, \$163,000 (ongoing);
 - o FY 2014-15 - Enforcement Staffing: 4.5, \$430,000 (ongoing); Licensing Staffing: 3.0 positions, \$218,000 [\$128,000 (ongoing), \$90,000 (limited)
 - o FY 2015-16 - Licensing Staffing: 3.0 positions, \$148,000 (two-year limited term)

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Board Statistics

Attached for your review are the quarterly performance statistics for the third fiscal quarter of 2014/2015. Processing times are still unavailable at this time. In lieu of licensing processing times, the processing date as of May 5, 2015 is provided. The processing dates represent the date the application was received by the Board that the licensing staff is currently evaluating.

Licensing Program

Overall, the receipt of all applications decreased in the third quarter. The LCSW examination application increased by 36%.

Application Volumes

Application type	3rd Quarter 1/1/15-3/31/15	2nd Quarter 10/1/14-12/31/14	Difference
MFT Intern	824	963	-14%
MFT Examination	466	775	-40%
ASW	547	835	-34%
LCSW Examination	528	389	36%
LEP Examination	15	29	-48%
LPCC Intern	108	151	-28%
LPCC Examination	25	37	-32%

Current processing dates as of May 5, 2015 are listed on the following page. The LMFT unit is evaluating applications within 53 days of receipt. The LCSW unit is evaluating applications within 64 days of receipt. All other applications types are evaluated within 15 days of receipt.

Licensing Processing Dates

License type	Current Processing Dates (5/5/15)	Processing Date at February Board Meeting (2/22/15)	Processing Date at November Board Meeting (11/10/14)
MFT Intern	4/23/2015	2/5/2015	10/23/2014
MFT Examination	2/19/2015	11/15/2014	6/25/2014
ASW	4/24/2015	2/12/2015	10/23/2014
LCSW Examination	2/4/2015	11/5/2014	4/21/2014
LEP Examination	4/19/2015	2/18/2015	11/3/2014
LPPC Intern	4/17/2015	1/26/2015	9/9/2014
LPCC Examination	4/27/2015	1/21/2015	9/8/2014

A total of 1,075 initial licenses were issued in the third quarter.

Examination Program

2,352 examinations were administered in the third quarter. Thirteen (13) examination development workshops were conducted January through March.

The Board staff initiated recruitment for participation in the Licensed Educational Psychologist (LEP) Occupational Analysis (OA). Board staff utilized current LEP email addresses and Survey Monkey to recruit for the LEP OA. Over 600 responses were received. The LEP OA will be completed in the upcoming months.

Administration Program

The Board received 7,913 applications in the third quarter. 7258 renewal applications were received and processed by DCA's central cashiering unit. The Board's cashier completed 1682 renewal applications. Online renewals increased over 200% with 2372 individuals renewing their license or registration online.

Enforcement Program

The Enforcement staff received 243 consumer complaints and 251 criminal convictions in the third quarter. 500 cases were closed this quarter and 30 cases were referred to the Attorney General's office for formal discipline. 23 Accusations and 11 Statement of Issues were filed this quarter. The current average for Formal Discipline is 548 days. The performance goal is 540 days.

Enforcement staff has completed its review of all SME applications. Thirty three (33) applications were approved. The Board has several SMEs for each license type encompassing a broad range of expertise. New contracts are in place for all SMEs and training has been scheduled for July 30, 2015 in the Sacramento Attorney General Office.

Outreach Activity

Recently the Board resumed its outreach activities in an effort to provide information regarding the recent and upcoming changes to Board programs. Board staff has either physically attended these events or participated via a phone conference.

Outreach Events

MFT Consortium Meetings throughout the state. Attendance at these events is primarily via phone conference.

- January 21, 2015
- February 20, 2015
- February 27, 2015
- March 18, 2015

CASP Conference Sacramento, CA, March 27, 2015

LPCC Conference San Diego, CA, March 6-7, 2015

USC School of Social Work Webinar, DCA Headquarters, March 24, 2015 (several other schools also attended)

NASW Lobby Days Sacramento, CA April 19, 2015

Upcoming Events

CAMFT Conference Burlingame, CA, May 14-17, 2015

Presentation to MFT Intern applicants, Sacramento, CA, June 19, 2015

Additional Outreach Efforts

The Board published a Winter 2015 newsletter. The newsletter is currently available on the Board's website. Board staff is currently working on articles for a second newsletter for a summer release.

Board staff developed informational material and FAQs regarding the examination restructure. This information was posted to the Board's website on March 16, 2015. A video tutorial for the examination restructure is currently in development. Once the tutorial is completed, it will be available on the Board's website.

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Board of Behavioral Sciences Quarterly Statistics Report As of March 31, 2015

This report provides statistical information relating to various aspects of the Board's business processes. Statistics are grouped by unit.

CASHIERING

The Board's Cashiering Unit processes license renewals and applications. Approximately 85% of renewal processing occurs in the Department of Consumer Affairs Central Cashiering Unit.

R													
Processed	552	1098	1101	1136	873	924	569	493	620				
Received	*	*	*	*	*	*	678	313	283				
Process Time	*	*	*	*	*	*	*	*	*				*

*Data Currently Unavailable

7366

1274

Renewals Processed By DCA Central Cashiering	Jul -14	Aug-14	Sept-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	YTD
Processed	2069	3647	2565	4175	2990	2688	2594	2280	2384				25392
Received	*	*	*	*	*	*	*	*	*	*	*	*	*
Process Time	*	*	*	*	*	*	*	*	*	*	*	*	*

*Data Currently Unavailable

Online Renewals	Jul -14	Aug-14	Sept-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	YTD
	N/A	N/A	N/A	N/A	298	478	579	760	1033				3148

Application Payments Processed In-House**	Jul -14	Aug-14	Sept-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	YTD
Processed	3227	2655	2532	2229	1628	1650	2321	1729	2181				20152
Received	*	*	*	*	*	*	2124	1603	1700				5427
Process Time	*	*	*	*	*	*	*	*	*	*	*	*	*

**These totals represent all other applications and do not include renewal applications

LICENSING

The Board’s Licensing Unit evaluates applications for registration and examination eligibility. This involves verifying educational and experience qualifications to ensure they meet requirements defined in statute and regulation.

Initial Licenses Issued	Jul -14	Aug-14	Sept-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	YTD
LMFT	122	112	151	194	196	313	332	140	233				
LCSW	119	108	118	117	152	157	90	72	131				
LEP	13	12	14	10	8	8	10	5	9				
PCE	19	32	24	15	16	30	10	8	1			1793	
LPCC	55	56	55	44	27	18	17	6	11			1064	
LCSW Examination Eligibility Applications	Jul -14	Aug-14	Sept-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	YTD
Received	197	62	157	200	113	76	136	165	227			155	
Approved	170	104	117	210	323	160	192	167	196			289	
Process Time	153	148	157	155	141	122	93	79	74				
Process Time Less Def Lapse	*	*	*	*	*	*	*	*	*	*	*	1333	*
LMFT Examination Eligibility Applications	Jul -14	Aug-14	Sept-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	YTD
Received	196	307	252	203	324	248	206	153	107				
Approved	245	368	407	414	327	333	257	265	268				
Process Time	173	148	133	110	100	89	78	71	56				
Process Time Less Def Lapse	*	*	*	*	*	*	*	*	*	*	*	1530	*
LPCC Examination Eligibility Applications	Jul -14	Aug-14	Sept-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	YTD
Received	10	2	13	16	10	11	6	8	11			*	
Approved	14	10	10	7	1	4	22	9	11				
Process Time	*	*	*	*	*	*	23	0	1				
Process Time Less Def Lapse	*	*	*	*	*	*	*	*	*	*	*	*	*
LEP Examination Eligibility Applications	Jul -14	Aug-14	Sept-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	YTD
Received	17	7	6	12	7	10	3	9	3			*	
Approved	24	16	10	14	10	8	10	7	5				
Process Time	25	15	13	12	8	11	2	4	4				
Process Time Less Def Lapse	*	*	*	*	*	*	*	*	*	*	*	*	*

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ASW Registration Applications	Jul -14	Aug-14	Sept-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	YTD
Received	842	195	436	363	220	252	192	175	180				
Approved	138	191	278	339	219	202	231	172	176				
Process Time	26	30	19	14	11	12	7	8	8				
Process Time Less Def Lapse	*	*	*	*	*	*	*	*	*	*	*	2855	*
LMFT Intern Registration Applications	Jul -14	Aug-14	Sept-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	YTD
Received	419	563	420	468	321	174	286	300	238				
Approved	330	251	237	519	267	327	261	293	270				
Process Time	15	17	21	16	15	16	10	13	7				
Process Time Less Def Lapse	*	*	*	*	*	*	*	*	*	*	*	3189	*
LPC Intern Registration Applications	Jul -14	Aug-14	Sept-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	YTD
Received	69	45	99	87	45	19	42	23	43				
Approved	85	50	46	40	25	27	47	44	33				
Process Time	32	39	44	47	45	56	52	21	13				
Process Time Less Def Lapse	*	*	*	*	*	*	*	*	*	*	*	472	*
PCE Applications	Jul -14	Aug-14	Sept-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	YTD
Received	23	35	35	17	20	39	0						
Approved	18	14	29	41	9	13	0						
Process Time	13	18	22	12	9	11	18						
Process Time Less Def Lapse	*	*	*	*	*	*	*					169	

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EXAMINATION

The Board's Examination Unit processes complaints and performs other administrative functions relating to the Board's examination processes.

Examinations Administered	Jul -14	Aug-14	Sept-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	YTD
LCSW Written	162	154	146	182	321	139	149	178	230				1661
LCSW CV	134	141	139	150	307	107	99	129	156				1362
LMFT Written	229	262	288	363	407	610	193	275	337				2964
LMFT CV	153	166	202	237	247	602	102	210	245				2164
LPCC GAP (LMFT)	37	62	49	4	3	1	1	0	1				158
LPCC GAP (LCSW)	0	0	2	0	0	0	0	0	0				2
LPCC GP L&E	5	3	4	2	0	1	0	0	0				15
LPCC Traditional L&E	6	8	4	5	5	2	6	4	11				51
LEP	13	18	12	14	12	10	9	6	11				105
Total Exams Administered	739	814	846	957	1302	1472	559	802	991				8482
Examination Workshops	4	2	7	5	1	2	3	5	5				36

ENFORCEMENT

The Board’s Enforcement Unit investigates consumer complaints and reviews prior and subsequent arrest reports for registrants and licensees. The pending total is a snapshot of all pending items at the close of a quarter.

Complaints (Complaint Intake*)	Jul -14	Aug-14	Sept-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	YTD
Received	94	84	112	90	92	67	81	76	86				782
Closed without Assignment for Investigation	33	22	52	*	*	*	*	*	*				107
Assigned for Investigation	71	43	53	44	65	52	58	59	53				498
Average Days to Close or Assigned for Investigation	8	7	6	15	8	7	4	4	4				7
Intake Pending	0	3	3	4	3	5	4	3	1				1

Convictions/Arrest Reports	Jul -14	Aug-14	Sept-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	YTD
Received	70	106	122	99	79	109	81	90	80				836
Closed / Assigned for Investigation	3	2	0	*	*	*	*	*	*				5
Assigned for Investigation	72	96	118	62	127	99	91	90	68				823
Average Days to Close	4	4	5	7	8	5	4	2	2				5
Intake Pending	0	1	0	4	0	3	0	0	5				5

INVESTIGATION**

Desk Investigation	Jul -14	Aug-14	Sept-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	YTD
Assigned	146	139	171	107	193	151	151	149	121				1328
Closed	175	161	200	163	108	128	181	198	142				1456
Average Days to Close	140	184	100	117	89	76	133	122	96				117
Pending	560	539	519	471	561	588	570	526	515				515
Field Investigation (Sworn)	Jul -14	Aug-14	Sept-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	YTD
Assigned	6	5	2	4	1	6	5	3	6				38
Closed	3	0	2	0	0	5	0	3	7				20
Average Days to Close	114	0	216	0	0	233	0	185	297				218
Pending	26	31	31	35	36	37	42	42	42				42
All Investigations	Jul -14	Aug-14	Sept-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	YTD
First Assignments	147	140	180	117	198	155	159	155	131				1382
Closed	168	147	203	154	108	127	167	194	139				1407
Average Days to Close	139	144	91	117	92	86	125	124	100				114
Pending	539	525	499	454	543	568	555	511	501				501

Enforcement Actions	Jul -14	Aug-14	Sept-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	YTD
AG Cases Initiated	16	5	13	14	18	14	13	5	12				110
AG Cases Pending	117	115	114	113	124	125	132	126	126				126
SOIs Filed	5	3	2	5	6	1	2	2	7				33
Accusations Filed	13	6	4	2	4	7	6	5	12				59
Proposed/Default Decisions Adopted	3	3	1	3	0	8	0	2	1				21
Stipulations Adopted	6	4	11	3	1	2	0	3	2				32
Disciplinary Orders	Jul -14	Aug-14	Sept-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	YTD
Final Orders (Proposed Decisions Adopted, Default Decisions, Stipulations)	10	13	8	17	1	10	11	2	13				85
Average Days to Complete***	616	747	561	383	351	632	410	587	531				548
Citations	Jul -14	Aug-14	Sept-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	YTD
Final Citations	4	5	1	0	1	1	0	0	5				17
Average Days to Complete****	311	276	128	0	133	918	0	0	168				525

Complaint Intake *

Complaints Received by the Program.

Investigations **

Complaints investigated by the program whether by desk investigation or by field investigation.
 Measured by date the complaint is received to the date the complaint is closed or referred for enforcement action.
 If a complaint is never referred for Field Investigation, it will be counted as 'Closed' under Desk Investigation.
 If a complaint is referred for Field Investigation, it will be counted as 'Closed' under Non-Sworn or Sworn.

Disciplinary Orders Average Days to Complete ***

Measured by the date the complaint is received to the date the order became effective.

Citations ****

Measured by the date the complaint is received to the date the citation was issued.

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To: Board Members

Date: May 8, 2015

From: Kim Madsen
Executive Officer

Telephone: (916) 574-7850

Subject: Personnel Update

New Employees

- Staff Services Analyst (SSA) (Full-time) – Licensing Program

Andrea Flores returns to the Board to serve as the lead analyst in the Licensing Program for the LMFT unit. Ms. Flores worked as a Licensing Evaluator in the LMFT unit from March 2014 to October 2014. Ms. Flores worked for the Bureau of Private Postsecondary Education as a Staff Services Analyst from November 2014 to May 2015. Ms. Flores will evaluate the more complex LMFT applications and serve as the outreach coordinator for the LMFT unit.

Promotions

- Darlene York, Licensing Evaluator for the LCSW unit, was promoted to a Staff Services Analyst in the LCSW unit. Ms. York has served as the LCSW evaluator since 2008. Ms. York will serve as the outreach coordinator and the lead for the LCSW unit.
- Ellen Viegas, cashier, was promoted to a Staff Services Analyst. Ms. Viegas has served as the renewal cashier since 2011. Ms. Viegas will serve as the lead for the cashiering unit, Board liaison with DCA cashiering, and subject matter expert for BreEZe cashiering functions.
- Relena Amaro, LEP Evaluator, was promoted to a Staff Services Analyst in the Examination Unit. Ms. Amaro has been with the Board since June 2014. Ms. Amaro will work with the Office of Professional Examination Services to recruit Subject Matter Experts for the Board's examination development workshops, review all examinations, and prepare all contracts related to examination development.
- Flores Lopes, Criminal Conviction Analyst, was promoted to Enforcement Analyst in the Consumer Complaint Unit. Ms. Flores has been with the Board since 2011 conducting

applicant criminal conviction reviews. Ms. Flores will serve as an Enforcement Analyst investigating consumer complaints.

Departures

Marlon McManus, Enforcement Analyst in the Consumer Complaint Unit, departed on April 24, 2015. Mr. McManus accepted a position that returns him to work in the Workers Compensation field. Mr. McManus had been with the Board since 2007.

Vacancies

Board staff has initiated the recruitment process for the positions noted below:

- Office Technician – Licensing (fill behind R. Amaro) - The Licensing Manager is currently reviewing applications for this position. Interviews will be scheduled this month.
- Staff Services Analyst (SSA) (Full-time) – Licensing (fill behind P. Fay) - The Licensing Manager is revising the duties of this vacancy to align with the Board's current operational needs and revisions to the Board's continuing education program. This position will be advertised this month.
- Staff Services Analyst (SSA) (Full-time) – Enforcement Program (fill behind F. Lopes) - The Enforcement Manager will initiate the request to fill the Applicant Criminal Conviction Review position this month.
- Associate Governmental Program Analyst (AGPA) (Full-time) (fill behind M. O'Connor) – The Administration Manager has completed his review of applications. Interviews will be scheduled this month.

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To: Board Members

Date: May 4, 2015

From: Steve Sodergren
Assistant Executive Officer

Telephone: (916) 574-7847

Subject: Strategic Plan Update

Management and staff continue to address the strategic goals and objectives. Attached for your review is the Strategic Plan update for May 2015.

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Licensing	DUE DATE	STATUS
<i>Establish licensing standards to protect consumers and allow reasonable and timely access to the profession.</i>		
1.1 Identify and implement improvements to the licensing process to decrease application processing times.	Q1 2015	Application processing times have continued to decrease; the processing times are not within the parameters set forth in Regulation.
1.2 Complete the processing of Licensed Professional Clinical Counselor grandfathered licensing application.	Q1 2014	Completed October 1, 2013
1.3 Review the current eligibility process for Licensed Marriage and Family Therapists and Licensed Professional Clinical Counselors to identify and reduce barriers and implement process improvements.	Q4 2018	On April 10, 2015 the fifth supervision committee meeting was conducted. The “buckets” legislation authored by Senator Marty Block has been assigned bill number SB620. The committee continues to discuss Supervisor requirements. The next meeting will be on June 26, 2015.
1.4 Explore development of uniform clinical supervision standards to ensure consistent supervision of registrants and trainees.	Q4 2015	On April 10, 2015 the fifth supervision committee meeting was conducted. The “buckets” legislation authored by Senator Marty Block has been assigned bill number SB620. The committee continues to discuss Supervisor requirements. The next meeting will be on June 26, 2015.

<p>1.5 Investigate the use of technology for record keeping and therapeutic services and its effects on patient safety and confidentiality and establish best practices for licensees.</p>	<p>Q4 2016</p>	
<p>1.6 Determine feasibility of license portability and pursue legislation if needed.</p>	<p>Q3 2020</p>	<p>Licensed portability will be improved with the acceptance of the national licensing exam, which will occur in 2016 with exam restructure for LCSW's. Legislations signed by the Governor in September 2014 modifies the out-of-state requirements for LMFTs and LPCCs with an effective date of 1/1/16.</p>
<p>1.7 Establish ongoing process to evaluate requirements for all license types to promote parity between licensing programs as appropriate.</p>	<p>Q4 2016</p>	<p>Staff effort continues. The "bucket" legislation introduced this year would make supervised experience requirements more uniform. The Supervision Committee is considering changes to supervisor qualifications and is working toward parity where appropriate.</p>
<p>1.8 Evaluate the feasibility of online application submission through the Breeze system and implement if possible.</p>	<p>Q2 2016</p>	<p>The Board has made the renewal application available through the online Breeze system.</p>

Examinations <i>Administer fair, valid, comprehensive, and relevant licensing examinations.</i>	DUE DATE	STATUS
2.1 Implement recommendations made by the Exam Program Review Committee to restructure the examination process and promulgate regulations as necessary.	Q1 2016	Rulemaking package approved by the Board in August 2014. Regulations were noticed in November 2014 and will be in place by January 1, 2016. Board staff members are currently working on implementation.
2.2 Establish a recruitment process for Subject Matter Experts to ensure a diverse pool on which to draw for examination development.	Q2 2016	The exam unit is now recruiting for SMEs using an electronic survey. The outcomes have been favorable. Exam staff is working with OPES in the recruitment process. The Board will be providing OPES with possible SMEs and OPES will complete the scheduling of the SMEs for workshops.
2.3 Create a process for evaluating the performance of Subject Matter Experts assisting with exam development.	Q4 2015	

Enforcement <i>Protect the health and safety of consumers through the enforcement of laws and regulations.</i>	DUE DATE	STATUS
3.1 Establish a recruitment process for Subject Matter Experts to ensure a diverse pool on which to draw for case evaluations.	Q4 2014	Staff effort, as reported in February, continues.
3.2 Develop a training program, including uniform standards for reports and evaluations, for all enforcement Subject Matter Experts.	Q1 2015	Staff effort, as reported in February, continues.
3.3 Improve internal process to regularly consult with the Attorney General’s office to advance pending disciplinary cases.	Q4 2014	Staff effort, as reported in February, continues.
3.4 Establish uniform standards and templates for reports and evaluations submitted to the Board related to disciplinary matters.	Q2 2015	
3.5 Create a process for evaluating the performance of Subject Matter Experts assisting on enforcement cases.	Q2 2015	An evaluation form was created to evaluate expert reviewer performance. Evaluations will be completed by the DAG’s and enforcement staff to measure performance and identify training needs.
3.6 Identify and implement improvements to the investigation process to decrease enforcement processing times.	Q1 2015	Staff effort, as reported in February, continues.

Legislation and Regulation <i>Ensure that statutes, regulations, policies, and procedures strengthen and support the Board’s mandate and mission.</i>	DUE DATE	STATUS
4.1 Adopt regulations to incorporate <u>Uniform Standards for Substance Abusing Licensees</u> to align with other healing arts boards.	Q2 2015	Submitted to DCA for final approval September 2014. Once approved by DCA, will need to be approved by Agency, Finance, and then OAL.
4.2 Modify regulations to shift oversight of continuing education providers to Approval Agencies.	Q4 2014	These regulations were approved. The effective dates are currently phasing in.(1/1/15 and 7/1/15)
4.3 Pursue legislation to implement the recommendations of the Out of State Education Review Committee to ensure parity with California educational requirements.	Q4 2014	Signed by the Governor in September 2014. The new out-of-state requirements become effective 1/1/16.
4.4 Pursue legislation to resolve the conflict in law that prohibits the Board’s access to information necessary for investigations regarding child custody reports.	Q4 2014	Signed by the Governor in September 2014. Became effective on 1/1/15.
4.5 Review regulatory parameters for exempt settings and modify, if necessary, to ensure adequate public protection.	Q4 2017	

Organizational Effectiveness <i>Build an excellent organization through proper Board governance, effective leadership, and responsible management.</i>	DUE DATE	STATUS
5.1 Pursue adequate staffing levels across all functional areas within the Board.	Q3 2015	Board continues to work on filling vacancies.
5.2 Evaluate internal procedures to identify areas for improvement to ensure prompt and efficient work processes.	Q1 2016	Staff effort, as reported in February, continues.
5.3 Enhance Board employee recognition program to reward exceptional performance and service.	Q4 2014	
5.4 Implement an internal training and education program for all Board staff to enhance skills and abilities for professional development.	Q3 2015	
5.5 Establish standing Board committees that align with the Board's strategic goal areas.	Q4 2014	Discussed at February Board meeting. Board will revisit this topic in 2016.

Outreach and Education <i>Engage stakeholders through continuous communication about the practice and regulation of the professions.</i>	DUE DATE	STATUS
6.1 Implement cost-effective ways to educate applicants and licensees on current requirements.	Q1 2015	Staff has been coordinating and conducting outreach for the new Continuing Education and Exam Restructure requirements. Frequently Asked Questions have been developed and staff is working with DCA staff to develop an informative video concerning Exam Restructure. The Board's Licensing staff will attend 8 outreach events in 2015. New analytical staff added to the Licensing unit will be coordinating future, on-going efforts in outreach.
6.2 Enhance the Board's outreach program by redesigning publications and the Board's website, leveraging new technologies and exploring the use of social media.	Q3 2015	A Winter newsletter has been published and distributed.
6.3 Partner with the Office of Statewide Planning Health and Development and other external stakeholder groups to encourage more diversity within the mental health professions.	Q4 2019	Staff effort, as reported in February, continues.

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To: Board Members
From: Steve Sodergren
Assistant Executive Officer
Date: April 28, 2015
Telephone: (916) 574-7847
Subject: Supervision Committee Update

The Supervision Committee held its sixth meeting on April 10, 2015 at Costa Mesa, California. During the meeting the following topics were discussed:

Update on Prior Committee Decisions

Staff reported that the “buckets” legislation, authored by Senator Marty Block, has been assigned bill number SB 620. The language reflects the committee’s and stakeholders’ desire to remove most of the “buckets” for LMFT and LPCC, and instead requires a minimum of 1,750 hours of direct counseling, and a maximum of 1,250 hours of non-clinical experience. Currently the language in the bill allows for a 2-year transition period. However, staff has requested amendments that would extend this to a 5-year transition period to ensure that no applicant is adversely affected by the changes.

The committee reviewed prior informal decisions that were agreed on by the committee and the stakeholders. These informal decisions may be incorporated into future legislation or regulatory changes depending on the final decisions the committee presents to the Board.

There was also a discussion about the remaining areas that the committee needs to address:

- Supervision Requirements including supervision definitions, amount and type of weekly supervisor contact, supervision formats, monitoring/evaluating the supervisee, etc.
- Supervisor Responsibilities including the Supervisor Responsibility Statement
- Employment/Employers including registrant/trainee employment, supervisor employment, offsite supervision, temp agency employers, etc.

Discussion Regarding Telehealth Supervised Work Experience

Several stakeholders have raised concern that SB 620, the “bucket” legislation, removes the limit on experience hours gained via telehealth. This could potentially allow an applicant to gain

all of his or her experience hours via telehealth. Current law limits LMFT and LPCC applicants to no more than 375 hours providing personal psychotherapy, crisis counseling, or other counseling services via telehealth.

The committee decided that the bill language should not be amended. There was a consensus that stipulating a limit on the hours would be arbitrary at this time. It was noted that more research and monitoring of telehealth experience would be beneficial in order to identify future issues that may indicate a need for such a limit.

Discussion Regarding Supervisor and Supervisee Survey Results

Staff presented the survey results from the Supervisor/Supervisee surveys that were published on March 2, 2015. As of March 23, 2015 the Board had collected 397 total responses (198 complete responses) for the Supervisee Survey and 357 total responses (342 complete responses) for the Supervisor Survey. (Attachment A) It was noted that the results and statistics presented were not fully stratified and validated and were simply meant to gain a better general consensus and aid in future discussions. Staff also explained that there were hundreds of comments received and that these comments would be presented topically during future committee meetings.

The committee concluded that both surveys should be open unit May 1, 2015. Staff was directed to review and better stratify the information to present to the committee at a later date. There was also discussion concerning the possibility of conducting a survey of community mental health agencies to gain a better understanding of how and if they are offering training to their supervisees.

Update on Board of Psychology and Medical Board Supervisor Requirements

During the last committee meeting, committee members requested information about the Board of Psychology and the California Medical Board, as Board staff was unaware of the requirements for a licensed psychologist or psychiatrist to become a supervisor. Staff presented their findings.

Discussion Regarding Supervisor Qualifications

The committee discussed supervisor qualifications that staff presented based on past committee work and the supervision survey results. The following topics were discussed:

- Increasing the initial training of LMFT and LPCC supervisors to 15 hours to be consistent with the current requirements for LCSW supervisors.
- Require 6 hours of ongoing training every two years for LCSW, consistent with current LMFT and LPCC requirements. The committee is interested in the possibility of using a competency-based model rather than specifying particular content. Staff was asked to research how other entities do this.
- Initially decided supervisor training must come from an acceptable CE provider, but asked staff to survey agency directors about the potential impact.
- Decided to accept an advanced supervisor certification in lieu of the requirement that supervisors must be licensed for two years before supervising. The possible acceptance of AAMFT, CAMFT, American Board of Examiners in Clinical Social Work and the Center for Credentialing and Education supervisor certification was discussed.

- Whether supervisors should have to receive a pre-approval or should be required to obtain a registration from the Board. There was a consensus that while pre-approval and registration would offer some benefit the bigger concern is greater oversight of supervisor.

Future Meeting Dates

June 26, 2015	Southern California
August 7, 2015	Sacramento
October 23, 2015	Sacramento

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SUPERVISOR SURVEY RESPONSES
March 23, 2015

What type of license do you hold? Select all that apply.		
	Response Percent	Response Count
Licensed Marriage and Family Therapist	63%	213
Licensed Clinical Social Worker	37%	125
Licensed Professional Clinical Counselor	10%	35
Psychologist	3%	9
Board Certified Psychiatrist	1%	2
Responses		342
There were approximately 42 respondents that were dual licensees.		

What type of license do you hold? Select all that apply.		
	Response Percent	Response Count
Masters	88%	295
Doctorate	12%	41
Responses		337

How long have you been licensed?	
Average Number of Years	14.80
Responses	341
Responses ranged from 2 to 46 years.	

How long have you been supervising?	
Average Number of Years	9.8
Responses	339
Responses ranged from 1month to 42 years.	

What type of registration do your supervisees hold? Select all that apply.

	Response Percent	Response Count
IMF	81%	269
ASW	61%	203
PCI	12%	41
Responses		331
skipped question		11

Do you believe you were adequately prepared for being a supervisor?

	Response Percent	Response Count
Yes	78%	264
No	22%	73
Please explain:		263
Responses		337

Sampling of comments to question. (266 total comments)

Yes, I was prepared

1	Lots of CEUs, reading and experience with my own supervisors.
2	I took a 3-unit, 45-hour (semester-long) doctoral-level class in supervision as part of my MFT doctorate. I was required to do 100 hours of supervision under the mentorship of an AAMFT Approved Supervisor and receive 36 hours of supe-of-supe. I had to then write a paper on my theory of supervision. This allowed me to become an AAMFT Approved Supervisor. I have had to renew my designation twice now, every 5 years, with 5 hours of training. I believe that the current system in California, of saying only "hold a license for 2 years and take 6 hours of training" is woefully inadequate in comparison. Yet California doesn't acknowledge or require the AAMFT Approved Supe status.
3	I learned from both excellent supervisor and those who did not have great skills. As a supervisee I understood there are more than one method to teach. And there are many types of learners.
4	I took the NASW supervisor training course for 2 days which was very helpful. Have taken several courses and had group supervision for supervisors.
5	using the role models of my own supervisors, plus CE courses, plus additional reading, plus peer support, yes
6	I worked in an agency setting, so I was provided with time to learn how to supervise while supervising bachelors level mental health providers. I moved to masters level clinicians when I was 2 years post licensure. I was provided support and repeated trainings to maintain my skills.
7	In addition to the 2 years licensing requirement I also earned designation as a AAMFT Approved Supervisor. That designation requires re-certification every 5 years through a course approved by AAMFT.
8	I have a lot of management and supervision experience in another field before getting

	my license which helped. The additional training requirements helped.
9	Yes, within my role as a clinician and a hospital employee, I read many journal articles, keep up with up to date info on evidenced based treatment, and periodically attend supervision training. In the MSW program I attended, I learned a lot about supervision, case consultation, process recordings, and other tools that I use with interns.
10	I had great supervisors who were amazing role models for how to do supervision. The CE classes are also very helpful.
11	In addition to the required continuing education courses, I met with the agencies director and another supervisor to received consultation about how to be a supervisor, read a number of articles and attended monthly supervisor meetings to share thoughts, concerns and receive feedback and advice.
12	The best preparation for being a supervisor has been 1. Having done the job with patients similar to those my supervisees see; 2. Having done my own clinical therapy for years; 3. Being open minded to evidence based practices yet understanding those modalities aren't best for everyone.
13	My organization provided supervisor training that included BBS standards, as well as agency supervisor information. I've also gone on the BBS website, read CAMFT articles, and utilized consultation with peers as support.
No, I was not Prepared	
1	Even though I took the course on supervision it wasn't geared for the population nor the type of cases my agency saw. The title of the course was general but the material was not general. I wished it would of given me more tools and samples of things/items/contracts/etc. I should implement in my supervision style.
2	The classroom or workshop provides great fundamentals, theory and opportunity to network. However, it does not adequately prepare for real life experience.
3	Other than taking the required CEUs, there was nothing in place to teach me hands on skills on providing direct supervision. The CEU courses that I have taken are very general in dynamic. Although they were helpful, I think it would be more beneficial for the 2 years post licensure to be spent observing (or being observed) supervision.
4	When I started supervising I mostly relied on my own experience of clinical supervision. Over the years I have gained skills through reading and asking for feedback from my supervisees. I'm not sure what, other than this experience, may have made me a better supervisor, just like being a social worker, experience improves our skills.
5	Although I had taken relevant coursework and training to be qualified, I had no formal mentorship to help me adequately prepare. However, I did begin to include clinical supervision into my own supervision with my administrator to ensure that there was some oversight of my work.
6	The level of awareness of detail in the clinical supervisory relationship, I did not feel I had adequate training on. Such as the parallel process, understanding how clinicians hold back info for various reasons, and how to give them the responsibility as they became more experienced. In addition, it is diffult to manage interns at differnt learning levels and clinical abilities. I found it a challenge early on shifting to meet each person's needs based on where they were at clinically. I felt prepared for providing feedback on clinical cases and assisting clinicains do Tx plans and diagnosising.
7	I had to seek out good trainings and it took a few years to realize what good training was.
8	I basically just jumped in because that's what happens where I worked at the time. I had only my own supervisors as samples. Later I got a certification and it was better. I also had support to get help.
9	I did not feel I had had the best supervision during my years of ASW supervision, so I

	did not have a great role model to base my supervision on. I went to several trainings, but most were theoretical, rather than practical, "how to" trainings. It would be nice to have an outline for basic topics to cover and some practical "how to" trainings.
10	Little to no training on the supervision process. I attended the field supervisor training for social workers which was somewhat helpful.
11	CEU trainings were to generic, covered law and ethics well but not the practical issues.
12	When I first became a supervisor, the literature on supervision was minimal. The emphasis was on training professionals to become counselors and PSYs, not training the trainers.
13	I had to take numerous on-line classes to supplement the mandatory 6-hour MFT and 1- hour LCSW.

Beyond the BBS required hours of supervisor training or coursework, how else have you prepared for being a supervisor?	
	Response Count
Open ended question	313
Responses	313

Sampling of comments to question. (313 comments total)	
1	Drawing on my own experience as a supervisee; coursework is key also as well as being a job supervisor
2	Discussed issues with peers, paid for consultation as needed, taken other courses.
3	Observing others supervisor styles
4	Independent classes regarding clinical supervision, reading articles related to supervision and social work practice, and my own supervision experience.
5	Keep current on BBS news and read CAMFT The Therapist magazine and talk regularly with other supervisors.
6	I have been a manager, administrator and college professor all of which I believe has prepared me.
7	Continuing to take it upon myself to get quality supervision - not all supervisors are equipped to be *good* supervisors.
8	I have attended many many supervision courses, completed my Approved AAMFT supervisor training, researched supervisor practice, organized some supervision conferences and co-authored (with 3 others) "The Transformed Supervisor" training with our AAMFT director Olivia Lowey.
9	Worked in consultation with numerous other supervisors to develop process, and interviewed many of their supervisees for their input.
10	During my own internship I paid close attention to what my supervisors taught me and apply some of their expertise to my own supervisory role. As well I engaged in numerous consultations with other Therapists and my Therapist.
11	I worked with several strong supervisors prior to being licensed, and had access to licensed peers for consultation when I began to supervise myself. I also took 2 supervision courses right away, and read what I could on the topic.
12	I shadowed other supervisors in their groups. i have had them watch me and provide me with feedback as well. I also have it as a standing agenda item on my bi-monthly supervision with my manager who is a clinician as well.

13	prior management training; observing myself and others in the role of supervisor; easily admitting when I've made a mistake
14	Continuing to learn and by continuing to treat clients.
15	I am currently reading a book on supervision but not much.
16	Being supervised while learning to supervise

Do you believe that six hours of supervision training or coursework is sufficient for a new supervisor?		
	Response	
Yes		
No		
Please explain:		257
Responses		337

Sampling of comments to question. (257 comments total)	
Yes, Six hours is sufficient	
1	Yes, I think it's enough for a seasoned, responsible, well-trained clinician who takes her profession seriously. On the other hand, if those things are not true, all the training in the world will not make that person a good supervisor.
2	Minimal but adequate. To require more would put a serious damper on the number of supervisors available. Maybe a separate designation for a "Supervisor's Supervisor" with more advanced training?
3	It is a reasonable "start." I am hesitant to advocate for creating barriers to supervision. It can be hard for non-profits that train interns to get and retain good supervisors. I do think weekly consultation for new supervisors, with experienced supervisors for maybe the first two years, at least, is a good idea.
4	I know in agencies that are strapped for money it is economical to ask anyone who has been licensed for more than 2 years to begin offering supervision. Often the supervision offered focuses on using the treatment philosophy of the agency and asking the supervisor to pass that information on. But I have talked with people in that situation and they often feel over their heads. A six hour training every two years is not sufficient to cover all that needs to be covered in order for a new supervisor to feel adequate.
5	Given that one cannot supervise until one has been licensed for at least 2 years (I believe) a 6 or 7 hr supervision for a new supervisor should be enough. After all, the person has had 3500 hours of their own supervision to "learn" and evaluate from. In addition, good supervision skills, like good clinical skills, are developed over time. Especially as one has more supervision experiences.
6	I believe that the educational requirements involved in becoming a therapist in addition to the 6 hours are enough.
7	I believe it's the experience of actually doing supervision that raises one's awareness about what is needed to do it well
8	It depends on the individual's other training and experience.
9	We all have to start somewhere and every supervisor was supervised for many hours
10	The six hours should be very precise with sample forms to assist the Supervisor. The person teaching the course should address all aspects of supervision, including the more problematic supervisee.

No, Six hours is not sufficient	
1	12 hours of training or coursework would be better for becoming a new supervisor. There is so much to becoming a Supervisor that a 6 hour Course isn't able to cover. The initial 12 hours could focus on the most critical areas of Supervision.
2	6 hours could be enough, but only in a live setting, but for the vast majority of issues that come up in supervision it likely will not prepare a supervisor. By the time that the legal aspects are covered of paperwork required, how ASWs differ from other supervisees, and the differences between trainees and IMFs, it leaves little time to cover how to conduct supervision and how to be as a supervisor.
3	I have seen people begin supervising after reading a short online course and completing a written exam. Like the work we do with our own clients, supervision is a relational process. Academic training, familiarity with the supervision literature, and a mentorship process are all important elements of forming a supervision skillset for mentoring junior clinicians.
4	I think there needs to be some specialized supervision courses, including mock supervision exercises, perhaps a panel of experienced supervisors who can field questions from newer supervisors presenting actual dydactic experiences.
5	I think there should also be a requirement for first time supervisors to choose a modality to train others in. Not that each supervisee will have to use that same modality, but it guarantees at least a touch of expertise in something.
6	It depends on where your supervisees are working and the agency requirements. I worked for a large state-run agency that regularly hired large numbers of new social workers, so the demands of supervision were quite challenging at times. Currently I work for a small college counseling center where I supervise only one supervisee, so the work is less challenging.
7	It is in no way adequate. It does not cover theories of supervision, contracting for supervision, application of theories of therapy, broadening your understanding of theories to supervise interns from different perspectives, cultural issues, isomorphic issues up and down the system, self-of-the-supervisor issues, etc.
8	Most supervision courses cover basic supervision issues, but not helping the supervisor conceptualize clearly what they are wanting to accomplish with their supervisee. One online training on supervision had major impact on my supervisorial approach - main pt was how does the supervisor help the supervisee to "get it", meaning the skills, the way to get in a therapeutic thinking mode, the way to attune, the way to hear things, the way to know where to go with a client, the way to craft fitting interventions.
9	New supervisors should have live training and good role models to learn from in their own internships. If they have had that & in their practicums, then they will be better prepared. Supervisors should be monitored by the BBS to be sure they are providing a high level of clinical, legal and ethical training and understand how to work most effectively to help clients/patients reduce their symptoms and provide them with skills to do so.
10	There are numerous consideration when supervising that cannot be covered in a 6 hour training; I would like to see trainings that specifically target working with trainees/unlicensed therapists and another that was specific to licensed or very experienced interns. Hopefully this would include concrete tasks to work on and how to move through the stages of a supervisee's growth.

Do you believe that licensees should be required to complete more training and coursework before supervising? If yes, what do you believe to be a sufficient amount of training or coursework?

	Response	
No		
Yes, 15 Hours of training or coursework		
Yes, 30 Hours of training or coursework		
Yes, 3 Unit course		
Please explain:		186
Responses		337

Sampling of comments to question. (186 comments total)

No		
1	I think the six hours of supervision training is enough to begin, however, I think licensees should be licensed longer than two years to be eligible to supervise.	
2	It is hard enough for interns to find supervisors willing to take them on, given the current structure. More training would make it even harder. I would only support a higher bar if a large number of interns are experiencing negative consequences due to unskilled supervision.	
3	I think that work experience as a supervisor should reduce the required hours of supervision training. I have not found the supervision courses to be useful at all.	
4	Take the courses and get to work; it is in the work that you learn.	
5	If the training could be designed as ethical and practical then more time wouldn't be necessary. The follow up hours needed could be carefully designed to meet any gaps in the original training.	
6	Coursework on supervision only gets you so far. I believe that consultation, where you present supervisory dilemmas to colleagues might be more helpful. Certainly, at least 6 units when you start supervising is important. Some non-profits that hire supervisors will pay for necessary courses and some won't. This can be an issue at non-profits with lower wages and lower budgets.	
Yes, 15 Hours of training or coursework		
1	I am caught between what I feel is sufficient (3 unit course) and what is required. I do not want what is required to stop people from becoming supervisors.	
2	Supervisors learn on the job and no amount of training or coursework can prepare you for that. Also more training is expensive and would burden supervisors unnecessarily and prevent some licensees from supervising.	
3	15 hours would be an improvement, but still not enough if the instruction is low-quality or lacking in basic necessary information.	
4	I'd support 15 hours only if the content is relevant and concrete. and not just more time.	
5	The training needs to be different than the training received by ongoing supervisors.	
Yes, 30 hours of training or coursework		
1	At least for a primary supervisor, that is, the one who is doing the majority of an intern's supervision, it is important that the supervisor is motivated and prepared adequately in order to mentor and guide the intern throughout the process. In order to do this, a supervisor needs solid training.	
2	I believe that there needs to be more application, theory, instructions on how to handle	

	disciplinary actions, how to "weed" out the individuals who don't need to be in the field.
3	Without the oral exams, supervisors are the gatekeepers and need to know more than in the past.
4	There are too many issues involved in supervision to be covered in anything less than a 30 hour course.
5	Graduate schools are not preparing graduates for BBS licensure clinical practice. And they are not providing the necessary clinical training in graduate internships. It will be upon the shoulders of post graduate Licensed supervisors to provide what is missing.
6	But spread out; and covering everything from reporting issues to discipline, and support for their questions.
1	Due to the complexity of supervision a course that prepares a supervisor is necessary.
2	Supervision should be at least as important as the core content areas we studied to receive a degree.

Do you believe that requiring a supervisor to complete six hours of supervision training or coursework for each renewal period is of value to a supervisor?		
	Response	
Yes		
No		
Please explain:		231
Responses		339

Sampling of comments to question. (231 comments total)	
Yes, Six hours per renewal period is of value	
1	It encourages supervisors to remain current on changes in the law and network with other supervisors
2	It is important that supervisors be held accountable to staying up with relevant information in order to continue providing well informed supervision. These courses would need to be well designed and have direct relevance to the work of supervision, including information about treatment to convey to interns.
3	I wish there were "advanced topics" available for the renewals, as retaking the same 6 hour training over and over is not that helpful.
4	Supervision is a specific skill that needs refreshing from time to time. It is also important for supervisors to be reminded of best practices
5	Those who supervise have an additional responsibility to the profession and to the consumer and they need to be reminded of that, as well as have an opportunity to reflect on their work with supervisees and to review their skills and what they need to improve.
6	I would not mind that and think it would be a good refresher if there are different aspects of supervision that are targeted. meaning, not just the same training reworked every 2 years
7	Absolutely It is an opportunity to acquire current knowledge and advancements in the field as well as an opportunity to network with other supervisors and create a

	consultation support system
8	This is most helpful in that it is an important way for me to keep up to date on new requirements, regulations and legal and ethical responsibilities.
No, Six hours per renewal period is not of value	
1	Not much changes in two years. Supervision is a skill. Although it is easy to get complacent, I typically don't get anything out of the repeat trainings.
2	In what way could the coursework be of value? Supervision is more of an art than a science, and the courses are extremely idiosyncratic, reflecting the styles and personalities of the presenter, which is of limited value. I trust my own extensive experience in developing rapport, teaching, encouraging, questioning, and validating the work of the people I supervise.
3	Over the past decade, things have changed so much that this is not enough. This leaves the supervisor to find what course they are interested. Yet those courses generally may not address up and coming issues, such as telehealth, social media issues, etc.
4	It's just one more thing on their to do list. Good supervisors make themselves good through curiosity, compassion, social consciousness, and desire and integrity.
5	Many of the trainings remain the same, so it is just retaking the same content over and over and is often more theoretically based, than practical information.
6	Maybe it's just because I've had additional training, or maybe it's just the luck of the draw of the courses I've taken, but by and large, I have not found the 6-hour trainings every other year to be that valuable.
7	Once the supervisor is experienced, I think having the legal/ethical class each renewal period would be sufficient.
8	It seems like it may be challenging to find new courses per renewal period focused on supervision and it would not be a good use of time to take the same course over and over again per renewal period.

How often do your supervisees review your performance? Select all that apply.		
	Response Percent	Response Count
Weekly	14%	47
Monthly	9%	31
Quarterly	27%	92
Yearly	28%	94
Never	18%	61
Other	12%	42
Responses		341

Have you ever charged for supervision?

	Response Percent	Response Count
Yes	32%	108
No	68%	233
Responses		341

How many supervisees have you supervised in the following settings? Please enter approximate number of supervisees for each setting.

	Response Average	Response Total	Response Count
Private Practice	3	670	207
Governmental Entity	9	1,512	165
Public Non-Profit Agency	28	6,833	240
Other Community Agency	10	1,358	139
Medical Facility	5	674	129
School, Colleges and Universities	27	4,244	155
Other	1	84	86
Responses			338

What type of supervision have you provided in the following settings? Select all that apply.

	Individual	Group	Both	Response Count
Private Practice	95	6	24	118
Governmental Entity	43	16	50	90
Public Non-Profit Agency	81	54	159	216
Other Community Agency	28	12	40	64
Medical Facility	30	6	26	54
School, Colleges and Universities	37	21	45	84
Other	8	0	6	14
Responses				339

**Where do you conduct your supervision for the following settings?
Please use the dropdown menus to select the approximate percentage.**

Onsite						
	N/A	0-25 %	25-50 %	50-75 %	75-100 %	Response Count
Private Practice	19	5	6	6	74	110
Governmental Entity	8	1	2	5	71	87
Public Non-Profit Agency	5	6	4	20	164	199
Other Community Agency	10	4	1	5	45	65
Medical Facility	12	3	0	5	38	58
School, Colleges and Universities	12	3	4	8	50	77
Other	12	1	2	0	9	24
Offsite						
	N/A	0-25 %	25-50 %	50-75 %	75-100 %	Response Count
Private Practice	13	10	4	1	12	40
Governmental Entity	11	12	0	2	5	30
Public Non-Profit Agency	19	27	2	4	17	69
Other Community Agency	11	8	0	4	8	31
Medical Facility	11	4	2	1	4	22
School, Colleges and Universities	8	10	2	1	11	32
Other	8	1	1	0	1	11
Videoconferencing						
	N/A	0-25 %	25-50 %	50-75 %	75-100 %	Response Count
Private Practice	14	4	1	2	1	22
Governmental Entity	12	9	0	0	0	21
Public Non-Profit Agency	24	14	3	2	0	43
Other Community Agency	11	4	0	0	0	15
Medical Facility	10	2	0	1	0	13
School, Colleges and Universities	11	4	0	1	2	18
Other	8	1	0	0	0	9
						Question Totals
Responses						330

Do you use a certain theory of supervision?		
		Response
Yes		
No		
Responses		323

What theory of supervision do you use? Select all that apply.		
	Response Percent	Response Count
Integrated Development Model	27%	86
Lifespan Model	13%	41
Psychodynamic Model	35%	110
Person-Centered Model	38%	121
Cognitive Behavior Model	45%	143
Reality Therapy/Choice Theory Model	10%	33
Family Therapy Model	35%	112
Feminist Model	7%	23
Discrimination Model	1%	2
Systems Approach Model	50%	159
Reflective Learning Model	21%	67
Solution-Oriented Model	38%	119
Schema-Focused Model	4%	12
Littrell, Lee-Borden & Lorenz Model	1%	4
Hawkins & Shoset Model	1%	3
Eclectic	44%	139
Other	16%	51
Other (please specify)		72
Responses		317
Other responses included Mindfulness, Hypnosis, Attachment, Humanistic-Existential, Gestalt, Dialectical Behavior Therapy, Mindfulness, Kudushins, Jungian, Narrative Therapy, Meta Frameworks, Harm Reduction Supervision Model, Interpersonal Process Recall, Recovery Oriented, Transactive Planning, Core Trauma, Somatic Approach, Reflective Supervision, Internal Family System Model, Bowenian Model, Collaborative, Body-Oriented Psychology		

What type of evaluation do you prefer to use when evaluating supervisees?		
	Response Percent	Response Count
Informal (Periodic discussions that are not documented)	46%	155
Formal (Scheduled discussions that are not documented)	16%	56
Formal/Documented (Scheduled discussions that are documented)	58%	197
Responses		

How frequently do you provide an informal evaluation to your supervisees? Mark all that apply.

	Response Percent	Response Count
Weekly	45%	152
Monthly	21%	72
Quarterly	26%	89
Yearly	8%	27
Never	4%	12
Other (please specify)	14%	47
Responses		338
Common Other responses included; varies, when needed, depends on the setting, when requested, depends on the supervisee		

How frequently do you provide a formal written evaluation to your supervisees?

	Response Percent	Response Count
Weekly	1%	4
Monthly	3%	9
Quarterly	32%	108
Yearly	40%	136
Never	16%	55
Other (please specify)	16%	53
Responses		339
Common Other responses included; twice a year, at the end of supervision, when requested, as needed.		

Are you recognized as a supervisor by the following entities? Select all that apply.

	Response Percent	Response Count
CAMFT	40%	68
AAMFT	20%	34
ACS	2%	4
NASW	27%	46
Other (please specify)	30%	52
Responses		171

Would you be in favor of requiring Supervisors to register with the Board?

	Response Percent	Response Count
Yes	54%	173
No	47%	150
Please explain:		155
Responses		318

Sampling of comments to question. (155 total comments)

Yes, I am in favor of requiring supervisors to register

1	I think there are a lot of therapists who are not well trained because the supervisors are not well trained. If there was some accountability the supervisors would be better equipped.
2	The Board needs to exercise more oversight to prevent fraudulent signing off of supervised hours.
3	It provides another level of authenticity; perhaps setting the standards higher.
4	I have seen and/or heard about supervisors that are not following the ethical or legal guidelines and/or regulations. I think it's important for the supervisee to have a portal for complaints

No, I am not in favor of requiring supervisors to register

1	No, because there would inevitably be a supervisor "qualification" examination.
2	This is unnecessary. The 6 hour CE requirement is enough and the board has shown no ability to evaluate counselors much less supervisors.
3	This feels like an additional bureaucratic layer that is unnecessary.
4	I think the profession should handle this issue. The board is a "blunt instrument" better purposed to monitor illegal conduct than improve the quality of supervision.
5	Providing supervision takes additional time and effort, in addition to my regular job duties. Providing supervision is not something I am required to provide as part of my job. I do it in order to support those in my agency who desire to advance to the LCSW level. There licensed individuals in my agency and elsewhere, who are not willing to provide supervision due to the additional time it takes to complete trainings and provide the ongoing supervision. I believe that the more requirements and constraints that are placed on it, the fewer people who will be willing to provide it, leading to limited supervisory resources for those seeking supervision. This may lead to them leaving an agency to seek supervision somewhere else, or having to pay for it as people will begin to market themselves as a Registered Supervisor. I am in favor of a little structure to encourage consistency, but do not believe that requiring registration is necessary.

Why did you become a supervisor?

	Response Percent	Response Count
It was required of my job	33%	112
I found the process interesting/rewarding	78%	265
I wanted to give back to the profession	73%	248
I wanted the additional income	15%	50
Please explain other	14%	47
Responses		340

Sampling of comments to question. (340 comments total)

1	I am committed to the field and wanted to do what I could to train competent professionals. I enjoy being on the journey for another's growth and development.
2	An opportunity to supervise an intern interested in somatic psychotherapy arose and I found the idea intriguing. I took the opportunity to become a CAMFT Certified Supervisor as I always enjoy learning more and expanding myself.
3	Personal request from Interns
4	It was requested that I do supervision.
5	By putting a lot of time and effort into providing excellent supervision, I am assisting others to grow personally and professionally and to effect change in future generations of Clients.
6	I was promoted several times at the same organization. At two years post-license I was offered the opportunity to add supervision hours as a backup supervisor. Currently, my income consists entirely of supervising at several agencies as an independent contractor.
7	Our agency needed to make cut backs which involved laying off the previous part time supervisor. I am a full staff Therapist at the agency and was asked if I would like to accept the position yet they wouldn't be able to offer additional income at this time (due to agency's funding decline). I accepted the position because I thought I would enjoy the role and wanted to empower other interns. I also get to keep seeing clients.
8	It was part of my doctoral program - semester-long class, 50 of my 100 required hours of mentored supervision, and 18 of my 36 hours of supervision-of-supervision. This got me halfway to the Approved Supervisor status. I completed the Approved Supe process in order to have the designation in case it was needed for my job. It has since been needed in teaching positions everywhere but California - in CA I have needed to supervise but did not need the AAMFT Approved Supe designation. Now I also supervise in my private practice. Part of my motivation is to help mentor new clinicians, particularly from under-represented groups, and help them develop their own businesses as well as achieve licensure and grow as clinicians.
9	Request from employer at first, and felt my experience would enable me to "pay it forward." It also enriched my own therapeutic experience.
10	It is the best way to enhance self awareness as a practitioner and to recognize what you know bs what you don't know. And to stay fresh with trends from younger practitioners
11	I was able to obtain my licensing supervision hours at my current employer, prior to becoming licensed. While it wasn't the greatest and didn't provide the best role model, my agency did support me being able to obtain my hours. Many people come to my agency for employment and are seeking supervision, but we have very few licensed staff who are

	willing to put in the extra time for training and providing supervision. I am doing it, so that we can retain those people and so they stay with our agency and are not forced to leave in order to obtain supervision. So, it is my "give back" not just to the profession, but also to the agency which supported me.
12	I enjoy teaching and learning from others

SUPERVISEE SURVEY RESPONSES
March 23, 2015

What type of registration do you have? Select all that apply.		
	Response Percent	Response Count
Marriage and Family Therapist Intern	54%	105
Associate Clinical Social Worker	34%	66
Professional Counselor Intern	12%	24
Responses		195
There were seven respondents that had a dual registration. Six had a MFTI and a PCI registration. One had a ASW and PCI registration.		

Is this your first registration?		
	Response Percent	Response Count
Yes	90%	173
No, This is my 2nd	9%	19
No, This is my 3 rd	1%	3
Responses		195

What were your reasons for needing a 2nd or 3rd registration?		
	Response Percent	Response Count
For employment purposes.	26%	6
I was unable to gain all of my hours in 6 years.	35%	8
Other	49%	8
Responses		20

Sampling of comments to question. (8 comments total)	
1	To maintain my intern status while preparing for or taking exam and maintaining employment.
2	Difficult to find a supervisor or working part time to obtain hours.
3	I was unable to attain a supervisor with the necessary requirements to sign off on hours I had accrued over the past 10 years.

Approximately how many supervised hours have you gained?		
	Response Average	Response Count
Clinical	1,587	195
Non-Clinical	946	151

What has been the approximate client mix of your supervised experience?						
	N/A	1-25%	25 - 50%	50 - 75%	75 - 100%	Response Count
Adult Individual	10	42	42	48	34	173
Groups	26	89	29	12	5	160
Couples	41	75	22	3	0	139
Children/Adolescents	17	51	37	36	28	168
Families	17	96	26	17	7	161
Other	43	16	1	1	1	62
Please Specify Other						11
Other responses included telemedicine, advocacy, elder adults and administrative.						

What has been your weekly average caseload?		
	Response Average	Response Count
Cases Per Week	15	195
Responses ranged from 2 to 67 cases per week.		

How many supervisors do/did you have?		
	Response Percentage	Response Count
1	100%	195
2	60%	117
3	29%	57
4	14%	28
5	7%	13
6	3%	6
7	1%	2

What type of license does your supervisor hold?		
	Response Percent	Response Count
Marriage and Family Therapist	53%	233
Licensed Clinical Social Worker	33%	144
Licensed Professional Clinical Counselor	2%	10
Psychologist	11%	46
Board Certified Psychiatrist	1%	3
Responses		436

What type of Supervision did you receive from this supervisor?		
	Response Percent	Response Count
Individual	37%	153
Group	17%	73
Both	46%	194
Responses		420

How many hours have you gained under this supervisor in the following settings?		
	Response Average	Response Count
Private Practice	332	78
Governmental Entity	634	98
Public Non-Profit Agency	777	205
Other Community Agency	621	73
Medical Facility	403	58
School, College or University	381	76
Other	174	33
Responses		621

Where did the supervision take place? Select all that apply.		
	Response Percent	Response Count
Onsite	78%	369
Offsite	18%	79
Videoconferencing	4%	12
Responses		460

Did you pay this supervisor?		
	Response Percent	Response Count
Yes	12%	48
No	88%	370
Responses		418

Did the Supervisor provide regular weekly feedback?		
	Response Percent	Response Count
Yes	81%	366
No	19%	52
Responses		418

Did your supervisor ask you for feedback on their supervision?		
	Response Percent	Response Count
Yes	51%	213
No	49%	206
Responses		418

What methods of supervision did this supervisor use? Select all that apply.		
	Response Percent	Response Count
Report by Supervisee	92%	386
Direct Observation	22%	92
Review of Case Notes	62%	261
Audio or Video Tape	17%	71
Co-Therapy	12%	49
Other (please specify)	8%	33
Responses		418
Other responses included case presentation, case consultation, role play, and report from other employees.		

Did your supervisor regularly discuss the following? Select all that apply.

	Response Percent	Response Count
Your Strengths	78%	313
Areas of Growth	79%	317
Setting Supervision Goals	51%	202
Achievement of Supervision Goals	41%	165
Legal and Ethical Issues	85%	340
Cultural Diversity	64%	255
Responses		399

How satisfied were you with the quality of this supervision?

	Response Percent	Response Count
Dissatisfied	10%	42
Somewhat Dissatisfied	12%	51
Satisfied	39%	161
Completely Satisfied	39%	162
Responses		416

Sampling of comments to question (143 comments total)

Dissatisfied	
1	Didn't get to talk much about the cases since we often got interrupted.
2	Didn't learn any clinical skills. I felt it was a waste of time.
3	I felt I needed more guidance in some areas
4	Gave more time to some than others. Difficult to arrange consistent time.
5	It was a group but supervisor was not very engaging.
6	The supervisor charged me for the assessments of clients, although she did not show me results or explain the process. The supervisor asked me to contact insurance company's and ask for case by case agreements. The supervisor asked that I only take cash, after the clients were told their insurance companies were approved by billing.
7	Supervisor was overloaded with responsibilities and work, making supervision with me individually a low priority. We still met regularly but our meetings did not meet my expectations and I did not feel as though I was learning or benefitting in my early career development from our time together in any way.
8	Supervision sessions did not help me develop the goals I have set. At times, supervision was used to discuss work related issues such as performance evaluations, work load, staff changes etc. At times, supervisor talked about herself & her personal problems. I did not have a lot of respect for my supervisor as she was more focused on achieving organizational goals vs advocating for clients or respecting their self-determination. Supervisor also did not back me up when issues arise with other interdisciplinary team members, instead just told me to let it go. Thus, I did not value her supervision advice.

9	I felt my supervisor was so much into the therapy; he neglected to pay attention to details such as the law and ethics. They are touched upon, yes, but I feel as though I'm asking more questions, therefore, he does answer them. Not enough initiative on his part.
10	Supervisor was non-empathetic toward clients, indirectly (no client contact). Supervisor used axis 2 diagnoses as labels in seemingly spiteful or at least minimizing manner. Supervisor was quick to answer questions which could have been left for supervisees to give a go first. Supervisor used hostile augmentation fallacies when faced with differing opinions (red herring, straw man, false duality, etc). Supervisees turned to each other for advice as to how to contain supervisor or at least navigate the less than ideal situation until hours have been met. In short some training is needed on how to use clinical skills (such as motivational interviewing and humanistic rapport building) to lead instead of traditional "my way or the highway", confrontational/authoritarian style. Supervisors should know that they too are being graded for accountability.
11	I didn't feel like I got feedback and instead just had my cases listened to. There was very little on how I could grow professionally or do things differently.
12	Supervision focused on administrative aspects and not necessarily challenges faced by supervisee.
13	She lacked clinical expertise. Additionally, she was not updated on current laws within the state of California.
14	None of my supervisors have worked from evidence-based practices, based interventions in consistent theoretical basis, nor used Socratic questioning.
15	Supervisor was too busy to be concerned about my needs. Felt like she relied on me for financial support. I decided to change supervisors to find someone who was truly invested in my growth as a therapist and not her individual and financial needs.
16	Supervisor was not experienced with the population that I worked with, unable to provide teaching/feedback with the types of cases I was dealing with. Supervisor was unable to teach me or help me develop my clinical skills, she was not a very effective teacher
17	This supervisor tells us what we should have done or said rather than using questioning to both help us arrive at it ourselves, and model what we should be doing in therapy. I have exactly 8 minutes most weeks to talk about all my cases, my business and any issues I need help with.
Satisfied	
1	Clinically satisfied, but dissatisfied about how this supervisor ran business and how little she provided specific feedback for areas for improvement.
2	I felt I really had to dig to get the support and guidance I needed
3	She pathologized clients really quickly. She focused on reports we had to write for the agency way too much. She offered little help that was valuable.
4	I've only had one direct supervisor. I am satisfied with my supervision, but I also have some aspects I find to be missing.
5	The supervision experience has been satisfying. I do wish we did more work with treatment planning.
6	My supervisor is very well spoken and gives good advice. However, I believe it would be helpful if he discussed interventions to use while in therapy as opposed to discussing the end goal we want to reach with the client. Knowing the end goal is a must, however there is a lot of work that goes into getting to that goal and having approved interventions that are discussed individually and as a group would be beneficial to the therapist and the client.

7	The supervision was what i needed for where I was at at the time. Learning to be a therapist can be overwhelming with all of the demands on our time. While focusing on strengths, areas of growth goals etc. would have been helpful, I would not want an over-focus here as it would feel like one more thing to have to do while trying to hold it all together and meet the other demands on my time.
8	Feedback was mostly limited to correction of errors.
9	This supervisor was a kind and well intentioned individual but did not possess the very much experience as a therapist to be as helpful as I would have liked in terms of improving my own skills as a therapist.
10	My individual supervisor for my practicum experience was somewhat helpful/qualified to provide supervision but I would have preferred a supervisor with more experience, especially as a practicum student seeing clients for the first time while still in school. I was glad that I was also provided with weekly feedback from professors in my graduate program to supplement the supervision I got at my site. Additionally, this supervisor was only at my site 1-2/week so she was not as readily available or responsive to my needs.
Completely Satisfied	
1	Excellent teacher - very supportive and knowledgeable - really built up confidence of new therapists
2	My first supervisor was wonderful. She had the perfect mixture of listening and instructing. I left her supervision feeling empowered.
3	I felt supported and also challenged to be a better therapist.
4	She is a calm and understanding person- very positive, and has a sense of humor.
5	My supervisor offers a Jungian perspective to the work we do with clients. This has been a great experience.
6	My supervisor was supportive and encouraging. She often provided feedback about my strengths. I sometimes felt uncertain about how to improve.
7	Pertinent subject matter was well covered, supervision meetings were consistent, it was a good learning environment.
8	The supervisor was supportive and made constructive suggestions.
9	This supervisor was also a professor and cared deeply about each one of his supervisees. He trained us in a fantastic model and coached us through he whole process. We worked with a co-therapist.
10	Supervision focused on administrative aspects and not necessarily challenges faced by supervisee.
11	My supervisor has been my "rock" in hard times and my "champion" during good times. I am very satisfied with the support and encouragement I get from her.
12	He was wise and knowledgeable and challenged my personal beliefs in an effort to broaden my understanding of the clients of different cultures or experiences.
13	Supervisor was open to discussion, able to discuss cases in-depth, provide feedback/suggestions to improve my clinical work
14	This was one of my onsite supervisors who ran the counseling agency. He was very attuned and conscientious of this site being a good fit for trainees.
15	I appreciated the quality of this supervision because it exceeded beyond my needs. I appreciated the individual attention in a group setting, along with helpful information to apply to general and specific situations. The overall quality of this supervision was completely satisfying, especially because I was not satisfied with my other supervisor.
16	Supervisor was open to discussion, able to discuss cases in-depth, provide feedback/suggestions to improve my clinical work

How satisfied were you with the responsiveness of your supervisor to your needs?

	Response Percent	Response Count
Dissatisfied	10%	43
Somewhat Dissatisfied	10%	42
Satisfied	40%	165
Completely Satisfied	40%	166
Responses		416

Sampling of comments to question (49 comments total)

Dissatisfied

1	She did not respond to my needs, at all, ever. She was unreachable and always so late to supervision we never really had supervision.
2	This supervisor did not really supervise.
3	I would bring up what I needed and she would discuss what she thought I needed.
4	She was not available after the two hours of group supervision. She wasn't open to individual supervision nor phone calls. She made me feel like I was bugging her.
5	Not engaging. could not relate what he knows to my job
6	My supervisor often uses "lack of available time" in her schedule as a reason for not being able to meet my needs (e.g. more supervision or joint supervision on special cases).
7	often times, my supervisor just told me to let it go & to work within the system. She also did not support me when I had conflicts with other professionals.
8	she was way too busy ad spread thin supervising too many (over 30) trainees/interns.
9	I felt I couldn't be completely honest with my supervisor. I felt that if my views or thoughts conflicted with hers, she was not willing to listen. This created conflict with certain clients/cases.

Satisfied

1	My supervisor is mostly available, but sometimes I find that she is not approachable due to her mood.
2	My supervisor has given me invaluable suggestions and feedback in our discussions and review of audio tapes of my sessions. My supervisor is very busy, so occasionally I don't feel like I have quite as much attention as I'd like to answer my questions regarding NON-CLINICAL issues like administrative tasks, forms, etc
3	Sometimes hard to contact for phone consultation due to her busy schedule.
4	Supervisor was overloaded with responsibilities and work, making supervision with me individually a low priority. We still met regularly but our meetings did not meet my expectations and I did not feel as though I was learning or benefitting in my early career development from our time together in any way.
5	My supervisor is not entirely unresponsive to my needs, and perhaps this is unrealistic, but I wish she were more invested in my development into a more skilled clinician.
6	Supervision focused on administrative aspects and not necessarily challenges faced by supervisee

Completely Satisfied	
1	I was grateful that my supervisor was flexible regarding personal needs
2	All I had to do was ask and she would respond to whatever need I expressed.
3	They were quick to get back to me and support me through struggles.
4	My supervisor was available to answer questions, was supportive, and encouraging.
5	I felt highly supported by this supervisor. I felt like he would be there whenever I called and had a question and he was very present during our supervision sessions.
6	If there was an answer she didn't have she would find it
7	Very involved and responsive. Passionate about marriage and family therapy.
8	When I have explained what I need in terms of skills developments she helps me examine my assessment, and than to develop a plan to develop the skills we identify together as needing improvement.
9	If I had an issue, I knew it would always be "okay" or "safe" to bring it up.
10	My supervisor is available to me at a moment's notice in person, phone, or via email

How satisfied were you with your supervisor's responsiveness when you were faced with a crisis?		
	Response Percent	Response Count
Dissatisfied	8%	33
Somewhat Dissatisfied	7%	28
Satisfied	31%	131
Completely Satisfied	42%	177
N/A	12%	49
Responses		418

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To: Board Members

Date: May 4, 2014

From: Steve Sodergren
Assistant Executive Officer

Telephone: (916) 574-7847

Subject: Exam Restructure Update

BACKGROUND

Effective January 1, 2016 the Board's Examination process will be changing. Currently, the licensing exams are taken upon completion of all other requirements for licensure which includes supervised experience hours. Under the new process, individuals who hold an ASW, MFT or PCC Intern registrations will be required to take a California Law and Ethics Exam a minimum of once per renewal period or until the exam is passed.

If a registrant does not take the Law and Ethics Exam during the renewal period, they will not be permitted to renew the registration until the exam has been taken. Also, if a registrant does not pass the Law and Ethics Exam during a renewal period, they will be required to take a 12-hour continuing education course on California Law and Ethics in order to be eligible to retake the Law and Ethics Exam during their next renewal period. The Law and Ethics course is only taken once during a renewal period if it is necessary. Registrants that apply for a second subsequent intern number will now be required to pass the Law and Ethics Exam before they are issued a subsequent number.

Another significant change is the Boards acceptance of the National Clinical ASWB Exam. This exam will replace the current Clinical Vignette for the LCSW applicants. Those who are currently in the exam process will have to take the new exams beginning January 1, 2016. At that time, if they have passed the current Standard Written Exam they would not have to take the California Law and Ethics exam if they stay current in their exam cycles.

Because these are significant changes, the Board has established grace periods to mitigate the impact that this change may have on registrants and examinees.

STATUS

Staff has developed a web page as well as FAQs concerning the implementation of the Exam Restructure. (Attachment A & B) Outreach efforts are being developed and will be implemented

during the following months in order to ensure that applicants and registrants will understand the impact that the changes may have on them.

Also, Staff has been working closely with the DCA Breeze team and exam vendors to ensure that system changes are ready for implementation. This effort is divided into five distinct phases: Analysis, Design, Build, Testing and Implementation. At this time the Design Phase effort is fifty percent complete.

Concurrently, staff is working to refining internal business process to ensure that staff is prepared for the upcoming changes.



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Exam Restructure FAQs for Registrants

(ASWs, MFT Interns and PCC Interns ONLY)

Effective Date: January 1, 2016

OVERVIEW

Effective January 1, 2016, the Board's examination process for Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), and Licensed Professional Clinical Counselor (LPCC) applicants will be changing as follows:

- **REGISTRANTS MUST TAKE A CALIFORNIA LAW AND ETHICS EXAM:**

Those who hold an ASW, MFT Intern or PCC Intern registration will be required to take a California Law and Ethics Exam while a registrant. (The timing for those who do not hold a registration and have applied to take the exams will not change.)

- **PASSING SCORE REQUIRED FOR SUBSEQUENT REGISTRATIONS:**

Effective January 1, 2017: Applicants will be unable to obtain a subsequent (2nd or 3rd) ASW or intern registration without first passing the Law and Ethics Exam.

Effective January 1, 2016: Applicants will be able to obtain a subsequent registration number without passing the Law and Ethics exam. However, such applicants must **pass the exam prior to the first registration renewal**. The subsequent registration cannot be renewed until the exam has been passed.

- **NEW LCSW & LMFT EXAMS:**

LCSW and LMFT applicants will be required to pass two new exams that replace the existing exams, as follows. Both are written, multiple choice exams. There are no changes to the LEP or LPCC exam types.

- California Law and Ethics Exam. This exam is designed to assess an applicant's knowledge of and ability to apply legal and ethical standards relating to clinical practice. It will replace the Standard Written Exam.
- Clinical Exam. This exam is designed to assess an applicant's knowledge of psychotherapeutic principles and methods in treatment and their application, and the ability to make judgments about appropriate techniques, methods and objectives as applicable to the profession's scope of practice. It will replace the Clinical Vignette Exam.

EXAM RESTRUCTURE FAQs
REGISTRANT QUESTIONS
MFT INTERNS, PCC INTERNS AND ASWS

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EXAM RESTRUCTURE FAQs
REGISTRANT QUESTIONS
MFT INTERNS, PCC INTERNS AND ASWS

THIS FAQ APPLIES TO REGISTRANTS ONLY

**IF YOU HOLD OR ANTICIPATE NEEDING A SUBSEQUENT (2nd, 3rd etc.) REGISTRATION,
SEE QUESTIONS #13, 14 and 15 FOR CRITICAL INFORMATION**

1. Who is considered a “registrant” under the exam restructure?

A registrant is defined as an ASW, MFT Intern or PCC Intern who holds a current or delinquent registration capable of being renewed. If you are not a registrant, see the *FAQs for Non-Registrants*.

2. Will all registrants be required to take an exam? When?

Yes, as described below:

A. Individuals issued a new, first registration number after January 1, 2016:

You will be required to take the California Law and Ethics Exam within the first year of registration.

B. Individuals who currently hold a renewable registration (initial or subsequent):

You will be required to take the California Law and Ethics Exam before your registration’s first expiration date that occurs after January 1, 2016, EXCEPT during the grace period described in #4.

3. What happens if I don’t take the Law and Ethics Exam before my registration’s expiration date?

Unless your registration’s expiration date falls within the grace period described below, you will NOT be permitted to renew your registration until you have taken the exam.

4. What is the grace period and who is eligible?

If you hold a renewable registration that expires no later than June 30, 2016, and your application for renewal is postmarked between January 1, 2016 and June 30, 2016, you may renew without first taking the Law and Ethics Exam. However, you must take the exam during the following renewal cycle in order to renew next time.

5. Do I need to take the exam in order to renew if my registration expires between January 1, 2016 and June 30, 2016?

It depends. If your application for renewal is postmarked no later than June 30, 2016, you do not need to take the exam in order to renew this time. However, if your application for renewal is postmarked after June 30, 2016, you must have taken the exam in order for your renewal to be processed. There are no exceptions.

EXAM RESTRUCTURE FAQs

6. Do I need to take the exam in order to renew a registration that expired before the exam restructure takes place? For example, my registration expired in 2014 and I may need to renew it after January 1, 2016.

If you meet ALL of the following requirements, you can renew without having taken the exam:

- Your registration must be renewable
- Your registration must have an expiration date that is no later than June 30, 2016 AND
- Your application for renewal must be postmarked no later than June 30, 2016

If you do not meet all three of the above requirements, you will be required to have taken the exam in order for your renewal to be processed. If your registration is not renewable, you will need to apply for a subsequent registration number.

7. What is a renewal cycle?

A renewal cycle is the one-year period that ends in the registration's expiration date.

8. What happens if I submit my renewal early and haven't yet taken the Law and Ethics Exam?

If you submit your registration renewal without having taken the exam during the renewal cycle immediately preceding the registration's expiration date, the Board will be unable to process your renewal.

9. What happens if I don't pass the Law and Ethics Exam?

You may retake the exam after at least 90 days have passed from the date you last took the exam. If you don't pass the exam prior to your registration's expiration date, you must complete a 12-hour course in California Law and Ethics before you will be allowed to retake the exam during the next renewal cycle.

10. Who can I take the 12-hour California Law and Ethics course from?

The course must be taken through a continuing education (CE) provider, a county, state or other governmental entity, or a college or university.

EXAM RESTRUCTURE FAQs
REGISTRANT QUESTIONS
MFT INTERNS, PCC INTERNS AND ASWS

11. What happens if I'm required to take the 12-hour course but am unable to complete it before my registration expires?

You will be permitted to renew your registration (provided your registration is eligible for renewal). However, you will not be permitted to retake the Law and Ethics Exam until the Board receives proof of course completion. Remember, if you do not take the exam at least once during any one-year renewal cycle, you will not be permitted to renew your registration until the exam has been taken.

12. How many attempts will I have to pass the Law and Ethics Exam during a renewal cycle? What is the waiting period between exam attempts?

The exam can be retaken after a 90-day waiting period, which provides registrants with at least three (3) attempts to pass the exam during each renewal cycle. To obtain the maximum number of attempts, applicants must submit a re-exam form and fee in a timely manner.

13. What happens if I haven't passed the Law and Ethics Exam by my registration's 6-year time limit?

California law permits a registration to be renewed a maximum of five (5) times before being cancelled. Effective January 1, 2017, an individual cannot be granted a subsequent registration number unless he or she has passed the Law and Ethics Exam. There are no exceptions.

14. How does the exam restructure affect individuals who will need to apply for a subsequent (2nd, 3rd, etc.) registration number?

Effective January 1, 2017, an individual cannot be granted a subsequent registration number unless he or she has passed the Law and Ethics Exam. There are no exceptions. However, this requirement will be phased in starting January 1, 2016, as described on the following page:

EXAM RESTRUCTURE FAQs
REGISTRANT QUESTIONS
MFT INTERNS, PCC INTERNS AND ASWS

If you will need to obtain a subsequent Intern or ASW registration number, and...

<p>A. Your application for subsequent registration is <u>postmarked</u> prior to January 1, 2016 (and is subsequently issued)</p>	<p>Your registration is treated the same as a first/initial registration in the exam restructure. You will be required to take the Law and Ethics Exam by your registration's first expiration date that occurs after January 1, 2016, (except during the grace period described in #4) in order to renew.</p>
<p>B. Your application for subsequent registration is <u>postmarked</u> between January 1, 2016 & January 1, 2017</p>	<p>You can be issued a subsequent registration without first passing the Law and Ethics Exam. However, you must <u>pass</u> the exam before your subsequent registration's initial expiration date if you wish to renew. You may continue to take the exam after your registration expires, and after passing, your registration can be renewed.</p>
<p>C. Your application for subsequent registration is <u>postmarked</u> after January 1, 2017</p>	<p>You will not be issued a subsequent registration until you have passed the Law and Ethics Exam. There are no exceptions.</p>

15. How does the exam restructure affect me if I already hold a subsequent (2nd, 3rd, etc.) registration number?

If you are issued a subsequent intern or associate registration number any time prior to January 1, 2016, and your subsequent registration is renewable, your registration is treated the same as a first/initial registration for purposes of the exam restructure.

This means you will be required to take the California Law and Ethics Exam by your registration's first expiration date that occurs after January 1, 2016, except during the grace period described in #4. Unless you meet the requirements of the grace period, you will not be permitted to renew your subsequent registration until you have taken the exam.

16. What happens once I pass the Law and Ethics Exam?

If you are still earning your hours of supervised experience, you will continue as a registrant until you have completed your hours. Once you have met all education and experience requirements, you will submit an *Application for Clinical Examination Eligibility*. Upon approval of your application, you will be required to take and pass either a California clinical or national clinical exam, as indicated below:

- LMFT: California Clinical exam
- LCSW: Association of Social Work Boards (ASWB) Clinical exam
- LPCC: National Clinical Mental Health Counseling Exam (NCMHCE)

EXAM RESTRUCTURE FAQs
REGISTRANT QUESTIONS
MFT INTERNS, PCC INTERNS AND ASWS

17. What if I am an ASW or MFT Intern and have already been approved to take the Standard Written Exam?

The LCSW and LMFT Standard Written Exams will no longer be available as of January 1, 2016. If you do not pass the Standard Written Exam by that time, you will be required to take the new Law and Ethics Exam.

18. What if I am an ASW or MFT Intern and have passed the Standard Written Exam by January 1, 2016?

You will have fulfilled the new Law and Ethics Exam requirement unless your Standard Written Exam score is more than seven (7) years old.

19. What if I am a PCC Intern and have already passed the LPCC Law and Ethics Exam?

You will have already fulfilled the Law and Ethics Exam requirement.

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Examination Restructure FAQs for Non-Registrants

(Individuals who do NOT hold a registration
as an ASW, MFT Intern or PCC Intern)

LCSW, LMFT & LPCC Programs

Effective Date: January 1, 2016

OVERVIEW

Effective January 1, 2016, the Board's examinations for LCSW, LMFT, and LPCC applicants will be changing as follows:

NEW LCSW & LMFT EXAMS:

LCSW and LMFT applicants will be required to pass two new exams that replace the existing exams, as follows. Both are written, multiple choice exams. There are no changes to the LEP or LPCC exam types.

- California Law and Ethics Exam. This exam is designed to assess an applicant's knowledge of and ability to apply legal and ethical standards relating to clinical practice. It will replace the Standard Written Exam.
- Clinical Exam. This exam is designed to assess an applicant's knowledge of psychotherapeutic principles and methods in treatment and their application, and the ability to make judgments about appropriate techniques, methods and objectives as applicable to the profession's scope of practice. It will replace the Clinical Vignette Exam.

THE FOLLOWING DOES NOT APPLY TO NON-REGISTRANTS AND IS PROVIDED FOR YOUR INFORMATION ONLY:

- **Registrants Must Take a California Law and Ethics Exam**
Those who hold an ASW, MFT Intern or PCC Intern registration will be required to take a California Law and Ethics Exam while a registrant.
- **Passing Score Required for Subsequent Registrations**
Effective January 1, 2017: Applicants will be unable to obtain a subsequent (2nd or 3rd) ASW or intern registration without first passing the Law and Ethics Exam.

Effective January 1, 2016: Applicants will be able to obtain a subsequent registration number without passing the Law and Ethics exam. However, such applicants must **pass the exam prior to the first registration renewal**. The subsequent registration cannot be renewed until the exam has been passed.

If you anticipate needing to apply for a registration while you are in the examination process, see the *Exam Restructure FAQs for Registrants* for more information.

EXAM RESTRUCTURE FAQs
EXAM CANDIDATES WHO DO NOT
HOLD A REGISTRATION

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**THIS FAQ DOES NOT APPLY TO INDIVIDUALS WHO HOLD
A REGISTRATION AS AN ASW, MFT INTERN OR PCC INTERN**

1. Who is considered a “candidate” under the exam restructure?

A “candidate” is an individual who does NOT hold a current or delinquent renewable ASW, MFT Intern or PCC Intern registration, and whose *Application for Examination Eligibility* (licensure) has been approved. If you are a registrant, please see the *Exam Restructure FAQs for Registrants*.

2. What if I am a LCSW or LMFT candidate who has already been approved to take the Standard Written Exam?

The LCSW and LMFT Standard Written exams will no longer be available as of January 1, 2016. If you do not pass the exam before that time, you will be required to take the new Law and Ethics Exam.

3. What happens if I pass the Standard Written Exam by January 1, 2016?

If you have already passed the LCSW or LMFT Standard Written, then you will have fulfilled the new Law and Ethics Exam requirement, unless your Standard Written Exam score is more than seven (7) years old.

4. Are the LPCC or LEP exams changing?

No. The LPCC program will continue to require a California Law and Ethics exam and the National Clinical Mental Health Counseling Exam. The LEP program will continue to require the LEP Written Exam.

5. What if a candidate has already passed the LPCC California Law and Ethics Exam?

A candidate who has already passed this exam will have fulfilled the new Law and Ethics Exam requirement.

6. What happens if a candidate does not pass the Law and Ethics Exam?

You may retake the exam after at least 90 days have passed from the date you last took the exam.

EXAM RESTRUCTURE FAQs
EXAM CANDIDATES WHO DO NOT
HOLD A REGISTRATION

7. Is there a required waiting period between retakes?

Yes, there is a 90-day waiting period.

8. Am I required to take a course on Law and Ethics if I don't pass the exam?

No. This requirement only pertains to registered ASWs, MFT Interns and PCC Interns.

9. Will candidates be required to take a second exam after passing the Law and Ethics Exam?

Yes, applicants will be required to take and pass either a California clinical or national clinical exam, as defined below:

LMFT: California Clinical Exam

LCSW: Association of Social Work Boards (ASWB) Clinical Exam

LPCC: National Clinical Mental Health Counseling Exam (NCMHCE)

10. I have already been approved to take the LCSW or LMFT Clinical Vignette Exam. What happens if I don't pass this exam by January 1, 2016?

The Clinical Vignette Exam will no longer be available as of January 1, 2016. If you do not pass the exam by that time, you will be required to take the new California Clinical or national clinical exam as indicated below:

LMFT: California Clinical exam

LCSW: Association of Social Work Boards (ASWB) Clinical exam

11. What happens if I passed the LMFT or LCSW Standard Written Exam more than seven (7) years ago and have yet to pass the Clinical Vignette Exam?

Once your passing score on the Standard Written Exam reaches seven (7) or more years old, you will be required to retake the Standard Written (if prior to January 1, 2016) or to take the new Law and Ethics Exam, in addition to the new California clinical or national clinical exam.

12. What happens if I pass the LMFT or LCSW Clinical Vignette Exam by January 1, 2016? Will I still have to take the new California Clinical or national clinical exam?

If you have passed the Clinical Vignette Exam, you are not required to take the new California Clinical or national clinical exam.

EXAM RESTRUCTURE FAQs
EXAM CANDIDATES WHO DO NOT
HOLD A REGISTRATION

13. Why isn't California using a national MFT clinical exam?

The Board has been working with the national Association of Marital and Family Therapy Regulatory Boards (AMFTRB) regarding the viability of using its exam for LMFT licensure in California in the future. For updates on this and other Board activity, sign up for our [email Subscriber's list](#).

14. How are the new LMFT and LCSW Clinical exams different from the Clinical Vignette exams?

The clinical vignette exams and the new clinical exams are both designed to be directly related to clinical practice situations. Both types of exams require the ability to integrate and apply professional knowledge and skills.

A clinical vignette exam contains a series of multiple choice items related to a single vignette, and typically consists of 5 to 7 vignettes with 4 to 7 multiple-choice questions associated with each vignette, for a total of 30 multiple-choice questions administered over a 2-hour period. A clinical vignette exam item is longer and can be more complex than a standard multiple choice item.

The new clinical exams will consist of standard multiple choice items, and will continue to include items based on vignettes, though each item will stand alone.

As of January 1, 2016, the new clinical exams will be as follows:

LCSW APPLICANTS

[ASWB National Clinical Exam](#) - this is a 150-item multiple choice exam administered over a period of four hours.

LMFT APPLICANTS

California Clinical Exam - This exam is currently in development, and will be designed to evaluate candidate knowledge, skills, and abilities in the following content areas:

Crisis Management, Clinical Evaluation, Treatment Planning, Treatment, and Law and Ethics. These are the same content areas upon which the Clinical Vignette Exam is currently based. The Clinical exam will consist of 150 multiple-choice items administered over a four-hour period.

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CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES

BILL ANALYSIS

BILL NUMBER: AB 85

VERSION: AMENDED APRIL 15, 2015

AUTHOR: WILK

SPONSOR: AUTHOR

RECOMMENDED POSITION: OPPOSE

SUBJECT: OPEN MEETINGS

Overview:

This bill would make an advisory body consisting of less than three members subject to the Bagley-Keene Open Meeting Act if a member of the state body is serving on it in his or her official capacity, and if the advisory body is supported, wholly or partially, by funds from the state body.

Existing Law:

- 1) Establishes the Bagley-Keene Open Meeting Act, which requires that actions and deliberations of state agencies be conducted openly. (Government Code (GC) §11120)
- 2) Defines a “state body” to mean any of the following (GC §11121):
 - A state board, commission, or multimember body of the state created by statute to conduct official meetings.
 - A board, commission or committee that exercises authority of a state body delegated by that state body.
 - An advisory board, commission, committee, or subcommittee that consists of three or more persons and is created by formal action by the state body or any of its members.
 - A board, commission, or committee on which a member of a state body serves in official capacity as a representative.
- 3) Requires that all meetings of a state body be open and all members of the public permitted to attend. (GC §11123)
- 4) Requires a state body to provide notice at least 10 days prior to a meeting, which includes an agenda for that meeting. (GC §11125)

This Bill:

- 1) Revises the definition of a state body subject to the Bagley-Keene Open Meeting Act. Under the proposed change, an advisory body consisting of less than three members would be subject to Bagley-Keene if a member is serving in his or her official capacity and if the advisory body is supported, wholly or partially, by funds from the state body. (GC §11121)

Comment:

- 1) **Author's Intent.** Current law allows standing committees of a state entity to hold meetings that are not subject to the Bagley-Keene Open Meeting Act if they contain fewer than three members and do not vote to take action on items of discussion. The author's office is concerned that some state agencies are conducting meetings with two or fewer members specifically to avoid open meeting requirements. The author notes it is the intent of the Legislature and the public for government to conduct its business visibly and transparently.
- 2) **Brown Act for Local Governments.** Local government entities must abide by the Brown Act, which is an open meeting act similar to Bagley-Keene. In the early 1990s, the Brown Act contained a similar allowance as Bagley-Keene. This was corrected as soon as the Legislature discovered it; however, a conforming change was not made to the Bagley-Keene Act at that time.
- 3) **Current Board Process.** The Board commonly utilizes two-member standing committees to address issues requiring in-depth discussion and analysis. The intent is to create an environment that encourages discussion and sharing of ideas between Board members, staff, and interested stakeholders, which may eventually be used to generate a legislative or regulatory proposal. No votes are taken at these meetings; any action must be approved by the Board at a board meeting.

The Continuing Education Provider Review Committee and the Supervision Committee are examples of recent two-member standing committees. The Board still notices an agenda for these two-member meetings ten days prior, as Bagley-Keene requires.

If this bill were to become law, additional staff time would be required to complete meeting minutes, but otherwise the Board is already in compliance with Bagley-Keene in regards to these types of two-member committee meetings.

However, sometimes boards form two member executive committee meetings to handle matters such as personnel issues, or to review applications when hiring an executive officer. This bill would require these types of meetings to be noticed and subject to the requirements of Bagley-Keene.

- 4) **Board Members Serving on Other Multimember Bodies.** The amendments in this bill would mean that a board member acting in official capacity on any multimember body, whether a state body or corporate body, would subject that body to the Bagley-Keene Act if that board member receives state funds. In such a case, the

Board must post notice of and an agenda for a meeting that it is not hosting. The cost and compliance issues that this would create may act as a disincentive for Board members to represent the Board at other meetings and events.

- 5) **Urgency Statute.** This bill is an urgency statute. Therefore, if signed by the Governor, it would become effective immediately.
- 6) **Previous Legislation.** AB 2058 (Wilk, 2014) proposed making an advisory body consisting of less than three members subject to the Bagley-Keene Open Meeting Act if the body was a standing committee with a continuing subject matter jurisdiction or a had a meeting schedule fixed by formal action of a state body.

The Board took a “support” position on AB 2058.

However, AB 2058 was vetoed by the Governor, who stated the following in his veto message:

“... Any meeting involving formal action by a state body should be open to the public. An advisory committee, however, does not have authority to act on its own and must present any findings and recommendations to a larger body in a public setting for formal action. That should be sufficient.”

- 7) **Recommended Position.** At its April 23, 2015 meeting, the Policy and Advocacy Committee recommended that the Board take an “oppose” position on this bill.
- 8) **Support and Opposition.**

Support

- California Association of Licensed Investigators

Opposition

- California Board of Accountancy

- 9) **History**

2015

04/22/15 In committee: Set, first hearing. Referred to APPR. suspense file.

04/16/15 Re-referred to Com. on APPR.

04/15/15 Read second time and amended.

04/14/15 From committee: Amend, and do pass as amended and re-refer to Com. on APPR. (Ayes 21. Noes 0.) (April 8).

01/26/15 Referred to Com. on G.O.

01/07/15 From printer. May be heard in committee February 6.

01/06/15 Read first time. To print.

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AMENDED IN ASSEMBLY APRIL 15, 2015

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL

No. 85

Introduced by Assembly Member Wilk

January 6, 2015

An act to amend Section 11121 of the Government Code, relating to state government, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 85, as amended, Wilk. Open meetings.

The Bagley-Keene Open Meeting Act requires that all meetings of a state body, as defined, be open and public and that all persons be permitted to attend and participate in a meeting of a state body, subject to certain conditions and exceptions.

This bill would specify that the definition of “state body” includes an advisory board, advisory commission, advisory committee, advisory subcommittee, or similar multimember advisory body of a state body that consists of 3 or more individuals, as prescribed, except a board, commission, committee, or similar multimember body on which a member of a body serves in his or her official capacity as a representative of that state body and that is supported, in whole or in part, by funds provided by the state body, whether the multimember body is organized and operated by the state body or by a private corporation.

~~This bill would make legislative findings and declarations, including, but not limited to, a statement of the Legislature’s intent that this bill is declaratory of existing law.~~

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

Vote: $\frac{2}{3}$. Appropriation: no. Fiscal committee: yes.
 State-mandated local program: no.

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

1 ~~SECTION 1. The Legislature finds and declares all of the~~
 2 ~~following:~~

3 ~~(a) The unpublished decision of the Third District Court of~~
 4 ~~Appeals in *Funeral Security Plans v. State Board of Funeral*~~
 5 ~~*Directors* (1994) 28 Cal. App.4th 1470 is an accurate reflection of~~
 6 ~~legislative intent with respect to the applicability of the~~
 7 ~~Bagley-Keene Open Meeting Act (Article 9 (commencing with~~
 8 ~~Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of~~
 9 ~~the Government Code) to a two-member standing advisory~~
 10 ~~committee of a state body.~~

11 ~~(b) A two-member committee of a state body, even if operating~~
 12 ~~solely in an advisory capacity, already is a “state body,” as define~~
 13 ~~in subdivision (d) of Section 11121 of the Government Code, if a~~
 14 ~~member of the state body sits on the committee and the committee~~
 15 ~~receives funds from the state body.~~

16 ~~(c) It is the intent of the Legislature that this bill is declaratory~~
 17 ~~of existing law.~~

18 ~~SEC. 2.~~

19 ~~SECTION 1.~~ Section 11121 of the Government Code is
 20 ~~amended to read:~~

21 ~~11121. As used in this article, “state body” means each of the~~
 22 ~~following:~~

23 ~~(a) Every state board, or commission, or similar multimember~~
 24 ~~body of the state that is created by statute or required by law to~~
 25 ~~conduct official meetings and every commission created by~~
 26 ~~executive order.~~

27 ~~(b) A board, commission, committee, or similar multimember~~
 28 ~~body that exercises any authority of a state body delegated to it by~~
 29 ~~that state body.~~

30 ~~(c) An advisory board, advisory commission, advisory~~
 31 ~~committee, advisory subcommittee, or similar multimember~~
 32 ~~advisory body of a state body, if created by formal action of the~~
 33 ~~state body or of any member of the state body, and if the advisory~~

1 body so created consists of three or more persons, except as in
2 subdivision (d).

3 (d) A board, commission, committee, or similar multimember
4 body on which a member of a body that is a state body pursuant
5 to this section serves in his or her official capacity as a
6 representative of that state body and that is supported, in whole or
7 in part, by funds provided by the state body, whether the
8 multimember body is organized and operated by the state body or
9 by a private corporation.

10 ~~SEC. 3.~~

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

15 In order to avoid unnecessary litigation and ensure the people's
16 right to access the meetings of public bodies pursuant to Section
17 3 of Article 1 of the California Constitution, it is necessary that
18 *this act take effect ~~immediately~~ immediately.*

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CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES

BILL ANALYSIS

BILL NUMBER: AB 250

VERSION: AMENDED MARCH 26, 2015

AUTHOR: OLBERNOLTE

**SPONSOR: CALIFORNIA ASSOCIATION OF
MARRIAGE AND FAMILY THERAPISTS
(CAMFT)**

RECOMMENDED POSITION: SUPPORT

SUBJECT: TELEHEALTH: MARRIAGE AND FAMILY THERAPIST INTERNS AND TRAINEES

Overview:

Business and Professions Code (BPC) §2290.5 does not specify that MFT trainees may practice telehealth. This bill would clarify that MFT interns and trainees may do this.

Existing Law:

- 1) Defines “telehealth” as a mode of delivering health care via information and communication technologies. The patient’s location is the originating site, and the health care provider’s location is the distant site. (BPC §2290.5)
- 2) Defines a “Health care provider” as a person who is licensed under Division 2 of the Business and Professions Code, which relates to healing arts. (BPC §2290.5)
- 3) Defines a “license” to mean a license, certificate, registration, or other means to engage in a business or profession regulated by the Business and Professions Code. (BPC §23.7)
- 4) Defines a marriage and family therapist trainee as an unlicensed person who is currently enrolled in a master’s or doctor’s degree program designed to qualify him or her for licensure, who has completed at least 12 semester units or 18 quarter units in that program. (BPC §4980.03(c))
- 5) Defines a marriage and family therapist intern as an unlicensed person who has earned his or her master’s or doctor’s degree qualifying him or her for licensure, and is registered with the board. (BPC §4980.03(b))
- 6) Permits MFT trainees to count some of their hours of supervised experience toward licensure. (BPC §§ 4980.43(a)(4), 4980.43(d)(1))
- 7) Requires hours of experience gained as a trainee to be coordinated between the school and the site where the hours are being approved. The school must approve each site and must have a written agreement with each site that details each party’s responsibilities, including supervision methods, progress reports, and performance evaluations. (BPC §4980.42(e))

- 8) Prohibits MFT trainees from providing services in a private practice (BPC §4980.43(d)(1)(C))
- 9) Allows applicants for licensure as an LMFT with the Board to count up to 375 hours of experience providing personal psychotherapy, crisis counseling, or other counseling services via telehealth, in accordance with BPC §2290.5. (BPC §4980.43(a)(11))

This Bill:

- 1) Clarifies that for purposes of the telehealth law (BPC §2290.5), MFT interns and trainees may provide services via telehealth. (BPC §4980.43(i))
- 2) Specifies that in order to provide telehealth services, MFT interns and trainees must be under licensed supervision as specified in BPC §4980.43(b), and must also comply with any telehealth regulations adopted by the Board. (BPC §4980.43(i))

Comments:

- 1) **Background.** The sponsor of this bill has raised concern that BPC §2290.5 is written only for licensed individuals (a definition which includes interns, but not trainees, based on BPC §23.7.) However, at the same time, BPC §4980.43 allows MFT trainees to count some of their experience, gained as a trainee, toward licensure if working in an exempt setting, and allows some of this experience to be via telehealth.

There is concern that MFT trainees and their supervisors may be vulnerable to liability for providing telehealth services because BPC §2290.5 does not include trainees.

This same concern does not apply to ASW or PCC trainees, as they work in exempt settings and they may not count hours earned as a trainee toward licensure. Therefore, they are not under the jurisdiction of the Board in any way.

- 2) **Intent of This Bill.** The sponsor of this bill states that the proposed amendments would resolve the conflict in law so that pre-licensees could practice telehealth under supervision.
- 3) **Previous Board and Committee Consideration.** At its January 30, 2015 meeting, the Policy and Advocacy Committee discussed this issue, and staff proposed similar language to that used in this proposal.

At this meeting, the Committee learned that CAMFT was also pursuing a legislative proposal, and had found an author for the language. The Policy and Advocacy Committee directed staff to continue to work with CAMFT on the proposed language. The Board gave the same direction at its February 26, 2015 meeting.

- 4) **Inclusion of Interns.** This bill clarifies that both interns and trainees may provide services via telehealth. Interns are technically included in the definition of a “license”

in BPC §23.7, and therefore the law indicates that interns may provide telehealth. However, additional clarification in the law may be helpful.

5) Recommended Position. At its April 23, 2015 meeting, the Policy and Advocacy Committee recommended that the Board take a “support” position on this bill.

6) Support and Opposition.

Support

- California Association of Marriage and Family Therapists (sponsor)
- Association of California Health Care Districts
- California Council of Community Mental Health Agencies
- California Primary Care Association

Opposition

- None

7) History.

2015

04/21/15 In committee: Set, first hearing. Hearing canceled at the request of author.

04/07/15 From committee: Do pass and re-refer to Com. on HEALTH. (Ayes 14.

Noes 0.) (April 7). Re-referred to Com. on HEALTH.

04/06/15 Re-referred to Com. on B. & P.

03/26/15 From committee chair, with author's amendments: Amend, and re-refer to Com. on B. & P. Read second time and amended.

02/17/15 Referred to Coms. on B. & P. and HEALTH.

02/10/15 From printer. May be heard in committee March 12.

02/09/15 Read first time. To print.

8) Attachments.

Attachment A: Current Telehealth Law and Definition of a “License” (BPC §§ 2290.5 and 23.7)

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AMENDED IN ASSEMBLY MARCH 26, 2015

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL

No. 250

Introduced by Assembly Member Obernolte

February 9, 2015

An act to amend Section ~~2290.5~~ 4980.43 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 250, as amended, Obernolte. Telehealth: marriage and family therapist interns and trainees.

Under existing law, “telehealth” is defined as 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. Existing law requires a health care provider prior to the delivery of health care services via telehealth to inform the patient about the use of telehealth and obtain verbal or written consent from the patient for the use of telehealth. For these purposes, existing law defines a health care provider as a healing arts licensee. Existing law, the Licensed Marriage and Family Therapist Act, provides for the registration of marriage and family therapist interns and regulates marriage and family therapist trainees. Existing law requires applicants for a marriage and family therapist license to complete specified experience subject to certain limitations, including no more than a certain number of hours providing counseling services via telehealth. *Existing law requires all marriage and family therapist trainees and registrants to be supervised at all times by a supervisor;*

as defined, responsible for ensuring that the extent, kind, and quality of counseling performed is consistent with the training and experience of the person being supervised. Existing law requires the supervisor to be responsible to the board for compliance with all laws, rules, and regulations governing the practice of marriage and family therapy.

~~This bill, for purposes of the telehealth provisions, would expand the definition of “health care provider” to also include~~ *authorize a marriage and family therapist intern and trainee, as specified to provide services via telehealth if he or she is supervised as required by the act, and is acting within the scope authorized by the act and in accordance with any regulations governing the use of telehealth promulgated by the Board of Behavioral Sciences.*

Vote: majority. Appropriation: no. Fiscal committee: no.
 State-mandated local program: no.

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

- 1 SECTION 1. Section 4980.43 of the Business and Professions
- 2 Code is amended to read:
- 3 4980.43. (a) Prior to applying for licensure examinations, each
- 4 applicant shall complete experience that shall comply with the
- 5 following:
- 6 (1) A minimum of 3,000 hours completed during a period of at
- 7 least 104 weeks.
- 8 (2) Not more than 40 hours in any seven consecutive days.
- 9 (3) Not less than 1,700 hours of supervised experience
- 10 completed subsequent to the granting of the qualifying master’s
- 11 or doctoral degree.
- 12 (4) Not more than 1,300 hours of supervised experience obtained
- 13 prior to completing a master’s or doctoral degree.
- 14 The applicant shall not be credited with more than 750 hours of
- 15 counseling and direct supervisor contact prior to completing the
- 16 master’s or doctoral degree.
- 17 (5) No hours of experience may be gained prior to completing
- 18 either 12 semester units or 18 quarter units of graduate instruction
- 19 and becoming a trainee except for personal psychotherapy.
- 20 (6) No hours of experience may be gained more than six years
- 21 prior to the date the application for examination eligibility was
- 22 filed, except that up to 500 hours of clinical experience gained in
- 23 the supervised practicum required by subdivision (c) of Section

1 4980.37 and subparagraph (B) of paragraph (1) of subdivision (d)
2 of Section 4980.36 shall be exempt from this six-year requirement.

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

5 (A) Direct supervisor contact.

6 (B) Professional enrichment activities. For purposes of this
7 chapter, “professional enrichment activities” include the following:

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

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

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

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

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

26 (B) Client centered advocacy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10 (7) All experience gained by a trainee shall be monitored by the
11 supervisor as specified by r gulation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18 (g) Except when employed in a private practice setting, all
19 postdegree hours of experience shall be credited toward licensure
20 so long as the applicant applies for the intern registration within
21 90 days of the granting of the qualifying master's or doctoral
22 degree and is thereafter granted the intern registration by the board.

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

26 (i) Trainees, interns, and applicants shall only perform services
27 at the place where their employers regularly conduct business,
28 which may include performing services at other locations, so long
29 as the services are performed under the direction and control of
30 their employer and supervisor, and in compliance with the laws
31 and regulations pertaining to supervision. *For purposes of section*
32 *2290.5, interns and trainees working under licensed supervision,*
33 *consistent with subdivision (b), may provide services via telehealth*
34 *within the scope authorized by this chapter and in accordance*
35 *with any regulations governing the use of telehealth promulgated*
36 *by the board.* Trainees and interns shall have no proprietary interest
37 in their employers' businesses and shall not lease or rent space,
38 pay for furnishings, equipment, or supplies, or in any other way
39 pay for the obligations of their employers.

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

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

22 SECTION 1. ~~Section 2290.5 of the Business and Professions~~
 23 ~~Code is amended to read:~~

24 ~~2290.5. (a) For purposes of this division, the following~~
 25 ~~definitions shall apply:~~

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

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

33 (3) ~~“Health care provider” means both of the following:~~

34 (A) ~~A person who is licensed under this division.~~

35 (B) ~~A marriage and family therapist intern and trainee, as~~
 36 ~~defined in Section 4980.03, completing supervised experience for~~
 37 ~~licensure pursuant to paragraph (11) of subdivision (a) of Section~~
 38 ~~4980.43.~~

39 (4) ~~“Originating site” means a site where a patient is located at~~
 40 ~~the time health care services are provided via a telecommunications~~

1 system or where the asynchronous store and forward service
2 originates:

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

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

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

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

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

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

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

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

38 (h) (1) Notwithstanding any other provision of law and for
39 purposes of this section, the governing body of the hospital whose
40 patients are receiving the telehealth services may grant privileges

1 to, and verify and approve credentials for, providers of telehealth
2 services based on its medical staff recommendations that rely on
3 information provided by the distant-site hospital or telehealth
4 entity, as described in Sections 482.12, 482.22, and 485.616 of
5 Title 42 of the Code of Federal Regulations.

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

10 (3) For the purposes of this subdivision, “telehealth” shall
11 include “telemedicine” as the term is referenced in Sections 482.12,
12 482.22, and 485.616 of Title 42 of the Code of Federal Regulations.

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ATTACHMENT A
CURRENT TELEHEALTH LAW AND DEFINITION OF A “LICENSE”

BPC § 23.7.

Unless otherwise expressly provided, “license” means license, certificate, registration, or other means to engage in a business or profession regulated by this code or referred to in Section 1000 or 3600.

BPC §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.

CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES

BILL ANALYSIS

BILL NUMBER: AB 333

VERSION: AMENDED APRIL 30, 2015

AUTHOR: MELENDEZ

SPONSOR: AUTHOR

RECOMMENDED POSITION: OPPOSE UNLESS AMENDED

SUBJECT: HEALING ARTS: CONTINUING EDUCATION

Overview:

This bill would allow a healing arts licensee who takes coursework toward, and becomes a certified instructor of, cardiopulmonary resuscitation (CPR) or automated external defibrillator (AED) use, to count one unit of credit toward his or her continuing education (CE) requirement. The CE credit would only count if the licensee's licensing board laws or regulations do not exclude counting such courses or activities.

Existing Law:

- 1) Requires the director of the Department of Consumer Affairs to establish, by regulation, guidelines to prescribe components for mandatory continuing education programs administered by any board within the department. The guidelines shall be developed to ensure that mandatory continuing education is used as a means to create a more competent licensing population, thereby enhancing public protection. ((Business and Professions Code §166)
- 2) Requires licensees of the Board of Behavioral Sciences (Board), upon renewal of their license, to certify to the Board that he or she has completed at least 36 hours of approved continuing education in or relevant to their field of practice. (BPC §§4980.54(c), 4989.34(a), 4996.22(a), 4999.76(a)).
- 3) Specifies that continuing education training, education, and coursework must be from approved providers and must incorporate one or more of the following(BPC §§4980.54, 4989.34, 4996.22,4999.76 :
 - a) Aspects of the discipline that are fundamental to the practice of the profession for which licensed;
 - b) Aspects of the discipline for which licensed where significant recent developments have occurred; and
 - c) Aspects of other disciplines that enhance the understanding or practice of the profession for which licensed.
- 4) Defines the following continuing education credit equivalencies (California Code of Regulations (CCR) §1887.5):

- One hour of instruction equals one hour of continuing education credit;
- One academic quarter unit equals 10 hours of continuing education credit; and
- One academic semester unit equals 15 hours of continuing education credit.

This Bill:

- 1) Allows a healing arts licensee who attends a course which results in him or her becoming a certified CPR or AED instructor to count one unit of coursework toward the licensing board's continuing education requirement, once per renewal cycle. (BPC §856(a))
- 2) Only allows the healing arts licensee to count such coursework if it is developed by the American Heart Association, the American Red Cross, or is otherwise nationally recognized. (BPC §856(a))
- 3) Allows a healing arts licensee who conducts CPR or AED training sessions for employees of school districts or community colleges to count up to two units of coursework toward the Board's continuing education requirement, once per renewal cycle. (BPC §856(b))
- 4) Only allows the healing arts licensee to claim CE credit for holding a training session if the training session is approved by his or her licensing board. (BPC §856(b))
- 5) Defines a "unit" as any measurement for continuing education, such as hours or course credits. (BPC §856(c))
- 6) Specifies that the provisions of this bill do not apply to a licensee if his or her licensing board's laws or regulations establishing CE requirements exclude such coursework. (BPC §856(d))

Comments:

- 1) **Author's Intent.** The author's office notes that AEDs are becoming more common on school campuses. However, pro bono instructors and training resources are rare, and paying for such training can be cost prohibitive.

Therefore, by allowing healing arts licensees to gain continuing education credit for becoming an instructor in CPR/AED use and for conducting training in schools, this bill creates an incentive that would benefit both licensees and schools.

- 2) **Current Continuing Education Requirements.** The Board has several one-time continuing educational requirements that must be completed by its LMFT, LCSW, and LPCC licensees. These additional courses must be completed prior to licensure or at the first renewal, depending on when the applicant began graduate study. These courses are as follows:

- Spousal/partner abuse (7 hours);
- Human sexuality (10 hours);
- Child abuse (7 hours);
- Substance abuse (15 hours);
- Aging/long term care (3 hours); and
- HIV/AIDS (7 hours).

All licensees must take a six-hour law and ethics course every renewal period. In total, a licensee must complete 36 hours of continuing education every renewal period.

- 3) Relevance to the Practice.** Current law specifies that continuing education must incorporate either aspects of the discipline for which licensed that are fundamental to the practice of the profession, aspects of the discipline where significant recent developments have occurred, or aspects of other disciplines that enhance the understanding or practice of the profession.

While CPR/AED training is important, it may be difficult to argue that it is fundamental to, or enhances the understanding of, the practice of psychotherapy.

- 4) Source of Coursework.** The Board’s statutes and regulations require that continuing education be obtained from either an accredited or approved postsecondary institution, an entity approved by a board-recognized approval agency, or a board-recognized continuing education provider.

CPR and AED instructor certification programs appear to be commonly offered by nonprofits such as the American Red Cross and the American Heart Association. These entities would not meet the definition of an organization that would be approved by a board-recognized approval agency.

- 5) Bill’s Definition of “Units” Unclear.** This bill states that a licensee may apply one unit of CE credit if he or she becomes a certified CPR or AED instructor, or up to two units of CE credit toward conducting CPR or AED training for employees of school districts or community colleges. The bill defines a “unit” of any measure of CE, such as hours or course credits.

The number of CE hours this bill intends to apply toward the CE requirements is unclear. Several nonprofit entities offer CPR and AED instructor courses, and while the programs vary, all programs appear to require many hours of training.

The Board’s continuing education regulations state that one academic semester unit equals 15 hours of continuing education coursework. If the instructor training course was offered in academic units, this interpretation may apply. However, the board’s regulations also define one hour of instruction as equaling one hour of continuing education credit. If the coursework is not offered in academic units, this interpretation may apply.

- 6) Recommended Position and Recent Amendments:** At its April 23, 2015 meeting, the Policy and Advocacy Committee recommended that the Board take an “oppose unless amended” position on this bill, and asked that the Board be removed from the bill’s provisions.

In part because of our Policy and Advocacy Committee’s concerns, the author’s office amended the bill on April 30, 2015. The following provisions were added:

- The provision allowing a licensee to count CE credit for conducting a CPR/AED training session only if the training session is approved by the Board.
- The provision which does not permit licensees to count CPR/AED training sessions or coursework for becoming certified if his or her licensing board’s laws or regulations regarding continuing education exclude such courses or activities.

- 7) Effect of Recent Amendments.** Although the recent amendments are an attempt to exclude Board licensees from the provisions of the bill, they do not explicitly state that Board licensees are excluded. Current Board law does not explicitly state that CPR/AED coursework and training is excluded from CE, although one could infer that it is not directly related to the practice of psychotherapy or relevant to the profession. However, there may be room for disagreement in this matter, which has the potential to cause confusion or differences of opinion among licensees.

8) Support and Opposition.

Support:

- The American Red Cross

Oppose:

- None at this time.

9) History.

2015

05/04/15 Re-referred to Com. on APPR.

04/30/15 Read second time and amended.

04/29/15 From committee: Amend, and do pass as amended and re-refer to Com. on APPR. (Ayes 14. Noes 0.) (April 28).

04/06/15 Re-referred to Com. on B. & P.

03/26/15 From committee chair, with author's amendments: Amend, and re-refer to Com. on B. & P. Read second time and amended.

03/26/15 Referred to Com. on B. & P.

02/17/15 From printer. May be heard in committee March 19.

02/13/15 Read first time. To print.

AMENDED IN ASSEMBLY APRIL 30, 2015

AMENDED IN ASSEMBLY MARCH 26, 2015

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL

No. 333

Introduced by Assembly Member Melendez

February 13, 2015

An act to add Section 856 to the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 333, as amended, Melendez. Healing arts: continuing education.

Existing law provides for the licensure and regulation of various healing arts licensees by various boards, as defined, within the Department of Consumer Affairs and imposes various continuing education requirements for license renewal.

This bill would allow specified healing arts licensees to apply one unit, as defined, of continuing education credit *once per renewal cycle* towards any required continuing education units for attending ~~a course~~ *certain courses that results result* in the licensee becoming a certified instructor of cardiopulmonary resuscitation (CPR) or the proper use of an automated external defibrillator ~~(AED)~~, (AED), and would allow specified healing arts licensees to apply up to 2 units of continuing education credit *once per renewal cycle* towards any required continuing education units for conducting *board-approved* CPR or AED training sessions for employees of school districts and community college districts in the state. *The bill would specify that these provisions would not apply if a licensing board's laws or regulations establishing*

continuing education requirements exclude the courses or activities mentioned above.

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 856 is added to the Business and
 2 Professions Code, to read:

3 856. (a) (1) A person licensed pursuant to this division who
 4 is required to complete continuing education units as a condition
 5 of renewing his or her license ~~may~~ *may, once per renewal cycle,*
 6 apply one unit of continuing education ~~credit~~ *credit, pursuant to*
 7 *paragraph (2), towards that requirement for attending a course*
 8 *that results in the licensee becoming a certified instructor of*
 9 *cardiopulmonary resuscitation (CPR) or the proper use of an*
 10 *automated external defibrillator (AED)*

11 (2) *A licensee may only apply continuing education credit for*
 12 *attending one of the following courses:*

13 (A) *An instructional program developed by the American Heart*
 14 *Association.*

15 (B) *An instructional program developed by the American Red*
 16 *Cross.*

17 (C) *An instructional program that is nationally recognized and*
 18 *based on the most current national evidence-based emergency*
 19 *cardiovascular care guidelines for the performance of CPR and*
 20 *the use of an AED.*

21 (b) (1) A person licensed pursuant to this division who is
 22 required to complete continuing education units as a condition of
 23 renewing his or her license ~~may~~ *may, once per renewal cycle,*
 24 apply up to two units of continuing education ~~credit~~ *credit,*
 25 *pursuant to paragraph (2), towards that requirement for conducting*
 26 *CPR or AED training sessions for employees of school districts*
 27 *and community college districts in the state.*

28 (2) *A licensee may only apply continuing education credit for*
 29 *holding a training session if the training session is approved by*
 30 *the applicable licensing board.*

31 (c) For purposes of this section, “unit” means any measurement
 32 for continuing education, such as hours or course credits.

1 *(d) This section shall not apply to a person licensed under this*
2 *division if the applicable licensing board's laws or regulations*
3 *establishing continuing education requirements exclude the courses*
4 *or activities described in subdivisions (a) and (b).*

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Comments:

- 1) Author's Intent.** The intent of this legislation is to allow federally qualified health centers and rural health clinics to be able to hire a marriage and family therapist and be reimbursed through Medi-Cal for covered mental health services. Under current law, a clinic may hire a marriage and family therapist. However, only clinical psychologists or licensed clinical social workers may receive Medi-Cal reimbursement for covered services in such settings. According to the author's office, the inability to receive Medi-Cal reimbursement serves as a disincentive for a FQHC or a RHC to consider hiring a marriage and family therapist. Allowing services provided by LMFTs to be reimbursed will maximize the availability of mental health services in rural areas.
- 2) Suggested Amendment.** Staff suggests an amendment be made to include the word "licensed" in front of the term "marriage and family therapist" in §14132.100(g)(1). This will clarify that the marriage and family therapist must be licensed by the Board, and it is consistent with the use of the term "licensed clinical social worker" in that code section. In addition, it is also consistent with the Board's August 18, 2011 decision that the title "Licensed Marriage and Family Therapist" be utilized in all new regulatory and legislative proposals.
- 3) Previous Legislation.** This bill was run as AB 1785 (B. Lowenthal) in 2012. The Board took a "support" position on AB 1785. However, the bill died in the Assembly Appropriations Committee.
- 4) Recommended Position.** At its April 23, 2015 meeting, the Policy and Advocacy Committee recommended that the Board take a "support" position on this bill.
- 5) Support and Opposition.**

Support:

California Primary Care Association (Sponsor)
Alameda Health Consortium
American Association for Marriage and Family Therapy, California Division
American Federation of State, County and Municipal Employees
Ampla Health
California Association of Marriage and Family Therapists
California Association of Rural Health Centers
California Council of Community Mental Health Agencies
California Immigrant Policy Center
California Medical Association
California School-Based Health Alliance
Central Valley Health Network
Clinica Sierra Vista
Community Clinic Consortium
Community Health Partnership

County Behavioral Health Directors Association
Family HealthCare Network
Family Health Centers of San Diego
Hill Country Community Clinic
Livingston Community Health
Mendocino Coast Clinics
Mountain Valleys Health Centers
North Coast Clinics Network
Northeast Valley Health Corporation
Ritter Health Center
San Francisco Community Clinic Consortium
San Ysidro Health Center
SEIU California

Oppose:

National Association of Social Workers-California Chapter

6) History

2015

04/22/15 In committee: Set, first hearing. Referred to APPR. suspense file.

04/08/15 From committee: Do pass and re-refer to Com. on APPR. (Ayes 18. Noes 0.) (April 7). Re-referred to Com. on APPR.

03/09/15 Referred to Com. on HEALTH.

02/26/15 From printer. May be heard in committee March 28.

02/25/15 Read first time. To print.

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ASSEMBLY BILL

No. 690

Introduced by Assembly Member Wood

February 25, 2015

An act to amend Section 14132.100 of the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

AB 690, as introduced, Wood. Medi-Cal: federally qualified health centers: rural health clinics.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law provides that federally qualified health center services and rural health clinic services, as defined, are covered benefits under the Medi-Cal program, to be reimbursed, to the extent that federal financial participation is obtained, to providers on a per-visit basis. "Visit" is defined as a face-to-face encounter between a patient of a federally qualified health center or a rural health clinic and specified health care professionals

This bill would include a marriage and family therapist within those health care professionals covered under that definition

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 14132.100 of the Welfare and Institutions
 2 Code is amended to read:
 3 14132.100. (a) The federally qualified health center services
 4 described in Section 1396d(a)(2)(C) of Title 42 of the United States
 5 Code are covered benefits
 6 (b) The rural health clinic services described in Section
 7 1396d(a)(2)(B) of Title 42 of the United States Code are covered
 8 benefits
 9 (c) Federally qualified health center services and rural health
 10 clinic services shall be reimbursed on a per-visit basis in
 11 accordance with the definition of “visit” set forth in subdivision
 12 (g).
 13 (d) Effective October 1, 2004, and on each October 1, thereafter,
 14 until no longer required by federal law, federally qualified health
 15 center (FQHC) and rural health clinic (RHC) per-visit rates shall
 16 be increased by the Medicare Economic Index applicable to
 17 primary care services in the manner provided for in Section
 18 1396a(bb)(3)(A) of Title 42 of the United States Code. Prior to
 19 January 1, 2004, FQHC and RHC per-visit rates shall be adjusted
 20 by the Medicare Economic Index in accordance with the
 21 methodology set forth in the state plan in effect on October 1,
 22 2001.
 23 (e) (1) An FQHC or RHC may apply for an adjustment to its
 24 per-visit rate based on a change in the scope of services provided
 25 by the FQHC or RHC. Rate changes based on a change in the
 26 scope of services provided by an FQHC or RHC shall be evaluated
 27 in accordance with Medicare reasonable cost principles, as set
 28 forth in Part 413 (commencing with Section 413.1) of Title 42 of
 29 the Code of Federal Regulations, or its successor.
 30 (2) Subject to the conditions set forth in subparagraphs (A) to
 31 (D), inclusive, of paragraph (3), a change in scope of service means
 32 any of the following:
 33 (A) The addition of a new FQHC or RHC service that is not
 34 incorporated in the baseline prospective payment system (PPS)
 35 rate, or a deletion of an FQHC or RHC service that is incorporated
 36 in the baseline PPS rate.
 37 (B) A change in service due to amended regulatory requirements
 38 or rules.

- 1 (C) A change in service resulting from relocating or remodeling
2 an FQHC or RHC.
- 3 (D) A change in types of services due to a change in applicable
4 technology and medical practice utilized by the center or clinic.
- 5 (E) An increase in service intensity attributable to changes in
6 the types of patients served, including, but not limited to,
7 populations with HIV or AIDS, or other chronic diseases, or
8 homeless, elderly, migrant, or other special populations.
- 9 (F) Any changes in any of the services described in subdivision
10 (a) or (b), or in the provider mix of an FQHC or RHC or one of
11 its sites.
- 12 (G) Changes in operating costs attributable to capital
13 expenditures associated with a modification of the scope of any
14 of the services described in subdivision (a) or (b), including new
15 or expanded service facilities, regulatory compliance, or changes
16 in technology or medical practices at the center or clinic.
- 17 (H) Indirect medical education adjustments and a direct graduate
18 medical education payment that reflects the costs of providing
19 teaching services to interns and residents.
- 20 (I) Any changes in the scope of a project approved by the federal
21 Health Resources and ~~Service~~ *Services* Administration (HRSA).
- 22 (3) No change in costs shall, in and of itself, be considered a
23 scope-of-service change unless all of the following apply:
- 24 (A) The increase or decrease in cost is attributable to an increase
25 or decrease in the scope of services defined in subdivisions (a) and
26 (b), as applicable.
- 27 (B) The cost is allowable under Medicare reasonable cost
28 principles set forth in Part 413 (commencing with Section 413) of
29 Subchapter B of Chapter 4 of Title 42 of the Code of Federal
30 Regulations, or its successor.
- 31 (C) The change in the scope of services is a change in the type,
32 intensity, duration, or amount of services, or any combination
33 thereof.
- 34 (D) The net change in the FQHC's or RHC's rate equals or
35 exceeds 1.75 percent for the affected FQHC or RHC site. For
36 FQHCs and RHCs that filed consolidated cost reports for multiple
37 sites to establish the initial prospective payment reimbursement
38 rate, the 1.75-percent threshold shall be applied to the average
39 per-visit rate of all sites for the purposes of calculating the cost
40 associated with a scope-of-service change. "Net change" means

1 the per-visit rate change attributable to the cumulative effect of all
2 increases and decreases for a particular fiscal year .

3 (4) An FQHC or RHC may submit requests for scope-of-service
4 changes once per fiscal year, only within 90 days following the
5 beginning of the FQHC's or RHC's fiscal year. Any approved
6 increase or decrease in the provider's rate shall be retroactive to
7 the beginning of the FQHC's or RHC's fiscal year in which the
8 request is submitted.

9 (5) An FQHC or RHC shall submit a scope-of-service rate
10 change request within 90 days of the beginning of any FQHC or
11 RHC fiscal year occurring after the effective date of this section,
12 if, during the FQHC's or RHC's prior fiscal year, the FQHC or
13 RHC experienced a decrease in the scope of services provided that
14 the FQHC or RHC either knew or should have known would have
15 resulted in a significantly lower per-visit rate. If an FQHC or RHC
16 discontinues providing onsite pharmacy or dental services, it shall
17 submit a scope-of-service rate change request within 90 days of
18 the beginning of the following fiscal year. The rate change shall
19 be effective as provided for in paragraph (4). As used in this
20 paragraph, "significantly lower" means an average per-visit rate
21 decrease in excess of 2.5 percent.

22 (6) Notwithstanding paragraph (4), if the approved
23 scope-of-service change or changes were initially implemented
24 on or after the first day of an FQHC's or RHC's fiscal year ending
25 in calendar year 2001, but before the adoption and issuance of
26 written instructions for applying for a scope-of-service change,
27 the adjusted reimbursement rate for that scope-of-service change
28 shall be made retroactive to the date the scope-of-service change
29 was initially implemented. Scope-of-service changes under this
30 paragraph shall be required to be submitted within the later of 150
31 days after the adoption and issuance of the written instructions by
32 the department, or 150 days after the end of the FQHC's or RHC's
33 fiscal year ending in 2003

34 (7) All references in this subdivision to "fiscal year" shall be
35 construed to be references to the fiscal year of the individual FQHC
36 or RHC, as the case may be.

37 (f) (1) An FQHC or RHC may request a supplemental payment
38 if extraordinary circumstances beyond the control of the FQHC
39 or RHC occur after December 31, 2001, and PPS payments are
40 insufficient due to these extraordinary circumstances. Supplemental

1 payments arising from extraordinary circumstances under this
2 subdivision shall be solely and exclusively within the discretion
3 of the department and shall not be subject to subdivision (l). These
4 supplemental payments shall be determined separately from the
5 scope-of-service adjustments described in subdivision (e).
6 Extraordinary circumstances include, but are not limited to, acts
7 of nature, changes in applicable requirements in the Health and
8 Safety Code, changes in applicable licensure requirements, and
9 changes in applicable rules or regulations. Mere inflation of costs
10 alone, absent extraordinary circumstances, shall not be grounds
11 for supplemental payment. If an FQHC's or RHC's PPS rate is
12 sufficient to cover its overall costs, including those associated with
13 the extraordinary circumstances, then a supplemental payment is
14 not warranted.

15 (2) The department shall accept requests for supplemental
16 payment at any time throughout the prospective payment rate year.

17 (3) Requests for supplemental payments shall be submitted in
18 writing to the department and shall set forth the reasons for the
19 request. Each request shall be accompanied by sufficient
20 documentation to enable the department to act upon the request.
21 Documentation shall include the data necessary to demonstrate
22 that the circumstances for which supplemental payment is requested
23 meet the requirements set forth in this section. Documentation
24 shall include all of the following:

25 (A) A presentation of data to demonstrate reasons for the
26 FQHC's or RHC's request for a supplemental payment.

27 (B) Documentation showing the cost implications. The cost
28 impact shall be material and significant, two hundred thousand
29 dollars (\$200,000) or 1 percent of a facility's total costs, whichever
30 is less.

31 (4) A request shall be submitted for each affected year.

32 (5) Amounts granted for supplemental payment requests shall
33 be paid as lump-sum amounts for those years and not as revised
34 PPS rates, and shall be repaid by the FQHC or RHC to the extent
35 that it is not expended for the specified purposes

36 (6) The department shall notify the provider of the department's
37 discretionary decision in writing.

38 (g) (1) An FQHC or RHC "visit" means a face-to-face
39 encounter between an FQHC or RHC patient and a physician,
40 physician assistant, nurse practitioner, certified nurse-midwife,

1 clinical psychologist, licensed clinical social worker, *marriage*
2 *and family therapist*, or a visiting nurse. For purposes of this
3 section, “physician” shall be interpreted in a manner consistent
4 with the Centers for Medicare and Medicaid Services’ Medicare
5 Rural Health Clinic and Federally Qualified Health Center Manual
6 (Publication 27), or its successor, only to the extent that it define
7 the professionals whose services are reimbursable on a per-visit
8 basis and not as to the types of services that these professionals
9 may render during these visits and shall include a physician and
10 surgeon, podiatrist, dentist, optometrist, and chiropractor. A visit
11 shall also include a face-to-face encounter between an FQHC or
12 RHC patient and a comprehensive perinatal services practitioner,
13 as defined in Section 51179.1 of Title 22 of the California Code
14 of Regulations, providing comprehensive perinatal services, a
15 four-hour day of attendance at an adult day health care center, and
16 any other provider identified in the state plan’s definition of an
17 FQHC or RHC visit.

18 (2) (A) A visit shall also include a face-to-face encounter
19 between an FQHC or RHC patient and a dental hygienist or a
20 dental hygienist in alternative practice.

21 (B) Notwithstanding subdivision (e), an FQHC or RHC that
22 currently includes the cost of the services of a dental hygienist in
23 alternative practice for the purposes of establishing its FQHC or
24 RHC rate shall apply for an adjustment to its per-visit rate, and,
25 after the rate adjustment has been approved by the department,
26 shall bill these services as a separate visit. However, multiple
27 encounters with dental professionals that take place on the same
28 day shall constitute a single visit. The department shall develop
29 the appropriate forms to determine which FQHC’s or RHC rates
30 shall be adjusted and to facilitate the calculation of the adjusted
31 rates. An FQHC’s or RHC’s application for, or the department’s
32 approval of, a rate adjustment pursuant to this subparagraph shall
33 not constitute a change in scope of service within the meaning of
34 subdivision (e). An FQHC or RHC that applies for an adjustment
35 to its rate pursuant to this subparagraph may continue to bill for
36 all other FQHC or RHC visits at its existing per-visit rate, subject
37 to reconciliation, until the rate adjustment for visits between an
38 FQHC or RHC patient and a dental hygienist or a dental hygienist
39 in alternative practice has been approved. Any approved increase
40 or decrease in the provider’s rate shall be made within six months

1 after the date of receipt of the department's rate adjustment forms
2 pursuant to this subparagraph and shall be retroactive to the
3 beginning of the fiscal year in which the FQHC or RHC submits
4 the request, but in no case shall the effective date be earlier than
5 January 1, 2008.

6 (C) An FQHC or RHC that does not provide dental hygienist
7 or dental hygienist in alternative practice services, and later elects
8 to add these services, shall process the addition of these services
9 as a change in scope of service pursuant to subdivision (e).

10 (h) If FQHC or RHC services are partially reimbursed by a
11 third-party payer, such as a managed care entity (as defined in
12 Section 1396u-2(a)(1)(B) of Title 42 of the United States Code),
13 the Medicare Program, or the Child Health and Disability
14 Prevention (CHDP) program, the department shall reimburse an
15 FQHC or RHC for the difference between its per-visit PPS rate
16 and receipts from other plans or programs on a contract-by-contract
17 basis and not in the aggregate, and may not include managed care
18 financial incentive payments that are required by federal law to
19 be excluded from the calculation.

20 (i) (1) An entity that first qualifies as an FQHC or RHC in the
21 year 2001 or later, a newly licensed facility at a new location added
22 to an existing FQHC or RHC, and any entity that is an existing
23 FQHC or RHC that is relocated to a new site shall each have its
24 reimbursement rate established in accordance with one of the
25 following methods, as selected by the FQHC or RHC:

26 (A) The rate may be calculated on a per-visit basis in an amount
27 that is equal to the average of the per-visit rates of three comparable
28 FQHCs or RHCs located in the same or adjacent area with a similar
29 caseload.

30 (B) In the absence of three comparable FQHCs or RHCs with
31 a similar caseload, the rate may be calculated on a per-visit basis
32 in an amount that is equal to the average of the per-visit rates of
33 three comparable FQHCs or RHCs located in the same or an
34 adjacent service area, or in a reasonably similar geographic area
35 with respect to relevant social, health care, and economic
36 characteristics.

37 (C) At a new entity's one-time election, the department shall
38 establish a reimbursement rate, calculated on a per-visit basis, that
39 is equal to 100 percent of the projected allowable costs to the
40 FQHC or RHC of furnishing FQHC or RHC services during the

1 first 12 months of operation as an FQHC or RHC. After the first
2 12-month period, the projected per-visit rate shall be increased by
3 the Medicare Economic Index then in effect. The projected
4 allowable costs for the first 12 months shall be cost settled and the
5 prospective payment reimbursement rate shall be adjusted based
6 on actual and allowable cost per visit.

7 (D) The department may adopt any further and additional
8 methods of setting reimbursement rates for newly qualified FQHCs
9 or RHCs as are consistent with Section 1396a(bb)(4) of Title 42
10 of the United States Code.

11 (2) In order for an FQHC or RHC to establish the comparability
12 of its caseload for purposes of subparagraph (A) or (B) of paragraph
13 (1), the department shall require that the FQHC or RHC submit
14 its most recent annual utilization report as submitted to the Office
15 of Statewide Health Planning and Development, unless the FQHC
16 or RHC was not required to file an annual utilization report. FQHCs
17 or RHCs that have experienced changes in their services or
18 caseload subsequent to the filing of the annual utilization report
19 may submit to the department a completed report in the format
20 applicable to the prior calendar year. FQHCs or RHCs that have
21 not previously submitted an annual utilization report shall submit
22 to the department a completed report in the format applicable to
23 the prior calendar year. The FQHC or RHC shall not be required
24 to submit the annual utilization report for the comparable FQHCs
25 or RHCs to the department, but shall be required to identify the
26 comparable FQHCs or RHCs.

27 (3) The rate for any newly qualified entity set forth under this
28 subdivision shall be effective retroactively to the later of the date
29 that the entity was first qualified by the applicable federal agency
30 as an FQHC or RHC, the date a new facility at a new location was
31 added to an existing FQHC or RHC, or the date on which an
32 existing FQHC or RHC was relocated to a new site. The FQHC
33 or RHC shall be permitted to continue billing for Medi-Cal covered
34 benefits on a fee-for-service basis until it is informed of its
35 enrollment as an FQHC or RHC, and the department shall reconcile
36 the difference between the fee-for-service payments and the
37 FQHC's or RHC's prospective payment rate at that time.

38 (j) Visits occurring at an intermittent clinic site, as defined in
39 subdivision (h) of Section 1206 of the Health and Safety Code, of
40 an existing FQHC or RHC, or in a mobile unit as defined by

1 paragraph (2) of subdivision (b) of Section 1765.105 of the Health
2 and Safety Code, shall be billed by and reimbursed at the same
3 rate as the FQHC or RHC establishing the intermittent clinic site
4 or the mobile unit, subject to the right of the FQHC or RHC to
5 request a scope-of-service adjustment to the rate.

6 (k) An FQHC or RHC may elect to have pharmacy or dental
7 services reimbursed on a fee-for-service basis, utilizing the current
8 fee schedules established for those services. These costs shall be
9 adjusted out of the FQHC's or RHC's clinic base rate as
10 scope-of-service changes. An FQHC or RHC that reverses its
11 election under this subdivision shall revert to its prior rate, subject
12 to an increase to account for all MEI increases occurring during
13 the intervening time period, and subject to any increase or decrease
14 associated with applicable scope-of-services adjustments as
15 provided in subdivision (e).

16 (l) FQHCs and RHCs may appeal a grievance or complaint
17 concerning ratesetting, scope-of-service changes, and settlement
18 of cost report audits, in the manner prescribed by Section 14171.
19 The rights and remedies provided under this subdivision are
20 cumulative to the rights and remedies available under all other
21 provisions of law of this state.

22 (m) The department shall, by no later than March 30, 2008,
23 promptly seek all necessary federal approvals in order to implement
24 this section, including any amendments to the state plan. To the
25 extent that any element or requirement of this section is not
26 approved, the department shall submit a request to the federal
27 Centers for Medicare and Medicaid Services for any waivers that
28 would be necessary to implement this section.

29 (n) The department shall implement this section only to the
30 extent that federal financial participation is obtained

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CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES

BILL ANALYSIS

BILL NUMBER: AB 796 **VERSION:** INTRODUCED FEBRUARY 26, 2015

AUTHOR: NAZARIAN **SPONSOR:** DIR FLOOR TIME COALITION

RECOMMENDED POSITION: NEUTRAL

SUBJECT: HEALTH CARE COVERAGE: AUTISM AND PERVASIVE DEVELOPMENTAL DISORDERS

Overview: This bill modifies the definition of “qualified autism service professional” and “qualified autism service paraprofessional” to allow insurance coverage for types of behavioral health treatment other than applied behavior analysis.

Existing Law:

- 1) Requires that every health care service plan or insurance policy that provides hospital, medical or surgical coverage must also provide coverage for behavioral health treatment for pervasive developmental disorder or autism (PDD/A). (Health and Safety Code (HSC) §1374.73(a), Insurance Code (IC) §10144.51(a))
- 2) Requires these health care service plans and health insurers subject to this provision to maintain an adequate network of qualified autism service providers. (HSC §1374.73(b), IC §10144.51(b))
- 3) Defines “behavioral health treatment” as professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs which develop or restore the functioning of an individual with pervasive developmental disorder or autism, and meets the following criteria (HSC §1374.73(c), IC §10144.51(c):
 - a) Is prescribed by a licensed physician and surgeon or is developed by a licensed psychologist;
 - b) Is provided under a treatment plan prescribed by a qualified autism service provider and administered by such a provider or by a qualified autism service professional under supervision and employment of a qualified autism service provider;
 - c) The treatment plan has measurable goals over a specific timeline and the plan is reviewed by the provider at least once every six months; and
 - d) Is not used for purposes of providing or for the reimbursement of respite, day care, or educational services.

- 4) Defines a “qualified autism service provider” as either (HSC §1374.73(c), IC §10144.51(c)):
 - a) A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited and which designs, supervises, or provides treatment for pervasive developmental disorder or autism; or
 - b) A person who is licensed as a specified healing arts practitioner, including a psychologist, marriage and family therapist, educational psychologist, clinical social worker, or professional clinical counselor. The licensee must design, supervise, or provide treatment for pervasive developmental disorder or autism and be within his or her experience and competence.
- 5) Defines a “qualified autism service professional” as someone who meets all of the following (HSC §1374.73(c), IC §10144.51(c)):
 - a) Provides behavioral health treatment;
 - b) Is employed and supervised by a qualified autism service provider;
 - c) Provides treatment according to a treatment plan developed and approved by the qualified autism service provider.
 - d) Is a behavioral service provider approved by a regional center to provide services as an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program as defined in Section 54342 of Title 17 of the California Code of Regulations (CCR); and
 - e) Has training and experience providing services for pervasive developmental disorder or autism pursuant to the Lanterman Developmental Disabilities Services Act.
- 6) Defines a “qualified autism service paraprofessional” as an unlicensed and uncertified person who meets all of the following (HSC §1374.73(c), IC §10144.51(c)):
 - a) Is employed and supervised by a qualified autism service provider;
 - b) Provides treatment according to a treatment plan developed and approved by the qualified autism service provider;
 - c) Meets criteria set forth in regulations regarding use of paraprofessionals in group practice providing behavioral intervention services; and
 - d) Is certified by a qualified autism service provider as having adequate education, training, and experience.

- 7) Defines vendor service codes and sets requirements for regional to classify the following professions (CCR 17 §54342):
 - a) Associate Behavior Analysts;
 - b) Behavior Analysts;
 - c) Behavior Management Assistants;
 - d) Behavior Management Consultants; and
 - e) Behavior Management Programs.

This Bill:

- 1) Modifies the qualifications of a “qualified autism service professional” to be either of the following (HSC §1374.73(c)(4)(D), IC §10144.51(c)(4)(D)):
 - a) A behavioral service provider approved by a regional center to provide services as an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program as defined in Section 54342 of Title 17 of the California Code of Regulations (CCR); or
 - b) Have a bachelor of arts or science degree and either:
 - i. Twelve semester units from an accredited institution in either applied behavioral analysis or clinical coursework in behavioral health, and one year of experience in designing or implementing behavioral health treatment; or
 - ii. Two years experience designing or implementing behavioral health treatment; or
 - iii. Is a registered psychological assistant or registered psychologist; or
 - iv. Is an associate clinical social worker registered with the Board.
- 2) Modifies the qualifications of a “qualified autism service paraprofessional” to be either of the following ((HSC §1374.73(c)(5)(C), IC §10144.51(c)(5)(C)):
 - a) Meets criteria set forth in regulations regarding use of paraprofessionals in group practice providing behavioral intervention services; or
 - b) Has all of the following:
 - i. A high school diploma or equivalent;
 - ii. Six months experience working with persons with developmental disabilities;

- iii. Thirty hours of training in evidence-based behavioral health treatment administered by a qualified autism service provider or professional
- iv. Passed a background check conducted by a state-approved agency.

Comments:

- 1) Author's Intent.** SB 946 (Chapter 650, Statutes of 2011) required health service plan and insurance policies to provide coverage for behavioral health treatment for pervasive developmental disorder or autism (PDD/A). Furthermore, SB 946 defined behavioral health treatment as certain professional services and treatment programs that include applied behavior analysis under qualified autism service providers, professionals, and paraprofessionals.

The author's office notes that SB 946 went on to specifically define "qualified autism service professionals" and "qualified autism service paraprofessionals" as behavioral health treatment providers meeting the requirements of Section 54342 of Title 17 of the CCR. However, this section of the CCR only refers to behavioral health treatment providers as applied behavior analyst providers, leaving out other types of evidence-based behavioral health treatment.

Therefore, the author is attempting to have the behavioral health coverage mandated by SB 946 apply to all types of evidence-based behavioral health treatment, not just applied behavior analysis. This bill does this by codifying the educational and professional requirements listed in Title 17 of the CCR for applied behavior analysts, and applying them to all behavioral health providers.

The author's goal in doing this is to ensure that the qualified medical professional who knows the child best can prescribe the appropriate behavioral health treatment for that child, even if that behavioral health treatment is not applied behavior analysis.

- 2) Inclusion of Board Registrants.** This bill allows an associate clinical social worker registered with the Board to be a qualified autism services professional if he or she provides behavioral health treatment, is employed and supervised by a qualified autism service provider and provides treatment pursuant to a treatment plan developed and approved by that provider, and has training and experience providing services for pervasive developmental disorder or autism pursuant to the Lanterman Developmental Disabilities Services Act.

It is unclear why associate clinical social workers are specified as being able to become qualified autism service professionals, but marriage and family therapist interns and professional clinical counselor interns are not.

- 3) Proposed Licensure of Behavior Analysts.** The author's office writes that the definitions of applied behavioral analysis in Section 54342 of Title 17 of the CCR were written before newer forms of behavioral health treatment therapy had been developed and tested, and that is why current coverage requirements specify applied behavior analysis.

Applied behavior analysis has become a well-established standard of treatment for PDD/A, and the California Association for Behavior Analysis is currently sponsoring a bill proposal (SB 479, Bates), which would create a licensure category under the Board of Psychology.

The prospect of competing types of effective behavioral health treatment may raise questions about the implications of establishing a licensure category for one of the treatment types, but not the others.

- 4) Previous Legislation.** SB 946 (Chapter 650, Statutes of 2011) requires every health care service plan contract and insurance policy that provides hospital, medical, or surgical coverage shall also provide coverage for behavioral health treatment for PDD/A.

AB 171 (Beall, 2012), would have required health care service plan contracts and health insurance policies to provide coverage for the screening, diagnosis, and treatment of PDD/A other than behavioral health treatment. This bill died in the Senate Health Committee.

SB 126 (Chapter 680, Statutes of 2013) extended the provisions of SB 946 until January 1, 2017.

- 5) Recommended Position.** At its April 23, 2015 meeting, the Policy and Advocacy committee recommended that the Board take a “neutral” position on this bill.

6) Support and Opposition.

Support:

- Hundreds of individuals

Oppose:

- Autism Research Group
- California Association of Behavior Analysts
- Center for Autism & Related Disorders
- Southern California Consortium for Behavior Analysis

7) History

2015

05/05/15 In committee: Set, first hearing. Failed passage.

04/09/15 (Ayes 51. Noes 26. Page 845.)

04/09/15 Re-referred to Coms. on B. & P. and HEALTH pursuant to Assembly Rule 96.

04/08/15 In committee: Hearing postponed by committee.

03/26/15 In committee: Hearing postponed by committee.

03/12/15 Referred to Coms. on HEALTH and B. & P.

02/27/15 From printer. May be heard in committee March 29.

02/26/15 Read first time. To print.

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ASSEMBLY BILL

No. 796

**Introduced by Assembly Member Nazarian
(Coauthor: Assembly Member Rendon)**

February 26, 2015

An act to amend Section 1374.73 of the Health and Safety Code, and to amend Section 10144.51 of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 796, as introduced, Nazarian. Health care coverage: autism and pervasive developmental disorders.

Existing law provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. A violation of those provisions is a crime. Existing law provides for the licensure and regulation of health insurers by the Department of Insurance.

Existing law requires every health care service plan contract and health insurance policy to provide coverage for behavioral health treatment for pervasive developmental disorder or autism. Existing law requires every health care service plan and health insurance policy to maintain an adequate network that includes qualified autism service providers who supervise and employ qualified autism service professionals or paraprofessionals who provide and administer behavioral health treatment. Existing law defines “qualified autism service professional” and “qualified autism service paraprofessional” for this purpose to mean a person who meets specified educational and training requirements.

This bill would expand the eligibility for a person to be a qualified autism service professional to include a person who possesses a bachelor

of arts or science degree and meets other specified requirements, a registered psychological assistant, a registered psychologist, or an associate clinical social worker. The bill would also expand the eligibility for a person to be a qualified autism service paraprofessional to include a person with a high school diploma or equivalent and, among other things, 6 months experience working with persons with developmental disabilities.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

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

- 1 SECTION 1. The Legislature finds and declares all of the
- 2 following:
- 3 (a) Autism and other pervasive developmental disorders are
- 4 complex neurobehavioral disorders that include impairments in
- 5 social communication and social interaction combined with rigid,
- 6 repetitive behaviors, interests, and activities.
- 7 (b) Autism covers a large spectrum of symptoms and levels of
- 8 impairment ranging in severity from somewhat limiting to a severe
- 9 disability that may require institutional care.
- 10 (c) One in 68 children born today will be diagnosed with autism
- 11 or another pervasive developmental disorder.
- 12 (d) Research has demonstrated that children diagnosed with
- 13 autism can often be helped with early administration of behavioral
- 14 health treatment.
- 15 (e) There are several forms of evidence-based behavioral health
- 16 treatment, including, but not limited to, applied behavioral analysis.
- 17 (f) Children diagnosed with autism respond differently to
- 18 behavioral health treatment.
- 19 (g) It is critical that each child diagnosed with autism receives
- 20 the specific type of evidence-based behavioral health treatment
- 21 best suited to him or her, as prescribed by his or her physician or
- 22 developed by a psychologist.
- 23 (h) The Legislature intends that all forms of evidence-based
- 24 behavioral health treatment be covered by health care service plans,
- 25 pursuant to Section 1374.73 of the Health and Safety Code, and
- 26 health insurance policies, pursuant to Section 10144.51 of the
- 27 Insurance Code.

1 (i) The Legislature intends that health care service plan provider
2 networks include qualified professionals practicing all forms of
3 evidence-based behavioral health treatment other than just applied
4 behavioral analysis.

5 SEC. 2. Section 1374.73 of the Health and Safety Code is
6 amended to read:

7 1374.73. (a) (1) Every health care service plan contract that
8 provides hospital, medical, or surgical coverage shall also provide
9 coverage for behavioral health treatment for pervasive
10 developmental disorder or autism no later than July 1, 2012. The
11 coverage shall be provided in the same manner and shall be subject
12 to the same requirements as provided in Section 1374.72.

13 (2) Notwithstanding paragraph (1), as of the date that proposed
14 final rulemaking for essential health benefits is issued, this section
15 does not require ~~any~~ benefits to be provided that exceed the
16 essential health benefits that all health plans will be required by
17 federal regulations to provide under Section 1302(b) of the federal
18 Patient Protection and Affordable Care Act (Public Law 111-148),
19 as amended by the federal Health Care and Education
20 Reconciliation Act of 2010 (Public Law 111-152).

21 (3) This section shall not affect services for which an individual
22 is eligible pursuant to Division 4.5 (commencing with Section
23 4500) of the Welfare and Institutions Code or Title 14
24 (commencing with Section 95000) of the Government Code.

25 (4) This section shall not affect or reduce any obligation to
26 provide services under an individualized education program, as
27 defined in Section 56032 of the Education Code, or an individual
28 service plan, as described in Section 5600.4 of the Welfare and
29 Institutions Code, or under the federal Individuals with Disabilities
30 Education Act (20 U.S.C. Sec. 1400 et seq.) and its implementing
31 regulations.

32 (b) Every health care service plan subject to this section shall
33 maintain an adequate network that includes qualified autism service
34 providers who supervise and employ qualified autism service
35 professionals or paraprofessionals who provide and administer
36 behavioral health treatment. Nothing shall prevent a health care
37 service plan from selectively contracting with providers within
38 these requirements.

39 (c) For the purposes of this section, the following definition
40 shall apply:

1 (1) “Behavioral health treatment” means professional services
2 and treatment programs, including applied behavior analysis and
3 evidence-based behavior intervention programs, that develop or
4 restore, to the maximum extent practicable, the functioning of an
5 individual with pervasive developmental disorder or autism and
6 that meet all of the following criteria:

7 (A) The treatment is prescribed by a physician and surgeon
8 licensed pursuant to Chapter 5 (commencing with Section 2000)
9 of, or is developed by a psychologist licensed pursuant to Chapter
10 6.6 (commencing with Section 2900) of, Division 2 of the Business
11 and Professions Code.

12 (B) The treatment is provided under a treatment plan prescribed
13 by a qualified autism service provider and is administered by one
14 of the following:

- 15 (i) A qualified autism service provider.
- 16 (ii) A qualified autism service professional supervised and
17 employed by the qualified autism service provider.
- 18 (iii) A qualified autism service paraprofessional supervised and
19 employed by a qualified autism service provider.

20 (C) The treatment plan has measurable goals over a specific
21 timeline that is developed and approved by the qualified autism
22 service provider for the specific patient being treated. The treatment
23 plan shall be reviewed no less than once every six months by the
24 qualified autism service provider and modified whenever
25 appropriate, and shall be consistent with Section 4686.2 of the
26 Welfare and Institutions Code pursuant to which the qualified
27 autism service provider does all of the following:

- 28 (i) Describes the patient’s behavioral health impairments or
29 developmental challenges that are to be treated.
- 30 (ii) Designs an intervention plan that includes the service type,
31 number of hours, and parent participation needed to achieve the
32 plan’s goal and objectives, and the frequency at which the patient’s
33 progress is evaluated and reported.
- 34 (iii) Provides intervention plans that utilize evidence-based
35 practices, with demonstrated clinical efficacy in treating pervasive
36 developmental disorder or autism.
- 37 (iv) Discontinues intensive behavioral intervention services
38 when the treatment goals and objectives are achieved or no longer
39 appropriate.

1 (D) The treatment plan is not used for purposes of providing or
2 for the reimbursement of respite, day care, or educational services
3 and is not used to reimburse a parent for participating in the
4 treatment program. The treatment plan shall be made available to
5 the health care service plan upon request.

6 (2) “Pervasive developmental disorder or autism” shall have
7 the same meaning and interpretation as used in Section 1374.72.

8 (3) “Qualified autism service provider” means either of the
9 following:

10 (A) A person, entity, or group that is certified by a national
11 entity, such as the Behavior Analyst Certification Board, that is
12 accredited by the National Commission for Certifying Agencies,
13 and who designs, supervises, or provides treatment for pervasive
14 developmental disorder or autism, provided the services are within
15 the experience and competence of the person, entity, or group that
16 is nationally certified

17 (B) A person licensed as a physician and surgeon, physical
18 therapist, occupational therapist, psychologist, marriage and family
19 therapist, educational psychologist, clinical social worker,
20 professional clinical counselor, speech-language pathologist, or
21 audiologist pursuant to Division 2 (commencing with Section 500)
22 of the Business and Professions Code, who designs, supervises,
23 or provides treatment for pervasive developmental disorder or
24 autism, provided the services are within the experience and
25 competence of the licensee.

26 (4) “Qualified autism service professional” means an individual
27 who meets all of the following criteria:

28 (A) Provides behavioral health treatment.

29 (B) Is employed and supervised by a qualified autism service
30 provider.

31 (C) Provides treatment pursuant to a treatment plan developed
32 and approved by the qualified autism service provider.

33 (D) Is a behavioral service provider ~~approved~~ *who meets one*
34 *of the following criteria:*

35 (i) *Is approved* as a vendor by a California regional center to
36 provide services as an Associate Behavior Analyst, Behavior
37 Analyst, Behavior Management Assistant, Behavior Management
38 Consultant, or Behavior Management Program as defined in
39 Section 54342 of Title 17 of the California Code of Regulations.

- 1 (ii) Possesses a bachelor of arts or science degree and has either
 2 of the following:
- 3 (I) Twelve semester units from an accredited institute of higher
 4 learning in either applied behavioral analysis or clinical
 5 coursework in behavioral health and one year of experience in
 6 designing or implementing behavioral health treatment.
- 7 (II) two years of experience in designing or implementing
 8 behavioral health treatment.
- 9 (iii) The person is a registered psychological assistant or
 10 registered psychologist pursuant to Chapter 6.6 (commencing with
 11 Section 2900) of Division 2 of the Business and Professions Code.
- 12 (iv) The person is an associate clinical social worker registered
 13 with the Board of Behavioral Sciences pursuant to Section 4996.18
 14 of the Business and Professions Code.
- 15 (E) Has training and experience in providing services for
 16 pervasive developmental disorder or autism pursuant to Division
 17 4.5 (commencing with Section 4500) of the Welfare and
 18 Institutions Code or Title 14 (commencing with Section 95000)
 19 of the Government Code.
- 20 (5) “Qualified autism service paraprofessional” means an
 21 unlicensed and uncertified individual who meets all of the
 22 following criteria:
- 23 (A) Is employed and supervised by a qualified autism service
 24 provider.
- 25 (B) Provides treatment and implements services pursuant to a
 26 treatment plan developed and approved by the qualified autism
 27 service provider.
- 28 (C) Meets the criteria set forth in the regulations adopted
 29 pursuant to Section 4686.3 of the Welfare and Institutions Code.
 30 Code or meets all of the following:
- 31 (i) Possesses a high school diploma or equivalent.
- 32 (ii) Has six months experience working with persons with a
 33 developmental disability.
- 34 (iii) Has 30 hours of training in the specific form of
 35 evidence-based behavioral health treatment administered by a
 36 qualified autism provider or qualified autism service professional.
- 37 (iv) Has successfully passed a background check conducted by
 38 a state-approved agency.
- 39 (D) Has adequate education, training, and experience, as
 40 certified by a qualified autism service provider.

- 1 (d) This section shall not apply to the following:
- 2 (1) A specialized health care service plan that does not deliver
3 mental health or behavioral health services to enrollees.
- 4 (2) A health care service plan contract in the Medi-Cal program
5 (Chapter 7 (commencing with Section 14000) of Part 3 of Division
6 9 of the Welfare and Institutions Code).
- 7 (3) A health care service plan contract in the Healthy Families
8 Program (Part 6.2 (commencing with Section 12693) of Division
9 2 of the Insurance Code).
- 10 (4) A health care benefit plan or contract entered into with the
11 Board of Administration of the Public Employees' Retirement
12 System pursuant to the Public Employees' Medical and Hospital
13 Care Act (Part 5 (commencing with Section 22750) of Division 5
14 of Title 2 of the Government Code).
- 15 (e) Nothing in this section shall be construed to limit the
16 obligation to provide services under Section 1374.72.
- 17 (f) As provided in Section 1374.72 and in paragraph (1) of
18 subdivision (a), in the provision of benefits required by this section,
19 a health care service plan may utilize case management, network
20 providers, utilization review techniques, prior authorization,
21 copayments, or other cost sharing.
- 22 (g) This section shall remain in effect only until January 1, 2017,
23 and as of that date is repealed, unless a later enacted statute, that
24 is enacted before January 1, 2017, deletes or extends that date.
- 25 SEC. 3. Section 10144.51 of the Insurance Code is amended
26 to read:
- 27 10144.51. (a) (1) Every health insurance policy shall also
28 provide coverage for behavioral health treatment for pervasive
29 developmental disorder or autism no later than July 1, 2012. The
30 coverage shall be provided in the same manner and shall be subject
31 to the same requirements as provided in Section 10144.5.
- 32 (2) Notwithstanding paragraph (1), as of the date that proposed
33 final rulemaking for essential health benefits is issued, this section
34 does not require any benefits to be provided that exceed the
35 essential health benefits that all health insurers will be required by
36 federal regulations to provide under Section 1302(b) of the federal
37 Patient Protection and Affordable Care Act (Public Law 111-148),
38 as amended by the federal Health Care and Education
39 Reconciliation Act of 2010 (Public Law 111-152).

1 (3) This section shall not affect services for which an individual
2 is eligible pursuant to Division 4.5 (commencing with Section
3 4500) of the Welfare and Institutions Code or Title 14
4 (commencing with Section 95000) of the Government Code.

5 (4) This section shall not affect or reduce any obligation to
6 provide services under an individualized education program, as
7 defined in Section 56032 of the Education Code, or an individual
8 service plan, as described in Section 5600.4 of the Welfare and
9 Institutions Code, or under the federal Individuals with Disabilities
10 Education Act (20 U.S.C. Sec. 1400 et seq.) and its implementing
11 regulations.

12 (b) Pursuant to Article 6 (commencing with Section 2240) of
13 Title 10 of the California Code of Regulations, every health insurer
14 subject to this section shall maintain an adequate network that
15 includes qualified autism service providers who supervise and
16 employ qualified autism service professionals or paraprofessionals
17 who provide and administer behavioral health treatment. Nothing
18 shall prevent a health insurer from selectively contracting with
19 providers within these requirements.

20 (c) For the purposes of this section, the following definition
21 shall apply:

22 (1) “Behavioral health treatment” means professional services
23 and treatment programs, including applied behavior analysis and
24 evidence-based behavior intervention programs, that develop or
25 restore, to the maximum extent practicable, the functioning of an
26 individual with pervasive developmental disorder or autism, and
27 that meet all of the following criteria:

28 (A) The treatment is prescribed by a physician and surgeon
29 licensed pursuant to Chapter 5 (commencing with Section 2000)
30 of, or is developed by a psychologist licensed pursuant to Chapter
31 6.6 (commencing with Section 2900) of, Division 2 of the Business
32 and Professions Code.

33 (B) The treatment is provided under a treatment plan prescribed
34 by a qualified autism service provider and is administered by one
35 of the following:

- 36 (i) A qualified autism service pr vider.
- 37 (ii) A qualified autism service professional supervised and
38 employed by the qualified autism service pr vider.
- 39 (iii) A qualified autism service paraprofessional supervised and
40 employed by a qualified autism service pr vider.

1 (C) The treatment plan has measurable goals over a specifi
2 timeline that is developed and approved by the qualified autism
3 service provider for the specific patient being treated. The treatment
4 plan shall be reviewed no less than once every six months by the
5 qualified autism service provider and modified whenever
6 appropriate, and shall be consistent with Section 4686.2 of the
7 Welfare and Institutions Code pursuant to which the qualifie
8 autism service provider does all of the following:

9 (i) Describes the patient’s behavioral health impairments or
10 developmental challenges that are to be treated.

11 (ii) Designs an intervention plan that includes the service type,
12 number of hours, and parent participation needed to achieve the
13 plan’s goal and objectives, and the frequency at which the patient’s
14 progress is evaluated and reported.

15 (iii) Provides intervention plans that utilize evidence-based
16 practices, with demonstrated clinical effica y in treating pervasive
17 developmental disorder or autism.

18 (iv) Discontinues intensive behavioral intervention services
19 when the treatment goals and objectives are achieved or no longer
20 appropriate.

21 (D) The treatment plan is not used for purposes of providing or
22 for the reimbursement of respite, day care, or educational services
23 and is not used to reimburse a parent for participating in the
24 treatment program. The treatment plan shall be made available to
25 the insurer upon request.

26 (2) “Pervasive developmental disorder or autism” shall have
27 the same meaning and interpretation as used in Section 10144.5.

28 (3) “Qualified autism service provider” means either of the
29 following:

30 (A) A person, entity, or group that is certified by a national
31 entity, such as the Behavior Analyst Certification Board, that is
32 accredited by the National Commission for Certifying Agencies,
33 and who designs, supervises, or provides treatment for pervasive
34 developmental disorder or autism, provided the services are within
35 the experience and competence of the person, entity, or group that
36 is nationally certified

37 (B) A person licensed as a physician and surgeon, physical
38 therapist, occupational therapist, psychologist, marriage and family
39 therapist, educational psychologist, clinical social worker,
40 professional clinical counselor, speech-language pathologist, or

1 audiologist pursuant to Division 2 (commencing with Section 500)
2 of the Business and Professions Code, who designs, supervises,
3 or provides treatment for pervasive developmental disorder or
4 autism, provided the services are within the experience and
5 competence of the licensee.

6 (4) “Qualified autism service professional” means an individual
7 who meets all of the following criteria:

8 (A) Provides behavioral health treatment.

9 (B) Is employed and supervised by a qualified autism service
10 provider.

11 (C) Provides treatment pursuant to a treatment plan developed
12 and approved by the qualified autism service provider.

13 (D) Is a behavioral service provider ~~approved~~ *who meets one*
14 *of the following criteria:*

15 (i) *Is approved* as a vendor by a California regional center to
16 provide services as an Associate Behavior Analyst, Behavior
17 Analyst, Behavior Management Assistant, Behavior Management
18 Consultant, or Behavior Management Program as defined in
19 Section 54342 of Title 17 of the California Code of Regulations.

20 (ii) *Possesses a bachelor of arts or science degree and has either*
21 *of the following:*

22 (I) *Twelve semester units from an accredited institute of higher*
23 *learning in either applied behavioral analysis or clinical*
24 *coursework in behavioral health and one year of experience in*
25 *designing or implementing behavioral health treatment.*

26 (II) *Two years of experience in designing or implementing*
27 *behavioral health treatment.*

28 (iii) *The person is a registered psychological assistant or*
29 *registered psychologist pursuant to Chapter 6.6 (commencing with*
30 *Section 2900) of Division 2 of the Business and Professions Code.*

31 (iv) *The person is an associate clinical social worker registered*
32 *with the Board of Behavioral Sciences pursuant to Section 4996.18*
33 *of the Business and Professions Code.*

34 (E) Has training and experience in providing services for
35 pervasive developmental disorder or autism pursuant to Division
36 4.5 (commencing with Section 4500) of the Welfare and
37 Institutions Code or Title 14 (commencing with Section 95000)
38 of the Government Code.

1 (5) “Qualified autism service paraprofessional” means an
2 unlicensed and uncertified individual who meets all of the
3 following criteria:

4 (A) Is employed and supervised by a qualified autism service
5 provider.

6 (B) Provides treatment and implements services pursuant to a
7 treatment plan developed and approved by the qualified autism
8 service provider.

9 (C) Meets the criteria set forth in the regulations adopted
10 pursuant to Section 4686.3 of the Welfare and Institutions Code.
11 *Code or meets all of the following:*

12 (i) *Possesses a high school diploma or equivalent.*

13 (ii) *Has six months experience working with persons with a*
14 *developmental disability.*

15 (iii) *Has 30 hours of training in the specific form of*
16 *evidence-based behavioral health treatment administered by a*
17 *qualified autism provider or qualified autism service professional.*

18 (iv) *Has successfully passed a background check conducted by*
19 *a state-approved agency.*

20 (D) Has adequate education, training, and experience, as
21 certified by a qualified autism service provider.

22 (d) This section shall not apply to the following:

23 (1) A specialized health insurance policy that does not cover
24 mental health or behavioral health services or an accident only,
25 specified disease, hospital indemnity, or Medicare supplement
26 policy.

27 (2) A health insurance policy in the Medi-Cal program (Chapter
28 7 (commencing with Section 14000) of Part 3 of Division 9 of the
29 Welfare and Institutions Code).

30 (3) A health insurance policy in the Healthy Families Program
31 (Part 6.2 (commencing with Section 12693)).

32 (4) A health care benefit plan or policy entered into with the
33 Board of Administration of the Public Employees’ Retirement
34 System pursuant to the Public Employees’ Medical and Hospital
35 Care Act (Part 5 (commencing with Section 22750) of Division 5
36 of Title 2 of the Government Code).

37 (e) Nothing in this section shall be construed to limit the
38 obligation to provide services under Section 10144.5.

39 (f) As provided in Section 10144.5 and in paragraph (1) of
40 subdivision (a), in the provision of benefits required by this section,

1 a health insurer may utilize case management, network providers,
2 utilization review techniques, prior authorization, copayments, or
3 other cost sharing.

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

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CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES

BILL ANALYSIS

BILL NUMBER: AB 832 **VERSION:** AMENDED APRIL 16, 2015

AUTHOR: GARCIA **SPONSOR:** AUTHOR

RECOMMENDED POSITION: SUPPORT

SUBJECT: CHILD ABUSE: REPORTABLE CONDUCT

Overview:

This bill would specify that voluntary acts of sodomy, oral copulation, and sexual penetration are not considered acts of sexual assault that must be reported by a mandated reporter, unless it is between a person age 21 or older and a minor under age 16.

Existing Law:

- 1) Establishes the Child Abuse and Neglect Reporting Act (CANRA) which requires a mandated reporter to make a report in instances in which he or she knows or reasonably suspects that a child has been the victim of child abuse or neglect. (Penal Code (PC) 11164 et seq)
- 2) Defines “sexual abuse” for the purposes of CANRA as sexual assault or exploitation consisting of any of the following: rape, statutory rape, rape in concert, incest, sodomy, oral copulation, certain lewd or lascivious acts upon a child, sexual penetration, or child molestation. (PC §11165.1(a))
- 3) Except under certain specified circumstances, declares any person who participates in an act of sodomy or oral copulation with a person under age 18 shall be punished by up to one year in state prison or county jail. (PC §§ 286(b)(1), 288a(b)(1))
- 4) Except under certain specified circumstances, declares any person over age 21 who participates in an act of sodomy or oral copulation with someone under age 16 is guilty of a felony. (PC §§ 286(b)(2), 288a(b)(2))
- 5) States that a person who engages in unlawful sexual intercourse with a minor who is not more than three years older or three years younger, is guilty of a misdemeanor. (PC §261.5(b))
- 6) States that a person who engages in unlawful sexual intercourse with a minor who is more than three years younger is guilty of either a misdemeanor or a felony. (PC §261.5(c))

- 7) States that any person age 21 or older who engages in unlawful sexual intercourse with a minor under age 16 is guilty of either a misdemeanor or a felony. (PC §261.5(d))

This Bill:

- 1) Specifies that voluntary acts of sodomy, oral copulation, or sexual penetration are not considered to be mandated reports of sexual assault under CANRA, unless the conduct is between a person age 21 or older and a minor under age 16. (PC §11165.1(a))

Comment:

- 1) **Author's Intent.** The author's office states that the reporting requirements for mandated reporters of child abuse are confusing, inconsistent, and discriminatory.

They note that current law states that consensual sodomy and oral copulation is illegal with anyone under age 18, and that it requires a mandated report as sexual assault under CANRA. However, the same reporting standards do not apply to consensual heterosexual intercourse.

The author is attempting to make the law consistent by ensuring that all types of voluntary activities are treated equally for purposes of mandated reporting under CANRA.

- 2) **Background.** The Board examined this issue in 2013 when stakeholders expressed concern that consensual oral copulation and sodomy among minors were mandated reports under CANRA, while other types of consensual sexual activity were not.

However, at the same time, staffers at the Legislature contacted Board staff to caution that there had been past legal opinions stating that this interpretation of CANRA was incorrect, and that amendments could potentially have ramifications for family planning agencies.

The Board was concerned about a potential legal misinterpretation of CANRA, but at the same time saw this as a valid effort. Therefore, it directed staff to obtain a legal opinion from the DCA legal office.

- 3) **DCA Legal Opinion.** In its legal opinion, DCA found that CANRA does not require a mandated reporter to report incidents of consensual sex between minors of a similar age for any actions described in PC Section 11165.1, unless there is reasonable suspicion of force, exploitation, or other abuse. DCA also found the following, based on past court cases:

- Courts have found that the legislative intent of the reporting law is to leave the distinction between abusive and non-abusive sexual relations to the judgment of professionals who deal with children.

- Review of other legal cases has found that the law does not require reporting of consensual sexual activities between similarly-aged minors for any sexual acts unless there is evidence of abuse.

- 4) **Board of Psychology Action.** The Board of Psychology is seeking an opinion from the Attorney General’s Office on the laws regarding mandated reporting, specifically whether consensual sexual conduct between minors of a like age differs depending upon the type of sexual conduct described by the minor.

The Board of Psychology asked the AG to resolve the following legal questions:

1. The Child Abuse and Neglect Reporting Act (CANRA; Pen. Code, sec. 11164 et seq.) requires “mandated reporters” to report instances of child sexual abuse, assault, and exploitation to specified law enforcement and/or child protection agencies. Does this requirement include the mandatory reporting of voluntary acts of sexual intercourse, oral copulation, or sodomy between minors of a like age?
2. Under CANRA is the activity of mobile device “sexting,” between minors of a like age, a form of reportable sexual exploitation?
3. Does CANRA require a mandated reporter to relay third-party reports of downloading, streaming, or otherwise accessing child pornography through electronic or digital media?

The opinion was sent to the AG by Assemblywoman Garcia. A response is expected this summer.

- 5) **Reportability if Adult is Under 21.** Board staff had a discussion with the author’s office to verify a question about how the amendments would affect the reportability of a situation of sexual activities between an adult under 21 and a significantly younger minor. For example, would an act of sodomy or oral copulation between a 20 year old and a 10 year old still be reportable under the law, even though it doesn’t fall under age range prescribed in the amendments?

Staff believed such an act would be reportable due to the provisions of Penal Code Section 288 (which addresses lewd and lascivious acts with someone under 14). The author’s office consulted with Legislative Counsel on this issue, and Legislative Counsel confirmed that such an act would still be reportable.

- 6) **Previous Legislation.** AB 1505 (Garcia, 2014) would have specified that consensual acts of sodomy and oral copulation are not acts of sexual assault that must be reported by a mandated reporter, unless it involved either a person over age 21 or a minor under age 16.

At its April 2014 meeting, the Policy and Advocacy Committee recommended that the Board take a “support” position on this bill. However, AB 1505 died before the Board was able to take a position on it.

7) **Recommended Position.** At its April 23, 2015 meeting, the Policy and Advocacy Committee recommended that the Board take a “support” position on this bill.

8) **Support and Opposition.**

Support:

- American Association for Marriage and Family Therapy, California Division
- American Civil Liberties Union of California
- California Public Defenders Association
- Equality California
- Gerry Grossman Seminars
- National Center for Youth Law
- 144 private individuals

Opposition

- California District Attorneys Association

9) **History**

2015

04/30/15 Read second time. Ordered to third reading.

04/29/15 From committee: Do pass. (Ayes 10. Noes 5.) (April 29).

04/20/15 Re-referred to Com. on APPR.

04/16/15 Read second time and amended.

04/15/15 From committee: Amend, and do pass as amended and re-refer to Com. on APPR. (Ayes 5. Noes 2.) (April 7).

03/12/15 Referred to Com. on PUB. S.

02/27/15 From printer. May be heard in committee March 29.

02/26/15 Read first time. To print.

10) **Attachments**

Attachment A: DCA Legal Opinion: Evaluation of CANRA Reform Proposal Related to Reporting of Consensual Sex Between Minors

Attachment B: Relevant Code Sections: Penal Code Sections 261.5, 286, 288, 288a, and 289

Attachment C: CAMFT Article: “Reporting Consensual Activity Between Minors: The Confusion Unraveled,” by Cathy Atkins, Revised May 2013

Attachment D: Santa Clara County Child Abuse Council “Child Abuse Reporting Guidelines for Sexual Activity Between and with Minors”

Attachment E: Santa Clara County information sheet for mandated reporters: “Mandated Reporters: When Must you Report Consensual Sexual Activity Involving Minors?”

AMENDED IN ASSEMBLY APRIL 16, 2015

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL

No. 832

**Introduced by Assembly Member Cristina Garcia
(Coauthor: Assembly Member Eggman)**

February 26, 2015

An act to amend Section 11165.1 of the Penal Code, relating to child abuse.

LEGISLATIVE COUNSEL'S DIGEST

AB 832, as amended, Cristina Garcia. Child abuse: reportable conduct.

The Child Abuse and Neglect Reporting Act requires a mandated reporter, as defined, to make a report to a specified agency whenever the mandated reporter, in his or her professional capacity or within the scope of his or her employment, has knowledge of or observes a child whom the mandated reporter knows or reasonably suspects has been the victim of child abuse or neglect. Existing law provides that “child abuse or neglect” for these purposes includes “sexual assault,” that includes, among other things, the crimes of sodomy, oral copulation, and sexual penetration.

This bill would provide that “sexual assault” for these purposes does not include ~~consensual~~ *voluntary* sodomy, oral copulation, or sexual penetration, unless that conduct is between a person who is 21 years of age or older and a minor who is under 16 years of age.

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 11165.1 of the Penal Code is amended
2 to read:

3 11165.1. As used in this article, “sexual abuse” means sexual
4 assault or sexual exploitation as defined by the following:

5 (a) “Sexual assault” means conduct in violation of one or more
6 of the following sections: Section 261 (rape), subdivision (d) of
7 Section 261.5 (statutory rape), 264.1 (rape in concert), 285 (incest),
8 286 (sodomy), subdivision (a) or ~~(b)~~, (b) of, or paragraph (1) of
9 subdivision (c) of, Section 288 (lewd or lascivious acts upon a
10 child), 288a (oral copulation), 289 (sexual penetration), or 647.6
11 (child molestation). “Sexual assault” for the purposes of this article
12 does not include ~~consensual~~ *voluntary* conduct in violation of
13 Section 286, 288a, or 289, unless the conduct is between a person
14 21 years of age or older and a minor who is under 16 years of age.

15 (b) Conduct described as “sexual assault” includes, but is not
16 limited to, all of the following:

17 (1) Penetration, however slight, of the vagina or anal opening
18 of one person by the penis of another person, whether or not there
19 is the emission of semen.

20 (2) Sexual contact between the genitals or anal opening of one
21 person and the mouth or tongue of another person.

22 (3) Intrusion by one person into the genitals or anal opening of
23 another person, including the use of an object for this purpose,
24 except that, it does not include acts performed for a valid medical
25 purpose.

26 (4) The intentional touching of the genitals or intimate parts,
27 including the breasts, genital area, groin, inner thighs, and buttocks,
28 or the clothing covering them, of a child, or of the perpetrator by
29 a child, for purposes of sexual arousal or gratification, except that
30 it does not include acts which may reasonably be construed to be
31 normal caretaker responsibilities; interactions with, or
32 demonstrations of affection for, the child; or acts performed for a
33 valid medical purpose.

34 (5) The intentional masturbation of the perpetrator’s genitals in
35 the presence of a child.

36 (c) “Sexual exploitation” refers to any of the following:

37 (1) Conduct involving matter depicting a minor engaged in
38 obscene acts in violation of Section 311.2 (preparing, selling, or

1 distributing obscene matter) or subdivision (a) of Section 311.4
2 (employment of a minor to perform obscene acts).

3 (2) A person who knowingly promotes, aids, or assists, employs,
4 uses, persuades, induces, or coerces a child, or a person responsible
5 for a child's welfare, who knowingly permits or encourages a child
6 to engage in, or assist others to engage in, prostitution or a live
7 performance involving obscene sexual conduct, or to either pose
8 or model alone or with others for purposes of preparing a film
9 photograph, negative, slide, drawing, painting, or other pictorial
10 depiction, involving obscene sexual conduct. For the purpose of
11 this section, "person responsible for a child's welfare" means a
12 parent, guardian, foster parent, or a licensed administrator or
13 employee of a public or private residential home, residential school,
14 or other residential institution.

15 (3) A person who depicts a child in, or who knowingly develops,
16 duplicates, prints, downloads, streams, accesses through any
17 electronic or digital media, or exchanges, a film, photograph,
18 videotape, video recording, negative, or slide in which a child is
19 engaged in an act of obscene sexual conduct, except for those
20 activities by law enforcement and prosecution agencies and other
21 persons described in subdivisions (c) and (e) of Section 311.3.

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MEMORANDUM

DATE	April 11, 2013
TO	Kim Madsen Members of the Board of Behavioral Sciences
FROM	DIANNE R. DOBBS Senior Staff Counsel, Legal Affairs
SUBJECT	Evaluation of CANRA Reform Proposal Related to Reporting of Consensual Sex Between Minors

Following presentation by Benjamin E. Caldwell, PsyD of a proposal to amend portions of the Child Abuse and Neglect Reporting Act ("CANRA") at the board meeting on February 28, 2013, the board requested a legal opinion on the proposal. The proposal seeks to amend CANRA to remove sodomy and oral copulation from the definition of sexual abuse, assault or exploitation. The purpose of the modification is to address concerns of mandated reporting in situations of consensual acts falling within these definitions when the actors are minors of like age under the law and the actions do not otherwise suggest other indications of abuse or neglect.

QUESTIONS PRESENTED

1. As written does Penal Code section 11165.1 require practitioners to report all conduct by minors that fall under the definition of sodomy and oral copulation?
2. Does the legal interpretation of CANRA warrant support of the proposed amendments?

SHORT ANSWERS

1. No. Court interpretation of CANRA dating back to 1986, and followed as recently as 2005 confirms that minors under and over age 14 can lawfully engage in consensual sexual activities with minors of a like age, and that not all sexual conduct involving a minor necessarily constitutes a violation of the law. That as such, a mandated reporter is required to report only those conditions and situations where the reporter has reason to know or suspects resulted from sexual conduct between the minor and an older adolescent or an adult and those contacts which resulted from undue influence, cohesion, use of force or other indicators of abuse.

2. No. Because practitioners are not required to report any non-abusive consensual sexual activities between minors of like age, amendment of the law is not necessary and should not be supported.

STATEMENT OF FACTS/BACKGROUND

1. Benjamin Caldwell PhD, ("Dr. Caldwell") Legislative and Advocacy Committee Chair of the American Association of Marriage and Family Therapy – California Division seeks to amend CANRA and is seeking the support of the Board of Behavioral Sciences ("Board").
2. Dr. Caldwell claims that CANRA's inclusion of sodomy and oral copulation in the definition of sexual assault found in Penal Code section 11165.1¹ requires mandated reporters to report all homosexual activities meeting these definitions whether or not the acts are consensual and not otherwise suggestive of abuse.
3. The Senior Legislative Assistant of Assembly member Tom Ammiano believes that Dr. Caldwell and others are misinterpreting CANRA.

ANALYSIS

CANRA does not require a mandated reporter to report incidents of consensual sex between minors of similar age, as provided in section 261.5, absent reasonable suspicion of force, exploitation or other indications of abuse. The California Court of Appeal decided this issue in its 1988 ruling in *Planned Parenthood v. Van De Kamp*. *Planned Parenthood v. Van De Kamp* (1988) 181 Cal.App.3e 245. In that case, Planned Parenthood sought to enjoin implementation of CANRA following an opinion of the Attorney General which provided that the inclusion of section 288 in the definition of sexual assault found in section 11165.1 (a) meant that all sexual activities between and with minors under age 14 was reportable. 67 Ops. Cal. Atty. Gen. 235 (1984).

In nullifying the AG's opinion, the court explored the legislative history and intent of CANRA and held that the legislative intent of the reporting law was to leave the distinction between abusive and non-abusive sexual relations to the judgment of those professionals who deal with children and who are by virtue of their training and experience particularly well suited to such judgment. The court reasoned that while the voluntary sexual conduct among minors under the age of 14 may be ill advised, it is not encompassed by section 288, and that the inclusion of that section in the reporting law does not mandate reporting of such activities. Id at 276.

¹ All further citations are to the Penal Code unless otherwise specified.

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After the court's ruling in *Planned Parenthood*, the Legislature amended CANRA and did nothing to nullify or change the effect of the court's decision. As such, the Legislature is deemed to have approved the interpretation because where a statute has been construed by judicial decision and that construction is not altered by subsequent legislation, it must be presumed that the Legislature is aware of the judicial construction and approved of it. See *People v. Stockton* (1988) 203 Cal.App.3d 225, citing *Wilkoff v. Superior Ct.*

Following *Planned Parenthood* several other Court of Appeal cases adopted the reasoning of the court including *People v. Stockton* later in 1988, and most recently with *People v. Davis* in 2005. All these cases discuss the CANRA reporting requirements in the context of section 288 which relates to lewd and lascivious conduct with minors under 14. Though none of the cases discuss any of the other acts which also constitute sexual assault under section 11165.1(a), the same reasoning applies to those acts in that absent other indications of abuse, the law does not require the reporting of consensual sexual activities between minors of similar age for any of these acts. This interpretation is consistent with the well settled legal principle that statutes are to be construed with reference to the entire system of law of which they are a part, including the various codes, and harmonized wherever possible to achieve a reasonable result. *Cossack v. City of Los Angeles* (1974) 11 Cal.3d 726, 732.

Dr. Caldwell claims that section 11165.1(a) requires mandated reporters to report all minors engaged in sodomy and oral copulation even where the conduct is consensual and is devoid of evidence of abuse is not supported by the law. All conduct enumerated in section 11165.1(a) must be treated the same for purposes of reporting. To interpret the law otherwise would be against the intent of the legislature to leave the distinction between abusive and non-abusive sexual relations to the judgment of the professionals. An interpretation that would require the reporting of all sodomy and oral copulation without reasonable suspicion of abuse would lead to an absurd result. The court in *Planned Parenthood* said it best when it stated, "...statutes must be construed in a reasonable and commonsense manner consistent with their apparent purpose and the legislative intent underlying them, practical rather than technical, and promoting a wise policy rather than mischief or absurdity. Even a statute's literal terms will not be given effect if to do so would yield an unreasonable or mischievous result." *Planned Parenthood* at 245. Therefore, sexual conduct of minors that meet the definition of sodomy and oral copulation must be treated as all other sexual conduct noted in section 11165.1(a) and is only reported if the acts are nonconsensual, abusive or involves minors of disparate ages, conduct between minors and adults, and situations where there is reasonable suspicion of undue influence, coercion, force or other indicators of abuse.

Section 11165.1(b) further outlines limited examples of conduct which qualifies as sexual assault. There is also no evidence that any of the examples in that section would lead to a discriminatory result to justify removal of sodomy or oral copulation from subsection (a).

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CONCLUSION

It is our opinion that CANRA does not require mandated reporters to report consensual sex between minors of like age for any of the actions noted in section 11165.1 unless the practitioner reasonably suspects that the conduct resulted from force, undue influence, coercion, or other indicators of abuse. Accordingly, it is not necessary to amend the statute to remove sodomy and oral copulation, as those acts are not treated differently from other acts outlined in the code.

DOREATHEA JOHNSON
Deputy Director, Legal Affairs



By: DIANNE R. DOBBS
Senior Staff Counsel
Legal Affairs

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Attachment B
Relevant Code Sections

Penal Code (PC)

PC §261.5.

(a) Unlawful sexual intercourse is an act of sexual intercourse accomplished with a person who is not the spouse of the perpetrator, if the person is a minor. For the purposes of this section, a “minor” is a person under the age of 18 years and an “adult” is a person who is at least 18 years of age.

(b) Any person who engages in an act of unlawful sexual intercourse with a minor who is not more than three years older or three years younger than the perpetrator, is guilty of a misdemeanor.

(c) Any person who engages in an act of unlawful sexual intercourse with a minor who is more than three years younger than the perpetrator is guilty of either a misdemeanor or a felony, and shall be punished by imprisonment in a county jail not exceeding one year, or by imprisonment pursuant to subdivision (h) of Section 1170.

(d) Any person 21 years of age or older who engages in an act of unlawful sexual intercourse with a minor who is under 16 years of age is guilty of either a misdemeanor or a felony, and shall be punished by imprisonment in a county jail not exceeding one year, or by imprisonment pursuant to subdivision (h) of Section 1170 for two, three, or four years.

(e) (1) Notwithstanding any other provision of this section, an adult who engages in an act of sexual intercourse with a minor in violation of this section may be liable for civil penalties in the following amounts:

(A) An adult who engages in an act of unlawful sexual intercourse with a minor less than two years younger than the adult is liable for a civil penalty not to exceed two thousand dollars (\$2,000).

(B) An adult who engages in an act of unlawful sexual intercourse with a minor at least two years younger than the adult is liable for a civil penalty not to exceed five thousand dollars (\$5,000).

(C) An adult who engages in an act of unlawful sexual intercourse with a minor at least three years younger than the adult is liable for a civil penalty not to exceed ten thousand dollars (\$10,000).

(D) An adult over the age of 21 years who engages in an act of unlawful sexual intercourse with a minor under 16 years of age is liable for a civil penalty not to exceed twenty-five thousand dollars (\$25,000).

(2) The district attorney may bring actions to recover civil penalties pursuant to this subdivision. From the amounts collected for each case, an amount equal to the costs of pursuing the action shall be deposited with the treasurer of the county in which the judgment was entered, and the remainder shall be deposited in the Underage Pregnancy Prevention Fund, which is hereby created in the State Treasury. Amounts deposited in the Underage Pregnancy Prevention Fund may be used only for the purpose of preventing underage pregnancy upon appropriation by the Legislature.

(3) In addition to any punishment imposed under this section, the judge may assess a fine not to exceed seventy dollars (\$70) against any person who violates this section with the proceeds of this fine to be used in accordance with Section 1463.23. The court shall, however, take into consideration the defendant's ability to pay, and no defendant shall be denied probation because of his or her inability to pay the fine permitted under this subdivision.

PC §286.

(a) Sodomy is sexual conduct consisting of contact between the penis of one person and the anus of another person. Any sexual penetration, however slight, is sufficient to complete the crime of sodomy.

(b) (1) Except as provided in Section 288, any person who participates in an act of sodomy with another person who is under 18 years of age shall be punished by imprisonment in the state prison, or in a county jail for not more than one year.

(2) Except as provided in Section 288, any person over 21 years of age who participates in an act of sodomy with another person who is under 16 years of age shall be guilty of a felony.

(c) (1) Any person who participates in an act of sodomy with another person who is under 14 years of age and more than 10 years younger than he or she shall be punished by imprisonment in the state prison for three, six, or eight years.

(2) (A) Any person who commits an act of sodomy when the act is accomplished against the victim's will by means of force, violence, duress, menace, or fear of immediate and unlawful bodily injury on the victim or another person shall be punished by imprisonment in the state prison for three, six, or eight years.

(B) Any person who commits an act of sodomy with another person who is under 14 years of age when the act is accomplished against the victim's will by means of force, violence, duress, menace, or fear of immediate and unlawful bodily injury on the victim or another person shall be punished by imprisonment in the state prison for 9, 11, or 13 years.

(C) Any person who commits an act of sodomy with another person who is a minor 14 years of age or older when the act is accomplished against the victim's will by means of force, violence, duress, menace, or fear of immediate and unlawful bodily injury on the victim or another person shall be punished by imprisonment in the state prison for 7, 9, or 11 years.

(D) This paragraph does not preclude prosecution under Section 269, Section 288.7, or any other provision of law.

(3) Any person who commits an act of sodomy where the act is accomplished against the victim's will by threatening to retaliate in the future against the victim or any other person, and there is a reasonable possibility that the perpetrator will execute the threat, shall be punished by imprisonment in the state prison for three, six, or eight years.

(d) (1) Any person who, while voluntarily acting in concert with another person, either personally or aiding and abetting that other person, commits an act of sodomy when the act is accomplished against the victim's will by means of force or fear of immediate and unlawful bodily injury on the victim or another person or where the act is accomplished against the victim's will by threatening to retaliate in the future against the victim or any other person, and there is a reasonable possibility that the perpetrator will execute the threat, shall be punished by imprisonment in the state prison for five, seven, or nine years.

(2) Any person who, while voluntarily acting in concert with another person, either personally or aiding and abetting that other person, commits an act of sodomy upon a victim who is under 14 years of age, when the act is accomplished against the victim's will by means of force or fear of immediate and unlawful bodily injury on the victim or another person, shall be punished by imprisonment in the state prison for 10, 12, or 14 years.

(3) Any person who, while voluntarily acting in concert with another person, either personally or aiding and abetting that other person, commits an act of sodomy upon a victim who is a minor 14 years of age or older, when the act is accomplished against the victim's will by means of force or fear of immediate and unlawful bodily injury on the victim or another person, shall be punished by imprisonment in the state prison for 7, 9, or 11 years.

(4) This subdivision does not preclude prosecution under Section 269, Section 288.7, or any other provision of law.

(e) Any person who participates in an act of sodomy with any person of any age while confined in any state prison, as defined in Section 4504, or in any local detention facility, as defined in Section 6031.4, shall be punished by imprisonment in the state prison, or in a county jail for not more than one year.

(f) Any person who commits an act of sodomy, and the victim is at the time unconscious of the nature of the act and this is known to the person committing the act, shall be punished by imprisonment in the state prison for three, six, or eight years. As used in this subdivision, "unconscious of the nature of the act" means incapable of resisting because the victim meets one of the following conditions:

(1) Was unconscious or asleep.

(2) Was not aware, knowing, perceiving, or cognizant that the act occurred.

(3) Was not aware, knowing, perceiving, or cognizant of the essential characteristics of the act due to the perpetrator's fraud in fact.

(4) Was not aware, knowing, perceiving, or cognizant of the essential characteristics of the act due to the perpetrator's fraudulent representation that the sexual penetration served a professional purpose when it served no professional purpose.

(g) Except as provided in subdivision (h), a person who commits an act of sodomy, and the victim is at the time incapable, because of a mental disorder or developmental or physical disability, of giving legal consent, and this is known or reasonably should be known to the person committing the act, shall be punished by imprisonment in the state prison for three, six, or eight years. Notwithstanding the existence of a conservatorship pursuant to the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code), the prosecuting attorney shall prove, as an element of the crime, that a mental disorder or developmental or physical disability rendered the alleged victim incapable of giving consent.

(h) Any person who commits an act of sodomy, and the victim is at the time incapable, because of a mental disorder or developmental or physical disability, of giving legal consent, and this is known or reasonably should be known to the person committing the act, and both the defendant and the victim are at the time confined in a state hospital for the care and treatment of the mentally disordered or in any other public or private facility for the care and treatment of the mentally disordered approved by a county mental health director, shall be punished by imprisonment in the state prison, or in a county jail for not more than one year. Notwithstanding the existence of a conservatorship pursuant to the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code), the prosecuting attorney shall prove, as an element of the crime, that a mental disorder or developmental or physical disability rendered the alleged victim incapable of giving legal consent.

(i) Any person who commits an act of sodomy, where the victim is prevented from resisting by an intoxicating or anesthetic substance, or any controlled substance, and this condition was known, or reasonably should have been known by the accused, shall be punished by imprisonment in the state prison for three, six, or eight years.

(j) Any person who commits an act of sodomy, where the victim submits under the belief that the person committing the act is someone known to the victim other than the accused, and this belief is induced by any artifice, pretense, or concealment practiced by the accused, with intent to induce the belief, shall be punished by imprisonment in the state prison for three, six, or eight years.

(k) Any person who commits an act of sodomy, where the act is accomplished against the victim's will by threatening to use the authority of a public official to incarcerate, arrest, or deport the victim or another, and the victim has a reasonable belief that the perpetrator is a public official, shall be punished by imprisonment in the state prison for three, six, or eight years.

As used in this subdivision, “public official” means a person employed by a governmental agency who has the authority, as part of that position, to incarcerate, arrest, or deport another. The perpetrator does not actually have to be a public official.

(l) As used in subdivisions (c) and (d), “threatening to retaliate” means a threat to kidnap or falsely imprison, or inflict extreme pain, serious bodily injury, or death.

(m) In addition to any punishment imposed under this section, the judge may assess a fine not to exceed seventy dollars (\$70) against any person who violates this section, with the proceeds of this fine to be used in accordance with Section 1463.23. The court, however, shall take into consideration the defendant’s ability to pay, and no defendant shall be denied probation because of his or her inability to pay the fine permitted under this subdivision.

PC §288.

(a) Except as provided in subdivision (i), any person who willfully and lewdly commits any lewd or lascivious act, including any of the acts constituting other crimes provided for in Part 1, upon or with the body, or any part or member thereof, of a child who is under the age of 14 years, with the intent of arousing, appealing to, or gratifying the lust, passions, or sexual desires of that person or the child, is guilty of a felony and shall be punished by imprisonment in the state prison for three, six, or eight years.

(b) (1) Any person who commits an act described in subdivision (a) by use of force, violence, duress, menace, or fear of immediate and unlawful bodily injury on the victim or another person, is guilty of a felony and shall be punished by imprisonment in the state prison for 5, 8, or 10 years.

(2) Any person who is a caretaker and commits an act described in subdivision (a) upon a dependent person by use of force, violence, duress, menace, or fear of immediate and unlawful bodily injury on the victim or another person, with the intent described in subdivision (a), is guilty of a felony and shall be punished by imprisonment in the state prison for 5, 8, or 10 years.

(c) (1) Any person who commits an act described in subdivision (a) with the intent described in that subdivision, and the victim is a child of 14 or 15 years, and that person is at least 10 years older than the child, is guilty of a public offense and shall be punished by imprisonment in the state prison for one, two, or three years, or by imprisonment in a county jail for not more than one year. In determining whether the person is at least 10 years older than the child, the difference in age shall be measured from the birth date of the person to the birth date of the child.

(2) Any person who is a caretaker and commits an act described in subdivision (a) upon a dependent person, with the intent described in subdivision (a), is guilty of a public offense and shall be punished by imprisonment in the state prison for one, two, or three years, or by imprisonment in a county jail for not more than one year.

(d) In any arrest or prosecution under this section or Section 288.5, the peace officer, district attorney, and the court shall consider the needs of the child victim or dependent person and

shall do whatever is necessary, within existing budgetary resources, and constitutionally permissible to prevent psychological harm to the child victim or to prevent psychological harm to the dependent person victim resulting from participation in the court process.

(e) Upon the conviction of any person for a violation of subdivision (a) or (b), the court may, in addition to any other penalty or fine imposed, order the defendant to pay an additional fine not to exceed ten thousand dollars (\$10,000). In setting the amount of the fine, the court shall consider any relevant factors, including, but not limited to, the seriousness and gravity of the offense, the circumstances of its commission, whether the defendant derived any economic gain as a result of the crime, and the extent to which the victim suffered economic losses as a result of the crime. Every fine imposed and collected under this section shall be deposited in the Victim-Witness Assistance Fund to be available for appropriation to fund child sexual exploitation and child sexual abuse victim counseling centers and prevention programs pursuant to Section 13837.

If the court orders a fine imposed pursuant to this subdivision, the actual administrative cost of collecting that fine, not to exceed 2 percent of the total amount paid, may be paid into the general fund of the county treasury for the use and benefit of the county.

(f) For purposes of paragraph (2) of subdivision (b) and paragraph (2) of subdivision (c), the following definitions apply:

(1) "Caretaker" means an owner, operator, administrator, employee, independent contractor, agent, or volunteer of any of the following public or private facilities when the facilities provide care for elder or dependent persons:

(A) Twenty-four hour health facilities, as defined in Sections 1250, 1250.2, and 1250.3 of the Health and Safety Code.

(B) Clinics.

(C) Home health agencies.

(D) Adult day health care centers.

(E) Secondary schools that serve dependent persons and postsecondary educational institutions that serve dependent persons or elders.

(F) Sheltered workshops.

(G) Camps.

(H) Community care facilities, as defined by Section 1402 of the Health and Safety Code, and residential care facilities for the elderly, as defined in Section 1569.2 of the Health and Safety Code.

(I) Respite care facilities.

(J) Foster homes.

(K) Regional centers for persons with developmental disabilities.

(L) A home health agency licensed in accordance with Chapter 8 (commencing with Section 1725) of Division 2 of the Health and Safety Code.

(M) An agency that supplies in-home supportive services.

(N) Board and care facilities.

(O) Any other protective or public assistance agency that provides health services or social services to elder or dependent persons, including, but not limited to, in-home supportive services, as defined in Section 14005.14 of the Welfare and Institutions Code.

(P) Private residences.

(2) "Board and care facilities" means licensed or unlicensed facilities that provide assistance with one or more of the following activities:

(A) Bathing.

(B) Dressing.

(C) Grooming.

(D) Medication storage.

(E) Medical dispensation.

(F) Money management.

(3) "Dependent person" means any person who has a physical or mental impairment that substantially restricts his or her ability to carry out normal activities or to protect his or her rights, including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have significantly diminished because of age. "Dependent person" includes any person who is admitted as an inpatient to a 24-hour health facility, as defined in Sections 1250, 1250.2, and 1250.3 of the Health and Safety Code.

(g) Paragraph (2) of subdivision (b) and paragraph (2) of subdivision (c) apply to the owners, operators, administrators, employees, independent contractors, agents, or volunteers working at these public or private facilities and only to the extent that the individuals personally commit, conspire, aid, abet, or facilitate any act prohibited by paragraph (2) of subdivision (b) and paragraph (2) of subdivision (c).

(h) Paragraph (2) of subdivision (b) and paragraph (2) of subdivision (c) do not apply to a caretaker who is a spouse of, or who is in an equivalent domestic relationship with, the dependent person under care.

(i) (1) Any person convicted of a violation of subdivision (a) shall be imprisoned in the state prison for life with the possibility of parole if the defendant personally inflicted bodily harm upon the victim.

(2) The penalty provided in this subdivision shall only apply if the fact that the defendant personally inflicted bodily harm upon the victim is pled and proved.

(3) As used in this subdivision, "bodily harm" means any substantial physical injury resulting from the use of force that is more than the force necessary to commit the offense.

PC §288a.

(a) Oral copulation is the act of copulating the mouth of one person with the sexual organ or anus of another person.

(b) (1) Except as provided in Section 288, any person who participates in an act of oral copulation with another person who is under 18 years of age shall be punished by imprisonment in the state prison, or in a county jail for a period of not more than one year.

(2) Except as provided in Section 288, any person over 21 years of age who participates in an act of oral copulation with another person who is under 16 years of age is guilty of a felony.

(c) (1) Any person who participates in an act of oral copulation with another person who is under 14 years of age and more than 10 years younger than he or she shall be punished by imprisonment in the state prison for three, six, or eight years.

(2) (A) Any person who commits an act of oral copulation when the act is accomplished against the victim's will by means of force, violence, duress, menace, or fear of immediate and unlawful bodily injury on the victim or another person shall be punished by imprisonment in the state prison for three, six, or eight years.

(B) Any person who commits an act of oral copulation upon a person who is under 14 years of age, when the act is accomplished against the victim's will by means of force, violence, duress, menace, or fear of immediate and unlawful bodily injury on the victim or another person, shall be punished by imprisonment in the state prison for 8, 10, or 12 years.

(C) Any person who commits an act of oral copulation upon a minor who is 14 years of age or older, when the act is accomplished against the victim's will by means of force, violence, duress, menace, or fear of immediate and unlawful bodily injury on the victim or another person, shall be punished by imprisonment in the state prison for 6, 8, or 10 years.

(D) This paragraph does not preclude prosecution under Section 269, Section 288.7, or any other provision of law.

(3) Any person who commits an act of oral copulation where the act is accomplished against the victim's will by threatening to retaliate in the future against the victim or any other person, and there is a reasonable possibility that the perpetrator will execute the threat, shall be punished by imprisonment in the state prison for three, six, or eight years.

(d) (1) Any person who, while voluntarily acting in concert with another person, either personally or by aiding and abetting that other person, commits an act of oral copulation (A) when the act is accomplished against the victim's will by means of force or fear of immediate and unlawful bodily injury on the victim or another person, or (B) where the act is accomplished against the victim's will by threatening to retaliate in the future against the victim or any other person, and there is a reasonable possibility that the perpetrator will execute the threat, or (C) where the victim is at the time incapable, because of a mental disorder or developmental or physical disability, of giving legal consent, and this is known or reasonably should be known to the person committing the act, shall be punished by imprisonment in the state prison for five, seven, or nine years. Notwithstanding the appointment of a conservator with respect to the victim pursuant to the provisions of the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code), the prosecuting attorney shall prove, as an element of the crime described under paragraph (3), that a mental disorder or developmental or physical disability rendered the alleged victim incapable of giving legal consent.

(2) Any person who, while voluntarily acting in concert with another person, either personally or aiding and abetting that other person, commits an act of oral copulation upon a victim who is under 14 years of age, when the act is accomplished against the victim's will by means of force or fear of immediate and unlawful bodily injury on the victim or another person, shall be punished by imprisonment in the state prison for 10, 12, or 14 years.

(3) Any person who, while voluntarily acting in concert with another person, either personally or aiding and abetting that other person, commits an act of oral copulation upon a victim who is a minor 14 years of age or older, when the act is accomplished against the victim's will by means of force or fear of immediate and unlawful bodily injury on the victim or another person, shall be punished by imprisonment in the state prison for 8, 10, or 12 years.

(4) This paragraph does not preclude prosecution under Section 269, Section 288.7, or any other provision of law.

(e) Any person who participates in an act of oral copulation while confined in any state prison, as defined in Section 4504 or in any local detention facility as defined in Section 6031.4, shall be punished by imprisonment in the state prison, or in a county jail for a period of not more than one year.

(f) Any person who commits an act of oral copulation, and the victim is at the time unconscious of the nature of the act and this is known to the person committing the act, shall be punished by imprisonment in the state prison for a period of three, six, or eight years. As used in this subdivision, "unconscious of the nature of the act" means incapable of resisting because the victim meets one of the following conditions:

(1) Was unconscious or asleep.

(2) Was not aware, knowing, perceiving, or cognizant that the act occurred.

(3) Was not aware, knowing, perceiving, or cognizant of the essential characteristics of the act due to the perpetrator's fraud in fact.

(4) Was not aware, knowing, perceiving, or cognizant of the essential characteristics of the act due to the perpetrator's fraudulent representation that the oral copulation served a professional purpose when it served no professional purpose.

(g) Except as provided in subdivision (h), any person who commits an act of oral copulation, and the victim is at the time incapable, because of a mental disorder or developmental or physical disability, of giving legal consent, and this is known or reasonably should be known to the person committing the act, shall be punished by imprisonment in the state prison, for three, six, or eight years. Notwithstanding the existence of a conservatorship pursuant to the provisions of the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code), the prosecuting attorney shall prove, as an element of the crime, that a mental disorder or developmental or physical disability rendered the alleged victim incapable of giving consent.

(h) Any person who commits an act of oral copulation, and the victim is at the time incapable, because of a mental disorder or developmental or physical disability, of giving legal consent, and this is known or reasonably should be known to the person committing the act, and both the defendant and the victim are at the time confined in a state hospital for the care and treatment of the mentally disordered or in any other public or private facility for the care and treatment of the mentally disordered approved by a county mental health director, shall be punished by imprisonment in the state prison, or in a county jail for a period of not more than one year. Notwithstanding the existence of a conservatorship pursuant to the provisions of the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code), the prosecuting attorney shall prove, as an element of the crime, that a mental disorder or developmental or physical disability rendered the alleged victim incapable of giving legal consent.

(i) Any person who commits an act of oral copulation, where the victim is prevented from resisting by any intoxicating or anesthetic substance, or any controlled substance, and this condition was known, or reasonably should have been known by the accused, shall be punished by imprisonment in the state prison for a period of three, six, or eight years.

(j) Any person who commits an act of oral copulation, where the victim submits under the belief that the person committing the act is someone known to the victim other than the accused, and this belief is induced by any artifice, pretense, or concealment practiced by the accused, with intent to induce the belief, shall be punished by imprisonment in the state prison for a period of three, six, or eight years.

(k) Any person who commits an act of oral copulation, where the act is accomplished against the victim's will by threatening to use the authority of a public official to incarcerate, arrest, or deport the victim or another, and the victim has a reasonable belief that the perpetrator is a public official, shall be punished by imprisonment in the state prison for a period of three, six, or eight years.

As used in this subdivision, “public official” means a person employed by a governmental agency who has the authority, as part of that position, to incarcerate, arrest, or deport another. The perpetrator does not actually have to be a public official.

(l) As used in subdivisions (c) and (d), “threatening to retaliate” means a threat to kidnap or falsely imprison, or to inflict extreme pain, serious bodily injury, or death.

(m) In addition to any punishment imposed under this section, the judge may assess a fine not to exceed seventy dollars (\$70) against any person who violates this section, with the proceeds of this fine to be used in accordance with Section 1463.23. The court shall, however, take into consideration the defendant’s ability to pay, and no defendant shall be denied probation because of his or her inability to pay the fine permitted under this subdivision.

PC §289.

(a) (1) (A) Any person who commits an act of sexual penetration when the act is accomplished against the victim’s will by means of force, violence, duress, menace, or fear of immediate and unlawful bodily injury on the victim or another person shall be punished by imprisonment in the state prison for three, six, or eight years.

(B) Any person who commits an act of sexual penetration upon a child who is under 14 years of age, when the act is accomplished against the victim’s will by means of force, violence, duress, menace, or fear of immediate and unlawful bodily injury on the victim or another person, shall be punished by imprisonment in the state prison for 8, 10, or 12 years.

(C) Any person who commits an act of sexual penetration upon a minor who is 14 years of age or older, when the act is accomplished against the victim’s will by means of force, violence, duress, menace, or fear of immediate and unlawful bodily injury on the victim or another person, shall be punished by imprisonment in the state prison for 6, 8, or 10 years.

(D) This paragraph does not preclude prosecution under Section 269, Section 288.7, or any other provision of law.

(2) Any person who commits an act of sexual penetration when the act is accomplished against the victim’s will by threatening to retaliate in the future against the victim or any other person, and there is a reasonable possibility that the perpetrator will execute the threat, shall be punished by imprisonment in the state prison for three, six, or eight years.

(b) Except as provided in subdivision (c), any person who commits an act of sexual penetration, and the victim is at the time incapable, because of a mental disorder or developmental or physical disability, of giving legal consent, and this is known or reasonably should be known to the person committing the act or causing the act to be committed, shall be punished by imprisonment in the state prison for three, six, or eight years. Notwithstanding the appointment of a conservator with respect to the victim pursuant to the provisions of the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code), the prosecuting attorney shall prove, as an element of the crime, that a mental disorder

or developmental or physical disability rendered the alleged victim incapable of giving legal consent.

(c) Any person who commits an act of sexual penetration, and the victim is at the time incapable, because of a mental disorder or developmental or physical disability, of giving legal consent, and this is known or reasonably should be known to the person committing the act or causing the act to be committed and both the defendant and the victim are at the time confined in a state hospital for the care and treatment of the mentally disordered or in any other public or private facility for the care and treatment of the mentally disordered approved by a county mental health director, shall be punished by imprisonment in the state prison, or in a county jail for a period of not more than one year. Notwithstanding the existence of a conservatorship pursuant to the provisions of the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code), the prosecuting attorney shall prove, as an element of the crime, that a mental disorder or developmental or physical disability rendered the alleged victim incapable of giving legal consent.

(d) Any person who commits an act of sexual penetration, and the victim is at the time unconscious of the nature of the act and this is known to the person committing the act or causing the act to be committed, shall be punished by imprisonment in the state prison for three, six, or eight years. As used in this subdivision, "unconscious of the nature of the act" means incapable of resisting because the victim meets one of the following conditions:

(1) Was unconscious or asleep.

(2) Was not aware, knowing, perceiving, or cognizant that the act occurred.

(3) Was not aware, knowing, perceiving, or cognizant of the essential characteristics of the act due to the perpetrator's fraud in fact.

(4) Was not aware, knowing, perceiving, or cognizant of the essential characteristics of the act due to the perpetrator's fraudulent representation that the sexual penetration served a professional purpose when it served no professional purpose.

(e) Any person who commits an act of sexual penetration when the victim is prevented from resisting by any intoxicating or anesthetic substance, or any controlled substance, and this condition was known, or reasonably should have been known by the accused, shall be punished by imprisonment in the state prison for a period of three, six, or eight years.

(f) Any person who commits an act of sexual penetration when the victim submits under the belief that the person committing the act or causing the act to be committed is someone known to the victim other than the accused, and this belief is induced by any artifice, pretense, or concealment practiced by the accused, with intent to induce the belief, shall be punished by imprisonment in the state prison for a period of three, six, or eight years.

(g) Any person who commits an act of sexual penetration when the act is accomplished against the victim's will by threatening to use the authority of a public official to incarcerate, arrest, or deport the victim or another, and the victim has a reasonable belief that the perpetrator is a

public official, shall be punished by imprisonment in the state prison for a period of three, six, or eight years.

As used in this subdivision, "public official" means a person employed by a governmental agency who has the authority, as part of that position, to incarcerate, arrest, or deport another. The perpetrator does not actually have to be a public official.

(h) Except as provided in Section 288, any person who participates in an act of sexual penetration with another person who is under 18 years of age shall be punished by imprisonment in the state prison or in a county jail for a period of not more than one year.

(i) Except as provided in Section 288, any person over 21 years of age who participates in an act of sexual penetration with another person who is under 16 years of age shall be guilty of a felony.

(j) Any person who participates in an act of sexual penetration with another person who is under 14 years of age and who is more than 10 years younger than he or she shall be punished by imprisonment in the state prison for three, six, or eight years.

(k) As used in this section:

(1) "Sexual penetration" is the act of causing the penetration, however slight, of the genital or anal opening of any person or causing another person to so penetrate the defendant's or another person's genital or anal opening for the purpose of sexual arousal, gratification, or abuse by any foreign object, substance, instrument, or device, or by any unknown object.

(2) "Foreign object, substance, instrument, or device" shall include any part of the body, except a sexual organ.

(3) "Unknown object" shall include any foreign object, substance, instrument, or device, or any part of the body, including a penis, when it is not known whether penetration was by a penis or by a foreign object, substance, instrument, or device, or by any other part of the body.

(l) As used in subdivision (a), "threatening to retaliate" means a threat to kidnap or falsely imprison, or inflict extreme pain, serious bodily injury or death.

(m) As used in this section, "victim" includes any person who the defendant causes to penetrate the genital or anal opening of the defendant or another person or whose genital or anal opening is caused to be penetrated by the defendant or another person and who otherwise qualifies as a victim under the requirements of this section.

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Reporting Consensual Activity Between Minors:

The Confusion Unraveled

CATHERINE ATKINS, STAFF ATTORNEY
(Revised May 2013)

Time and time again, there seems to be much confusion with regard to whether an MFT must, or is even permitted to, report consensual sexual activity involving minors. The information below applies only to consensual sexual activity-not incest, date rape or any situation in which the minor did not fully consent to the sexual activity. Involuntary sexual activity involving minors, and incest involving a minor (even when voluntary), is always a mandatory report.

Below is a chart which identifies the various ages of children and consensual sexual activity at issue¹:

"Child" refers to the person that the mandated child abuse reporter is involved with.	Definitions and Comments	Mandatory Report	Not Mandatory Report
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A. Child younger than 14 years old

1. Partner is younger than 14 years old and of similar chronological or maturational age. Sexual behavior is voluntary & consensual. There are no indications of intimidation, coercion, bribery or other indications of an exploitive relationship.	See, <i>Planned Parenthood Affiliates of California v. John K. Van De Kamp</i> (1986) 181 Cal. App. 3d 245 (1986); See also, <i>In re Jerry M.</i> 59 Cal. App. 4th 289.		X
2. Partner is younger than 14 years old, but there is disparity in chronological or maturational age or indications of intimidation, coercion or bribery or other indications of an exploitive relationship.		X	

<i>"Child" refers to the person that the mandated child abuse reporter is involved with.</i>	Definitions and Comments	Mandatory Report	Not Mandatory Report
3. Partner is 14 years or older.		X	
4. Lewd & Lascivious acts committed by a partner of any age.	The perpetrator has the intent of "Arousing, appealing to or gratifying the lust, passions, or sexual desires of the perpetrator or the child". This behavior is generally of an exploitative nature; for instance, "flashing" a minor-exposing one's genitals to a minor.	X	
5. Partner is alleged spouse and over 14 years of age.	The appropriate authority will determine the legality of the marriage.	X	

B. Child 14 or 15 years old

1. Partner is less than 14		X	
2. Unlawful Sexual Intercourse with a partner older than 14 and less than 21 years of age & there is no indication of abuse or evidence of an exploitive relationship.			X
3. Unlawful Sexual Intercourse with a partner older than 21 years of age.		X	

<i>"Child" refers to the person that the mandated child abuse reporter is involved with.</i>	Definitions and Comments	Mandatory Report	Not Mandatory Report
4. Lewd & Lascivious acts committed by a partner more than 10 years older than the child.	The perpetrator has the intent of "Arousing, appealing to or gratifying the lust, passions, or gratifying the lust, passions, or sexual desires of the perpetrator or the child". This behavior is generally of an exploitative nature; for instance, 'flashing' a minor-exposing one's genitals to a minor.	X	
5. Partner is alleged spouse and over 21 years of age.	The appropriate authority will determine the legality of the marriage.	X	

C. Child 16 or 17 years old

1. Partner is less than 14		X	
2. Unlawful Sexual Intercourse with a partner older than 14 & there is no indication of an exploitive relationship.			X
3. Unlawful Sexual Intercourse with a partner older than 14 & there is evidence of an exploitive relationship.		X	
4. Partner is alleged spouse and there is evidence of an exploitive relationship.	The appropriate authority will determine the legality of the marriage.	X	

D. Oral Copulation and Sodomy of Child under the age of 18

Historically most county agencies and professional associations stated that under Penal Code section 11165.1, all sodomy, oral copulation, penetration of a genital or anal opening by a foreign object, even if consensual, with a partner of any age, was a mandatory report.

However, on April 11, 2013, the Board of Behavioral Sciences (BBS) released an evaluation of the Child Abuse and Neglect Reporting Act (CANRA), specifically answering the question: "Did Penal Code 11165.1 require practitioners to report all conduct by minors that fall under the definition of sodomy and oral copulation?"

Counsel to the BBS stated, in summary, that court interpretations throughout the years confirmed that minors can lawfully engage in consensual sex with other minors *of like age*, without the necessity of a mandatory report. Counsel further stated that while the cases cited in her analysis did not directly discuss oral copulation and sodomy between minors, the same reasoning applied and as such, practitioners were not required to report all conduct by minors that fell under the definition of sodomy and oral copulation.

So what does this mean? When a provider learns of consensual, non-abusive sexual activity between two minors, the provider would:

1. Utilize the chart above to determine if the ages are "of like ages."
2. If there is a mandatory report, based on the ages above, for intercourse, certainly there would be a mandatory report for oral copulation or sodomy.
3. However, if there is no mandatory report, based on the ages above, according to the BBS, there would be no mandatory report necessary in the case of oral copulation or sodomy either.
4. Forced, coerced, and/or non-consensual sexual activity is always a mandatory report.

NOTE: It is important to note that the recent BBS evaluation is the BBS' interpretation of law. While the BBS evaluation would be a good evidentiary resource in defense of a provider who is challenged in court for not making a mandatory report for consensual oral copulation or sodomy, the laws regarding mandatory reporting have not changed. Since state law regarding reporting of consensual oral copulation and sodomy has not changed and this exact issue has not been examined by the courts, the conservative approach, in order to gain immunity from suit under CANRA, would be to continue to report those types of consensual acts between minors.

This information is intended to provide guidelines for addressing difficult legal dilemmas. It is not intended to address every situation that could potentially arise, nor is it intended to be a substitute for independent legal advice or consultation. When using such information as a guide, be aware that laws, regulations and technical standards change over time, and thus one should verify and update any references or information contained herein. ☞

REFERENCES

- 1 This chart was adapted from the Child Abuse Council of Santa Clara County found at www.cacsc.org.



Catherine L. Atkins, JD, is a Staff Attorney and the Deputy Executive Director at CAMFT. Cathy is available to answer members' questions regarding legal, ethical, and licensure issues.

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Child Abuse Reporting Guidelines for Sexual Activity Between and with Minors

Santa Clara County Child Abuse Council

This is a guide for mandated reporters and the information contained in this document is designed to assist those mandated by California Child Abuse Reporting Laws to determine their reporting responsibilities. It is not intended to be and should not be considered legal advice. In the event there are questions regarding reporting responsibilities in a specific case, the advice of legal counsel should be sought. This guide incorporates changes in the Child Abuse Reporting Law, effective January, 1998. For more detailed information refer to Penal Code Section 11164 & 11165.1 et al.

I. INVOLUNTARY SEXUAL ACTIVITY is always reportable.

II. INCEST, even if voluntary is always reportable. Incest is a marriage or act of intercourse between parents and children; ancestors and descendants of every degree; brothers and sisters of half and whole blood and uncles and nieces or aunts and nephews. (Family Code, § 2200.)

III. VOLUNTARY SEXUAL ACTIVITY may or may not be reportable. Even if the behavior is voluntary, there are circumstances where the behavior is abusive, either by Penal Code definition or because of an exploitive relationship and this behavior must be reported. Review **either** section A, B or C **and** section D. In addition, if there is reasonable suspicion of sexual abuse prior to the consensual activity, the abuse must be reported.

"Child" refers to the person that the mandated child abuse reporter is involved with.	Definitions and Comments	Mandatory Report	Not Mandatory Report
A. Child younger than 14 years old			
1. Partner is younger than 14 years old and of similar chronological or maturational age. Sexual behavior is voluntary &	See, <i>Planned Parenthood Affiliates of California v. John K. Van De Kamp</i> (1986) 181 Cal. App. 3d 245		X

consensual. There are no indications of intimidation, coercion, bribery or other indications of an exploitive relationship.	(1986) & <i>In re Jerry M.</i> 59 Cal. App. 4th 289		
2. Partner is younger than 14 years old, but there is disparity in chronological or maturational age or indications of intimidation, coercion or bribery or other indications of an exploitive relationship.		X	
3. Partner is 14 years or older.		X	
4. Lewd & Lascivious acts committed by a partner of any age.	The perpetrator has the intent of "Arousing, appealing to or gratifying the lust, passions, or sexual desires of the perpetrator or the child".?	X	
5. Partner is alleged spouse and over 14 years of age.	The appropriate authority will determine the legality of the marriage.	X	
B. Child 14 or 15 years old			
1. Partner is less than 14		X	
2. Unlawful Sexual Intercourse with a partner older than 14 and less than 21 years of age & there is no indication of abuse or evidence of an exploitive relationship.			X
3. Unlawful Sexual Intercourse with a partner older than 21 years of age.		X	
4. Lewd & Lascivious acts	The perpetrator has the	X	

committed by a partner more than 10 years older than the child.	intent of "Arousing, appealing to or gratifying the lust, passions, or gratifying the lust, passions, or sexual desires of the perpetrator or the child".		
5. Partner is alleged spouse and over 21 years of age.	The appropriate authority will determine the legality of the marriage.	X	
C. Child 16 or 17 years old			
1. Partner is less than 14		X	
2. Unlawful Sexual Intercourse with a partner older than 14 & there is no indication of an exploitive relationship.			X
3. Unlawful Sexual Intercourse with a partner older than 14 & there is evidence of an exploitive relationship.		X	
4. Partner is alleged spouse and there is evidence of an exploitive relationship.	The appropriate authority will determine the legality of the marriage.	X	
D. Child under the age of 18			
1. Sodomy, oral copulation, penetration of a genital or anal opening by a foreign object, even if consensual, with a partner of any age.		X	

Mandated reports of sexual activity must be reported to either The Department of Family & Children's Services (DFCS) or to the appropriate police jurisdiction. This information will then be cross-reported to the other agency. Reporting does not necessarily mean that a civil or criminal proceeding will be initiated against the suspected abuser.

Failure to report known or reasonable suspicion of child abuse, including sexual abuse, is a misdemeanor. Mandated reporters are provided immunity from civil or criminal liability as a result of making a mandated report of child abuse.

Child Abuse Council, Interagency Collaboration Committee (3/12/98). Reviewed February 2008..
Adapted from Orange County Reporting Guidelines

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MANDATED REPORTERS: WHEN MUST YOU REPORT *CONSENSUAL* SEXUAL ACTIVITY INVOLVING MINORS?

The question of whether the Child Abuse and Neglect Reporting Act (CANRA) (Penal Code §§ 11165 - 11174) requires designated professionals to report consensual sexual activity involving minors remains a “hopelessly blurred” area of the law. On the one hand, *Planned Parenthood v. Van de Kamp* (1986) 181 Cal.App.3d 245 holds that laws which require the reporting of voluntary, nonabusive sexual behavior between minors of a similar age violate a minor’s right to sexual privacy. On the other hand, *People v. Stockton Pregnancy Control Medical Clinic, Inc.* (1988) 203 Cal.App.3d 225, as well as legislative changes in 1997, affirm that certain types of sexual conduct involving minors still must be reported even if consensual. (See AB 327, Stats. 1997, c. 83.) The following guidelines are designed to synthesize conflicting legal authority and provide mandated reporters with reasonable guidance.

- ☞ **Both children are under age 14? No report is required** unless there is disparate age, intimidation, coercion, exploitation or bribery.
- ☞ **One child is under age 14, the other child is age 14 - 17? Yes, a report is required.** Penal Code sections 11165.1(a) and 288(a) afford special protection to children under age 14.
- ☞ **Both children are ages 14 - 17? No report is required**, unless the sexual activity involves incest (see Penal Code § 285, Family Code 2200) or there is evidence of abuse or an exploitative relationship.
- ☞ **The child is age 14 - 17, the other person 18 or older? No report is required**, unless the sexual activity involves one of the following: 1. Incest (see Penal Code § 285, Family Code 2200); 2. Unlawful Sexual Intercourse (also known as “Statutory Rape”) involving a person over age 21 with a child age 14 or 15 (see Penal Code § 261.5(d)); and 3. Lewd and Lascivious Acts involving a child age 14 or 15 and a person who is at least ten years older than the child (see Penal Code § 288(c)(1)).

While consensual sexual intercourse between a child (a person under age 18) and an adult (a person age 18 or older) is still a crime and thus subject to prosecution, California law only requires that it be reported if the child is under age 16 and the adult is over age 21. (See Penal Code § 261.5(a).)

Note: Sodomy (Penal Code § 286); Oral Copulation (Penal Code § 288a) and Penetration by Foreign Object (Penal Code § 289) (which includes a penetration by a finger) are still listed as reportable offenses under Penal Code § 11165.1, but recent cases such as *People v. Hofsheier* (2006) 37 Cal. 4th 1185 and *Lawrence v. Texas* (2003) 539 U.S. 558 cast doubt on the constitutionality of treating these types of consensual sexual activity different from sexual intercourse.

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CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES

BILL ANALYSIS

BILL NUMBER: AB 1001 **VERSION:** INTRODUCED FEBRUARY 26, 2015

AUTHOR: MAIENSCHIN **SPONSOR:** CHILDREN'S ADVOCACY INSTITUTE
AT UNIVERSITY OF SAN DIEGO
SCHOOL OF LAW

RECOMMENDED POSITION: SUPPORT

SUBJECT: CHILD ABUSE: REPORTING

Overview:

This bill clarifies that it is illegal for anyone, including a supervisor, to impede or interfere with the making of a mandated report of suspected child abuse or neglect.

Existing Law:

- 1) Specifies that licensees of the Board of Behavioral Sciences (Board) are mandated reporters under the Child Abuse and Neglect Reporting Act and as such, he or she must submit a report whenever in their professional capacity, they have knowledge of, or observe a child who is known, or reasonably suspected to have been, a victim of child abuse or neglect. (Penal Code (PC) §§11165.7(a)(21) – (25) and 11166(a))
- 2) Requires mandated reports of suspected child abuse or neglect be made to any police or sheriff's department, the county probation department, or the county welfare department. (PC §11165.9)
- 3) Makes mandated reporting duties individual. This means that supervisors or administrators may not impede reporting duties, and mandated reporters shall not be subject to sanctions for making a report. (PC §11166(i)(1))
- 4) States that reporting a case of possible child abuse or neglect to an employer or supervisor is not a substitute for making a mandated report to a designated agency. (PC §11166(i)(3))
- 5) States that a supervisor or administrator who impedes reporting duties shall be punished by a fine up to \$1,000 and/or up to six months in county jail. (PC §11166.01)

This Bill:

- 1) Prohibits a person from impeding or interfering with the making of a mandated report of suspected child abuse or neglect. (PC §11166(l))

- 2) States that a person who impedes or interferes with a mandated report is guilty of a misdemeanor and may be liable for actual damages to the victim. (PC §11166(l))

Comment:

- 1) **Author's Intent.** The author's office believes that mandated reporters should have a clear path to reporting and eliminating child abuse and neglect without interference. However, they have learned that social workers who work for private, non-profit foster family agencies, as well as one teacher, have confidentially reported to the Children's Advocacy Institute at the University of San Diego School of Law that supervisors at foster family agencies sometimes override mandated reporting.

They believe that this bill will clarify the law and provide consequences, in the form of a misdemeanor and liability, for those who interfere with a mandated report.

- 2) **Recommended Position.** At its April 23, 2015 meeting, the Policy and Advocacy Committee recommended that the Board take a "support" position on this bill.

- 3) **Support and Opposition.**

Support

- Children's Advocacy Institute (Sponsor)
- California Association of Private School Organizations
- California District Attorneys Association
- California State Sheriffs' Association
- Crime Victims United
- Junior Leagues of California

Opposition

- California Attorneys for Criminal Justice California Public Defenders Association

- 4) **History**

2015

04/21/15 In committee: Set, second hearing. Hearing canceled at the request of author.

04/07/15 In committee: Set, first hearing. Hearing canceled at the request of author.

03/19/15 Referred to Com. on PUB. S.

02/27/15 From printer. May be heard in committee March 29.

02/26/15 Read first time. To print.

ASSEMBLY BILL

No. 1001

Introduced by Assembly Member Maienschein
(Principal coauthor: Senator Vidak)
(Coauthors: Assembly Members Chávez, Olsen, and Waldron)
(Coauthor: Senator Bates)

February 26, 2015

An act to amend Section 11166 of the Penal Code, relating to child abuse.

LEGISLATIVE COUNSEL'S DIGEST

AB 1001, as introduced, Maienschein. Child abuse: reporting.

The Child Abuse and Neglect Reporting Act requires a mandated reporter, as defined, to make a report to a specified agency whenever the mandated reporter, in his or her professional capacity or within the scope of his or her employment, has knowledge of or observes a child whom the mandated reporter knows or reasonably suspects has been the victim of child abuse or neglect. Under existing law, the failure to make this report is a crime.

This bill would prohibit a person from impeding or interfering with the making of a report of suspected child abuse or neglect by a mandated reporter. The bill would provide that an intentional violation of these provisions is a misdemeanor and may subject the offender to liability for actual damages sustained by a victim of child abuse or neglect for any abuse or neglect that occurs after the person impeded or interfered with the report being made.

By creating a new crime, this bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason

Vote: majority. Appropriation: no. Fiscal committee: yes.

State-mandated local program: yes.

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

1 SECTION 1. Section 11166 of the Penal Code is amended to
2 read:

3 11166. (a) Except as provided in subdivision (d), and in
4 Section 11166.05, a mandated reporter shall make a report to an
5 agency specified in Section 11165.9 whenever the mandated
6 reporter, in his or her professional capacity or within the scope of
7 his or her employment, has knowledge of or observes a child whom
8 the mandated reporter knows or reasonably suspects has been the
9 victim of child abuse or neglect. The mandated reporter shall make
10 an initial report by telephone to the agency immediately or as soon
11 as is practicably possible, and shall prepare and send, fax, or
12 electronically transmit a written followup report within 36 hours
13 of receiving the information concerning the incident. The mandated
14 reporter may include with the report any nonprivileged
15 documentary evidence the mandated reporter possesses relating
16 to the incident.

17 (1) For purposes of this article, “reasonable suspicion” means
18 that it is objectively reasonable for a person to entertain a suspicion,
19 based upon facts that could cause a reasonable person in a like
20 position, drawing, when appropriate, on his or her training and
21 experience, to suspect child abuse or neglect. “Reasonable
22 suspicion” does not require certainty that child abuse or neglect
23 has occurred nor does it require a specific medical indication of
24 child abuse or neglect; any “reasonable suspicion” is sufficient
25 For purposes of this article, the pregnancy of a minor does not, in
26 and of itself, constitute a basis for a reasonable suspicion of sexual
27 abuse.

28 (2) The agency shall be notified and a report shall be prepared
29 and sent, faxed, or electronically transmitted even if the child has
30 expired, regardless of whether or not the possible abuse was a

1 factor contributing to the death, and even if suspected child abuse
2 was discovered during an autopsy.

3 (3) A report made by a mandated reporter pursuant to this
4 section shall be known as a mandated report.

5 (b) If, after reasonable efforts, a mandated reporter is unable
6 to submit an initial report by telephone, he or she shall immediately
7 or as soon as is practicably possible, by fax or electronic
8 transmission, make a one-time automated written report on the
9 form prescribed by the Department of Justice, and shall also be
10 available to respond to a telephone followup call by the agency
11 with which he or she filed the report. A mandated reporter who
12 files a one-time automated written report because he or she was
13 unable to submit an initial report by telephone is not required to
14 submit a written followup report.

15 (1) The one-time automated written report form prescribed by
16 the Department of Justice shall be clearly identifiable so that it is
17 not mistaken for a standard written followup report. In addition,
18 the automated one-time report shall contain a section that allows
19 the mandated reporter to state the reason the initial telephone call
20 was not able to be completed. The reason for the submission of
21 the one-time automated written report in lieu of the procedure
22 prescribed in subdivision (a) shall be captured in the Child Welfare
23 Services/Case Management System (CWS/CMS). The department
24 shall work with stakeholders to modify reporting forms and the
25 CWS/CMS as is necessary to accommodate the changes enacted
26 by these provisions.

27 (2) This subdivision shall not become operative until the
28 CWS/CMS is updated to capture the information prescribed in this
29 subdivision.

30 (3) This subdivision shall become inoperative three years after
31 this subdivision becomes operative or on January 1, 2009,
32 whichever occurs first

33 (4) On the inoperative date of these provisions, a report shall
34 be submitted to the counties and the Legislature by the State
35 Department of Social Services that reflects the data collected from
36 automated one-time reports indicating the reasons stated as to why
37 the automated one-time report was filed in lieu of the initial
38 telephone report.

39 (5) Nothing in this section shall supersede the requirement that
40 a mandated reporter first attempt to make a report via telephone,

1 or that agencies specified in Section 11165.9 accept reports from
2 mandated reporters and other persons as required.

3 (c) A mandated reporter who fails to report an incident of
4 known or reasonably suspected child abuse or neglect as required
5 by this section is guilty of a misdemeanor punishable by up to six
6 months confinement in a county jail or by a fine of one thousand
7 dollars (\$1,000) or by both that imprisonment and fine. If a
8 mandated reporter intentionally conceals his or her failure to report
9 an incident known by the mandated reporter to be abuse or severe
10 neglect under this section, the failure to report is a continuing
11 offense until an agency specified in Section 11165.9 discovers the
12 offense.

13 (d) (1) A clergy member who acquires knowledge or a
14 reasonable suspicion of child abuse or neglect during a penitential
15 communication is not subject to subdivision (a). For the purposes
16 of this subdivision, “penitential communication” means a
17 communication, intended to be in confidence, including, but not
18 limited to, a sacramental confession, made to a clergy member
19 who, in the course of the discipline or practice of his or her church,
20 denomination, or organization, is authorized or accustomed to hear
21 those communications, and under the discipline, tenets, customs,
22 or practices of his or her church, denomination, or organization,
23 has a duty to keep those communications secret.

24 (2) Nothing in this subdivision shall be construed to modify or
25 limit a clergy member’s duty to report known or suspected child
26 abuse or neglect when the clergy member is acting in some other
27 capacity that would otherwise make the clergy member a mandated
28 reporter.

29 (3) (A) On or before January 1, 2004, a clergy member or any
30 custodian of records for the clergy member may report to an agency
31 specified in Section 11165.9 that the clergy member or any
32 custodian of records for the clergy member, prior to January 1,
33 1997, in his or her professional capacity or within the scope of his
34 or her employment, other than during a penitential communication,
35 acquired knowledge or had a reasonable suspicion that a child had
36 been the victim of sexual abuse and that the clergy member or any
37 custodian of records for the clergy member did not previously
38 report the abuse to an agency specified in Section 11165.9. The
39 provisions of Section 11172 shall apply to all reports made pursuant
40 to this paragraph.

1 (B) This paragraph shall apply even if the victim of the known
2 or suspected abuse has reached the age of majority by the time the
3 required report is made.

4 (C) The local law enforcement agency shall have jurisdiction
5 to investigate any report of child abuse made pursuant to this
6 paragraph even if the report is made after the victim has reached
7 the age of majority.

8 (e) (1) A commercial film, photographic print, or image
9 processor who has knowledge of or observes, within the scope of
10 his or her professional capacity or employment, any film
11 photograph, videotape, negative, slide, or any representation of
12 information, data, or an image, including, but not limited to, any
13 film, filmstrip, photograph, negative, slide, photocopy, videotape,
14 video laser disc, computer hardware, computer software, computer
15 floppy disk, data storage medium, CD-ROM, computer-generated
16 equipment, or computer-generated image depicting a child under
17 16 years of age engaged in an act of sexual conduct, shall,
18 immediately or as soon as practicably possible, telephonically
19 report the instance of suspected abuse to the law enforcement
20 agency located in the county in which the images are seen. Within
21 36 hours of receiving the information concerning the incident, the
22 reporter shall prepare and send, fax, or electronically transmit a
23 written followup report of the incident with a copy of the image
24 or material attached.

25 (2) A commercial computer technician who has knowledge of
26 or observes, within the scope of his or her professional capacity
27 or employment, any representation of information, data, or an
28 image, including, but not limited to, any computer hardware,
29 computer software, computer file, computer floppy disk, data
30 storage medium, CD-ROM, computer-generated equipment, or
31 computer-generated image that is retrievable in perceivable form
32 and that is intentionally saved, transmitted, or organized on an
33 electronic medium, depicting a child under 16 years of age engaged
34 in an act of sexual conduct, shall immediately, or as soon as
35 practicably possible, telephonically report the instance of suspected
36 abuse to the law enforcement agency located in the county in which
37 the images or material are seen. As soon as practicably possible
38 after receiving the information concerning the incident, the reporter
39 shall prepare and send, fax, or electronically transmit a written

1 followup report of the incident with a brief description of the
2 images or materials.

3 (3) For purposes of this article, “commercial computer
4 technician” includes an employee designated by an employer to
5 receive reports pursuant to an established reporting process
6 authorized by subparagraph (B) of paragraph (43) of subdivision
7 (a) of Section 11165.7.

8 (4) As used in this subdivision, “electronic medium” includes,
9 but is not limited to, a recording, CD-ROM, magnetic disk memory,
10 magnetic tape memory, CD, DVD, thumbdrive, or any other
11 computer hardware or media.

12 (5) As used in this subdivision, “sexual conduct” means any of
13 the following:

14 (A) Sexual intercourse, including genital-genital, oral-genital,
15 anal-genital, or oral-anal, whether between persons of the same or
16 opposite sex or between humans and animals.

17 (B) Penetration of the vagina or rectum by any object.

18 (C) Masturbation for the purpose of sexual stimulation of the
19 viewer.

20 (D) Sadoomasochistic abuse for the purpose of sexual stimulation
21 of the viewer.

22 (E) Exhibition of the genitals, pubic, or rectal areas of a person
23 for the purpose of sexual stimulation of the viewer.

24 (f) Any mandated reporter who knows or reasonably suspects
25 that the home or institution in which a child resides is unsuitable
26 for the child because of abuse or neglect of the child shall bring
27 the condition to the attention of the agency to which, and at the
28 same time as, he or she makes a report of the abuse or neglect
29 pursuant to subdivision (a).

30 (g) Any other person who has knowledge of or observes a child
31 whom he or she knows or reasonably suspects has been a victim
32 of child abuse or neglect may report the known or suspected
33 instance of child abuse or neglect to an agency specified in Section
34 11165.9. For purposes of this section, “any other person” includes
35 a mandated reporter who acts in his or her private capacity and
36 not in his or her professional capacity or within the scope of his
37 or her employment.

38 (h) When two or more persons, who are required to report,
39 jointly have knowledge of a known or suspected instance of child
40 abuse or neglect, and when there is agreement among them, the

1 telephone report may be made by a member of the team selected
2 by mutual agreement and a single report may be made and signed
3 by the selected member of the reporting team. Any member who
4 has knowledge that the member designated to report has failed to
5 do so shall thereafter make the report.

6 (i) (1) The reporting duties under this section are individual,
7 and no supervisor or administrator may impede or inhibit the
8 reporting duties, and no person making a report shall be subject
9 to any sanction for making the report. However, internal procedures
10 to facilitate reporting and apprise supervisors and administrators
11 of reports may be established provided that they are not inconsistent
12 with this article.

13 (2) The internal procedures shall not require any employee
14 required to make reports pursuant to this article to disclose his or
15 her identity to the employer.

16 (3) Reporting the information regarding a case of possible child
17 abuse or neglect to an employer, supervisor, school principal,
18 school counselor, coworker, or other person shall not be a substitute
19 for making a mandated report to an agency specified in Section
20 11165.9.

21 (j) A county probation or welfare department shall immediately,
22 or as soon as practicably possible, report by telephone, fax, or
23 electronic transmission to the law enforcement agency having
24 jurisdiction over the case, to the agency given the responsibility
25 for investigation of cases under Section 300 of the Welfare and
26 Institutions Code, and to the district attorney's office every known
27 or suspected instance of child abuse or neglect, as defined in
28 Section 11165.6, except acts or omissions coming within
29 subdivision (b) of Section 11165.2, or reports made pursuant to
30 Section 11165.13 based on risk to a child which relates solely to
31 the inability of the parent to provide the child with regular care
32 due to the parent's substance abuse, which shall be reported only
33 to the county welfare or probation department. A county probation
34 or welfare department also shall send, fax, or electronically transmit
35 a written report thereof within 36 hours of receiving the information
36 concerning the incident to any agency to which it makes a
37 telephone report under this subdivision.

38 (k) A law enforcement agency shall immediately, or as soon
39 as practicably possible, report by telephone, fax, or electronic
40 transmission to the agency given responsibility for investigation

1 of cases under Section 300 of the Welfare and Institutions Code
 2 and to the district attorney’s office every known or suspected
 3 instance of child abuse or neglect reported to it, except acts or
 4 omissions coming within subdivision (b) of Section 11165.2, which
 5 shall be reported only to the county welfare or probation
 6 department. A law enforcement agency shall report to the county
 7 welfare or probation department every known or suspected instance
 8 of child abuse or neglect reported to it which is alleged to have
 9 occurred as a result of the action of a person responsible for the
 10 child’s welfare, or as the result of the failure of a person responsible
 11 for the child’s welfare to adequately protect the minor from abuse
 12 when the person responsible for the child’s welfare knew or
 13 reasonably should have known that the minor was in danger of
 14 abuse. A law enforcement agency also shall send, fax, or
 15 electronically transmit a written report thereof within 36 hours of
 16 receiving the information concerning the incident to any agency
 17 to which it makes a telephone report under this subdivision.

18 *(l) A person shall not impede or interfere with the making of a*
 19 *report of suspected child abuse or neglect required under this*
 20 *section. A person who intentionally impedes or interferes with a*
 21 *report of suspected child abuse or neglect being made is guilty of*
 22 *a misdemeanor, and may be liable for actual damages sustained*
 23 *by a victim of child abuse or neglect for any abuse or neglect that*
 24 *occurs after the person impeded or interfered with the report being*
 25 *made.*

26 SEC. 2. No reimbursement is required by this act pursuant to
 27 Section 6 of Article XIII B of the California Constitution because
 28 the only costs that may be incurred by a local agency or school
 29 district will be incurred because this act creates a new crime or
 30 infraction, eliminates a crime or infraction, or changes the penalty
 31 for a crime or infraction, within the meaning of Section 17556 of
 32 the Government Code, or changes the definition of a crime within
 33 the meaning of Section 6 of Article XIII B of the California
 34 Constitution.

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CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES

BILL ANALYSIS

BILL NUMBER: AB 1279

VERSION: AMENDED APRIL 20, 2015

AUTHOR: HOLDEN

SPONSOR: THE CERTIFICATION BOARD FOR
MUSIC THERAPISTS

RECOMMENDED POSITION: NEUTRAL

SUBJECT: MUSIC THERAPY

Overview:

This bill seeks to define music therapy in statute and to provide guidance to consumers and agencies regarding the education and training requirements of a qualified music therapist.

Existing Law:

- 1) Several state agencies define music therapy in their regulations.
 - The California Department of Education was the most recent agency to do this, adopting a definition for music therapy as it relates to special education in July 2014. (5 CCR (California Code of Regulations) §3051.21)
 - The CCR also defines music therapy under its regulations on Licensing and Certification of Health Facilities, when discussing skilled nursing facilities, immediate care facilities, adult day health centers, and general acute care hospitals. (22 CCR §§ 70055, 72069, 73065, 76105, 78065)
 - The Department of Mental Health regulations include a definition when discussing mental health rehabilitation centers. (9 CCR §782.36)
 - The Public Health title of the CCR defines music therapy when describing vender number codes. (17 CCR 54342)

There is some variance in the definitions of music therapy across these regulations.

This Bill:

- 1) Establishes the Music Therapy Act. (BPC Chapter 10.7, §§ 4650-4654)
- 2) States that it is the intent of the Legislature to provide statutory definitions related to the practice of music therapy and to enable consumers and agencies to more easily identify qualified music therapists. (BPC §4652)

- 3) Defines “music therapy” as the clinical and evidence-based use of music therapy interventions in developmental, rehabilitative, habilitative, medical, mental health, preventive, wellness care, or educational settings to accomplish individualized goals for people of all ages within a therapeutic relationship by a qualified individual. (BPC §4653)
- 4) Includes the following in the scope of music therapy (BPC §4653):
 - a) Development of music therapy treatment plans specific to the needs and strengths of the client;
 - b) Individualized treatment plans for each client; and
 - c) Establishment of goals, objectives, and strategies of music therapy services appropriate for the client and setting.
- 5) Defines music therapy interventions as including the following: music improvisation, receptive music listening, song writing, lyric discussion, music and imagery, singing, music performance, learning through music, music combined with other arts, music-assisted relaxation, music-based patient education, electronic music technology, adapted music intervention, and movement to music. (BPC §4653)
- 6) Defines a “qualified individual” as one who has completed the education and clinical training requirements established by the American Music Therapy Association. The individual must also hold a current board certification from the Certification Board for Music Therapists. (BPC §4653)
- 7) Prohibits use of the term “Board Certified Music Therapist” unless the person meets the definition of “qualified individual” and has obtained the “Music Therapist – Board Certified” (MT-BC) credential from the Certification Board of Music Therapists. (BPC §4654)
- 8) States that it is not the intent of the bill for a music therapist to be able to imply that he or she practices psychotherapy if he or she is not licensed to do so. (BPC §4655)
- 9) States that the use of music therapy does not imply that a person is a Board Certified Music Therapist. (BPC §4655)

Comments:

- 1) **Author’s Intent.** The author is seeking to create a uniform definition for music therapy in statute. They note that several agencies have established definitions of music therapy in regulation; however the definitions are inconsistent and sometimes refer to obsolete entities. The goal of this bill is to protect consumers from harm and misrepresentation from practitioners who are not board certified music therapists and who are not practicing under the Certified Board for Music Therapists’ Code of Professional Practice.

- 2) Existing Certification Process.** Two organizations are jointly involved in the certification process for music therapists. They are the American Music Therapy Association and the Certification Board for Music Therapists.

American Music Therapy Association (AMTA): The AMTA approves music therapy college and university programs. Once a bachelor's degree is completed from an approved program and the 1,200 hours of clinical training requirements are met, an applicant is eligible to take the national board certification exam. The AMTA has also developed standards of clinical practice and a code of ethics.

Certification Board for Music Therapists (CBMT): This agency is fully accredited and certifies music therapists to practice nationally. It offers a credential title of Music Therapist – Board Certified (MT-BC). It states its purpose is to provide an objective national standard that can be used as a measure of professionalism.

The certification board administers its own board certification examination. Once passed, the certification is valid for five years. To recertify after this time, the exam must either be passed again, or continuing education must be completed. The certification board has a code of professional practice that all its certified music therapists must follow, and it includes disciplinary measures.

- 3) Scope of Practice.** The AMTA and the CBMT have jointly developed a definition of the scope of music therapy practice. This document, "Scope of Music Therapy Practice (2015)" can be found in **Attachment A**.

The document defines music therapy practice as the clinical and evidence-based use of music interventions to accomplish individualized goals for people of all ages and ability levels within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program. It states that music therapy clinical practice may be in developmental, rehabilitative, habilitative, medical, mental health, preventive, wellness care, or educational areas.

- 4) Single Specialty Recognition.** Music therapy is one of several sub-types of specialty therapies. Many of these specialty therapies have an independent certification board that will issue a certification or credential if specified requirements are met. Examples of other specialties are dance and movement therapy (certified by the Dance/Movement Therapy Certification Board), and art therapy (certified by the Art Therapy Credentials Board).

- 5) Effect on BBS Licensees who Practice Music Therapy.** Recent amendments to this bill clarify a concern staff had with the previous version of this bill, that the bill would restrict Board licensees from practicing music therapy. The bill now states that various professionals may utilize music therapy, as long as they do not use the title Board Certified Music Therapist.

Recent amendments to this bill also clarify that music therapists may not claim to use mental health counseling or psychotherapy, unless they are appropriately licensed to do so.

6) Recommended Position. At its April 23, 2015 meeting, the Policy and Advocacy Committee recommended that the Board take a “neutral” position on this bill.

7) Support and Opposition.

Support

- Certification Board for Music Therapists (sponsor)
- California Athletic Trainers' Association
- Mobile Music Therapy Services of Orange County
- Numerous individuals

Oppose

- None at this time.

8) History.

2015

04/30/15 Read second time. Ordered to third reading.

04/29/15 From committee: Do pass. (Ayes 14. Noes 0.) (April 28).

04/21/15 Re-referred to Com. on B. & P.

04/20/15 From committee chair, with author's amendments: Amend, and re-refer to Com. on B. & P. Read second time and amended.

04/06/15 Re-referred to Com. on B. & P.

03/26/15 From committee chair, with author's amendments: Amend, and re-refer to Com. on B. & P. Read second time and amended.

03/26/15 Referred to Com. on B. & P.

03/02/15 Read first time.

03/01/15 From printer. May be heard in committee March 31.

02/27/15 Introduced. To print.

9) Attachments.

Attachment A: Scope of Music Therapy Practice, 2015 (American Music Therapy Association, Certification Board for Music Therapists)

AMENDED IN ASSEMBLY APRIL 20, 2015

AMENDED IN ASSEMBLY MARCH 26, 2015

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL

No. 1279

Introduced by Assembly Member Holden

February 27, 2015

An act to add Chapter 10.7 (commencing with Section 4650) to Division 2 of the Business and Professions Code, relating to music therapy.

LEGISLATIVE COUNSEL'S DIGEST

AB 1279, as amended, Holden. Music therapy.

Existing law provides for the licensure and regulation of various healing arts practitioners by boards within the Department of Consumer Affairs. ~~Existing law does not provide for the licensure of music therapists.~~

Existing law establishes the State Department of Public Health and sets forth its powers and duties over the regulation of health facilities and adult day health care centers, including, but not limited to, adopting regulations setting forth applicable staffing standards. Existing regulations of the department applicable to intermediate care facilities for the developmentally disabled and for adult day health care centers define "music therapist" as a person who has a bachelor's degree in music therapy and who is registered or eligible for registration by the National Association for Music Therapy, now known as the American Music Therapy Association.

~~This bill would provide that only a qualified person, defined as an individual who~~ *prohibit a person who provides music therapy*

interventions, as defined, from using the title of “Board Certified Music Therapist” unless the person has completed the education and clinical training requirements established by a specified music therapy association the American Music Therapy Association and who holds current board certification and an MT-BC credential from a specific certification organization, shall be permitted to perform music therapy interventions. The bill would further provide that an individual providing music therapy interventions shall not refer to himself or herself using the title of “Board Certified Music Therapist” unless the individual meets certain criteria and has been awarded a credential from the specified certification organization. the Certification Board for Music Therapists. This bill would prohibit its provisions from being construed to authorize a person engaged in music therapy to state or imply that he or she provides mental health counseling or psychotherapy for which a license is required and provide that use of music therapy shall not imply or suggest that the person is a Board Certified Music Therapist, if he or she does not meet specified criteria

Vote: majority. Appropriation: no. Fiscal committee: no.
 State-mandated local program: no.

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

1 SECTION 1. Chapter 10.7 (commencing with Section 4650)
 2 is added to Division 2 of the Business and Professions Code, to
 3 read:

4
 5 CHAPTER 10.7. MUSIC THERAPY

6
 7 4650. This chapter shall be known, and may be cited, as the
 8 Music Therapy Act.

9 4651. The Legislature finds and declares the following:

- 10 (a) Existing national certification of music therapist requires
 11 the therapist to have graduated with a bachelor’s degree or its
 12 equivalent, or higher, from a music therapy degree program
 13 approved by the American Music Therapy Association (AMTA),
 14 successful completion of a minimum of 1,200 hours of supervised
 15 clinical work through preinternship training at an approved degree
 16 program, and internship training through approved national roster
 17 or university affiliated internship programs, or an equivalent.

1 (b) Upon successful completion of the AMTA academic and
2 clinical training requirements or its international equivalent, an
3 individual is eligible to sit for the national board certification exam
4 administered by the Certification Board for Music Therapists
5 (CBMT), an independent, nonprofit corporation fully accredited
6 by the National Commission for Certifying Agencies.

7 (c) The CBMT grants the Music Therapist-Board Certificate
8 (MT-BC) credential to music therapists who have demonstrated
9 the knowledge, skills, and abilities for competence in the current
10 practice of music therapy. The purpose of board certification in
11 music therapy is to provide an objective national standard that can
12 be used as a measure of professionalism and competence by
13 interested agencies, groups, and individuals.

14 (d) The MT-BC is awarded by the CBMT to an individual upon
15 successful completion of an academic and clinical training program
16 approved by the AMTA or an international equivalent and
17 successful completion of an objective written examination
18 demonstrating current competency in the profession of music
19 therapy. The CBMT administers this examination, which is based
20 on a nationwide music therapy practice analysis that is reviewed
21 and updated every five years to reflect current clinical practice.

22 (e) Once certified, a music therapist must adhere to the CBMT
23 Code of Professional Practice and recertify every five years through
24 either a program of continuing education or reexamination.

25 4652. It is the intent of the Legislature that this chapter do the
26 following:

27 (a) Provide statutory definitions relating to the practice of music
28 therapy.

29 (b) Enable consumers and state and local agencies to more easily
30 identify qualified music therapists.

31 4653. As used in this chapter:

32 (a) "Music therapy" means the clinical and evidence-based use
33 of music therapy interventions in developmental, rehabilitative,
34 habilitative, medical, mental health, preventive, wellness care, or
35 educational settings to accomplish individualized goals for people
36 of all ages and ability levels within a therapeutic relationship by
37 a qualified individual. Music therapy includes all of the following:

38 (1) The development of music therapy treatment plans specific
39 to the needs and strengths of the client who may be seen
40 individually or in groups.

1 (2) Individualized treatment plans for each client.

2 (3) The establishment of goals, objectives, and potential
3 strategies of the music therapy services appropriate for the client
4 and setting.

5 (b) “Music therapy interventions” include, but are not limited
6 to, music improvisation, receptive music listening, song writing,
7 lyric discussion, music and imagery, singing, music performance,
8 learning through music, music combined with other arts,
9 music-assisted relaxation, music-based patient education, electronic
10 music technology, adapted music intervention, and movement to
11 music.

12 (c) “Qualified individual” includes an individual who has
13 completed the education and clinical training requirements
14 established by the American Music Therapy Association and who
15 holds current board certification from the Certification Board for
16 Music Therapists.

17 ~~4654. Only qualified persons, as defined in subdivision (c) of~~
18 ~~Section 4653, shall be permitted to perform music therapy~~
19 ~~interventions in the State of California.~~ An individual providing
20 music therapy interventions shall not refer to himself or herself
21 using the title of “Board Certified Music Therapist” unless the
22 individual meets the criteria specified in subdivision (c) of Section
23 4653 and has been awarded the MT-BC credential from the
24 Certification Board of Music Therapists.

25 *4655. This chapter shall not be construed to authorize a person*
26 *engaged in music therapy to state or imply that he or she provides*
27 *mental health counseling or psychotherapy for which a license is*
28 *required under this division. While the use of music is not restricted*
29 *to any profession, the use of music therapy shall not imply or*
30 *suggest that the person is a Board Certified Music Therapist, if*
31 *he or she does not meet the criteria specified in subdivision (c) of*
32 *Section 4653.*

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CERTIFICATION
BOARD FOR
MUSIC
THERAPISTS

SCOPE OF MUSIC THERAPY PRACTICE

2015

Preamble

The scope of music therapy practice defines the range of responsibilities of a fully qualified music therapy professional with requisite education, clinical training, and board certification. Such practice also is governed by requirements for continuing education, professional responsibility and accountability. This document is designed for music therapists, clients, families, health and education professionals and facilities, state and federal legislators and agency officials, private and public payers, and the general public.

Statement of Purpose

The purpose of this document is to define the scope of music therapy practice by:

1. Outlining the knowledge, skills, abilities, and experience for qualified clinicians to practice safely, effectively and ethically, applying established standards of clinical practice and performing harm to the public;
2. Defining the potential for harm by individuals without formalized music therapy training and credentials; and
3. Describing the education, clinical training, board certification, and continuing education requirements for music therapists.

Definition of Music Therapy and Music Therapist

Music therapy is defined as the clinical and evidence-based use of music interventions to accomplish individualized goals for people of all ages and ability levels within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program. A music therapist is an individual who has completed the education and clinical training requirements established by the American Music Therapy Association (AMTA) and who holds current board certification from The Certification Board for Music Therapists (CBMT).

Assumptions

The scope of music therapy practice is based on the values of non-maleficence, beneficence, ethical practice; professional integrity, respect, excellence; and diversity. The following assumptions are the foundation for this document:

- **Public Protection.** The public is entitled to have access to qualified music therapists who practice competently, safely, and ethically.
- **Requisite Training and Skill Sets.** The scope of music therapy

practice includes professional and advanced competencies.

The music therapist only provides services within the scope of practice that reflect his/her level of competence. The music therapy profession is not defined by a single music intervention or experience, but rather a continuum of skills sets (simple to complex) that make the profession unique.

- **Evidence-Based Practice.** A music therapist's clinical practice is guided by the integration of the best available research evidence, the client's needs, values, and preferences, and the expertise of the clinician.
- **Overlap in Services.** Music therapists recognize that in order for clients to benefit from an integrated, holistic treatment approach, there will be some overlap in services provided by multiple professions. We acknowledge that other professionals may use music, as appropriate, as long as they are working within their scope.
- **Professional Collaboration.** A competent music therapist will make referrals to other providers (music therapists and non-music therapists) when faced with issues or situations beyond the original clinician's own practice competence, or where greater competence or specialty care is determined as necessary or helpful to the client's condition.
- **Client-Centered Care.** A music therapist is respectful of, and responsive to the needs, values, and preferences of the client and the family. The music therapist involves the client in the treatment planning process, when appropriate.

Music Therapy Practice

Music therapy means the clinical and evidence-based use of music interventions to accomplish individualized goals for people of all ages and ability levels within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program. Music therapists develop music therapy treatment plans specific to the needs and strengths of the client who may be seen individually or in groups.

203 Music therapy treatment plans are individualized for each client. The

goals, objectives, and potential strategies of the music therapy services are appropriate for the client and setting. The music therapy interventions may include music improvisation, receptive music listening, song writing, lyric discussion, music and imagery, singing, music performance, learning through music, music combined with other arts, music-assisted relaxation, music-based patient education, electronic music technology, adapted music intervention, and movement to music. Music therapy clinical practice may be in developmental, rehabilitative, habilitative, medical, mental health, preventive, wellness care, or educational areas. Standards of practice in music therapy include:

- Accepting referrals for music therapy services from medical, developmental, mental health, and education professionals; family members; clients; caregivers; or others involved and authorized with provision of client services. Before providing music therapy services to a client for an identified clinical or developmental need, the music therapist collaborates, as applicable, with the primary care provider(s) to review the client's diagnosis, treatment needs, and treatment plan. During the provision of music therapy services to a client, the music therapist collaborates, as applicable, with the client's treatment team;
- Conducting a music therapy assessment of a client to determine if treatment is indicated. If treatment is indicated, the music therapist collects systematic, comprehensive, and accurate information to determine the appropriateness and type of music therapy services to provide for the client;
- Developing an individualized music therapy treatment plan for the client that is based upon the results of the music therapy assessment. The music therapy treatment plan includes individualized goals and objectives that focus on the assessed needs and strengths of the client and specify music therapy approaches and interventions to be used to address these goals and objectives;
- Implementing an individualized music therapy treatment plan that is consistent with any other developmental, rehabilitative, habilitative, medical, mental health, preventive, wellness care, or educational services being provided to the client;
- Evaluating the client's response to music therapy and the music therapy treatment plan, documenting change and progress, and suggesting modifications, as appropriate;
- Developing a plan for determining when the provision of music therapy services is no longer needed in collaboration with the client, physician, or other provider of health care or education of the client, family members of the client, and any other appropriate person upon whom the client relies for support;
- Minimizing any barriers to ensure that the client receives music therapy services in the least restrictive environment;
- Collaborating with and educating the client and the family, caregiver of the client, or any other appropriate person regarding the needs of the client that are being addressed in music therapy and the manner in which the music therapy treatment addresses those needs; and
- Utilizing appropriate knowledge and skills to inform practice including use of research, reasoning, and problem solving skills to determine appropriate actions in the context of each specific clinical setting.

Music therapists are members of an interdisciplinary team of healthcare, education, and other professionals who work collaboratively to address the needs of clients while protecting client confidentiality and privacy. Music therapists function as independent clinicians within the context

of the interdisciplinary team, supporting the treatment goals and co-treating with physicians, nurses, rehabilitative specialists, neurologists, psychologists, psychiatrists, social workers, counselors, behavioral health specialists, physical therapists, occupational therapists, speech-language pathologists, audiologists, educators, clinical case managers, patients, caregivers, and more.

Music therapy-specific assessment, treatment planning, and implementation consider diagnosis and history, are performed in a manner congruent with the client's level of functioning, and address client needs across multiple domains.

Potential for Harm

Music therapists are trained to independently analyze client non-verbal, verbal, psychological, and physiological responses to music and non-music stimuli in order to be clinically effective and refrain from contra-indicated practices. The music therapist implements ongoing evaluation of client responses and adapts the intervention accordingly to protect the client from negative outcomes.

Music therapists use their knowledge, skills, training and experience to facilitate therapeutic, goal oriented music-based interactions that are meaningful and supportive to the function and health of their clients. These components of clinical practice continue to evolve with advances in basic science, translational research, and therapeutic implementation. Music therapists, therefore, participate in continued education to remain competent, know their limitations in professional practice, and recognize when it is appropriate to seek assistance, advice, or consultation, or refer the client to another therapist or professional. In addition, music therapists practice safely and ethically as defined by the AMTA Code of Ethics, AMTA Standards of Clinical Practice, CBMT Code of Professional Practice, CBMT Board Certification Domains, and other applicable state and federal laws. Both AMTA and CBMT have mechanisms by which music therapists who are in violation of safe and ethical practice are investigated.

The use of live music interventions demands that the therapist not only possess the knowledge and skills of a trained therapist, but also the unique skill set of a trained musician in order to manipulate the music therapy intervention to fit clients' needs. Given the diversity of diagnoses with which music therapists work and the practice settings in which they work independently, clinical training and experience are necessary. Individuals attempting to provide music therapy treatment interventions without formalized music therapy training and credentials may pose risks to clients.

To protect the public from threats of harm in clinical practice, music therapists comply with safety standards and competencies such as, but not limited to:

- Recognize and respond to situations in which there are clear and present dangers to a client and/or others.
- Recognize the potential harm of music experiences and use them with care.
- Recognize the potential harm of verbal and physical interventions during music experiences and use them with care.
- Observe infection control protocols (e.g., universal precautions, disinfecting instruments).

- Recognize the client populations and health conditions for which music experiences are contraindicated.
- Comply with safety protocols with regard to transport and physical support of clients.

Definition of Governing Bodies

AMTA's mission is to advance public awareness of the benefits of music therapy and increase access to quality music therapy services in a rapidly changing world. AMTA strives to improve and advance the use of music, in both its breadth and quality, in clinical, educational, and community settings for the betterment of the public health and welfare. The Association serves as the primary organization for the advancement of education, clinical practice, research, and ethical standards in the music therapy profession.

AMTA is committed to:

- Promoting quality clinical treatment and ethical practices regarding the use of music to restore, maintain, and improve the health of all persons.
- Establishing and maintaining education and clinical training standards for persons seeking to be credentialed music therapists.
- Educating the public about music therapy.
- Supporting music therapy research.

The mission of the CBMT is to ensure a standard of excellence in the development, implementation, and promotion of an accredited certification program for safe and competent music therapy practice. CBMT is an independent, non-profit, certifying agency fully accredited by the National Commission for Certifying Agencies (NCCA). This accreditation serves as the means by which CBMT strives to maintain the highest standards possible in the construction and administration of its national examination and recertification programs, ultimately designed to reflect current music therapy practice for the benefit of the consumer.

CBMT is committed to:

- Maintaining the highest possible standards, as established by the Institute for Credentialing Excellence (ICE) and NCCA, for its national certification and recertification programs.
- Maintaining standards for eligibility to sit for the National Examination: Candidates must have completed academic and clinical training requirements established by AMTA.
- Defining and assessing the body of knowledge that represents safe and competent practice in the profession of music therapy and issuing the credential of Music Therapist Board Certified (MT-BC) to individuals that demonstrate the required level of competence.
- Advocating for recognition of the MT-BC credential and for access to safe and competent practice.
- Maintaining certification and recertification requirements that reflect current practice in the profession of music therapy.
- Providing leadership in music therapy credentialing.

The unique roles of AMTA (education and clinical training) and CBMT (credentialing and continuing education) ensure that the distinct, but related, components of the profession are maintained. This scope of music therapy practice document acknowledges the

separate but complementary contributions of AMTA and CBMT in developing and maintaining professional music therapists and evidence-based practices in the profession.

Education and Clinical Training Requirements

A qualified music therapist:

- Must have graduated with a bachelor's degree (or its equivalent) or higher from a music therapy degree program approved by the American Music Therapy Association (AMTA); and
- Must have successfully completed a minimum of 1,200 hours of supervised clinical work through pre-internship training at the AMTA-approved degree program, and internship training through AMTA-approved National Roster or University Affiliated internship programs, or an equivalent.

Upon successful completion of the AMTA academic and clinical training requirements or its international equivalent, an individual is eligible to sit for the national board certification exam administered by the Certification Board for Music Therapists (CBMT).

Board Certification Requirements

The Music Therapist – Board Certified (MT-BC) credential is granted by the Certification Board for Music Therapists (CBMT) to music therapists who have demonstrated the knowledge, skills, and abilities for competence in the current practice of music therapy. The purpose of board certification in music therapy is to provide an objective national standard that can be used as a measure of professionalism and competence by interested agencies, groups, and individuals. The MT-BC credential may also be required to meet state laws and regulations. Any person representing him or herself as a board certified music therapist must hold the MT-BC credential awarded by CBMT, an independent, nonprofit corporation fully accredited by the National Commission for Certifying Agencies (NCCA).

The board certified music therapist credential, MT-BC, is awarded by the CBMT to an individual upon successful completion of an academic and clinical training program approved by the American Music Therapy Association (or an international equivalent) and successful completion of an objective written examination demonstrating current competency in the profession of music therapy. The CBMT administers this examination, which is based on a nationwide music therapy practice analysis that is reviewed and updated every five years to reflect current clinical practice. Both the practice analysis and the examination are psychometrically sound and developed using guidelines issued by the Equal Employment Opportunity Commission, and the American Psychological Association's standards for test validation.

Once board certified, a music therapist must adhere to the CBMT Code of Professional Practice and recertify every five years through either a program of continuing education or re-examination.

By establishing and maintaining the certification program, CBMT is in compliance with NCCA guidelines and standards that require certifying agencies to: 1) have a plan for periodic recertification, and 2) provide evidence that the recertification program is designed to measure or enhance the continuing competence of the individual.

The CBMT recertification program provides music therapists with guidelines for remaining current with safe and competent practice and enhancing their knowledge in the profession of music therapy.

The recertification program contributes to the professional development of the board certified music therapist through a program of continuing education, professional development, and professional service opportunities. All three recertification categories are reflective of the Practice Analysis Study and relevant to the knowledge, skills and abilities required of the board certified music therapist. Documentation guidelines in the three categories require applying learning outcomes to music therapy practice and relating them to the CBMT Board Certification Domains. Integrating and applying new knowledge with current practice, developing enhanced skills in delivery of services to clients, and enhancing a board certified music therapist's overall abilities are direct outcomes of the recertification program. To support CBMT's commitment of ensuring the competence of the board certified music therapist and protecting the public, certification must be renewed every five years with the accrual of 100 recertification credits.

NCCA accreditation demonstrates that CBMT and its credentialing program undergo review to demonstrate compliance with certification standards set by an impartial, objective commission whose primary focus is competency assurance and protection of the consumer. The program provides valuable information for music therapists, employers, government agencies, payers, courts and professional organizations. By participating in the CBMT Recertification Program, board certified music therapists promote continuing competence and the safe and effective clinical practice of music therapy.

AMTA and CBMT created this document as a resource pertinent to the practice of music therapy. However, CBMT and AMTA are not offering legal advice, and this material is not a substitute for the services of an attorney in a particular jurisdiction. Both AMTA and CBMT encourage users of this reference who need legal advice on legal matters involving statutes to consult with a competent attorney. Music therapists may also check with their state governments for information on issues like licensure and for other relevant occupational regulation information. Additionally, since laws are subject to change, users of this guide should refer to state governments and case law for current or additional applicable materials.

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CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES

BILL ANALYSIS

BILL NUMBER: SB 479

VERSION: AMENDED APRIL 6, 2015

AUTHOR: BATES

**SPONSOR: CALIFORNIA ASSOCIATION FOR
BEHAVIOR ANALYSIS**

RECOMMENDED POSITION: NEUTRAL

SUBJECT: HEALING ARTS: BEHAVIOR ANALYSIS: LICENSING

Overview This bill establishes licensure for behavior analysts and assistant behavior analysts under the Board of Psychology.

Existing Law:

- 1) Requires that every health care service plan or insurance policy that provides hospital, medical or surgical coverage must also provide coverage for behavioral health treatment for pervasive developmental disorder or autism (PDD/A). (Health and Safety Code (HSC) §1374.73(a), Insurance Code (IC) §10144.51(a))
- 2) Requires these health care service plans and health insurers subject to this provision to maintain an adequate network of qualified autism service providers. (HSC §1374.73(b), IC §10144.51(b))
- 3) Defines “behavioral health treatment” as professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs which develop or restore the functioning of an individual with pervasive developmental disorder or autism, and meets the following criteria (HSC §1374.73(c), IC §10144.51(c):
 - Is prescribed by a licensed physician and surgeon or is developed by a licensed psychologist;
 - Is provided under a treatment plan prescribed by a qualified autism service provider and administered by such a provider or by a qualified autism service professional under supervision and employment of a qualified autism service provider;
 - The treatment plan has measurable goals over a specific timeline and the plan is reviewed by the provider at least once every six months; and

- Is not used for purposes of providing or for the reimbursement of respite, day care, or educational services.
- 4) Defines a “qualified autism service provider” as either (HSC §1374.73(c), IC §10144.51(c)):
- A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited and which designs, supervises, or provides treatment for pervasive developmental disorder or autism; or
 - A person who is licensed as a specified healing arts practitioner, including a psychologist, marriage and family therapist, educational psychologist, clinical social worker, or professional clinical counselor. The licensee must design, supervise, or provide treatment for pervasive developmental disorder or autism and be within his or her experience and competence.
- 5) Defines a “qualified autism service professional” as someone who meets all of the following (HSC §1374.73(c), IC §10144.51(c)):
- Provides behavioral health treatment;
 - Is employed and supervised by a qualified autism service provider;
 - Provides treatment according to a treatment plan developed and approved by the qualified autism service provider.
 - Is a behavioral service provider approved by a regional center to provide services as an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program as defined in Section 54342 of Title 17 of the California Code of Regulations (CCR); and
 - Has training and experience providing services for pervasive developmental disorder or autism pursuant to the Lanterman Developmental Disabilities Services Act.
- 6) Defines a “qualified autism service paraprofessional” as an unlicensed and uncertified person who meets all of the following (HSC §1374.73(c), IC §10144.51(c)):
- Is employed and supervised by a qualified autism service provider;
 - Provides treatment according to a treatment plan developed and approved by the qualified autism service provider;

- Meets criteria set forth in regulations regarding use of paraprofessionals in group practice providing behavioral intervention services; and
 - Is certified by a qualified autism service provider as having adequate education, training, and experience.
- 7) Establishes billing service codes and definitions for the following types of professionals used in regional centers for functions related to behavioral analysis for persons with developmental disabilities: (17 California Code of Regulations (CCR) §54342(a))
- Associate Behavior Analyst;
 - Behavior Analyst;
 - Behavior Management Assistant; and
 - Behavior Management Consultant.

This Bill:

- 1) Establishes the Behavior Analyst Act to license behavior analysts and assistant behavior analysts under the Board of Psychology beginning January 1, 2018. (Business and Professions Code (BPC) §2999.10, et. seq.)
- 2) Defines the “practice of behavior analysis” as the design, implementation, and evaluation of instructional and environmental modifications to produce socially significant improvements in human behavior. It includes the following (BPC §2999.12):
 - a) Empirical identification of functional relations between behavior and environmental factors;
 - b) Interventions based on scientific research and direct observation and measurement of behavior and the environment; and
 - c) Utilization of contextual factors, motivating operations, antecedent stimuli, positive reinforcement, and other consequences to help develop new behaviors, increase or decrease existing behaviors, and emit behaviors under specific environmental conditions.
- 3) Specifies that the practice of behavior analysis does not include psychological testing, diagnosis of a mental or physical disorder, neuropsychology, psychotherapy, cognitive therapy, sex therapy, psychoanalysis, hypnotherapy, or counseling. (BPC §2999.12)
- 4) Creates the Behavior Analyst Committee, under the jurisdiction of the Board of Psychology, with the mandate to protect the public from unauthorized and unqualified practice of applied behavior analysis. (BPC §2999.25)

5) Licensure as a Behavior Analyst (BPC §§2999.31 and 2999.32)

- i. Requires an applicant for licensure as a Behavior Analyst to maintain active status as a certified behavior analyst with the Behavior Analyst Certification Board (BACB), or a national organization with a behavior analyst certification program approved by the board and accredited by the National Commission for Certifying Agencies. The applicant must also have passed the BACB's exam and be in compliance with its ethical and disciplinary standards. The applicant must also pass a California Law and Ethics Exam.
- ii. Requires the applicant to have met the following requirements:
 - a. Possess a master's degree or higher in behavior analysis or other field related to behavior analysis approved by the certifying entity.
 - b. Completion of one of the following options:

Option One:

Completion of 270 hours of graduate level coursework in specified content areas and either 1,500 hours of supervised independent field work in behavior analysis, 1,000 hours of supervised practicum in behavior analysis, 750 hours of supervised intensive practicum in behavior analysis, or a combination thereof.

Option Two:

Completion of one academic year as a full time faculty at a college or university where he or she taught classes on principals of behavior analysis, and conducted and published research on behavior analysis, and either 1,500 hours of supervised independent field work in behavior analysis, 1,000 hours of supervised practicum in behavior analysis, 750 hours of supervised intensive practicum in behavior analysis, or a combination thereof.

Option Three:

Possess a doctoral degree conferred at least ten years prior to application, in behavior analysis, psychology, education, or related field, and have ten years verified and documented postdoctoral experience practicing behavior analysis.

6) Licensure as an Assistant Behavior Analyst (BPC §§2999.33 and 2999.34)

- i. Requires an applicant for licensure as an Assistant Behavior Analyst to maintain active status as a certified assistant behavior analyst with the Behavior Analyst Certification Board (BACB), or a national organization with a behavior analyst certification program approved by the board and accredited by the National Commission for Certifying Agencies. The applicant must also have passed the BACB's exam and be in compliance with its ethical and

disciplinary standards. The applicant must also pass a California Law and Ethics Exam.

- ii. Requires the applicant to provide proof of ongoing supervision by a licensed behavior analyst.
 - iii. Requires the applicant to have a bachelor's degree from an accredited institution.
 - iv. Requires the applicant to complete 180 hours of undergraduate or graduate instruction in specified content areas, and either 1,000 hours of supervised independent field work in behavior analysis, 670 hours of supervised practicum in behavior analysis, 500 hours of supervised intensive practicum in behavior analysis, or a combination thereof.
- 7) Prohibits a person from engaging in the practice of behavior analysis, representing his or her self as a licensed behavior analyst or licensed assistant behavior analyst, or using the title or letters, without being licensed (BPC §2999.36).
- 8) Exempts the following practitioners from the provisions of this licensing act if the person is acting within the scope of his or her licensed scope of practice and within the scope of his or her training and competence (BPC §2999.37):
- a) Licensed psychologists;
 - b) Licensed occupational therapists;
 - c) Licensed physical therapists;
 - d) **Licensed marriage and family therapists;**
 - e) **Licensed educational psychologists;**

Any of the above individuals must not represent that they are a licensed behavior analyst or licensed assistant behavior analyst, unless they actually hold that license.

- 9) Exempts certain other, nonlicensed persons from the provisions of this licensing act, including the following (BPC §2999.37):
- a) A person acting under authority and direction of a licensed behavior analyst, assistant licensed behavior analyst, or one of the licensed professionals listed in Item 8 above;
 - b) A family member of a recipient of behavior analysis services acting under the authority and direction of a licensed behavior analyst or licensed assistant behavior analyst;
 - c) A college or university student practicing as part of a course of study or practicum, under supervision;
 - d) An unlicensed individual pursuing supervised experience in behavior analysis;
 - e) An individual vendorized by a regional center.

10) Allows reciprocity by permitting the Board of Psychology to license a person as a behavior analyst or assistant behavior analyst if he or she is licensed in another state, if that state has comparable license requirements, and if that state offers reciprocity to California licensees. The applicant must be in good standing and must also pass the California law and ethics exam. (BPC §2999.40)

11) Sets forth criteria for renewing a license. (BPC §§2999.44-2999.46)

12) Sets forth unprofessional conduct provisions. (BPC §2999.62)

Comments:

1) Intent of This Bill. Applied Behavior Analysis (ABA) is commonly used to treat autism spectrum disorders. During the past decade, there has been increasing evidence that ABA therapy is effective in the treatment of autism, and there has been an increase in the practice of this profession in California. State law now mandates that insurance plans provide coverage for ABA treatment. However, the California Business and Professions Code does not apply any standard requirements to the practice of ABA.

Because there is no licensure for ABAs, it is difficult for consumers to make an informed decision when choosing an applied behavior analyst. In some cases, ABA programs may be designed, supervised, and/or implemented by someone who lacks training and experience.

The goal of this bill is establish licensure for behavior analysts and assistant behavior analysts, so that individuals with autism are protected from unqualified practitioners.

2) Certification Requirement. In order to qualify for licensure, this bill would require an applicant for a behavior analyst or assistant behavior analyst license to hold an active certification with the Behavior Analyst Certification Board (BACB).

The BACB is a nonprofit corporation that certifies Board Certified Behavior Analysts (BCBAs) and Board Certified Assistant Behavior Analysts (BCaBAs). The Behavior Analyst Certification Board's BCBA and BCaBA credentialing programs are accredited by the National Commission for Certifying Agencies in Washington, DC.

According to the author's office, as of March 2014 there were 2,198 practitioners certified by the BACB in California.

Individuals who wish to become a BCBA must meet the following requirements:

- a. Possess a Master's Degree;
- b. Have 270 classroom hours of specific graduate-level coursework;
- c. Meet supervised experience requirements; and
- d. Pass the Board Certified Behavior Analyst Examination.

Persons wishing to become a BCaBA must meet the following requirements:

- a. Possess a Bachelor's Degree;
- b. Have 180 classroom hours of specific coursework;
- c. Meet supervised experience requirements; and
- d. Pass the Board Certified Assistant Behavior Analyst Examination.

All BACB certificants must accumulate continuing education credit to maintain their credentials.

- 3) Exemptions from Licensure.** Section 2999.37 of this bill exempts licensed psychologists, licensed marriage and family therapists, and licensed educational psychologists from needing a license to practice ABA, provided they are acting within their scope of practice and also within the scope of their training and competence.

However, licensed clinical social workers and licensed professional clinical counselors are not included in this exemption. It is unknown why these two license types were excluded.

SB 946 (Chapter 650, Statutes of 2011), which is the Steinberg bill requiring health plans to cover behavioral health treatment for autism, defines a “qualified autism service provider.” That definition includes all of BBS’s licensees, as follows:

Health and Safety Code 1374.73(c):

(3) “Qualified autism service provider” means either of the following:

(A) A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person, entity, or group that is nationally certified.

(B) A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.

- 4) Reciprocity.** This bill allows reciprocity for licensed behavior analysts or assistant behavior analysts in other states, as long as the state in which licensed has comparable licensing requirements, and if that state offers reciprocity to California licensees. The applicant must be licensed in good standing and must pass a California law and ethics exam.

According to the author's office, approximately 17 other states have some form of licensure or certification for behavior analysts. The reciprocity policies of these states are unknown, however, it may be punitive to exclude an otherwise qualified licensee from licensure in California, simply because the state in which he or she is licensed does not offer reciprocity.

- 5) Related Legislation.** AB 796 (Nazarian) proposes modifying the definition of "qualified autism service professional" and "qualified autism service paraprofessional" to allow insurance coverage for types of behavioral health treatment other than ABA.
- 6) Previous Legislation.** AB 1282 (Steinberg, 2010) was proposed in 2010. This bill, which failed passage, attempted to establish a certification process for practitioners of behavior analysis. It would have established the California Behavioral Certification Organization (CBCO), a nonprofit organization that would have provided for the certification and registration of applied behavioral analysis practitioners if they met certain conditions, one of which was being certified by the BACB or a similar entity. The Board took an oppose position on this legislation.

AB 1205 (Berryhill, 2011), proposed licensing behavior analysts and assistant behavior analysts under the Board of Behavioral Sciences. The Board did not take a position on this legislation. The bill died in the Assembly Appropriations Committee.

SB 946 (Chapter 650, Statutes of 2011) requires every health care service plan contract and insurance policy that provides hospital, medical, or surgical coverage shall also provide coverage for behavioral health treatment for pervasive developmental disorder or autism, effective July 1, 2012.

SB 126 (Chapter 680, Statutes of 2013) extended the provisions of SB 946 until January 1, 2017.

- 7) Recommended Position.** At its April 23, 2015 meeting, the Policy and Advocacy Committee recommended that the Board take a "neutral" position on this bill.

8) Support and Opposition.

Support:

- California Association for Behavior Analysis (Sponsor)
- Behavior Frontiers
- California Association of Private Special Education Schools
- Center for Learning and Autism Support Services, Inc.
- Clinic 4 Kidz
- Southern California Consortium for Behavior Analysis
- Southwest California Legislative Council
- Numerous individuals

Support if Amended:

- Center for Autism and Related Disorders

Concerns:

- California Psychological Association

Opposition:

- California Speech-Language-Hearing Association

9) History.

2015

05/01/15 Set for hearing May 11.

04/28/15 From committee: Do pass and re-refer to Com. on APPR. (Ayes 8. Noes 0. Page 794.) (April 27). Re-referred to Com. on APPR.

04/10/15 Set for hearing April 27.

04/09/15 Re-referred to Com. on B., P. & E.D.

04/06/15 From committee with author's amendments. Read second time and amended. Re-referred to Com. on RLS.

03/12/15 Referred to Com. on RLS.

02/27/15 From printer. May be acted upon on or after March 29.

02/26/15 Introduced. Read first time. To Com. on RLS. for assignment. To print.

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AMENDED IN SENATE APRIL 6, 2015

SENATE BILL

No. 479

Introduced by Senator Bates

February 26, 2015

An act to amend Sections 27 and 2920 of, to amend, repeal, and add Sections 2922, 2923, and 2927 of, to add Chapter 6.7 (commencing with Section 2999.10) to Division 2 of, and to repeal Section 2999.25 of, the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 479, as amended, Bates. ~~Healing arts:~~ *arts: behavior analysis: licensing.*

Existing law provides for the licensure and regulation of various healing arts licensees by various boards, as defined, within the Department of Consumer Affairs, including the Board of Behavioral Sciences and the Board of Psychology. *Under existing law, until January 1, 2017, the board is vested with the power to enforce the Psychology Licensing Law, and consists of 9 members, 4 of whom are public members and 5 of whom are licensed psychologists. Existing law requires the board to post information on its licensees, as specified including, among others, psychological assistants. Existing law specifies that a quorum of the board requires 5 members.*

~~This bill would declare the intent of the legislature to enact legislation to license and regulate the profession of applied behavioral analysis.~~

This bill would, on and after July 1, 2017, increase the number of members on the board to 11, and would increase the number of members for a quorum to 6 members. The bill would require the 2 new members to meet certain requirements, including, but not limited to, that they practice behavior analysis, as defined

This bill would establish the Behavior Analyst Act. The bill would require a person to apply for and obtain a license from the board prior to engaging in the practice of behavior analysis, as defined, either as a behavior analyst or an assistant behavior analyst. The bill would require applicants to, among other things, meet certain educational and training requirements, and submit fingerprints for both a state and federal criminal background check.

This bill would, until January 1, 2021, vest the board with the power to enforce the Behavior Analyst Act, and would require the board to, among other things, post information regarding licensed behavior analysts and licensed assistant behavior analysts, as specified. The bill would, until January 1, 2021, create the Behavior Analyst Committee within the jurisdiction of the board, and would require the committee to be comprised of 5 members who shall be appointed as specified. The bill would authorize the committee to make recommendations to the board regarding the implementation of the act.

This bill would define certain terms for these purposes. The bill would require the board to conduct disciplinary hearings, as specified. The bill on and after January 1, 2018, make it unlawful to, among other things, practice behavior analysis without being licensed by the board, except as specified

This bill would make a violation of any of these provisions a misdemeanor punishable by 6 months in the county jail or a fine not to exceed \$2,500, or by both imprisonment and a fine . By creating a new crime, this bill would result in a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: ~~no~~-yes. State-mandated local program: ~~no~~-yes.

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

- 1 SECTION 1. Section 27 of the Business and Professions Code
- 2 is amended to read:
- 3 27. (a) Each entity specified in subdivisions (c), (d), and (e)
- 4 shall provide on the Internet information regarding the status of

1 every license issued by that entity in accordance with the California
2 Public Records Act (Chapter 3.5 (commencing with Section 6250)
3 of Division 7 of Title 1 of the Government Code) and the
4 Information Practices Act of 1977 (Chapter 1 (commencing with
5 Section 1798) of Title 1.8 of Part 4 of Division 3 of the Civil Code).
6 The public information to be provided on the Internet shall include
7 information on suspensions and revocations of licenses issued by
8 the entity and other related enforcement action, including
9 accusations filed pursuant to the Administrative Procedure Act
10 (Chapter 3.5 (commencing with Section 11340) of Part 1 of
11 Division 3 of Title 2 of the Government Code) taken by the entity
12 relative to persons, businesses, or facilities subject to licensure or
13 regulation by the entity. The information may not include personal
14 information, including home telephone number, date of birth, or
15 social security number. Each entity shall disclose a licensee's
16 address of record. However, each entity shall allow a licensee to
17 provide a post office box number or other alternate address, instead
18 of his or her home address, as the address of record. This section
19 shall not preclude an entity from also requiring a licensee, who
20 has provided a post office box number or other alternative mailing
21 address as his or her address of record, to provide a physical
22 business address or residence address only for the entity's internal
23 administrative use and not for disclosure as the licensee's address
24 of record or disclosure on the Internet.

25 (b) In providing information on the Internet, each entity specific
26 in subdivisions (c) and (d) shall comply with the Department of
27 Consumer Affairs' guidelines for access to public records.

28 (c) Each of the following entities within the Department of
29 Consumer Affairs shall comply with the requirements of this
30 section:

31 (1) The Board for Professional Engineers, Land Surveyors, and
32 Geologists shall disclose information on its registrants and
33 licensees.

34 (2) The Bureau of Automotive Repair shall disclose information
35 on its licensees, including auto repair dealers, smog stations, lamp
36 and brake stations, smog check technicians, and smog inspection
37 certification stations

38 (3) The Bureau of Electronic and Appliance Repair, Home
39 Furnishings, and Thermal Insulation shall disclose information on
40 its licensees and registrants, including major appliance repair

1 dealers, combination dealers (electronic and appliance), electronic
2 repair dealers, service contract sellers, and service contract
3 administrators.

4 (4) The Cemetery and Funeral Bureau shall disclose information
5 on its licensees, including cemetery brokers, cemetery salespersons,
6 cemetery managers, crematory managers, cemetery authorities,
7 crematories, cremated remains disposers, embalmers, funeral
8 establishments, and funeral directors.

9 (5) The Professional Fiduciaries Bureau shall disclose
10 information on its licensees.

11 (6) The Contractors' State License Board shall disclose
12 information on its licensees and registrants in accordance with
13 Chapter 9 (commencing with Section 7000) of Division 3. In
14 addition to information related to licenses as specified in
15 subdivision (a), the board shall also disclose information provided
16 to the board by the Labor Commissioner pursuant to Section 98.9
17 of the Labor Code.

18 (7) The Bureau for Private Postsecondary Education shall
19 disclose information on private postsecondary institutions under
20 its jurisdiction, including disclosure of notices to comply issued
21 pursuant to Section 94935 of the Education Code.

22 (8) The California Board of Accountancy shall disclose
23 information on its licensees and registrants.

24 (9) The California Architects Board shall disclose information
25 on its licensees, including architects and landscape architects.

26 (10) The State Athletic Commission shall disclose information
27 on its licensees and registrants.

28 (11) The State Board of Barbering and Cosmetology shall
29 disclose information on its licensees.

30 (12) The State Board of Guide Dogs for the Blind shall disclose
31 information on its licensees and registrants.

32 (13) The Acupuncture Board shall disclose information on its
33 licensees.

34 (14) The Board of Behavioral Sciences shall disclose
35 information on its licensees, including licensed marriage and family
36 therapists, licensed clinical social workers, licensed educational
37 psychologists, and licensed professional clinical counselors.

38 (15) The Dental Board of California shall disclose information
39 on its licensees.

1 (16) The State Board of Optometry shall disclose information
2 regarding certificates of registration to practice optometry,
3 statements of licensure, optometric corporation registrations, branch
4 office licenses, and fictitious name permits of its licensee

5 (17) The Board of Psychology shall disclose information on its
6 licensees, including psychologists, psychological assistants, ~~and~~
7 ~~registered psychologists.~~ *psychologists, behavior analysts, and*
8 *assistant behavior analysts.*

9 (d) The State Board of Chiropractic Examiners shall disclose
10 information on its licensees.

11 (e) The Structural Pest Control Board shall disclose information
12 on its licensees, including applicators, field representatives, and
13 operators in the areas of fumigation, general pest and wood
14 destroying pests and organisms, and wood roof cleaning and
15 treatment.

16 (f) "Internet" for the purposes of this section has the meaning
17 set forth in paragraph (6) of subdivision (f) of Section 17538.

18 *SEC. 2. Section 2920 of the Business and Professions Code is*
19 *amended to read:*

20 2920. (a) The Board of Psychology shall enforce and
21 administer this ~~chapter.~~ *chapter and Chapter 6.7 (commencing*
22 *with Section 2999.10).* The board shall consist of nine members,
23 four of whom shall be public members.

24 (b) *On and after July 1, 2017, notwithstanding paragraph (a),*
25 *the board shall consist of 11 members, four of whom shall be public*
26 *members.*

27 ~~(b)~~

28 (c) This section shall remain in effect only until January 1, 2017,
29 and as of that date is ~~repealed, unless a later enacted statute, that~~
30 ~~is enacted before January 1, 2017, deletes or extends that date.~~
31 *repealed.*

32 ~~(e)~~

33 (d) Notwithstanding any other ~~provision of~~ law, the repeal of
34 this section renders the board subject to review by the appropriate
35 policy committees of the Legislature.

36 *SEC. 3. Section 2922 of the Business and Professions Code is*
37 *amended to read:*

38 2922. (a) In appointing the members of the board, except the
39 public members, the Governor shall use his or her judgment to

1 select psychologists who represent, as widely as possible, the varied
 2 professional interests of psychologists in California.

3 ~~The~~

4 (b) ~~The~~ Governor shall appoint two of the public members and
 5 the fi e licensed members of the board qualified as provided in
 6 Section 2923. ~~The Senate Rules Committee on Rules and the~~
 7 ~~Speaker of the Assembly shall each appoint a public member, and~~
 8 ~~their initial appointment shall be made to fill, respectively, the firs-~~
 9 ~~and second public member vacancies which occur on or after~~
 10 ~~January 1, 1983: member.~~

11 (c) *This section shall become inoperative on July 1, 2017, and,*
 12 *as of January 1, 2018, is repealed.*

13 SEC. 4. *Section 2922 is added to the Business and Professions*
 14 *Code, to read:*

15 2922. (a) *In appointing the licensed members of the board,*
 16 *the Governor shall use his or her judgment to select psychologists*
 17 *and behavior analysts who represent, as widely as possible, the*
 18 *varied professional interests of psychologists and behavior analysts*
 19 *in California.*

20 (b) *The Governor shall appoint two of the public members and*
 21 *the seven licensed members of the board qualified as provided in*
 22 *Section 2923. The Senate Committee on Rules and the Speaker of*
 23 *the Assembly shall each appoint a public member.*

24 (c) *This section shall become operative on July 1, 2017.*

25 SEC. 5. *Section 2923 of the Business and Professions Code is*
 26 *amended to read:*

27 2923. (a) Each member of the board shall have all of the
 28 following qualifications

29 ~~(a)~~

30 (1) He or she shall be a resident of this state.

31 ~~(b)~~

32 (2) Each member appointed, except the public members, shall
 33 be a licensed psychologist.

34 ~~The~~

35 (b) *The public members shall not be licentiates of the board or*
 36 *of any board under this division or of any board referred to in the*
 37 *Chiropractic Act or the Osteopathic Act.*

38 (c) *This section shall become inoperative on July 1, 2017, and,*
 39 *as of January 1, 2018, is repealed.*

1 SEC. 6. Section 2923 is added to the Business and Professions
2 Code, to read:

3 2923. (a) Each member of the board shall be a resident of this
4 state.

5 (b) Five members of the board shall be licensed as psychologists
6 under this chapter.

7 (c) One member shall be licensed as a psychologist under this
8 chapter and shall be qualified to practice behavior analysis, as
9 defined in Section 2999.12, as follows

10 (1) For the fi st appointment after the operative date of this
11 section, the member shall hold a certificate as a certified behavior
12 analyst from a certifying entity, as defined in Section 2999.12

13 (2) For subsequent appointments, the member shall be licensed
14 as a behavior analyst under Chapter 6.7 (commencing with Section
15 2999.10).

16 (d) One member shall be qualified to practice behavior analysis,
17 as defined in Section 2999.12, as follows

18 (1) For the fi st appointment after the operative date of this
19 section, the member shall hold a certificate as a certified behavior
20 analyst from a certifying entity, as defined in Section 2999.12

21 (2) For subsequent appointments, the member shall be licensed
22 as a behavior analyst under Chapter 6.7 (commencing with Section
23 2999.10).

24 (e) The public members shall not be licentiates of the board or
25 of any board under this division or of any board referred to in the
26 Chiropractic Act or the Osteopathic Act.

27 (f) This section shall become operative on July 1, 2017.

28 SEC. 7. Section 2927 of the Business and Professions Code is
29 amended to read:

30 2927. (a) Five members of the board shall at all times
31 constitute a quorum.

32 (b) This section shall become inoperative on July 1, 2017, and,
33 as of January 1, 2018, is repealed.

34 SEC. 8. Section 2927 is added to the Business and Professions
35 Code, to read:

36 2927. (a) Six members of the board shall at all times constitute
37 a quorum.

38 (b) This section shall become operative on July 1, 2017.

39 SEC. 9. Chapter 6.7 (commencing with Section 2999.10) is
40 added to Division 2 of the Business and Professions Code, to read:

1
2 *CHAPTER 6.7. BEHAVIOR ANALYSTS*
3

4 *Article 1. General Provisions*
5

6 2999.10. *This chapter shall be known and may be cited as the*
7 *Behavior Analyst Act.*

8 2999.11. (a) *The Legislature finds and declares that the*
9 *practice of behavior analysis in California affects the public health,*
10 *safety, and welfare, and is subject to regulation to protect the*
11 *public from the unauthorized and unqualified practice of behavior*
12 *analysis, and unprofessional, unethical or harmful conduct by*
13 *persons licensed to practice behavior analysis.*

14 (b) *It is the intent of the Legislature that the board begin*
15 *accepting applications for behavior analyst licensure and assistant*
16 *behavior analyst licensure no later than January 1, 2018, provided*
17 *that the funds necessary to implement this chapter have been*
18 *appropriated by the Legislature as specified in Section 2999.98*

19 2999.12. *For purposes of this chapter, the following terms*
20 *have the following meanings:*

21 (a) *“Board” means the Board of Psychology.*

22 (b) *“Certifying entity” means the Behavior Analyst Certificatio*
23 *Board or its successor, or a national organization with a behavior*
24 *analyst certification program approved by the board and*
25 *accredited by the National Commission for Certifying Agencies.*

26 (c) *“Committee” means the Behavior Analyst Committee.*

27 (d) *“Department” means the Department of Consumer Affairs.*

28 (e) *“Licensed assistant behavior analyst” means a person*
29 *licensed under this chapter to practice behavior analysis under*
30 *the supervision of a licensed behavior analyst and who meets the*
31 *requirements of Section 2999.33.*

32 (f) *“Licensed behavior analyst” means a person licensed under*
33 *this chapter to practice behavior analysis and who meets the*
34 *requirements of Section 2999.31.*

35 (g) (1) *“Practice of behavior analysis” or “to practice behavior*
36 *analysis” means the design, implementation, and evaluation of*
37 *instructional and environmental modifications to produce socially*
38 *significant improvements in human behavior and includes any of*
39 *the following:*

1 (A) *The empirical identification of functional relations between*
2 *behavior and environmental factors, known as functional*
3 *assessment and analysis.*

4 (B) *Interventions based on scientific research and the direct*
5 *observation and measurement of behavior and the environment.*

6 (C) *Utilization of contextual factors, motivating operations,*
7 *antecedent stimuli, positive reinforcement, and other consequences*
8 *to help people develop new behaviors, increase or decrease existing*
9 *behaviors, and emit behaviors under specific environmental*
10 *conditions.*

11 (2) *The practice of behavior analysis does not include*
12 *psychological testing, diagnosis of a mental or physical disorder,*
13 *neuropsychology, psychotherapy, cognitive therapy, sex therapy,*
14 *psychoanalysis, hypnotherapy, or counseling as treatment*
15 *modalities.*

16
17 *Article 2. Administration*
18

19 2999.20. (a) *The Board of Psychology is vested with the power*
20 *to administer the provisions and requirements of this chapter, and*
21 *may make and enforce rules and regulations that are reasonably*
22 *necessary to carry out its provisions.*

23 (b) *This section shall remain in effect only until January 1, 2021,*
24 *and as of that date is repealed. Notwithstanding any other law,*
25 *the repeal of this section renders the board subject to review by*
26 *the appropriate policy committees of the Legislature.*

27 2999.21. *Protection of the public shall be the highest priority*
28 *for the board in exercising its licensing, regulatory, and*
29 *disciplinary functions pursuant to this chapter. Whenever the*
30 *protection of the public is inconsistent with other interests sought*
31 *to be promoted, the protection of the public shall be paramount.*

32 2999.22. *Upon recommendation of the committee, the board*
33 *shall adopt, amend, and repeal regulations to implement the*
34 *requirements of this chapter. All regulations adopted by the board*
35 *shall comply with the provisions of Chapter 3.5 (commencing with*
36 *Section 11340) of Part 1 of Division 3 of Title 2 of the Government*
37 *Code.*

38 2999.23. *The board may employ, subject to civil service and*
39 *other laws, employees as may be necessary to carry out the*

1 provisions of this chapter under the direction of the executive
2 officer of the board.

3 2999.24. The board shall maintain, and make available to the
4 public, a list of all licensees. The board shall make available on
5 its Internet Web site information regarding the status of every
6 license issued by the board under this chapter pursuant to Section
7 27.

8 2999.25. (a) The Behavior Analyst Committee is hereby
9 created within the jurisdiction of the board to protect the public
10 from the unauthorized and unqualified practice of applied behavior
11 analysis, and unprofessional, unethical, or harmful conduct by
12 persons licensed to practice behavior analysis.

13 (b) The committee shall consist of five members. Two members
14 shall be licensed behavior analysts. One member shall be a
15 psychologist licensed under Chapter 6.6 (commencing with Section
16 2900) who is also a member of the Board of Psychology and who
17 holds a license as a behavior analyst. One member shall be a
18 licensed assistant behavior analyst. One member shall be a public
19 member who is a consumer of behavior analysis services and who
20 is not licensed under this chapter, under any chapter within this
21 division, or by any board referred to in the Chiropractic Act or
22 the Osteopathic Act.

23 (c) The Governor shall appoint one licensed behavior analyst
24 member, the licensed psychologist member, and the licensed
25 assistant behavior analyst member. The Senate Committee on
26 Rules shall appoint the public member, and the Speaker of the
27 Assembly shall appoint one licensed behavior analyst member.

28 (d) Notwithstanding subdivisions (b) and (c), the initially
29 appointed members of the committee shall be appointed as follows:

30 (1) The initial members appointed by the Governor shall be as
31 follows:

32 (A) One member shall hold a certificate as a certified behavior
33 analyst from a certifying entity and shall serve an initial term of
34 one year.

35 (B) One member shall hold a certificate as a certified assistant
36 behavior analyst from a certifying entity and shall serve an initial
37 term of two years.

38 (C) One member shall be a licensed psychologist who holds a
39 certificate as a certified behavior analyst from a certifying entity
40 and shall serve an initial term of three years.

1 (2) *The initial member appointed by the Senate Committee on*
2 *Rules shall serve a term of four years.*

3 (3) *The initial member appointed by the Speaker of the Assembly*
4 *shall hold a certificate as a certified behavior analyst from a*
5 *certifying entity and shall serve an initial term of four years.*

6 (e) *Except as provided in paragraph (d), each member of the*
7 *committee shall hold office for a term of four years, and shall serve*
8 *until the appointment of his or her successor or until one year has*
9 *elapsed since the expiration of the term for which he or she was*
10 *appointed, whichever occurs fi st. Vacancies shall be filled by the*
11 *appointing power for the unexpired portion of the terms in which*
12 *they occur. A member shall not serve for more than two consecutive*
13 *terms.*

14 (f) *All terms shall begin on July 1 and expire on June 30.*

15 (g) *Each member of the committee shall receive per diem and*
16 *expenses as provided in Sections 103 and 113.*

17 (h) *Three members of the committee shall at all times constitute*
18 *a quorum.*

19 (i) *This section shall become operative on July 1, 2017.*

20 (j) *This section shall remain in effect only until January 1, 2021,*
21 *and as of that date is repealed. Notwithstanding any other law,*
22 *the repeal of this section renders the committee subject to review*
23 *by the appropriate policy committees of the Legislature.*

24 2999.26. *The committee shall do all of the following:*

25 (a) *Meet at least once per quarter. All meetings of the committee*
26 *shall be public meetings. Notice of each regular meeting of the*
27 *board shall be given in accordance with the Bagley-Keene Open*
28 *Meeting Act (Article 9 (commencing with Section 11120) of*
29 *Chapter 1 of Part 1 of Division 3 of Title 2 of the Government*
30 *Code).*

31 (b) *Committee meetings may be called upon reasonable notice*
32 *at the discretion of the chair, and shall be called at any time upon*
33 *reasonable notice by a written request of two committee members*
34 *to the chair.*

35 (c) *The committee shall elect a chair and a vice chair from*
36 *among its members at the fi st meeting held in each fiscal year.*
37 *The chair shall preside at all meetings of the committee and shall*
38 *work with the executive officer of the board to coordinate the*
39 *committee's business. If the chair is unable to attend a meeting,*
40 *the vice chair shall preside at the meeting.*

1 2999.27. (a) *The committee may make recommendations to*
 2 *the board regarding licensing and practice standards.*

3 (b) *The committee may make recommendations to the board*
 4 *regarding the adoption, amendment, and repeal of regulations to*
 5 *implement the requirements of this chapter including, but not*
 6 *limited to, the setting of fees and the establishment of disciplinary*
 7 *actions.*

8 2999.28. *Any action taken by the committee under this chapter*
 9 *shall only be effective after adoption by majority vote of the*
 10 *members of the committee and after adoption by a majority vote*
 11 *of the members of the board.*

12

13

Article 3. Licensing

14

15 2999.30. *To qualify for licensure as a licensed behavior analyst*
 16 *or a licensed assistant behavior analyst, each applicant shall meet*
 17 *the board's regulatory requirements for behavior analyst or*
 18 *assistant behavior analyst licensure, as applicable, including all*
 19 *of the following:*

20 (a) *The applicant has not committed acts or crimes constituting*
 21 *grounds for denial of licensure under Section 480.*

22 (b) *The board shall not issue a license or registration to any*
 23 *person who has been convicted of a crime in this state, or another*
 24 *state, or in a territory of the United States that involves sexual*
 25 *abuse of a child, or who is required to register pursuant to Section*
 26 *290 of the Penal Code or the equivalent in another state or*
 27 *territory.*

28 (c) *The applicant has successfully passed a state and federal*
 29 *level criminal offender record information search conducted*
 30 *through the Department of Justice, as follows:*

31 (1) *The board shall direct applicants to electronically submit*
 32 *to the Department of Justice fingerprint images and related*
 33 *information required by the Department of Justice for the purpose*
 34 *of obtaining information as to the existence and content of a record*
 35 *of state and federal level convictions and arrests and information*
 36 *as to the existence and content of a record of state or federal level*
 37 *arrests for which the Department of Justice establishes that the*
 38 *person is free on bail or on his or her own recognizance pending*
 39 *trial or appeal.*

1 (2) The Department of Justice shall forward the fingerprint
2 images and related information received pursuant to paragraph
3 (1) to the Federal Bureau of Investigation and request a federal
4 summary for criminal history information.

5 (3) The Department of Justice shall review the information
6 returned from the Federal Bureau of Investigation and compile
7 and disseminate a response to the board pursuant to paragraph
8 (1) of subdivision (p) of Section 11105 of the Penal Code.

9 (4) The board shall request from the Department of Justice
10 subsequent arrest notification service, pursuant to Section 11105.2
11 of the Penal Code, for each person who submitted information
12 pursuant to paragraph (1).

13 (5) The Department of Justice shall charge a fee sufficient to
14 cover the cost of processing the request described in this section.

15 2999.31. (a) To obtain a license as a behavior analyst, an
16 individual shall submit an application on a form approved by the
17 board accompanied by the fees required by the board as specified
18 in Section 2999.93.

19 (b) The board shall verify with the certifying entity that the
20 applicant meets all of the following requirements:

21 (1) Has passed the Board Certified Behavior Analyst
22 examination administered by the Behavior Analyst Certification
23 Board.

24 (2) Maintains an active status as a certified behavior analyst
25 with the certifying entity.

26 (3) Is in compliance with all ethical and disciplinary standards
27 published by the certifying entity.

28 (c) Each applicant shall obtain a passing score on a California
29 law and ethics examination administered by the board.

30 2999.32. (a) In order for an individual to be licensed as a
31 behavior analyst under this chapter, he or she shall possess a
32 master's degree or higher level of education from an institution,
33 which meets the requirements described in Section 2999.35, that
34 was conferred in behavior analysis or other natural science,
35 education, human services, engineering, medicine, or a field related
36 to behavior analysis and approved by the certifying entity.

37 (b) In addition to subdivision (a), an individual shall meet one
38 of the following in order to be licensed under this chapter:

39 (1) An individual shall have completed both of the following:

- 1 (A) Completed 270 hours of classroom graduate-level
2 instruction in the following content areas:
- 3 (i) Ethical and professional conduct coursework consisting of
4 45 hours. The content must be taught in one or more freestanding
5 courses devoted to ethical and professional conduct of behavior
6 analysts.
- 7 (ii) Concepts and principles of behavior analysis consisting of
8 45 hours.
- 9 (iii) Research methods in behavior analysis, consisting of 25
10 hours of measurement, including data analysis, and 20 hours of
11 experimental design.
- 12 (iv) Applied behavior analysis, consisting of 45 hours of
13 fundamental elements of behavior change and specific behavior
14 change procedures, 30 hours of identification of the problem and
15 assessment, 10 hours of intervention and behavior change
16 considerations, 10 hours of behavior change systems, and 10 hours
17 of implementation, management and supervision.
- 18 (v) Discretionary coursework in behavior analysis consisting
19 of 30 hours.
- 20 (B) Obtained experience by any of the following:
- 21 (i) Completed 1,500 hours of independent field work in behavior
22 analysis supervised in accordance with the requirements of the
23 certifying entity.
- 24 (ii) Completed, with a passing grade, 1,000 hours of supervised
25 practicum in behavior analysis within a university practicum
26 approved by the certifying entity and taken for graduate academic
27 credit.
- 28 (iii) Completed, with a passing grade, 750 hours of supervised
29 intensive practicum in behavior analysis within a university
30 practicum approved by the certifying entity and taken for graduate
31 academic credit.
- 32 (iv) Completed a combination of the supervised experience in
33 clause (i), (ii), or (iii). Hours may be completed in any combination
34 of the categories of supervised experience. Hours accrued through
35 a combination of supervised experience shall be proportionately
36 calculated.
- 37 (2) An individual shall have done both of the following:
- 38 (A) Completed one academic year as a full-time faculty
39 appointment at a college or university, as described in Section
40 2999.35, during which he or she did all of the following:

- 1 (i) Taught classes on basic principles of behavior, single-subject
2 research methods, applications of basic principles of behavior in
3 applied settings, and ethical issues.
- 4 (ii) Conducted and published research in behavior analysis.
- 5 (B) Obtained experience by any of the following:
- 6 (i) Completed 1,500 hours of independent field work in behavior
7 analysis supervised in accordance with the requirements of the
8 certifying entity.
- 9 (ii) Completed, with a passing grade, 1,000 hours of supervised
10 practicum in behavior analysis within a university practicum
11 approved by the certifying entity and taken for graduate academic
12 credit.
- 13 (iii) Completed, with a passing grade, 750 hours of supervised
14 intensive practicum in behavior analysis within a university
15 practicum approved by the certifying entity and taken for graduate
16 academic credit.
- 17 (iv) Completed a combination of the supervised experience in
18 clause (i), (ii), or (iii). Hours may be completed in any combination
19 of the categories of supervised experience. Hours accrued through
20 a combination of supervised experience shall be proportionately
21 calculated.
- 22 (3) An individual shall have both of the following:
- 23 (i) A doctoral degree, conferred at least 10 years prior to the
24 date of application in the field of behavior analysis, psychology,
25 education, or a related field approved by the certifying entity.
- 26 (ii) Ten years of verified and documented postdoctoral
27 experience practicing behavior analysis.
- 28 (c) If an individual is certified by a certifying entity whose
29 requirements for initial certification as a certified behavior analyst
30 at the time of license application meet or surpass the requirements
31 in subdivisions (a) and (b), the applicant for licensure shall be
32 deemed to have satisfied the requirements in subdivisions (a) and
33 (b).
- 34 2999.33. (a) To obtain a license as an assistant behavior
35 analyst, an individual shall submit an application on a form
36 approved by the board accompanied by the fees required by the
37 board as specified in Section 2999.93
- 38 (b) The board shall verify with the certifying entity that the
39 applicant meets all of the following requirements:

1 (1) Has passed the Board Certified Assistant Behavior Analyst
2 examination administered by the certifying entity.

3 (2) Maintains an active status as a board certified assistant
4 behavior analyst with the certifying entity.

5 (3) Is in compliance with all ethical and disciplinary standards
6 published by the certifying entity.

7 (c) Each applicant shall obtain a passing score on a California
8 law and ethics examination administered by the board.

9 (d) Each applicant shall provide proof of ongoing supervision
10 by a licensed behavior analyst in a manner consistent with the
11 certifying entity's requirements for supervision of assistant
12 behavior analysts.

13 2999.34. (a) In order for an individual to be licensed as an
14 assistant behavior analyst under this chapter, he or she shall
15 possess a baccalaureate degree or higher level of education from
16 an institution that meets the requirements described in Section
17 2999.35.

18 (b) In addition to subdivision (a), an individual shall meet both
19 of the following in order to be licensed under this chapter:

20 (1) Completed 180 classroom hours of undergraduate or
21 graduate level instruction in the following content areas:

22 (A) Ethical and professional conduct coursework of behavior
23 analysis consisting of 15 hours.

24 (B) Concepts and principles of behavior analysis consisting of
25 45 hours.

26 (C) Research methods in behavior analysis, consisting of 10
27 hours of measurement, including data analysis, and five hours of
28 experimental design.

29 (D) Applied behavior analysis, consisting of 45 hours of
30 fundamental elements of behavior change and specific behavior
31 change procedures, 30 hours of identification of the problem and
32 assessment, five hours of intervention and behavior change
33 considerations, five hours of behavior change systems, and five
34 hours of implementation, management and supervision.

35 (E) Discretionary coursework in behavior analysis consisting
36 of 15 hours.

37 (2) Obtained experience by any of the following:

38 (A) Completed 1,000 hours of independent field work in behavior
39 analysis supervised in accordance with the requirements of the
40 certifying entity.

1 (B) Completed, with a passing grade, 670 hours of supervised
2 practicum in behavior analysis within a university practicum
3 approved by the certifying entity and taken for academic credit.

4 (C) Completed, with a passing grade, 500 hours of supervised
5 intensive practicum in behavior analysis within a university
6 practicum approved by the certifying entity and taken for academic
7 credit.

8 (D) Completed a combination of the supervised experience in
9 paragraph (A), (B), or (C). Hours may be completed in any
10 combination of the categories of supervised experience. Hours
11 accrued through a combination of supervised experience shall be
12 proportionately calculated.

13 (c) If an individual is certified by a certifying entity whose
14 requirements for initial certification as a certified assistant
15 behavior analyst at the time of license application meet or surpass
16 the requirements in subdivisions (a) and (b), the applicant for
17 licensure shall be deemed to have satisfied the requirements in
18 subdivisions (a) and (b).

19 2999.35. The education required to obtain a behavior analyst
20 license or an assistant behavior analyst license shall be from any
21 of the following:

22 (a) A United States institution of higher education listed by the
23 Council for Higher Education Accreditation.

24 (b) A Canadian institution of higher education that is a member
25 of the Association of Universities and Colleges of Canada or the
26 Association of Canadian Community Colleges.

27 (c) An institution of higher education located outside the United
28 States or Canada that, at the time the applicant was enrolled and
29 at the time the applicant graduated, maintained a standard of
30 training equivalent to the standards of training of those institutions
31 accredited in the United States as demonstrated by a member of
32 the National Association of Credential Evaluation Services.

33 2999.36. On and after January 1, 2018, it shall be unlawful
34 for any person to engage in any of the following acts:

35 (a) Engage in the practice of behavior analysis, as defined in
36 Section 2999.12, without first having complied with the provisions
37 of this chapter and without holding a current, valid, and active
38 license as required by this chapter.

- 1 **(b)** Represent himself or herself by the title “licensed behavior
2 analyst,” or “licensed assistant behavior analyst” without being
3 duly licensed according to the provisions of this chapter.
- 4 **(c)** Make any use of any title, words, letters, or abbreviations
5 that may reasonably be confused with a designation provided by
6 this chapter to denote a standard of professional or occupational
7 competence without being duly licensed.
- 8 **(d)** Materially refuse to furnish the board information or records
9 required or requested pursuant to this chapter.
- 10 2999.37. This chapter does not apply to any of the following:
- 11 **(a)** An individual licensed to practice psychology in this state
12 under Chapter 6.6 (commencing with Section 2900), if the practice
13 of behavior analysis engaged in by the licensed psychologist is
14 within the licensed psychologist’s training and competence.
- 15 **(b)** An occupational therapist licensed under Chapter 5.6
16 (commencing with Section 2570), a physical therapist licensed
17 under Chapter 5.7 (commencing with Section 2600), a marriage
18 and family therapist licensed under Chapter 13 (commencing with
19 Section 4980) or an educational psychologist licensed under
20 Chapter 13.5 (commencing with Section 4980.10) acting within
21 his or her licensed scope of practice and within the scope of his
22 or her training and competence, provided that he or she does not
23 represent himself or herself as a licensed behavior analyst or
24 licensed assistant behavior analyst.
- 25 **(c)** An individual, including a paraprofessional technician,
26 acting under the authority and direction of a licensed behavior
27 analyst, a licensed assistant behavior analyst, or an individual
28 described in paragraph (a) or (b).
- 29 **(d)** A family member of a recipient of behavior analysis services
30 who acts under the extended authority and direction of a licensed
31 behavior analyst or a licensed assistant behavior analyst.
- 32 **(e)** A matriculated college or university student who practices
33 behavior analysis as a part of a defined program of study, course,
34 practicum, internship, or postdoctoral fellowship, provided that
35 the behavior analysis activities are directly supervised by a
36 licensed behavior analyst or by an instructor in a course sequence
37 approved by the certifying entity.
- 38 **(f)** An unlicensed individual pursuing supervised experience in
39 behavior analysis consistent with the experience requirements of

1 *the certifying entity, provided such experience is supervised in*
2 *accordance with the requirements of the certifying entity.*

3 *(g) An individual who teaches behavior analysis or conducts*
4 *behavior analytic research, provided that such teaching or*
5 *research does not involve the direct delivery of behavior analysis*
6 *services.*

7 *(h) A behavior analyst licensed in another state or certified by*
8 *the certifying entity to practice independently, and who temporarily*
9 *provides behavior analysis services in California during a period*
10 *of not more than 90 days in a calendar year.*

11 *(i) An individual who is vendorized by one or more regional*
12 *centers of the California Department of Developmental Services*
13 *while practicing behavior analysis services authorized under that*
14 *vendorization. That individual shall not represent himself or herself*
15 *as a licensed behavior analyst or licensed assistant behavior*
16 *analyst unless he or she holds a license under this chapter, and*
17 *shall not offer behavior analysis services to any person or entity*
18 *other than the regional centers with which he or she is vendorized*
19 *or accept remuneration for providing behavior analysis services*
20 *other than the remuneration received from those regional centers.*

21 *(j) An individual employed by a school board performing the*
22 *duties of his or her position, provided that he or she shall only*
23 *offer behavior analysis services within the scope of that*
24 *employment by the school board.*

25 *2999.40. (a) The board shall issue a license to a person who*
26 *is licensed as a behavior analyst or an assistant behavior analyst*
27 *in another state, if that state currently imposes comparable*
28 *licensure requirements as those required by this state and if that*
29 *state offers reciprocity to individuals licensed under this chapter.*
30 *Applicants for a license under reciprocity shall submit an*
31 *application on a form approved by the board accompanied by the*
32 *fees required by the board as specified in Section 2999.93. Each*
33 *applicant shall complete any other eligibility requirements*
34 *established by the board, including, but not limited to, the criminal*
35 *background check required by Section 2999.30.*

36 *(b) The board shall verify that the applicant meets all of the*
37 *following:*

38 *(1) Holds an active license as a licensed behavior analyst or*
39 *licensed assistant behavior analyst in another state.*

1 (2) *Is not subject to any disciplinary action by another state or*
2 *certifying entity.*

3 (3) *Maintains an active status as board certified behavior*
4 *analyst or board certified assistant behavior analyst with the*
5 *certifying entity.*

6 (4) *Is in compliance with all ethical and disciplinary standards*
7 *published by the certifying entity.*

8 (c) *Each applicant shall obtain a passing score on a California*
9 *law and ethics examination administered by the board.*

10 2999.41. *A licensee shall give written notice to the board of a*
11 *name change within 30 days after each change, giving both the*
12 *old and new names. A copy of the legal document authorizing the*
13 *name change, such as a court order or marriage certificat , shall*
14 *be submitted with the notice.*

15 2999.44. (a) *A license shall expire and become invalid two*
16 *years after it is issued at 12 midnight on the last day of the month*
17 *in which it was issued, if not renewed.*

18 (b) *To renew an unexpired license, the licensee shall, on or*
19 *before the date on which it would otherwise expire, apply for*
20 *renewal on a form provided by the board, accompanied by the*
21 *renewal fee set by the board. The board shall obtain verificatio*
22 *from the certifying entity that the renewal applicant maintains an*
23 *active certification status with the certifying entit .*

24 (c) *To renew an assistant behavior analyst license, in addition*
25 *to the requirements in paragraph (b), the licensee shall submit*
26 *proof of ongoing supervision by a licensed behavior analyst in a*
27 *manner consistent with the certifying entity's requirements for*
28 *supervision of assistant behavior analysts.*

29 2999.45. (a) *A license that has expired may be renewed at any*
30 *time within three years after its expiration by applying for renewal*
31 *on a form provided by the board, payment of all accrued and*
32 *unpaid renewal fees, and the delinquency fee specified in Sectio*
33 *2999.93. The board shall obtain verification from the certifying*
34 *entity of the licensee's active certification status with the certifying*
35 *entity.*

36 (b) *Except as provided in Section 2999.46, a license that is not*
37 *renewed within three years of its expiration shall not be renewed,*
38 *restored, or reinstated, and the license shall be canceled*
39 *immediately upon expiration of the three year-period.*

1 2999.46. (a) *A suspended license is subject to expiration and*
2 *shall be renewed as provided in this article, but such renewal does*
3 *not entitle the licensee, while the license remains suspended, and*
4 *until it is reinstated, to engage in the licensed activity or in any*
5 *other activity or conduct in violation of the order or judgment by*
6 *which the license was suspended.*

7 (b) *A license revoked on disciplinary grounds is subject to*
8 *expiration as provided in this article, but it may not be renewed.*
9 *If it is reinstated after its expiration, the licensee, as a condition*
10 *of reinstatement, shall pay a reinstatement fee in an amount equal*
11 *to the renewal fee, plus the delinquency fee and any fees accrued*
12 *at the time of its revocation.*

13
14 *Article 4. Enforcement*
15

16 2999.60. *The board may on its own, and shall, upon the receipt*
17 *of a complaint from any person, investigate the actions of any*
18 *licensee. The board shall review a licensee's alleged violation of*
19 *statute, regulation, or any other law and any other complaint*
20 *referred to it by the public, a public agency, or the department,*
21 *and may upon a finding of a violation take disciplinary action*
22 *under this article.*

23 2999.61. *A license issued under this chapter may be denied,*
24 *revoked, or otherwise sanctioned upon demonstration of*
25 *ineligibility for licensure, including, but not limited to, failure to*
26 *maintain active certification by the certifying entity or falsificatio*
27 *of documentation submitted to the board for licensure or submitted*
28 *to the certifying authority for certification*

29 2999.62. *The board may deny a license application, may issue*
30 *a license with terms and conditions, may suspend or revoke a*
31 *license, or may place a license on probation if the applicant or*
32 *licensee has been guilty of unprofessional conduct. Unprofessional*
33 *conduct shall include, but not be limited to:*

34 (a) *Conviction of a crime substantially related to the*
35 *qualifications, functions, or duties of a licensed behavior analyst*
36 *or a licensed assistant behavior analyst.*

37 (b) *Use of any controlled substance as defined in Division 10*
38 *(commencing with Section 11000) of the Health and Safety Code,*
39 *dangerous drug, or any alcoholic beverage to an extent or in a*
40 *manner dangerous to himself or herself, any other person, or the*

- 1 *public, or to an extent that this use impairs his or her ability to*
2 *safely perform the practice of behavior analysis.*
- 3 *(c) Fraudulently or neglectfully misrepresenting the type or*
4 *status of a license actually held.*
- 5 *(d) Impersonating another person holding a license or allowing*
6 *another person to use his or her license.*
- 7 *(e) Use of fraud or deception in applying for a license or in*
8 *passing any examination required by this chapter.*
- 9 *(f) Paying, offering to pay, accepting, or soliciting any*
10 *consideration, compensation, or remuneration, whether monetary*
11 *or otherwise, for the referral of clients.*
- 12 *(g) Violating Section 17500.*
- 13 *(h) Willful, unauthorized communication of information received*
14 *in professional confidenc .*
- 15 *(i) Violating any rule of professional conduct promulgated by*
16 *the board and set forth in regulations duly adopted under this*
17 *chapter.*
- 18 *(j) Being grossly negligent in the practice of his or her*
19 *profession.*
- 20 *(k) Violating any of the provisions of this chapter or regulations*
21 *duly adopted thereunder.*
- 22 *(l) The aiding or abetting of any person to engage in the*
23 *unlawful practice of behavior analysis.*
- 24 *(m) The suspension, revocation, or imposition of probationary*
25 *conditions or other disciplinary action by another state or country*
26 *of a license, certificat , or registration to practice behavior*
27 *analysis issued by that state or country to a person also holding*
28 *a license issued under this chapter if the act for which the*
29 *disciplinary action was taken constitutes a violation of this section.*
30 *A certified copy of the decision or judgment of the other state or*
31 *country shall be conclusive evidence of that action.*
- 32 *(n) The commission of any dishonest, corrupt, or fraudulent*
33 *act.*
- 34 *(o) Any act of sexual abuse or sexual relations with a patient*
35 *or former patient within two years following termination of therapy,*
36 *or sexual misconduct that is substantially related to the*
37 *qualifications, functions, or duties of a licensed behavior analyst*
38 *or a licensed assistant behavior analyst.*

1 (p) Functioning outside of his or her particular field or field
2 of competence as established by his or her education, training,
3 and experience.

4 (q) Willful failure to submit, on behalf of an applicant for
5 licensure, verification of supervised experience to the board.

6 (r) Repeated acts of negligence.

7 (s) Failure to comply with all ethical and disciplinary standards
8 published by the certifying entity.

9 2999.63. (a) Except as provided in subdivisions (b), (c), and
10 (e), any accusation filed against a licensee pursuant to Section
11 11503 of the Government Code shall be filed within three years
12 from the date the board discovers the alleged act or omission that
13 is the basis for disciplinary action, or within seven years from the
14 date the alleged act or omission that is the basis for disciplinary
15 action occurred, whichever occurs first.

16 (b) An accusation filed against a licensee pursuant to Section
17 11503 of the Government Code alleging the procurement of a
18 license by fraud or misrepresentation is not subject to the
19 limitations set forth in subdivision (a).

20 (c) The limitation provided for by subdivision (a) shall be tolled
21 for the length of time required to obtain compliance when a report
22 required to be filed by the licensee or registrant with the board
23 pursuant to Article 11 (commencing with Section 800) of Chapter
24 1 is not filed in a timely fashion

25 (d) If an alleged act or omission involves a minor, the seven-year
26 limitations period provided for by subdivision (a) and the 10-year
27 limitations period provided for by subdivision (e) shall be tolled
28 until the minor reaches the age of majority.

29 (e) An accusation filed against a licensee pursuant to Section
30 11503 of the Government Code alleging sexual misconduct shall
31 be filed within three years after the board discovers the act or
32 omission alleged as the ground for disciplinary action, or within
33 10 years after the act or omission alleged as the ground for
34 disciplinary action occurs, whichever occurs first.

35 (f) The limitations period provided by subdivision (a) shall be
36 tolled during any period if material evidence necessary for
37 prosecuting or determining whether a disciplinary action would
38 be appropriate is unavailable to the board due to an ongoing
39 criminal investigation.

1 2999.64. *Notwithstanding Section 2999.62, any proposed*
2 *decision or decision issued under this chapter in accordance with*
3 *the procedures set forth in Chapter 5 (commencing with Section*
4 *11500) of Part 1 of Division 3 of Title 2 of the Government Code*
5 *that contains any finding of fact that the licensee engaged in any*
6 *act of sexual contact, as defined in Section 728, when that act is*
7 *with a patient, or with a former patient, within two years following*
8 *termination of services, shall contain an order of revocation. The*
9 *revocation shall not be stayed by the administrative law judge.*

10 2999.66. *The board may deny an application for, or issue*
11 *subject to terms and conditions, or suspend or revoke, or impose*
12 *probationary conditions upon, a license or registration after a*
13 *hearing as provided in Section 2999.70.*

14 2999.67. *A plea or verdict of guilty or a conviction following*
15 *a plea of nolo contendere made to a charge which is substantially*
16 *related to the qualifications, functions, and duties of a licensed*
17 *behavior analyst or licensed assistant behavior analyst is deemed*
18 *to be a conviction within the meaning of this article. The board*
19 *may order the license suspended or revoked, or may decline to*
20 *issue a license when the time for appeal has elapsed, the judgment*
21 *of conviction has been affirmed on appeal, or when an order*
22 *granting probation is made suspending the imposition of sentence,*
23 *irrespective of a subsequent order under Section 1203.4 of the*
24 *Penal Code allowing the person to withdraw his or her plea of*
25 *guilty and to enter a plea of not guilty, or setting aside the verdict*
26 *of guilty, or dismissing the accusation, information, or indictment.*

27 2999.68. *Any person required to register as a sex offender*
28 *pursuant to Section 290 of the Penal Code, is not eligible for*
29 *licensure by the board.*

30 2999.69. *An administrative disciplinary decision that imposes*
31 *terms of probation may include, among other things, a requirement*
32 *that the licensee who is being placed on probation pay the*
33 *monetary costs associated with monitoring the probation.*

34 2999.70. *The proceedings under this article shall be conducted*
35 *by the board in accordance with Chapter 5 (commencing with*
36 *Section 11500) of Part 1 of Division 3 of Title 2 of the Government*
37 *Code.*

38 2999.80. *A person who violates any of the provisions of this*
39 *chapter is guilty of a misdemeanor punishable by imprisonment*
40 *in a county jail not exceeding six months or by a fine not exceeding*

1 two thousand five hundred dollars (\$2,500), or by both that fin
2 and imprisonment.

3 2999.81. In addition to other proceedings provided in this
4 chapter, whenever any person has engaged, or is about to engage,
5 in any acts or practices that constitute, or will constitute, an offense
6 against this chapter, the superior court in and for the county
7 wherein the acts or practices take place, or are about to take place,
8 may issue an injunction or other appropriate order restraining
9 that conduct on application of the board, the Attorney General,
10 or the district attorney of the county. Proceedings under this
11 section shall be governed by Chapter 3 (commencing with Section
12 525) of Title 7 of Part 2 of the Code of Civil Procedure, except
13 that it shall be presumed that there is no adequate remedy at law
14 and that irreparable damage will occur if the continued violation
15 is not restrained or enjoined. On the written request of the board,
16 or on its own motion, the board may commence an action in the
17 superior court under this section.

18

19

Article 5. Revenue

20

21 2999.90. The board shall report each month to the Controller
22 the amount and source of all revenue received pursuant to this
23 chapter and at the same time deposit the entire amount thereof in
24 the State Treasury for credit to the Psychology Fund established
25 by Section 2980.

26 2999.91. (a) The moneys credited to the Psychology Fund
27 under Section 2999.90 shall, upon appropriation by the
28 Legislature, be used for the purposes of carrying out and enforcing
29 the provisions of this chapter.

30 (b) The board shall keep records that will reasonably ensure
31 that funds expended in the administration of each licensing
32 category bear a reasonable relation to the revenue derived from
33 each category, and shall so notify the department no later than
34 May 31 of each year.

35 2999.93. The board shall assess fees for the application for
36 and the issuance and renewal of licenses to cover, but not exceed,
37 administrative and operating expenses of the board related to this
38 chapter. The fees shall be fixed by the board in regulations that
39 are duly adopted under this chapter. Fees assessed pursuant to
40 this section shall not exceed the following:

- 1 (a) The fee for the application for licensure shall be not more
2 than _____ dollars (\$_____).
- 3 (b) The fee for the law and ethics examination shall be not more
4 than _____ dollars (\$_____).
- 5 (c) The fee for the issuance of a license shall be not more than
6 _____ dollars (\$_____).
- 7 (d) The fee for a biennial renewal of a license shall be not more
8 than _____ dollars (\$_____).
- 9 (e) The delinquency fee shall be 50 percent of the biennial
10 renewal fee.
- 11 (f) The fee for rescoring an examination shall be twenty dollars
12 (\$20).
- 13 (g) The fee for issuance of a replacement license shall be twenty
14 dollars (\$20).
- 15 (h) The fee to change a name or address on the board's records
16 shall be twenty dollars (\$20).
- 17 (i) The fee for issuance of a certificate or letter of good standing
18 shall be twenty-five dollars (\$25).
- 19 2999.94. (a) A person licensed under this chapter is exempt
20 from the payment of the renewal fee in any one of the following
21 instances:
- 22 (1) While engaged in full-time active service in the Army, Navy,
23 Air Force, or Marines.
- 24 (2) While in the United States Public Health Service.
- 25 (3) While a volunteer in the Peace Corps or Vista.
- 26 (b) Every person exempted from the payment of the renewal fee
27 by this section shall not engage in any private practice and shall
28 become liable for the fee for the current renewal period upon the
29 completion of his or her period of full-time active service and shall
30 have a period of 60 days after becoming liable within which to
31 pay the fee before the delinquency fee becomes applicable. Any
32 person who completes his or her period of full-time active service
33 within 60 days of the end of a renewal period is exempt from the
34 payment of the renewal fee for that period.
- 35 (c) The time spent in that full-time active service or full-time
36 training and active service shall not be included in the computation
37 of the three-year period for renewal of an expired license specific
38 in Section 2999.45.
- 39 (d) The exemption provided by this section shall not be
40 applicable if the person engages in any practice for compensation

1 *other than full-time service in the Army, Navy, Air Force or*
2 *Marines or in the United States Public Health Service or the Peace*
3 *Corps or Vista.*

4 2999.98. *The licensing and regulatory program under this*
5 *chapter shall be supported from fees assessed to applicants and*
6 *licensees. Startup funds to implement this program shall be derived,*
7 *as a loan, from the reserve fund of the Board of Psychology, subject*
8 *to an appropriation by the Legislature in the annual Budget Act.*
9 *The board shall not implement this chapter until funds have been*
10 *appropriated.*

11 *SEC. 10. No reimbursement is required by this act pursuant*
12 *to Section 6 of Article XIII B of the California Constitution because*
13 *the only costs that may be incurred by a local agency or school*
14 *district will be incurred because this act creates a new crime or*
15 *infraction, eliminates a crime or infraction, or changes the penalty*
16 *for a crime or infraction, within the meaning of Section 17556 of*
17 *the Government Code, or changes the definition of a crime within*
18 *the meaning of Section 6 of Article XIII B of the California*
19 *Constitution.*

20 ~~SECTION 1. It is the intent of the legislature to enact legislation~~
21 ~~to license and regulate the profession of applied behavioral~~
22 ~~analysis.~~

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CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES

BILL ANALYSIS

BILL NUMBER: SB 614

VERSION: AMENDED APRIL 6, 2015

AUTHOR: LENO

**SPONSOR: COUNTY BEHAVIORAL HEALTH
DIRECTORS ASSOCIATION**

RECOMMENDED POSITION: OPPOSE UNLESS AMENDED

**SUBJECT: MEDI-CAL: MENTAL HEALTH SERVICES: PEER AND FAMILY SUPPORT
SPECIALIST CERTIFICATION**

Overview:

This bill requires the State Department of Health Care Services to develop a peer and family support specialist certification program.

Existing Law:

- 1) States that certain essential mental health and substance use disorder services are covered Medi-Cal benefits effective January 1, 2014. (Welfare and Institutions Code (WIC) §14132.03)

This Bill:

- 1) Establishes the Peer and Family Support Specialist Certification Program Act of 2015. (WIC Article 1.4, §§ 14045.10 – 14045.20)
- 2) By July 1, 2016, requires the State Department of Health Care Services (DHCS) to establish a certification body and to provide statewide certification for adult peer support specialists, family peer support specialists, and parent peer support specialists (WIC §14045.13)
- 3) Requires DHCS to establish the following for peer and family support specialists (WIC §14045.13):
 - a) The range of responsibilities and practice guidelines;
 - b) Curriculum and core competencies, including areas of specialization;
 - c) Training requirements allowing for multiple qualified training entities, and that requires training to include individuals with practical experience as peer support service consumers;
 - d) Continuing education requirements;

- e) Clinical supervision requirements;
 - f) A code of ethics and a process for revocation of certification;
 - g) A process for certification renewal; and
 - h) A process to allow those currently employed in the peer support field to obtain certification.
- 4) Requires DHCS to collaborate with the Office of Statewide Health Planning and Development (OSHPD), the County Behavioral Health Director’s Association of California, the California Mental Health Planning Council, health plans participating in the Medi-Cal program, and other interested parties, when developing, implementing, and administering the peer and family support specialist certification program. (WIC §14045.14)
 - 5) Requires DHCS to amend its Medicaid state plan to include a peer and family support specialist as a provider type, and to include peer support specialists as a distinct service type. (WIC §14045.16)
 - 6) Allows DHCS to use Mental Health Services Act Funds, as well as funds from certain other specified programs, to develop and administer the peer and family support specialist certification program. (WIC §14045.18)
 - 7) Allows DHCS to implement this law via plan letters, bulletins, or similar instructions, without regulations, until regulations are adopted. Regulations must be adopted by July 1, 2018.

Comments:

- 1) **Background.** The author’s office defines a peer provider as someone who “uses his or her lived experience with mental illness and recovery, plus skills learned in formal training, to deliver services in a behavioral health setting to promote mind-body recovery and resiliency.” (SB 614 fact sheet, March 2015) The author’s office notes that peers can be persons with experience as clients, family members, or caretakers.

The author cites benefits of peer certification including establishing a standard of practice and code of ethics, providing peer support employees with a professional voice, and qualifying peer services for federal financial participation.

- 2) **Intent of This Bill.** According to the author’s office, the goal of this bill is twofold:
 - Require DHCS to establish a peer support specialist certification program; and
 - Authorize DHCS to add peer support providers as a provider type within the Medi-Cal program.

- 3) Peer Certification in Other States.** In 2013, 31 states and the federal Department of Veteran’s Affairs certified and employed peer specialists. The services peer specialists provide in these states are Medicaid billable.¹

In 2007, the federal Centers for Medicare and Medicaid released guidance for states to establish a certification program for peers to enable the use of federal Medicaid.

California has not established a peer certification program at this time. There is a stakeholder group, the “Working Well Together Statewide Technical Assistance Center” which in 2013 released a report of recommendations about certification. The Executive Summary of this report is in **Attachment B**.

4) Examples of Requirements in Other States.

Several other states recognize certified peer counselors.

Washington

The state of Washington allows peer counselors to work in various settings, such as community clinics, hospitals, and crisis teams. Peer counselors must be supervised by a mental health professional. Examples of things they may do include assisting an individual in identifying services that promote recovery, share their own recovery stories, advocacy, and modeling skills in recovery and self-management.

In order to become a peer counselor in Washington, a person must be accepted as a training applicant. They must complete a 40 hour training program and pass a state exam.

Tennessee

According to the State of Tennessee’s Department of Mental Health and Substance Abuse Services, Certified Peer Recovery Specialists must complete an extensive application. If accepted, they complete an intensive 40 hour training program. They must be supervised by a mental health professional or a substance use disorder professional.

New Mexico

The State of New Mexico offers peer support worker certification. Applicants must demonstrate 2 years of sustained recovery, complete a written application and phone interview, complete a 40 hour training program, and pass an examination.

- 5) Lack of a Clear Definition.** This bill specifically identifies several uses for peer and family support specialists, including providing increased family support, providing as part of a wraparound continuum of services, and collaborating with others providing care or support. However, it does not provide an exact definition of a peer and family support specialist. It also does not define a scope of practice. These tasks appear to be delegated to DHCS.

¹ “Peer Certification: What are we Waiting For?,” by the California Mental Health Planning Council, February 2015

- 6) Fingerprinting and Examination Not Required for Certification.** This bill does not specify fingerprinting or passage of an examination as requirements to obtain certification as a peer and family support specialist.
- 7) Requirements Not Established in Legislation.** This bill requires DHCS to establish the requirements of the peer certification program, including curriculum, continuing education, training, supervision, and renewal, via regulation. Assuming this bill was to pass, it would become effective January 1, 2016, and the certification program must be established by July 1, 2016. Regulations must be established by July 1, 2018. However, the bill leaves discretion to DHCS to implement the program via various instructions, until regulations are adopted.
- 8) Recommended Position.** At its April 23, 2014 meeting, the Policy and Advocacy Committee recommended that the Board take an “oppose unless amended” position on this bill. The amendments that the Committee suggested are as follows:
- a) Include in statute a clear definition of peer counseling;
 - b) Include in statute of a defined scope of practice for peer counseling;
 - c) Specify required hours of supervision for a peer counselor, and who may provide this supervision;
 - d) Specify education requirements;
 - e) Addition of a fingerprinting requirement;

9) Support and Opposition.

Support:

- County Behavioral Health Directors Association of California (sponsor)
- Association of California Health Care Districts
- California Association of Mental Health Peer-Run Organizations
- California Association of Social Rehabilitation Agencies
- California Council of Community Mental Health Agencies
- California State Association of Counties
- Disability Rights California
- National Alliance on Mental Illness California
- Pacific Clinics
- Peers Envisioning and Engaging in Recovery Services (PEERS)
- Sacramento County Board of Supervisors
- SEIU California
- Steinberg Institute
- Western Center on Law and Poverty

Oppose:

- None received.

10)History.

2015

04/27/15 April 27 hearing: Placed on APPR. suspense file.

04/17/15 Set for hearing April 27.

04/16/15 From committee: Do pass and re-refer to Com. on APPR. (Ayes 9. Noes 0. Page 651.) (April 15). Re-referred to Com. on APPR.

04/06/15 From committee with author's amendments. Read second time and amended. Re-referred to Com. on HEALTH.

03/20/15 Set for hearing April 15.

03/12/15 Referred to Com. on HEALTH.

03/02/15 Read first time.

03/02/15 From printer. May be acted upon on or after April 1.

02/27/15 Introduced. To Com. on RLS. for assignment. To print.

11) Attachments.

Attachment A: *"Peer Certification: What are we Waiting For?"* by the California Mental Health Planning Council, February 2015

Attachment B: Executive Summary from *"Final Report: Recommendations from the Statewide Summit on Certification of Peer Providers,"* Working Well Together, 2013

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AMENDED IN SENATE APRIL 6, 2015

SENATE BILL

No. 614

Introduced by Senator Leno

February 27, 2015

An act to add Article 1.4 (commencing with Section 14045.10) to Chapter 7 of Part 3 of Division 9 of, the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

SB 614, as amended, Leno. Medi-Cal: mental health services: peer and family support specialist certification

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income persons receive health care benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid provisions. Existing law provides for a schedule of benefits under the Medi-Cal program and provides for various services, including various behavioral and mental health services.

Existing law, the Mental Health Services Act (*MHSA*), an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, establishes the continuously appropriated Mental Health Services Fund to fund various county mental health programs. The act also requires funds to be reserved for the costs for the State Department of Health Care Services, the California Mental Health Planning Council, the Office of Statewide Health Planning and Development (OSHPD), the Mental Health Services Oversight and Accountability Commission, the State Department of Public Health, and any other state agency to implement all duties pursuant to certain programs provided for by the act, subject to appropriation in the annual

Budget Act. The act provides that it may be amended by the Legislature by a $\frac{2}{3}$ vote of each house as long as the amendment is consistent with and furthers the intent of the act, and that the Legislature may also clarify procedures and terms of ~~he~~ *the* act by majority vote.

This bill would require the State Department of Health Care Services to establish, by July 1, 2016, a statewide peer and family support specialist certification program, as a part of the state's comprehensive mental health delivery system *and the Medi-Cal program*. The bill would include 3 certification categories: adult peer support specialists, family peer support specialists, and parent peer support specialists. The certification program's components would include, among others, defining responsibilities and practice guidelines, determining curriculum and core competencies, specifying training and continuing education requirements, and establishing a code of ethics and certification revocation processes.

This bill would require the department to collaborate with OSHPD and interested stakeholders in developing the certification program, and to obtain technical assistance pursuant to a specified joint state-county decisionmaking process. The bill would authorize the department to use funding provided through the MHSA and designated funds administered by OSHPD, to develop and administer the program.

This bill would require the department to amend the Medicaid state plan to include a certified peer and family support specialist as a provider type for purposes of the Medi-Cal program, but would implement this provision only if and to the extent that federal financial participation is available and the department obtains all necessary federal approvals. *The bill would authorize the department to enter into exclusive or nonexclusive contracts on a bid or nonbid basis, as specified, on a statewide or more limited geographic basis. This bill also would authorize the department to implement, interpret, or make specific its provisions by various informational documents until regulations are adopted.*

This bill would declare that it clarifies terms and procedures under the Mental Health Services Act.

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. Article 1.4 (commencing with Section 14045.10)
2 is added to Chapter 7 of Part 3 of Division 9 of the Welfare and
3 Institutions Code, to read:

4
5 Article 1.4. Peer and Family Support Specialist Certificatio

6
7 14045.10. This article shall be known, and may be cited, as
8 the Peer and Family Support Specialist Certification Program Act
9 of 2015.

10 14045.11. The Legislature finds and declares all of the
11 following:

12 (a) With the enactment of the Mental Health Services Act in
13 2004, support to include peer providers identified as consumers,
14 parents, and family members for the provision of services has been
15 on the rise.

16 (b) There are over 6,000 peer support specialists in California
17 who provide individualized support, coaching, facilitation, and
18 education to clients with mental health care needs, in a variety of
19 settings, yet no statewide scope of practice, standardized
20 curriculum, training standards, supervision standards, or
21 certification protocol is available.

22 (c) The United States Department of Veterans Affairs and over
23 30 states utilize standardized curricula and certification protocols
24 for peer provider services.

25 (d) The federal Centers for Medicare and Medicaid Services
26 (CMS) recognizes peer support services as an evidence-based
27 mental health model of care and notes it is an important component
28 in a state's delivery of effective treatment. The CMS encourages
29 states to offer peer support services as a component of a
30 comprehensive mental health delivery system and federal financia
31 participation is available for this purpose.

32 (e) A substantial number of research studies demonstrate that
33 peer providers improve client functioning, increase client
34 satisfaction, reduce family burden, alleviate depression and other
35 symptoms, reduce hospitalizations and hospital days, increase
36 client activation, and enhance client self-advocacy.

37 (f) Certification at the state level can incentivize the public
38 mental health system *and the Medi-Cal program*, to increase the

1 number, diversity, and availability of peer providers and
2 peer-driven services.

3 14045.12. It is the intent of the Legislature that the peer and
4 family support specialist certification program, established under
5 this article, achieve all of the following:

6 (a) Establish the ongoing provision of peer support services for
7 beneficiaries with mental health care needs by certified peer support
8 specialists, including adults 18 years of age or older.

9 (b) Provide increased family support, building on the strengths
10 of families and helping them achieve desired outcomes.

11 (c) Provide a part of a wraparound continuum of services, in
12 conjunction with other community mental health services.

13 (d) Collaborate with others providing care or support to the
14 beneficiary or family.

15 (e) Assist parents, when applicable, in developing coping
16 mechanisms and problem-solving skills.

17 (f) Provide an individualized focus on the beneficiary, the
18 family, or both, as needed.

19 (g) Promote socialization, recovery, self-sufficiency,
20 self-advocacy, development of natural supports, and maintenance
21 of skills learned in other support services.

22 14045.13. No later than July 1, 2016, the department shall
23 establish a certified peer and family support specialist program,
24 which program that, at a minimum, shall do all of the following:

25 (a) Establish a certifying body to provide for the certification
26 of peer and family support specialists.

27 (a)
28 (b) Provide for a statewide certification for each of the following
29 categories: categories of peer support specialist providers, as
30 contained in federal guidance issued by the Centers for Medicare
31 and Medicaid Services, State Medical Director Letter (SMDL)
32 #07-011:

33 (1) Adult peer support specialists, 18 years of age or older.

34 (2) Family peer support specialists.

35 (3) Parent peer support specialists.

36 (b)

37 (c) Define the range of responsibilities and practice guidelines
38 for peer support specialists.

39 (e)

1 (d) Determine curriculum and core competencies, including
2 areas of specialization, such as veterans, family support, and
3 forensics.

4 ~~(d)~~

5 (e) ~~Specify required training and continuing education~~
6 ~~requirements for certification~~ *training requirements, allowing for*
7 *multiple qualified training entities, and requiring training to*
8 *include individuals with practical experience as consumers of peer*
9 *support services, or their family members.*

10 (f) *Specify required continuing education requirements for*
11 *certification*

12 ~~(e)~~

13 (g) Determine clinical supervision requirements for personnel
14 certified under this section

15 ~~(f)~~

16 (h) Establish a code of ethics and processes for revocation of
17 certification

18 ~~(g)~~

19 (i) Determine the process for certification renewal.

20 (j) *Determine a process for allowing existing personnel*
21 *employed in the peer support field to obtain certification under*
22 *this article, at their option.*

23 14045.14. The department shall closely collaborate with the
24 Office of Statewide Health Planning and Development (OSHPD)
25 and its associated workforce collaborative, and regularly consult
26 with interested stakeholders, including peer support and family
27 organizations, mental health providers and organizations, the
28 County Behavioral Health Directors ~~Association~~, *Association of*
29 *California, health plans participating in the Medi-Cal managed*
30 *care program*, the California Mental Health Planning Council, and
31 other interested parties, as deemed appropriate by the department,
32 in developing, implementing, and administering the peer and family
33 support specialist certification program

34 14045.15. The department may contract to obtain technical
35 assistance for the development of the peer and family support
36 specialist certification program, as provided in Section 4061.

37 14045.16. (a) The department shall amend its Medicaid state
38 plan to ~~include a peer and family support specialist pursuant to~~
39 ~~this article as a provider type for purposes of this chapter.~~ *do both*
40 *of the following:*

1 (1) *Include a peer and family support specialist certifie*
2 *pursuant to this article as a provider type for purposes of this*
3 *chapter.*

4 (2) *Include peer support specialist services as a distinct service*
5 *type for purposes of this chapter.*

6 (b) The department may seek any federal waivers or other state
7 plan amendments as necessary to implement the certificatio
8 program provided for under this article.

9 (c) This article shall be implemented only if and to the extent
10 that federal financial participation under Title XIX of the federal
11 Social Security Act (42 U.S.C. Sec. 1396 et seq.) is available and
12 all necessary federal approvals have been obtained.

13 14045.17. It is not the intent of the Legislature in enacting this
14 article to modify the Medicaid state plan in any manner that would
15 otherwise change or nullify the requirements, billing, or
16 reimbursement of the “other qualified provider” provider type, as
17 currently authorized by the Medicaid state plan.

18 14045.18. The department may utilize Mental Health Services
19 Act funds, as authorized in subdivision (d) of Section 5892, and
20 any designated Workforce Education and Training Program
21 resources, including funding, as administered by OSHPD pursuant
22 to Section 5820, to develop and administer the peer and family
23 support specialist certification program

24 14045.19. *For the purposes of implementing this article, the*
25 *department may enter into exclusive or nonexclusive contracts on*
26 *a bid or negotiated basis, including contracts for the purpose of*
27 *obtaining subject matter expertise or other technical assistance.*
28 *Contracts may be statewide or on a more limited geographic basis.*

29 14045.20. *Notwithstanding Chapter 3.5 (commencing with*
30 *Section 11340) of Part 1 of Division 3 of Title 2 of the Government*
31 *Code, the department may implement, interpret, or make specifi*
32 *this article by means of plan letters, plan or provider bulletins, or*
33 *similar instructions, without taking regulatory action, until the*
34 *time regulations are adopted. The department shall adopt*
35 *regulations by July 1, 2018, in accordance with the requirements*
36 *of Chapter 3.5 (commencing with Section 11340) of Part 1 of*
37 *Division 3 of Title 2 of the Government Code. Notwithstanding*
38 *Section 10231.5 of the Government Code, beginning six months*
39 *after the effective date of this article, the department shall provide*
40 *semiannual status reports to the Legislature, in compliance with*

1 *Section 9795 of the Government Code, until regulations have been*
2 *adopted.*

3 SEC. 2. The Legislature finds and declares that this act clarifie
4 procedures and terms of the Mental Health Services Act within
5 the meaning of Section 18 of the Mental Health Services Act.

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PEER CERTIFICATION:

CHAIRPERSON
Cindy Clafin

EXECUTIVE OFFICER
Jane Adcock

WHAT ARE WE WAITING FOR?

- **Advocacy**
- **Evaluation**
- **Inclusion**

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*Examining the Opportunities, Barriers, and Precedents for the Official
Recognition and Certification of Peer Specialists in California.*

February 2015

¹ “When you talk to people who have been through these programs and ask them what helped them, it is not the drugs, not the diagnosis. It’s the lasting, one-on-one relationships with adults who listen....”

¹ <http://www.npr.org/blogs/health/2014/10/20/356640026/halting-schizophrenia-before-it-starts>

Leading the Way, yet Lagging Behind:

California is accustomed to being at the forefront of progressive, compassionate policy and legislation. Voters passed the Mental Health Services Act because they couldn't stand to see the misery of unaddressed mental illness and the state was an early adopter of parity laws and Medicaid expansion. As a state, we have been proud of our leadership. So, where has California lagged behind? California has yet to follow the example of 31 other states and the Veterans Administration in establishing and utilizing a standardized curriculum and certification protocol for Peer Specialists' services.

Peers are persons with lived experience as consumers and family members or caretakers of individuals living with mental illness. Their experiences make Peer Specialists invaluable members of a service team. Employment and certification simultaneously bridges the gap between those that need it and those that can best provide it while reinforcing the peer provider's own wellness and sense of purpose.

Right now, more than half of the United States has a Peer Certification Program in place – people practicing, producing, and billing. Making a difference in the lives of people they intimately understand because they have already staved off the same potential devastation. Because if you ask somebody struggling with a life-altering, all-consuming episode of any type of mental distress if they have sought help yet, the response - more often than not - would be *“they don't understand”* or *“I just can't deal with the process of getting that help”*. California has not been able to summon up the political will it would take to make the most basic and meaningful connection with somebody who needs it the most.

“A leader is not someone who stands before you, but someone who stands with you”²

What are Peer Specialists?

Peer Specialists are empathetic guides and coaches who understand and model the process of recovery and healing while offering moral support and encouragement to people who need it. Moral support and encouragement have proven to result in greater compliance with treatment/services, better health function, lower usage of emergency departments, fewer medications and prescriptions, and a higher sense of purpose and connectedness on the part of the consumer.

Peer Specialists also model and train on communication between health care provider and consumer in order to educate both on potential barriers or side effects of existing medications or treatment plans. In a world where primary care intersects with mental health care, but

² Native American Proverb

medical records are not necessarily shared, this alone is huge. Bridging that gap becomes one of the single highest predictors of effective treatment plans and positive outcomes. In a population with mortality rates that average 25 years sooner than non-SMI groups - for conditions that could be easily managed or cured - this one benefit alone is worth the investment.

It might be easier to describe Peer specialists by defining what they are NOT. Peer Specialists differ from Case Managers in that they do not identify resources, arrange for social or supportive services, or facilitate job trainings, educational opportunities, or living arrangements. They are not certified to offer medical advice or diagnoses, psychiatric or otherwise, or suggest, prescribe, or manage medications. Their function is not to “do for” but rather to “do with” and ultimately model and train wellness principles and self-sufficiency.

What is Peer Specialist Certification?

Peer Specialist Certification is an official recognition by a certifying body that the practitioner has met qualifications that include lived experience and training from a standardized curriculum on mental health issues. The standardized curriculum has been approved by the certifying body and includes a mandatory number of hours of training in various topics pertaining to mental health care, coaching, and ethics. The “specialist” designation is conferred when additional hours of training specific to special populations or age groups has been completed and the candidate has demonstrated thorough knowledge, skills, and ability within that subgroup.

The standardized curriculum includes topics such as documentation, boundaries and ethics, communication skills, working with specific populations, developing wellness plans, systems of care, principles of practices (i.e., engagement, strength-based planning, WRAP plans, case management); and advocacy, to name a few. At this time, there are several courses available through the community college system, but not on a statewide basis. Working Well Together has compiled an excellent comprehensive report - *Certification of Consumer, Youth, Family, and Parent Providers; A Review of the Research* – which provides detailed information, background, and context.³

Why Certification?

*“Regardless of the means selected to demonstrate competency, it is critical that the core competencies of a peer (knowledge, skills, job tasks, and performance domains of the profession) are identified according to a recognized process, such as a job task analysis or role delineation study. **This is because –all other program requirements, policies, and standards must tie back to the core competencies of the profession being credentialed.**”⁴*

³ http://www.inspiredatwork.net/uploads/WWT_Peer_Certification_Research_Report_FINAL_6.20.12__1_.pdf

⁴ Hendry, P., Hill, T., Rosenthal, H. Peer Services Toolkit: A Guide to Advancing and Implementing Peer-run Behavioral Health Services. ACMHA: The College for Behavioral Health Leadership and Optum, 2014

Defining and standardizing the classification of Peer Specialist through certification prevents engagement outside one's expertise. Like any other profession, the certification defines the level of care and services so that the parameters established by the standardized curriculum and certification requirements are respected and understood statewide. Any hiring organization can expect these levels of qualifications, training, and expertise in the person they hire and can plan their organizational functions around the duties encompassed by that expertise. It also provides guidance to the peer practitioner through an established code of ethics. This means that roles and functions of other providers will not be usurped or second-guessed by the Peer Specialists.

The role of the certified peer specialist is to encourage partners and lead through example on the best ways to advocate for oneself. Sometimes it is not enough to suggest resources and make recommendations for services – sometimes you have to walk the walk along with the person for the first few steps, or even the first few miles. In this respect, the Peer Specialist is the Sherpa of the mental health care world. As partners, they teach participants how to communicate with care providers, navigate insurance companies and bureaucracies, and lessen the anxieties that arise from these various interactions. As models, they demonstrate that recovery *is* possible.

The Time is Now

First and foremost, the time is now because Affordable Health Care, Mental Health Parity, Coordinated Care Initiative, and potentially even the Public Safety Realignment create workforce shortages, particularly in the area of rehabilitative services. The time is now because recognizing the value of Peer Specialists does not translate into standardized training, skill sets, duties, or pay scales. This will make it difficult to operationalize and maintain utilization on a scale sufficient to meet the workforce needs or government standards and requirements for reimbursement. In other words “failing to plan is planning to fail”.

The Center for Medicaid Services gave California permission to amend its State Plan to include Peer Providers in 2007, stating “*We encourage States to consider comprehensive programs but note that regardless of how a State models its mental health and substance use disorder service delivery system, the State Medicaid agency continues to have the authority to determine the service delivery system, medical necessity criteria, and to define the amount, duration, and scope of the service*”⁵.

The time is now because the state is starting to fully understand the concept and value of peer services as part of both mental health care and the larger arena of primary care. Examples of this are their inclusion in the SB 82 (Steinberg) Investment in Mental Health and Wellness Act

⁵ Center for Medicare and Medicaid Services; SMDL #07-011; August 15, 2007

grant requirements for mobile crisis teams; the intent in the original Prop 63 language to include peers, family members, and parent providers as part of the MHSA workforce; and a one-time dedicated state budget allocation of training funds to the Office of Statewide Health Planning and Development for peers to be trained as mobile crisis team members. All of these components will be working together as part of the larger mental health network of care, but run the risk of operating at disparate training levels, scope of work, code of ethics, and pay levels from county to county.

Finally, the time is now because trying to standardize the classification after a piecemeal acceptance is put into place is inefficient and uninformative to potential employers. Moreover, it is unfair to people who are willing to share their expertise and demonstrate their commitment to this important and effective aspect of care and services.

To draw a timely comparison, the classification of drug and alcohol counselors, which often has a strong peer component as part of the qualifications for employment, received an early welcome into the workforce. However, this acceptance was unaccompanied by any defined training, experience, or education requirements. There has been an attempt to retroactively achieve some standardization across the lines, but proponents are finding that, due to the unstructured engagement of their services, there is no uniform requirement or skill level across treatment sites. Worse, there is a reluctance to champion a certification process, due to potential hardships and setbacks created for current successful peer employees who might not meet certification standards after the fact.

Is it Cost-Effective?

In Alameda County, a Peer Mentoring pilot project provided 40 hours of training to 26 peers called “The Art of Facilitating Self-Determination” and matched them with people recently released from psychiatric hospitals. Those accepting a peer mentor experienced a 72% reduction in readmissions to the hospital. The cost savings for Alameda County was over a million dollars with an initial investment of \$238K- making a 470% return on investment⁶.

The Pew Trusts reported recently “In Georgia, a 2003 study compared patients diagnosed with schizophrenia, bipolar disorder and major depression whose treatment had included peer support, with patients who received traditional day treatment services without peers. The patients who had peer support had better health outcomes—and at a lower cost. The average annual cost of day treatment services is \$6,400 per person, while support services cost about \$1,000.”⁷

⁶ <http://www.oshpd.ca.gov/HWDD/pdfs/wet/PowerPoint-Peer-Support-Specialist-A-Galvez-S-Kuehn.pdf>

⁷ <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2013/09/11/peers-seen-easing-mental-health-worker-shortage>; last accessed 11/5/2014

Who Employs Peer Specialists?

Between October 2013 and January 2015, the Advocacy Committee of the California Mental Health Planning Council (CMHPC) heard presentations from Peer Specialist Advocates and Peer-run programs throughout the state. The programs represented different models ranging from peer-run respite to peer partners in health care, but all of them reported positive outcomes for the participants, cost savings for their respective counties, and a bolstering of their own wellness commitment. Here is a brief review of a few of the models the Advocacy Committee heard from.

Health Navigators USC

The Peer Health navigator connects consumers to mental health, primary care, substance use, and specialty health care services; teaches them how to advocate for themselves and effectively communicate their needs; create a follow-up plan and other self-management skills through a “modeling, coaching, fading”. They differ from Case Managers or care coordinators in that the health navigator will ultimately step away from the participant once the modeling/coaching/fading process is successful.

Typically a full-time navigator will have 12 – 15 clients at any one time, and averages 30-40 clients annually, depending on how quickly the clients moves into full self-management. Many of the services are Medicaid billable under Targeted Case Management or Rehabilitation providing the documentation reflects justification for the services rendered. Participants are trained on billing codes and documentation. The program has developed its own curriculum and provides its own training and certification.

2nd Story, Santa Cruz

2nd Story is a SAMHSA-funded program that is an entirely Peer-Run Crisis Center in Santa Cruz. All staff are trained in “Intentional Peer Support” and all wellness class topics are determined by the guests. The program provides its own training. The length of stay is no longer than two weeks, and guests are encouraged to maintain their “normal” life (school, work) during their stay. Outreach is conducted by staff posted at County mental health departments telling potential guests about the program. Referrals are also made by psychiatrists, care managers, and Telecare, a county mental health services provider/contractor, sometimes diverts people to 2nd Story rather than enrolling them in a longer term, more structured social rehabilitation facility. The program is proving to be a key preventative service in Santa Cruz that forestalls or reduces the need for crisis residential and sub-acute stabilization programs.

In-Home Outreach Team (IHOT), San Diego

As Assisted Outpatient Treatment steadily gains ground in more California counties, a small program in San Diego is providing an effective and legitimate alternative at promoting and facilitating voluntary access to services. IHOT teams consist of a Peer Specialist, family member, personal service coordinator and team lead. They provide in-home outreach to adults with serious mental illness (SMI) who are reluctant or resistant to receiving mental health services. IHOT also provides support and education to family members and/or caretakers of IHOT participants. They work with individuals living with severe mental illness and who may also be dually diagnosed with a substance use disorder or drug dependency. Teams serve a combined 240-300 consumers per year (80-100 per team).

A 2013 San Diego Health and Human Services report notes that the average cost per IHOT participant amounts to \$8,100, compared to an annual cost per individual in a Full Service Partnership (\$20,000 including housing) and Assisted Outpatient Treatment (\$34,000). Staff ratios are similarly proportionate: IHOT = 1:25 staff to client ratio; FSP and AOT each have a 1:10 staff to client ratio.

What Other States Employ and Certify Peer Specialists?

As of 2013, Certified Peer Specialists were certified and employed in 31 states and the federal Department of Veteran's Affairs. The extent of engagement and responsibility varies from state to state, but all services are Medicaid billable. These 31 states are consistent in their belief and trust in Peer Specialists – when will California join them?

What is Stopping California?

Despite all of the merits, fiscal and clinical, of Certified Peer Specialists, California has not been able to match its actions to its talk in this area. California embraces the concept of recovery, wellness, and resilience – and recognizes the essential components of both employment and inclusion as part of those processes – but it has failed to turn those concepts to tangible actions.

No State Department feels that it is in their purview to establish, implement or oversee a state certification process. Education may approve a curriculum, but it is not empowered to grant certification. Department of Health Care Services may be able to approve billable services, but is not empowered to establish curriculum or gage mastery of the subject matter. The Office of Statewide Health Planning and Development (OSHPD) has a Workforce Development Division, and is specifically charged with mental health workforce development issues, but without specific language or policy permitting OSHPD to include or pursue the specific classification of Peer Specialist, OSHPD does not felt comfortable facilitating it. In short, the single, largest barrier has been the identification of a lead agency or organization that can be charged with facilitation, implementation, and identification of a certification and oversight

body. There may be philosophical or conceptual agreement on the importance of Peer Specialists, but no policy or political direction to move it forward.

How Can California Catch Up?

Peer Specialist Certification is a cross-cutting, inclusive, and cost-saving classification that has applications across all vulnerable and at-risk populations in the state – veterans, homeless, Transition Age Youth, elderly, and criminal justice populations to name a few - and has particular utility in integrated services for the dually diagnosed and co-morbid conditions in health care.

The California Mental Health Planning Council (CMHPC) recommends that the Legislature continue and solidify its mission to create a seamless, comprehensive, continuum of mental health services and care by:

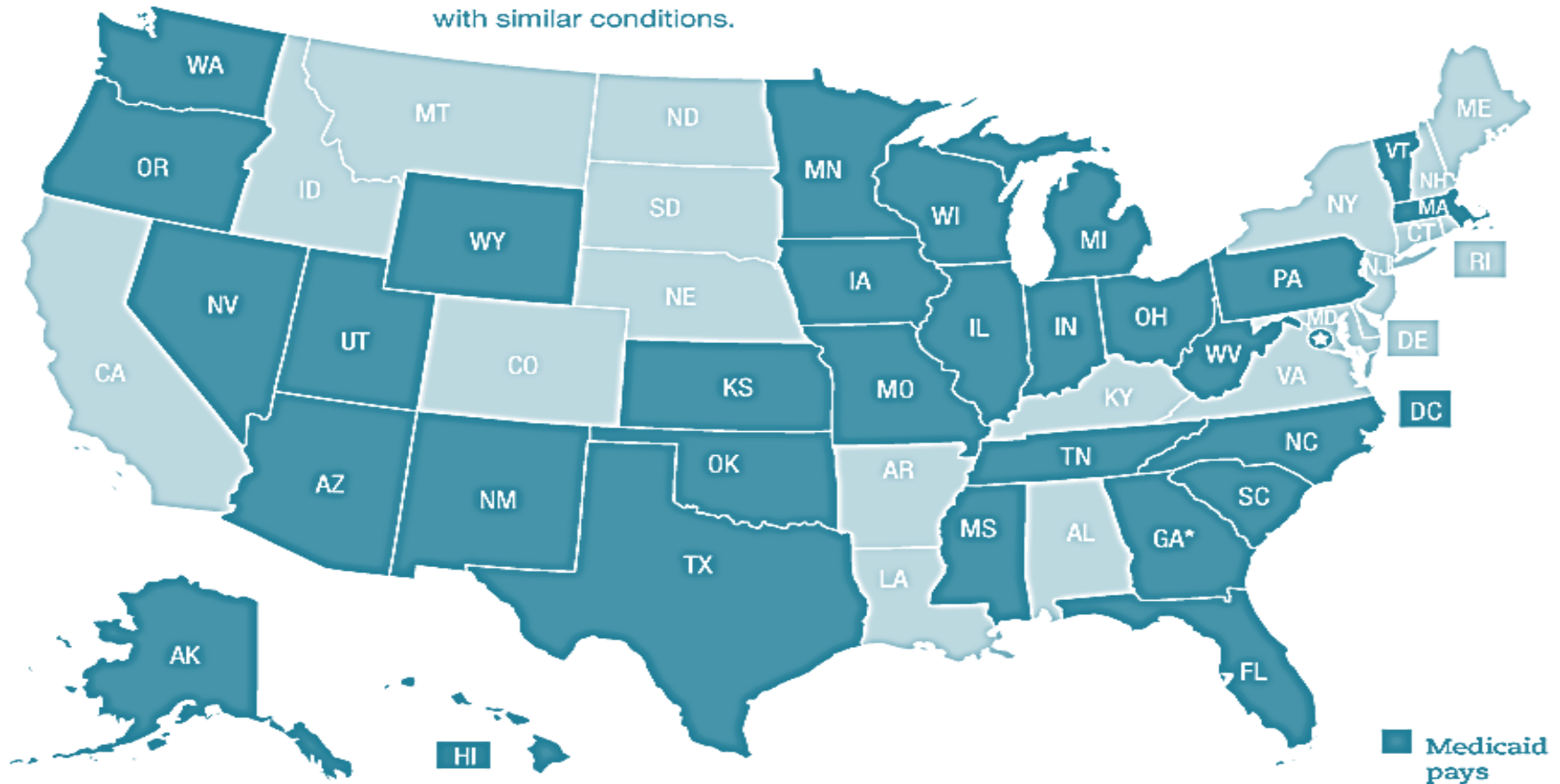
- developing clarifying legislative language that MHSAs and/or other funding may be used to establish an implementation and oversight body for statewide Peer Specialist Certification; and/or
- making Peer Certification a priority of the 2015-16 Legislative Session as a stand-alone issue ; and/or
- requiring the Certification of Peer Specialists in legislation pertaining to workforce expansion or expanded services for vulnerable populations: and/or
- identifying and including funding for the establishment of a Peer Specialist certifying and oversight body through the annual Budget Act.

The CMHPC has been following and supporting the efforts of Inspired at Work, California Association of Mental Health Peer Run Organizations (CAMHPRO), United Advocates for Children and Families (UACF), National Alliance on Mental Illness (NAMI) and the former Working Well Together Group to bring this issue to the forefront of mental health policy. These groups dedicated countless hours to investigating best practices, training models, potential curriculums, and workforce applications for Certified Peer Specialists and have generously shared their time and information to bring the CMHPC and others up to speed. Their work deserves attention and close consideration by anybody that might be in a position to support the implementation process. For detailed information on the background, issues, application, and potential processes, please visit: <http://workingwelltogether.org/resources/recruiting-hiring-and-workforce-retention/wwt-toolkit-employing-individuals-lived> or <http://www.inspiredatwork.net/Resources.html>,

Mental Health Peer Specialists

States where Medicaid pays for them

In 31 states, Medicaid pays for licensed peer specialists, counselors recovering from severe mental illness or substance addiction who are trained to help others with similar conditions.



Source: OptumHealth and Appalachian Consulting Group
 NOTE: In Georgia, Medicaid pays peer specialists to provide "whole health" counseling.

Stateline infographic by Adam Rotmil and Christine Vestal
 September 11, 2013

2013

Final Report: Recommendations from the Statewide Summit on Certification of Peer Providers



Working Well Together
Training and Technical Assistance Center



Report prepared for CAMHRO-PEERS
under Working Well Together
by Inspired at Work
Lucinda Dei Rossi, MPA, CPRP and
Debra Brasher, MS, CPRP

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We'd like to specially recognize Karin Lettau for her diligence, hard work and grace in ensuring that all stakeholders felt heard and understood throughout the process.

DISCLAIMER

The views expressed in this publication do not necessarily reflect the views of the Office of Statewide Health Planning and Development.

Executive Summary

Working Well Together is the only statewide organization dedicated to transforming systems to be client and family-driven by supporting the sustained development of client, family member and parent/caregiver employment within every level of the public mental health workforce. As part of this effort Working Well Together has, for the last three years, engaged in researching and evaluating the feasibility of inclusion of Peer Support into a State Plan Amendment for Specialty Mental Health services. This three year effort has included thorough state-wide and national research and extensive stakeholder involvement and has yielded seventeen recommendations for the development of Peer Support as an integral service within the public mental health system.

The statewide survey conducted to evaluate the current practice of hiring consumers and family members into the mental health workforce revealed that most counties have indeed hired people with lived experience of a mental health challenge or parents/family members of individuals with a mental health issue into the mental health workforce. However the survey also revealed that there remain significant workforce issues that must be addressed. Of the thirty responding counties that hire people with lived experience, none required previous training or education beyond a high school diploma as a qualification for hire. This was found to be true even in counties that have developed excellent training programs for Peer Support. Additional findings revealed that a variety of generalist job titles are used to hire Peer Support Specialists, job duties and descriptions vary widely and may or may not include peer support as a job duty.

The stakeholder process exposed a number of workforce issues that must be addressed to further the professional development of Peer Support as a discipline and Peer Support Specialists as practitioners. Perhaps the most pressing issue is the lack of a definition and/or understanding of Peer Support. While most counties have hired individuals with lived experience as well as parents and family members to provide services, many of these practitioners are providing services that are traditionally considered “case management” and include collateral, targeted case management and rehabilitation services. Another identified trend was the use of peer employees as clerical support, transportation providers and social or recreational activities support. Interestingly, while many of these practitioners are providing billable services within the scope of practice of “Other Qualified Provider”, very few

counties (approximately nine) are billing Medi-Cal for these services. Going forward it is vital that Peer Support is identified as a separate and distinct service from other services provided under the current definitions of Specialty Mental Health services. Additional workforce issues identified by stakeholders necessary to advance the development for and respect of Peer Support include the;

1. Creation of welcoming environments that embrace these practitioners.
2. Development of multi-disciplinary teams that respect this new discipline.
3. Education and training of County Directors and Administration as well as the existing workforce on the value, role and legitimacy of peer support.
4. Training and acceptance of Medi-Caid approved use of recovery/resilience/wellness language in documentation.

While stakeholders strongly support the inclusion of peer support into a State Plan Amendment, they also support flexibility in what services individuals with lived experience can provide within the mental health system. Stakeholders strongly support career ladders that include non-certified peer providers as well as people with lived experience continuing their education and advancing into existing positions traditionally used in mental health settings, including supervision and management as well as the development of career ladders that include advancement opportunities within the practice of peer support. In short, stakeholders support maximum flexibility in what people with lived experience can provide and bill for within the existing State Plan as well as the inclusion of peer support as a new service category.

Stakeholders also emphasize the importance of recognizing that there are a number of services that enhance wellness and recovery/resiliency that peers may provide but that may not be reimbursed by Medi-Caid. It will be vital, when considering adding peer support as a new service, that reimbursement for peer support services not become the primary driving focus when offering/providing these services to clients and their families.

Working Well Together has engaged stakeholders in on-going teleconferences, webinars, work-groups, and five regional stakeholder meetings to provide feedback and recommendations that will support the requirements as laid out by the CMS letter regarding inclusion of peer support as a part of services provided under Specialty Mental Health. This resulted in several recommendations in support of the development of a statewide

Certification for Peer Support Specialists. In May of 2013 a final Statewide Stakeholder Summit was convened to provide further vetting with the goal of finalizing recommendations for the inclusion of peer support into the State Plan Amendment as well as the development of a statewide Certification for Peer Support Specialists. By and large the vast majority of stakeholders support the original recommendations, however, where appropriate, adjustments have been made in alignment with stakeholder feedback. Also where appropriate, additional edits to specific recommendations have been made to provide clarity. The seventeen recommendations are listed below.

DRAFT

Final Stakeholder Recommendations regarding Certification of Peer Support Specialists

Recommendation 1

Develop a statewide certification for Peer Support Specialists, to include:

- Adult Peer Support Specialists
- Young Adult Peer Support Specialists
- Older Adult Peer Support Specialists
- Family Peer Support Specialists (Adult Services)
- Parent Peer Support Specialists (Child/Family Services)

- 1.1 Require Peer Support Specialists to practice within the adopted Peer Support Specialist Code of Ethics.
 - 1.1.1 Seek final approval of Peer Support Code of Ethics by the Governing Board of Working Well Together.
- 1.2 Develop or adopt standardized content for a state-wide curriculum for training Peer Support Specialists.
- 1.3 Require a total of 80 hours of training for Peer Support Specialist Certification.
 - 1.3.1 55-hour core curriculum of general peer support education that all peer support specialists will receive as part of the required hours towards certification.
 - 1.3.2 25-hours of specialized curriculum specific to each Peer Support Specialist category.
- 1.4 Require an additional 25 hours of training to become certified in a specialty area such as forensics, co-occurring services, whole health and youth in foster care.
- 1.5 Require six months full-time equivalent experience in providing peer support services.
 - 1.5.1 This experience can be acquired through employment, volunteer work or as part of an internship experience.
- 1.6 Require 15 hours of CEU's per year in subject matter relevant to peer support services to maintain certification.
- 1.7 Require re-certification every three years.
- 1.8 Allow a grandfathering-in process in lieu of training.

- 1.8.1 Require one year of full-time equivalent employment in peer support services.
- 1.8.2 Require three letters of recommendation. One letter must be from a supervisor.
The other letters may come from co-workers or people served.
- 1.9 Require an exam to demonstrate competency.
 - 1.9.1 Provide test-taking accommodations as needed.
 - 1.9.2 Provide the exam in multiple languages and assure cultural competency of exam.

Recommendation 2

Identify or create a single certifying body that is peer-operated and/or partner with an existing peer-operated entity with capacity for granting certification.

Recommendation 3

Include Peer Support as a service and Peer Support Specialist as a provider type within a new State Plan Amendment.

- 3.1 Seek adoption of the definitions of Peer Support Specialist providers and Peer Support services by the Governing Board of Working Well Together for use within the State Plan Amendment.
- 3.2 Maintain the ability for people with lived experience to provide services as “other qualified provider” within their scope of practice, including but not limited to rehabilitation services, collateral and targeted case management.
- 3.2 Acknowledge that there are important and non-billable services that Peer Support Specialists can and do provide.

Recommendation 4

Include in the State Plan the ability to grant site certification for peer-operated agencies to provide billable peer support services.

- 4.1 Allow for peer-operated agencies to provide other services billable under “other qualified provider” within their scope of practice, including but not limited to rehabilitation services, collateral and targeted case management.

Recommendation 5

Address the concern that current practice of documentation for billing may not be aligned with the values and principles of peer support and a wellness, recovery and resiliency orientation.

- 5.1 Engage with partners such as Department of Health Care Services and the California Mental Health Director’s Association in order to develop an action plan to advocate for the use of CMS-approved recovery/resiliency-oriented language in documentation.

Recommendation 6

Investigate the options for broadening the definition of “service recipient” to include parents and family members of minors receiving services so that peer support services can be accessed more easily.

Recommendation 7

Convene a working group consisting of Working Well Together, the Mental Health Directors, the Office of Statewide Healthcare Planning and Development (OSHPD) and the Department of Health Care Services to develop buy-in and policies that will create consistency of practice regarding peer support services across the state.

Recommendation 8

Develop standards and oversight for the provider/entity that provides training of Peer Support Specialists.

- 8.1 Allow for multiple qualified training entities.
- 8.2 Training organizations must demonstrate infrastructure capacity that will allow for peer trainers.
- 8.3 Training must be provided by either individuals with lived experience or by a team that includes individuals with lived experience.

Recommendation 9

Establish qualifications for who may supervise Peer Support Specialists.

- 9.1 Engage with the Mental Health Directors to develop a policy that outlines key qualifications necessary for the supervision of Peer Support Specialists.
- 9.2 Preferred supervisors are those individuals with lived experience and expertise in peer support.
- 9.3 Due to capacity issues, supervisors may include qualified people who receive specific training on the role, values and philosophy of peer support.
- 9.4 Recognize and define the specific qualities and skills within supervision that are required for the supervision of Peer Support Specialists. These skills should align with the values and philosophy of peer support.

Recommendation 10

Develop a plan to provide extensive and expansive training on the values, philosophy and efficacy of peer support to mental health administration and staff.

Recommendation 11

Develop a plan to ensure that welcoming environments are created that embrace the use of multi-disciplinary teams that can incorporate Peer Support Specialists fully onto mental health teams.

Recommendation 12

Develop a policy statement that recognizes and defines the unique service components of peer support as separate and distinct from other disciplines and services in order to maintain the integrity of peer support services.

Recommendation 13

Develop a policy statement and plan that supports the professional development of Peer Support Specialists that allows the practitioner to maintain and hone his/her professional values, ethics and principles.

Recommendation 14

Develop a plan for funding the development of certification.

- 14.1 Work with the Office of Statewide Healthcare Planning and Development to utilize

state-wide monies from the MHSA Workforce, Education and Training fund.

14.2 Investigate other potential funding sources.

14.3 Develop recommendations for funding of components of certification such as financial assistance with training, exam and certification fees.

Recommendation 15

Seek representation on committees and workgroups that are addressing civil service barriers to the employment of Peer Support Specialists.

Recommendation 16

Work with Mental Health Directors to seek agreement on a desired workforce minimum of Peer Support Specialists within each county to more fully actualize the intent of the MHSA.

Recommendation 17

Develop state-wide models that can inform county leadership on the development of career ladders for Peer Support Specialists that begin with non-certified Peer Support Specialists and creates pathways into management and leadership positions.

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To: Board Members

Date: May 8, 2015

From: Rosanne Helms
Legislative Analyst

Telephone: (916) 574-7897

Subject: SB 594: Child Custody

Attachment A shows the latest version of SB 594, as amended April 27, 2014.

As currently written, this bill specifies that a child custody evaluation, investigation, or assessment shall only be considered by the court in a child custody case if it was conducted in accordance with the Judicial Council's standards.

At the April 23, 2015 Policy and Advocacy Committee meeting, the Committee considered an earlier version of this bill and recommended an "oppose" position. That version of the bill would have required the Board to investigate a complaint against a mediator, if the mediator held a Board license. Unlike child custody evaluators, for which the Board does investigate complaints, mediators are not required to hold a board license.

However, the most recent version of this bill no longer requires Board investigation of mediators.

Attachments

Attachment A: SB 594

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AMENDED IN SENATE APRIL 27, 2015

AMENDED IN SENATE APRIL 13, 2015

SENATE BILL

No. 594

Introduced by Senator Wieckowski

February 27, 2015

An act to amend Sections 3111, 3118, 3170, and 3183 of, and to add Section 3117.5 to, *Section 3111* of the Family Code, relating to child custody.

LEGISLATIVE COUNSEL'S DIGEST

SB 594, as amended, Wieckowski. Child custody.

Existing law allows a court, in any contested hearing involving child custody or visitation rights, to appoint a child custody evaluator, as specified. Existing law requires the Judicial Council to adopt standards for the child custody evaluation.

This bill would specify that a child custody evaluation, investigation, or assessment, and any report conducted pursuant to that determination, may only be considered by the court if the evaluation, investigation, or assessment is conducted in accordance with the minimum requirements.

Existing law requires the court to require an evaluation, investigation, or assessment in any contested proceeding involving child custody or visitation rights when the court has appointed a child custody evaluator or has referred a case for a full or partial court-connected evaluation, investigation, or assessment, and the court determines that there is a serious allegation of child sexual abuse. Existing law establishes certain minimum requirements for the evaluation, investigation, or assessment. Existing law authorizes a mediator to submit a recommendation to the court as to the custody of, or visitation with, a child. A mediator acting in that capacity is called a child custody recommending counselor.

~~This bill would require the Judicial Council to, not later than January 1, 2016, develop a form that every investigator, evaluator, or child custody recommending counselor conducting an investigation would be required to submit to the court. The bill would require the form to delineate each requirement and require that the person conducting an investigation provide documentation in, or attached to, the form, showing that each task has been completed as required. The bill would provide that on or after January 1, 2016, an investigation that is not documented on the Judicial Council form would not meet the minimum requirements for an investigation as required by the provisions described above. The bill would require, on or after January 1, 2016, that documentation showing compliance with those requirements and the results of the investigation be submitted to the court on the form developed by the Judicial Council.~~

~~Existing law also requires a court, if it appears on the face of a petition, application, or other pleading to modify or obtain a temporary or permanent custody or visitation order that custody, visitation, or both are contested, to set the contested issues for mediation. Existing law provides that domestic violence cases shall be handled in accordance with a separate written protocol approved by the Judicial Council.~~

~~This bill would require the Judicial Council to, not later than January 1, 2016, develop a form to be used to help implement the separate written protocol approved by the Judicial Council.~~

Vote: majority. Appropriation: no. Fiscal committee: *yes-no*.
State-mandated local program: no.

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

1 *SECTION 1. Section 3111 of the Family Code is amended to*
2 *read:*
3 3111. (a) In any contested proceeding involving child custody
4 or visitation rights, the court may appoint a child custody evaluator
5 to conduct a child custody evaluation in cases where the court
6 determines it is in the best interests of the child. The child custody
7 evaluation shall be conducted in accordance with the standards
8 adopted by the Judicial Council pursuant to Section 3117, and all
9 other standards adopted by the Judicial Council regarding child
10 custody evaluations. If directed by the court, the court-appointed
11 child custody evaluator shall file a written confidential report on
12 his or her evaluation. At least 10 days before any hearing regarding

1 custody of the child, the report shall be filed with the clerk of th
2 court in which the custody hearing will be conducted and served
3 on the parties or their attorneys, and any other counsel appointed
4 for the child pursuant to Section 3150. ~~The report may be~~
5 ~~considered by the court.~~ *A child custody evaluation, investigation,*
6 *or assessment, and any report conducted pursuant to that*
7 *determination shall be considered by the court only if the*
8 *evaluation, investigation, or assessment is conducted in accordance*
9 *with the minimum requirements set forth in this section in*
10 *determining custody or visitation rights.*

11 (b) The report shall not be made available other than as provided
12 in subdivision (a) or Section 3025.5, or as described in Section
13 204 of the Welfare and Institutions Code or Section 1514.5 of the
14 Probate Code. Any information obtained from access to a juvenile
15 court case file, as defined in subdivision (e) of Section 827 of the
16 Welfare and Institutions Code, is confidential and shall only be
17 disseminated as provided by paragraph (4) of subdivision (a) of
18 Section 827 of the Welfare and Institutions Code.

19 (c) The report may be received in evidence on stipulation of all
20 interested parties and is competent evidence as to all matters
21 contained in the report.

22 (d) If the court determines that an unwarranted disclosure of a
23 written confidential report has been made, the court may impose
24 a monetary sanction against the disclosing party. The sanction
25 shall be in an amount sufficient to deter repetition of the conduct,
26 and may include reasonable attorney's fees, costs incurred, or both,
27 unless the court finds that the disclosing party acted with substantial
28 justification or that other circumstances make the imposition of
29 the sanction unjust. The court shall not impose a sanction pursuant
30 to this subdivision that imposes an unreasonable financial burden
31 on the party against whom the sanction is imposed. This
32 subdivision shall become operative on January 1, 2010.

33 (e) The Judicial Council shall, by January 1, 2010, do the
34 following:

35 (1) Adopt a form to be served with every child custody
36 evaluation report that informs the report recipient of the
37 confidentiality of the report and the potential consequences for the
38 unwarranted disclosure of the report.

1 (2) Adopt a rule of court to require that, when a court-ordered
2 child custody evaluation report is served on the parties, the form
3 specified in paragraph (1) shall be included with the report

4 (f) For purposes of this section, a disclosure is unwarranted if
5 it is done either recklessly or maliciously, and is not in the best
6 interests of the child.

7 SECTION 1. ~~Section 3111 of the Family Code is amended to~~
8 ~~read:~~

9 ~~3111. (a) In any contested proceeding involving child custody~~
10 ~~or visitation rights, the court may appoint a child custody evaluator~~
11 ~~to conduct a child custody evaluation in cases when the court~~
12 ~~determines it is in the best interests of the child. The child custody~~
13 ~~evaluation shall be conducted in accordance with the standards~~
14 ~~adopted by the Judicial Council pursuant to Section 3117, and all~~
15 ~~other standards adopted by the Judicial Council regarding child~~
16 ~~custody evaluations. If directed by the court, the court-appointed~~
17 ~~child custody evaluator shall file a written confidential report on~~
18 ~~his or her evaluation, which shall be submitted on, or attached to,~~
19 ~~the completed form developed pursuant to Section 3117.5. At least~~
20 ~~10 days before any hearing regarding custody of the child, the~~
21 ~~report shall be filed with the clerk of the court in which the custody~~
22 ~~hearing will be conducted and served on the parties or their~~
23 ~~attorneys, and any other counsel appointed for the child pursuant~~
24 ~~to Section 3150. The report may be considered by the court if, (1)~~
25 ~~it is submitted on, or attached to, the completed Judicial Council~~
26 ~~form, and, (2) it documents compliance with the minimum~~
27 ~~state-mandated standards applicable to the scope of the evaluation.~~

28 ~~(b) The report shall not be made available other than as provided~~
29 ~~in subdivision (a) or Section 3025.5, or as described in Section~~
30 ~~204 of the Welfare and Institutions Code or Section 1514.5 of the~~
31 ~~Probate Code. Any information obtained from access to a juvenile~~
32 ~~court case file, as defined in subdivision (c) of Section 827 of the~~
33 ~~Welfare and Institutions Code, is confidential and shall only be~~
34 ~~disseminated as provided by paragraph (4) of subdivision (a) of~~
35 ~~Section 827 of the Welfare and Institutions Code.~~

36 ~~(c) The report may be received in evidence on stipulation of all~~
37 ~~interested parties and is competent evidence as to all matters~~
38 ~~contained in the report.~~

39 ~~(d) If the court determines that an unwarranted disclosure of a~~
40 ~~written confidential report has been made, the court may impose~~

1 a monetary sanction against the disclosing party. The sanction
2 shall be in an amount sufficient to deter repetition of the conduct,
3 and may include reasonable attorney's fees, costs incurred, or both,
4 unless the court finds that the disclosing party acted with substantial
5 justification or that other circumstances make the imposition of
6 the sanction unjust. The court shall not impose a sanction pursuant
7 to this subdivision that imposes an unreasonable financial burden
8 on the party against whom the sanction is imposed. This
9 subdivision shall become operative on January 1, 2010.

10 (e) The Judicial Council shall, by January 1, 2010, do both of
11 the following:

12 (1) Adopt a form to be served with every child custody
13 evaluation report that informs the report recipient of the
14 confidentiality of the report and the potential consequences for the
15 unwarranted disclosure of the report.

16 (2) Adopt a rule of court to require that, when a court-ordered
17 child custody evaluation report is served on the parties, the form
18 specified in paragraph (1) shall be included with the report.

19 (f) For purposes of this section, a disclosure is unwarranted if
20 it is done either recklessly or maliciously, and is not in the best
21 interests of the child.

22 SEC. 2. Section 3117.5 is added to the Family Code, to read:

23 3117.5. (a) The Judicial Council shall, no later than January
24 1, 2016, develop a form to be used by every investigator or
25 evaluator conducting a child custody evaluation. The form shall
26 delineate each requirement of, and incorporate any standards
27 established by, Sections 3117 and 3118. The form shall also
28 incorporate all other standards adopted under this code regarding
29 child custody evaluations, and require that the investigator or
30 evaluator provide documentation in, or attached to, the form
31 showing that each task has been completed as required. For
32 purposes of this section, a child custody evaluation means an
33 investigation and analysis of the health, safety, welfare, and best
34 interest of a child with regard to disputed custody and visitation
35 issues conducted pursuant to Section 3111, 3118, or 3183 of this
36 code, Section 730 of the Evidence Code, or Article 1 (commencing
37 with Section 2032.010) of Chapter 15 of Title 4 of Part 4 of the
38 Code of Civil Procedure. The child custody evaluation form shall
39 be consistent with Sections 3011, 3020, and 3044.

1 ~~(b) Child custody evaluations filed with the court on and after~~
2 ~~January 1, 2016, shall be submitted on, or attached to, the report~~
3 ~~form developed pursuant to subdivision (a). The evaluation report~~
4 ~~may be considered by the court if, (1) it is submitted on, or attached~~
5 ~~to, the completed Judicial Council form, and, (2) it documents~~
6 ~~compliance with the minimum state-mandated standards applicable~~
7 ~~to the scope of the evaluation.~~

8 SEC. 3.— Section 3118 of the Family Code is amended to read:

9 3118. (a) ~~In any contested proceeding involving child custody~~
10 ~~or visitation rights, where the court has appointed a child custody~~
11 ~~evaluator or has referred a case for a full or partial court-connected~~
12 ~~evaluation, investigation, or assessment, and the court determines~~
13 ~~that there is a serious allegation of child sexual abuse, the court~~
14 ~~shall require an evaluation, investigation, or assessment pursuant~~
15 ~~to this section. When the court has determined that there is a serious~~
16 ~~allegation of child sexual abuse, any child custody evaluation,~~
17 ~~investigation, or assessment conducted subsequent to that~~
18 ~~determination shall be considered by the court only if the~~
19 ~~evaluation, investigation, or assessment is conducted in accordance~~
20 ~~with the minimum requirements set forth in this section in~~
21 ~~determining custody or visitation rights, except as specified in~~
22 ~~paragraph (1). For purposes of this section, a serious allegation of~~
23 ~~child sexual abuse means an allegation of child sexual abuse, as~~
24 ~~defined in Section 11165.1 of the Penal Code, that is based in~~
25 ~~whole or in part on statements made by the child to law~~
26 ~~enforcement, a child welfare services agency investigator, any~~
27 ~~person required by statute to report suspected child abuse, or any~~
28 ~~other court-appointed personnel, or that is supported by substantial~~
29 ~~independent corroboration as provided for in subdivision (b) of~~
30 ~~Section 3011. When an allegation of child abuse arises in any other~~
31 ~~circumstances in any proceeding involving child custody or~~
32 ~~visitation rights, the court may require an evaluator or investigator~~
33 ~~to conduct an evaluation, investigation, or assessment pursuant to~~
34 ~~this section. The order appointing a child custody evaluator or~~
35 ~~investigator pursuant to this section shall provide that the evaluator~~
36 ~~or investigator have access to all juvenile court records pertaining~~
37 ~~to the child who is the subject of the evaluation, investigation, or~~
38 ~~assessment. The order shall also provide that any juvenile court~~
39 ~~records or information gained from those records remain~~
40 ~~confidential and shall only be released as specified in Section 3111.~~

- 1 ~~(1) This section does not apply to any emergency court-ordered~~
2 ~~partial investigation that is conducted for the purpose of assisting~~
3 ~~the court in determining what immediate temporary orders may~~
4 ~~be necessary to protect and meet the immediate needs of a child.~~
5 ~~This section does apply when the emergency is resolved and the~~
6 ~~court is considering permanent child custody or visitation orders.~~
7 ~~(2) This section does not prohibit a court from considering~~
8 ~~evidence relevant to determining the safety and protection needs~~
9 ~~of the child.~~
10 ~~(3) Any evaluation, investigation, or assessment conducted~~
11 ~~pursuant to this section shall be conducted by an evaluator or~~
12 ~~investigator who meets the qualifications set forth in Section~~
13 ~~3110.5.~~
14 ~~(b) The evaluator or investigator shall, at a minimum, do all of~~
15 ~~the following:~~
16 ~~(1) Consult with the agency providing child welfare services~~
17 ~~and law enforcement regarding the allegations of child sexual~~
18 ~~abuse, and obtain recommendations from these professionals~~
19 ~~regarding the child's safety and the child's need for protection.~~
20 ~~(2) Review and summarize the child welfare services agency~~
21 ~~file. No document contained in the child welfare services agency~~
22 ~~file may be photocopied, but a summary of the information in the~~
23 ~~file, including statements made by the children and the parents,~~
24 ~~and the recommendations made or anticipated to be made by the~~
25 ~~child welfare services agency to the juvenile court, may be recorded~~
26 ~~by the evaluator or investigator, except for the identity of the~~
27 ~~reporting party. The evaluator's or investigator's notes~~
28 ~~summarizing the child welfare services agency information shall~~
29 ~~be stored in a file separate from the evaluator's or investigator's~~
30 ~~file and may only be released to either party under order of the~~
31 ~~court.~~
32 ~~(3) Obtain from a law enforcement investigator all available~~
33 ~~information obtained from criminal background checks of the~~
34 ~~parents and any suspected perpetrator that is not a parent, including~~
35 ~~information regarding child abuse, domestic violence, or substance~~
36 ~~abuse.~~
37 ~~(4) Review the results of a multidisciplinary child interview~~
38 ~~team (hereafter MDIT) interview if available, or if not, or if the~~
39 ~~evaluator or investigator believes the MDIT interview is inadequate~~
40 ~~for purposes of the evaluation, investigation, or assessment,~~

1 interview the child or request an MDIT interview, and shall
2 wherever possible avoid repeated interviews of the child.

3 (5) Request a forensic medical examination of the child from
4 the appropriate agency, or include in the report required by
5 paragraph (6) a written statement explaining why the examination
6 is not needed.

7 (6) File a confidential written report with the clerk of the court
8 in which the custody hearing will be conducted and which shall
9 be served on the parties or their attorneys at least 10 days prior to
10 the hearing. This report may not be made available other than as
11 provided in this subdivision. This report shall include, but is not
12 limited to, the following:

13 (A) Documentation of material interviews, including any MDIT
14 interview of the child or the evaluator or investigator, written
15 documentation of interviews with both parents by the evaluator or
16 investigator, and interviews with other witnesses who provided
17 relevant information.

18 (B) A summary of any law enforcement investigator's
19 investigation, including information obtained from the criminal
20 background check of the parents and any suspected perpetrator
21 that is not a parent, including information regarding child abuse,
22 domestic violence, or substance abuse.

23 (C) Relevant background material, including, but not limited
24 to, a summary of a written report from any therapist treating the
25 child for suspected child sexual abuse, excluding any
26 communication subject to Section 1014 of the Evidence Code,
27 reports from other professionals, and the results of any forensic
28 medical examination and any other medical examination or
29 treatment that could help establish or disprove whether the child
30 has been the victim of sexual abuse.

31 (D) The written recommendations of the evaluator or
32 investigator regarding the therapeutic needs of the child and how
33 to ensure the safety of the child.

34 (E) A summary of the following information: whether the child
35 and his or her parents are or have been the subject of a child abuse
36 investigation and the disposition of that investigation; the name,
37 location, and telephone number of the children's services worker;
38 the status of the investigation and the recommendations made or
39 anticipated to be made regarding the child's safety; and any

1 dependency court orders or findings that might have a bearing on
2 the custody dispute:

3 (F) ~~Any information regarding the presence of domestic violence~~
4 ~~or substance abuse in the family that has been obtained from a~~
5 ~~child protective agency in accordance with paragraphs (1) and (2),~~
6 ~~a law enforcement agency, medical personnel or records, prior or~~
7 ~~currently treating therapists, excluding any communication subject~~
8 ~~to Section 1014 of the Evidence Code, or from interviews~~
9 ~~conducted or reviewed for this evaluation, investigation, or~~
10 ~~assessment.~~

11 (G) ~~Which, if any, family members are known to have been~~
12 ~~deemed eligible for assistance from the Victims of Crime Program~~
13 ~~due to child abuse or domestic violence.~~

14 (H) ~~Any other information the evaluator or investigator believes~~
15 ~~would be helpful to the court in determining what is in the best~~
16 ~~interests of the child.~~

17 (I) ~~On and after January 1, 2016, documentation showing~~
18 ~~compliance with all requirements of this section and the results of~~
19 ~~the investigation shall be submitted to the court on, or attached to,~~
20 ~~the completed form developed pursuant to Section 3117.5 by the~~
21 ~~Judicial Council.~~

22 (e) ~~If the evaluator or investigator obtains information as part~~
23 ~~of a family court mediation, that information shall be maintained~~
24 ~~in the family court file, which is not subject to subpoena by either~~
25 ~~party. If, however, the members of the family are the subject of~~
26 ~~an ongoing child welfare services investigation, or the evaluator~~
27 ~~or investigator has made a child welfare services referral, the~~
28 ~~evaluator or investigator shall so inform the family law judicial~~
29 ~~officer in writing and this information shall become part of the~~
30 ~~family law file. This subdivision may not be construed to authorize~~
31 ~~or require a mediator to disclose any information not otherwise~~
32 ~~authorized or required by law to be disclosed.~~

33 (d) ~~In accordance with subdivision (d) of Section 11167 of the~~
34 ~~Penal Code, the evaluator or investigator may not disclose any~~
35 ~~information regarding the identity of any person making a report~~
36 ~~of suspected child abuse. Nothing in this section is intended to~~
37 ~~limit any disclosure of information by any agency that is otherwise~~
38 ~~required by law or court order.~~

39 (e) ~~The evaluation, investigation, or assessment standards set~~
40 ~~forth in this section represent minimum requirements of evaluation~~

1 and the court shall order further evaluation beyond these minimum
2 requirements when necessary to determine the safety needs of the
3 child.

4 (f) If the court orders an evaluation, investigation, or assessment
5 pursuant to this section, the court shall consider whether the best
6 interests of the child require that a temporary order be issued that
7 limits visitation with the parent against whom the allegations have
8 been made to situations in which a third person specified by the
9 court is present or whether visitation will be suspended or denied
10 in accordance with Section 3011.

11 (g) An evaluation, investigation, or assessment pursuant to this
12 section shall be suspended if a petition is filed to declare the child
13 a dependent child of the juvenile court pursuant to Section 300 of
14 the Welfare and Institutions Code, and all information gathered
15 by the evaluator or investigator shall be made available to the
16 juvenile court.

17 (h) This section may not be construed to authorize a court to
18 issue any orders in a proceeding pursuant to this division regarding
19 custody or visitation with respect to a minor child who is the
20 subject of a dependency hearing in juvenile court or to otherwise
21 supersede Section 302 of the Welfare and Institutions Code.

22 (i) On and after January 1, 2016, documentation showing
23 compliance with all requirements of this section and the results of
24 the investigation shall be submitted to the court on, or attached to,
25 the completed form developed pursuant to Section 3117.5 by the
26 Judicial Council.

27 SEC. 4. Section 3170 of the Family Code is amended to read:

28 3170. (a) If it appears on the face of a petition, application, or
29 other pleading to obtain or modify a temporary or permanent
30 custody or visitation order that custody, visitation, or both are
31 contested, the court shall set the contested issues for mediation.

32 (b) (1) Domestic violence cases shall be handled by Family
33 Court Services in accordance with a separate written protocol
34 approved by the Judicial Council. The Judicial Council shall adopt
35 guidelines for services, other than services provided under this
36 chapter, that courts or counties may offer to parents who have been
37 unable to resolve their disputes. These services may include, but
38 are not limited to, parent education programs, booklets, video
39 recordings, or referrals to additional community resources.

1 ~~(2) The Judicial Council shall, no later than January 1, 2016,~~
2 ~~develop a form to be used to help implement the written protocol~~
3 ~~for handling domestic violence cases.~~

4 ~~SEC. 5. Section 3183 of the Family Code is amended to read:~~

5 ~~3183. (a) Except as provided in Section 3188, the mediator~~
6 ~~may, consistent with local court rules, submit a recommendation~~
7 ~~to the court as to the custody of or visitation with the child, if the~~
8 ~~mediator has first provided the parties and their attorneys, including~~
9 ~~counsel for any minor children, with the recommendations in~~
10 ~~writing in advance of the hearing. The court shall make an inquiry~~
11 ~~at the hearing as to whether the parties and their attorneys have~~
12 ~~received the recommendations in writing. If the mediator is~~
13 ~~authorized to submit a recommendation to the court pursuant to~~
14 ~~this subdivision, the mediation and recommendation process shall~~
15 ~~be referred to as “child custody recommending counseling” and~~
16 ~~the mediator shall be referred to as a “child custody recommending~~
17 ~~counselor.” Mediators who make those recommendations are~~
18 ~~considered mediators for purposes of Chapter 11 (commencing~~
19 ~~with Section 3160), and shall be subject to all requirements for~~
20 ~~mediators for all purposes under this code and the California Rules~~
21 ~~of Court. On and after January 1, 2012, all court communications~~
22 ~~and information regarding the child custody recommending~~
23 ~~counseling process shall reflect the change in the name of the~~
24 ~~process and the name of the providers.~~

25 ~~(b) A child custody recommending counselor who makes child~~
26 ~~custody and visitation recommendations to the court is considered~~
27 ~~a child custody evaluator for purposes of Chapter 11 (commencing~~
28 ~~with Section 3160) and is considered a child custody evaluator for~~
29 ~~purposes of Chapter 6 (commencing with Section 3110). A child~~
30 ~~custody recommending counselor shall be subject to all~~
31 ~~requirements for mediators and custody evaluators for all purposes~~
32 ~~under this code and the California Rules of Court. Commencing~~
33 ~~January 1, 2016, a child custody recommending counselor’s report~~
34 ~~shall be submitted on, or attached to, the completed form developed~~
35 ~~pursuant to Section 3117.5. The recommendation report may be~~
36 ~~considered by the court if, (1) it is submitted on, or attached to,~~
37 ~~the completed Judicial Council form, and, (2) it documents~~
38 ~~compliance with the minimum state-mandated child custody~~
39 ~~evaluation standards applicable to the scope of the evaluation.~~

- 1 ~~(e) If the parties have not reached agreement as a result of the~~
2 ~~mediation proceedings, the mediator may recommend to the court~~
3 ~~that an investigation be conducted pursuant to Chapter 6~~
4 ~~(commencing with Section 3110) or that other services be offered~~
5 ~~to assist the parties to effect a resolution of the controversy before~~
6 ~~a hearing on the issues.~~
- 7 ~~(d) In appropriate cases, the mediator may recommend that~~
8 ~~restraining orders be issued, pending determination of the~~
9 ~~controversy, to protect the well-being of the child involved in the~~
10 ~~controversy.~~

O

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To: Board Members

Date: May 8, 2015

From: Christina Kitamura
Administrative Analyst

Telephone: (916) 574-7835

Subject: **Crime Victim Update**

The Crime Victim Update will be provided at the Board Meeting on May 21st.

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To: Board Members
From: Rosanne Helms
Legislative Analyst
Date: May 8, 2015
Telephone: (916) 574-7897
Subject: Proposed Telehealth Regulations

Background

As therapy via electronic means (telehealth) increases in popularity, many state licensing entities and professional associations are beginning to adopt laws, regulations and guidelines regarding its use. Reflecting this trend, board staff continues to receive an increasing number of inquiries regarding the lawful practice of telehealth.

At its past three meetings, the Policy and Advocacy Committee discussed several aspects of telehealth, including the following:

- Telehealth laws, regulations, and policies in other states;
- Client appropriateness for telehealth;
- Mandated reporting and telehealth;
- Trainees' ability to perform telehealth lawfully; and
- Utilizing security and encryption in telehealth.

Definition of Telehealth and Current Board Statute

Current law (Business and Professions Code (BPC) §2290.5) defines telehealth for all healing arts professions regulated by the Department of Consumer Affairs (DCA), including the Board's licensees. It sets patient consent and confidentiality standards and it makes failure to comply with these standards unprofessional conduct (**Attachment B**).

However, Board licensing law offers little guidance regarding telehealth practice. The law requires a valid state license in marriage and family therapy, clinical social work, educational psychology, or clinical counseling, respectively, before a person can engage in the practice of any of these professions in this state. (BPC §§4980, 4989.50, 4996, 4999.30 and 4999.82).

This implies that a licensee in another state may not counsel an individual who is located in the State of California, unless they hold a California license. If the client is not located in California,

the state where the client is located would have jurisdiction. However, this is not stated specifically.

Draft Telehealth Regulations

Based on the discussions at the Policy and Advocacy Committee, staff drafted telehealth regulations, which are provided in **Attachment A**. At its April 23, 2015 meeting, the Committee directed staff to bring the proposed regulations to the Board for consideration as a regulatory proposal.

Recommendation

Conduct an open discussion regarding the draft telehealth regulations. Direct staff to make any discussed changes, and any non-substantive changes to the attached amendments, and submit to the Board for approval as a regulatory proposal.

Attachments

Attachment A: Draft Telehealth Regulations

Attachment B: 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 client who is physically located in this State must have a valid and current license or registration issued by the Board.
- (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) Upon initiation of telehealth services, a licensee or registrant shall do the following:
- i. Obtain informed consent from the client consistent with Section 2290.5 of the Code.
 - ii. Inform the client of the potential risks and limitations of receiving treatment via telehealth.
 - iii. Provide the client with his or her license or registration number and the type of license or registration.
 - iv. Provide the client with written procedures to follow in an emergency situation. This shall include contact information for emergency services near the client's location.
- (d) Each time a licensee or registrant provides services via telehealth, he or she shall do the following:
- i. Verbally obtain from the client and document the client's full name and address of present location, at the beginning of each telehealth session.
 - ii. Assess whether the client is appropriate for telehealth, including, but not limited to, consideration of the client's psychosocial situation.

iii. Utilize industry best practices for telehealth to ensure both client confidentiality and the security of the communication medium.

(e) A licensee or registrant of this state may provide telehealth services to clients located in another jurisdiction only if the California licensee or registrant meets the requirements to lawfully provide services in that jurisdiction, and delivery of services via telehealth is allowed by that jurisdiction.

(f) Failure to comply with these provisions shall be considered unprofessional conduct.

Attachment B
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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To: Board Members

Date: April 23, 2015

From: Rosanne Helms
Legislative Analyst

Telephone: (916) 574-7897

Subject: Legislative Update

Board staff is currently pursuing the following legislative proposals:

1. SB 531 (Bates) Board of Behavioral Sciences Enforcement Process

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.

Status: This bill has passed through the Senate and is on first reading in the Assembly.

2. SB 620 (Block) Board of Behavioral Sciences: Licensure Requirements

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.

Status: This bill is on third reading in the Senate.

3. SB 800 (Senate Business, Professions, and Economic Development Committee) Healing Arts (Omnibus Bill)

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.

Status: This bill is in the Senate Appropriations Committee.

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. It was published in its California Regulatory Notice Register on March 6, 2015. The public comment period has now ended, and staff is preparing the file for submittal to the Department of Consumer Affairs for review.

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To: Board Members

Date: May 4, 2015

From: Rosanne Helms
Legislative Analyst

Telephone: (916) 574-7897

Subject: Update on Suicide Prevention Training for Mental Health Professionals

Background

During the 2013-2014 Legislative Session, AB 2198 (Levine) was introduced in an effort to ensure that licensed mental health professionals were receiving adequate training in suicide assessment, treatment, and management. The bill would have required licensees of the Board of Behavioral Sciences (Board) and the Board of Psychology to complete a six-hour training course in suicide assessment, treatment, and management. Applicants for licensure would have been required to complete a 15-hour course in this subject area.

While the Board shared the author's concerns that some health care professionals may lack training in suicide assessment, treatment, and management, it did not believe that the bill would accomplish its objective.

Upon veto of the bill, the Governor asked the licensing boards to evaluate the issues raised and take any needed actions.

Survey of Master's Degree Programs

The Board wanted to determine the extent of exposure to the topics of suicide assessment, treatment, and management, for a student enrolled in a Master's degree program intended to lead to licensure. In order to assess this, the Board designed a survey for schools in California offering a degree program leading to Board licensure. The Board conducted outreach to both stakeholder groups and mental health educator consortiums, in order to emphasize the importance of the topic and encourage participation in the survey.

Degree programs were asked to report the following:

- Courses required by the degree which cover the topic of suicide assessment, treatment, and management;
- Number of units or hours each required course spends on these topics;

- A description of the topics or methods covered by each required course; and
- Additional relevant courses offered as electives in the degree program.

A total of 28 Master's degree programs responded to the survey.

Survey Findings

The survey results indicate that schools appear to be providing training for suicide assessment, treatment, and management:

- The data support the claim by the schools that they commonly integrate the topic across a variety of courses, discussing it as it is relevant to the particular focus of a course.
- Many schools also indicated that the topics in question are discussed in practicum, where the students are doing the most hands-on portion of their learning.
- Several schools offer additional elective coursework on the topic, for students seeking further specialization.
- Schools consistently reported teachings of a wide range of aspects of suicidality, including legal and ethical issues, crisis intervention, assessment instruments for suicide risk factors, and role playing activities.

Alternative Solutions

It appears as though degree programs are already providing extensive coverage of the topic of suicide assessment. However, some of the following solutions may be effective in addressing the treatment of suicidal individuals:

- Ensuring front-line health care professionals (such as registered and vocational nurses, physician's assistants, and unlicensed school and county mental health care or medical care workers) have adequate training in suicide assessment, treatment, and management.
- Formation of a task force among mental health educators and suicide experts to discuss the latest research in suicidology, and to develop model curriculum so that educators can ensure they are covering the latest suicide assessment techniques and concepts in their programs.
- Assessment of resources at the county mental health care level to determine if there is an adequate level of support for suicidal individuals. Consider seeking additional funding to adequately staff county mental health facilities.
- Increase public awareness through various media campaigns in an effort to reduce the stigma of seeking mental health services and to identify available local resources.

Next Steps

Board staff has been providing the Governor's office with technical assistance on this topic and will continue to do so as requested.

Attachments

Attachment A: Master's Degree Program Survey Results: Coverage of Suicide Assessment, Treatment, and Management

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). Principles & processes of crisis intervention and treatment. Clinical management and treatment of suicidality. Clinical assessment of suicidality. Students role-play to practice skills at clinical assessment and intervention in suicide. Community resources for suicidal clients. Assessment instruments for depression and suicide risk.	
PSY 6325 Crisis & Trauma	3 hours		
PSY 6322 MFT Theory and Technique II	2 hours		
PSY 6323 MFT Theory and Technique II Lab	2 hours		
PSY 6360 Preparation for Community Practice	3 hours		
PSY 7314 MFT Assessment	2 hours		
Azusa Pacific University - Master of Social Work Program			
SOCW 514 Practice I - Interviewing and Assessment	5 hours	Students trained using Applied Suicide Intervention Skills Training model as a framework for suicide intervention. Discussion of risk factors, signs. Role playing. Review of risk assessment and intervention Suicidality and risk across the life course Risk assessment and intervention reviewed as part of internship training.	
SOCW 550 Intermediate Praxis	2 hours		
SOCW 513 Micro Theory and Human Development	3 hours		
SOCW 534/544 Field Seminar III & IV	3 hours		
			-SOCW 536 Advanced Practice I: Adult Mental Health (2 hours); Suicide risk associated with various mental health conditions. -SOCW Child and Adolescents (2 hours); Suicide risk & assessment unique to children/adolescents.
California Southern University - MA in Psychology w/ Emphasis in Marriage and Family Therapy			
PSY86502 Counseling Theories and Strategies MFT 86504 Ethical Issues in Marriage Family and Child Therapy PSY 86506 Psychopathology MFT 86510 Child and Adolescent Therapy PSY 86511 Alcoholism/Chemical Dependency Detection and Treatment PSY 86512 Group Psychology PSY 86517 Psychology of Aging MFT 86700 Psychopharmacology PSY 87519 Psychology of Trauma PSY 87534 Dual Diagnosis	Approx. 18 hours total	Risk assessment, suicidality, reporting, treatment, and prevention.	
California State University, Bakersfield - MS in Counseling Psychology			
CPSY 535 Domestic Violence CPSY 630 Clinical Ethics CPSY 631 Legal & Professional Issues in MFT			Suicide assessment, treatment & management is also highlighted in all 3 practicum and traineeships in reference to specific client situations.
California State University, Dominguez Hills - Masters of Science in Marital & Family Therapy			
MFT 530 Community Mental Health Practicum MFT 584 Laws and Ethics MFT 511, 521, 531, 541 Fieldwork Practice MFT 566 Psychopathology in MFT	Approx. 6 hours Approx. 6 hours Approx. 6 hours Approx. 6 hours	-Legal and ethical courses talk about therapist's responsibilities when making clinical decision on suicide. -Suicidality among specific populations (does not look the same for each gender, culture, or ages) -Clinical assessments, paperwork, documentation/reporting when conducting a suicide assessment.	
MFT 588 Treatment of Trauma	Approx. 6 hours		

Required Courses in Degree Covering Topic	Units or Hours Courses Spend on Topic	Topic Areas Covered	Additional Elective Courses (Not Required)
California State University, 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.	
California State University, Fullerton - MS in Counseling			
COUN 511 Pre-Practicum	2 hours	Assessment & suicide prevention (reading, lecture & role plays)	
COUN 522 Techniques in Brief Treatment and Assessment	2 hours	Assessment & intervention management (reading, lecture & role plays)	
COUN 526 Professional, Ethical and Legal Issues in Counseling	1 hour	Ethical issues in suicide assessment, management & prevention (reading, lecture & case scenarios)	
COUN 538 Crisis and Trauma Counseling	2 hours	Suicide intervention & management (reading & role plays)	
COUN 530 Beginning Practicum	2-4 hours	Discussion of suicide assessment, management, and intervention	
COUN 534 Advanced Practicum	2-4 hours	Discussion of suicide assessment, management, and intervention	
California State University, Humboldt - Counseling Masters of Arts			
PSY 660 Law and Ethics in Psychology	2 hours	Assessment, voluntary & involuntary hospitalization.	
PSY 630 Advanced Psychopathology	1 hour	Adjustment w/ depression and disorders w/ suicide risk factors.	
PSY 653 Advanced Psychopathology with Children & Families	16 hours	Understanding suicidal ideation & behavior; understanding prevention practices; Suicide Intervention Model (Snyder) (connect, understand, assist), safe plan options, attitudes toward intervention.	
California State University, 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		
California State University, Sacramento - MS in Counseling; specializations in Career Counseling (CC), Marriage & Family Therapy (MFT), School Counseling (SC)			
EDC 212 Gender Roles & Sexuality (required all specializations)	2 hours	law & ethics, 5150/harm to self, LBGQT risk factors, domestic violence, child abuse, and terminal illness prevalence/risk factors for suicide.	
EDC 216 Counseling Theory (required all specializations)	1 hour	Limits of confidentiality, 5150 harm to self, law & ethics regarding suicide, brief overview of assessment of suicidality.	
EDC 218 Assessment in Counseling (required all specializations)	6 hours	Assessment models of suicide/self-harm, assessment tools for evaluating risk factors, review of legal & ethical responsibilities.	
EDC 231 Diagnosis & Treatment Planning (required all specializations)	6 hours	Discussion of risk factors & their treatment.	
EDC 233 Substance Abuse and the Family (required all specializations)	6 hours	Discussion of risk factors associated with substance abuse & their treatment.	
EDC 242 Play and Art Therapy (Required SC, elective for MFT)	1 hour	Suicidality in young children, treatment of children who have attempted suicide/self harm.	
EDC 244 Trauma & Crisis Counseling (Required CC & MFT, elective for St)	6 hours	Coping strategies to prevent suicide, assessment for risk factors.	
EDC 252 Legal & Ethical Issues in Prof. Counseling (req'd all specializatio	6 hours	In depth discussion of legal/ethical responsibilities, analysis of case studies, assessment/evaluation, community resources.	
EDC 254 Counseling & Psychotropic Medicine (Req'd MFT, elective SC and CC)	3 hours	prevalence by age group, risk increase for prescription use, increased suicidality as side effect of prescription use, suicide safety contracts, co-occurring conditions that increase risk.	
EDC 268 Career/Job Search (Required for CC)	3 hours	Impact of unemployment /job loss risk factors	

Required Courses in Degree Covering Topic	Units or Hours Courses Spend on Topic	Topic Areas Covered	Additional Elective Courses (Not Required)
EDC 272 Counseling Children & Youth (Required MFT and SC)	6 hours	Suicide assessment in children/adolescents, assessment & treatment of risk factors, legal/ethical responsibilities, community resources.	
EDC 274 Guidance & Consultation in School Counseling (Required for SC)	3 hours	Prevention of suicide through assessment and treatment of risk factors; explore community resources.	
EDC 475 Practicum in Counseling (Required all specializations)	3 hours min.	Discuss practicum cases, review of assessment, treatment, risk factors, legal/ethical responsibilities, discussion of self harm assessment/treatment.	
EDC 480 Field Study in Counseling (Required all specializations)	3 hours min.	Discussion of internship cases, review of assessment techniques, risk factors, treatment protocol for those who have attempted suicide, legal/ethical responsibilities.	
California State University, San Francisco - Master of Science in Marriage, Family & Child Counseling			
COUN 706 Practicum & Counseling Process	3 hours	dangerousness (suicide/homicide) assessment & treatment. Readings, demonstration, role playing, case study.	
COUN 715 Assessment in Counseling	2 assignments	Two homework assignments: identification of psychological tests & reviews that assess suicide/homicide potential. Development of an instrument to measure counselor competence in managing crisis	
COUN 857 Law and Ethics in Counseling	3 hours	Dangerousness (suicide/homicide) assessment & management.	
COUN 858 Couple and Family Counseling		Impact of suicidality within context of families, including prevention strategies.	
COUN 705, 736, 890, 891 Counseling Practicum and Internship		Practicum/internship training program must have an agency crisis protocol, where trainees receive training in assessing/managing suicidal clients.	
California State University, San Jose - MS in Clinical Psychology			
PSY 203A Assessment	3 unit course	Lecture on suicide assessment.	
PSYC 228 Ethics	3 unit course	Discussion of the topic.	
PSYC 211 Child Psychopathology	3 unit course	Topic repeatedly discussed.	
PSYC 260 Crisis and Trauma Counseling	3 unit course	Topic is a focus of a section of the course.	
Chapman University - Master of Arts in Marriage and Family Therapy			
MFT 516 Assessment of Individuals and Families	Approx. 2 hours	Suicide risk assessment methods	
MFT 573 Crisis Management and Clinical Process	6 hours	Suicide assessment & management (handouts & lectures)	
MFT 578 Ethics and Professional Issues for MFTs	1.5 hours	Suicide assessment, relevant CA laws/regulations, ethical code, resources	
The Chicago School of Professional Psychology - Masters in Clinical Psychology w/ Marital & Family Therapy Specialization			
MM520 Adult Psychopathology	6 hours	Mental status exams, risk factors associated with suicide and aggressive behaviors	
MM 511 Law and Professional Ethics	6 hours	Danger to self, danger to others, Tarasoff & Ewing ruling	
Fuller Theological Seminary - Master of Science in Marital and Family Therapy			
FT 530B Clinical Foundations II	3.5 hours		
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	The use of anti-depressants and their risk of suicidal tendencies in consumers.	
Holy Names University - MA in Counseling Psychology/Dual Counseling and Forensic Psychology			
CPSY 200	1.5 hours	Assessment	
CPSY 215	3 hours	Legal/ethical./reporting/therapeutic approaches: treatment and management	
CPSY 220	3 hours	Human development research on suicidality across lifespan: assessment	
CPSY 271	4 hours	Working with families of traumatic event; management and treatment	
			-CPSY 270 Trauma Types and Transformation: Assessment; Management

Required Courses in Degree Covering Topic	Units or Hours Courses Spend on Topic	Topic Areas Covered	Additional Elective Courses (Not Required)
Hope International University - MA in Marriage & Family Therapy			
PSY 5240 Disaster Trauma & Abuse Response	2 units	Courses cover suicide assessment via vignettes and readings from text.	
PSY 5230 Family Violence	2 units		
PSY 6800 Practicum Course	2 units		
PSY 8120 Professional Ethics & Law	2 units		
Northcentral University; School of Marriage and Family Sciences - MA in Marriage and Family Therapy			
MFT 6201 California Law and Professional Ethics	5 hours	Legal/ethical responsibilities of therapist facing a client expressing suicidal ideations.	
MFT 5103 Systemic Evaluation and Case Management	15 hours	Methods of client risk assessment/assessing issues of safety; case management in crisis situation	
MFT 6106 Families in Crisis	8 hours	Adolescent self harm, suicidal ideations and behaviors, suicide in the elderly, assessment and etiology of suicide.	
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	
Saybrook University - Marriage and Family Therapy License Program			
MFT 2562 (CO) Crisis and Trauma Intervention	Approx. 6 hours	Stages of assessment and intervention; emphasizes interventions for crisis and trauma.	
Touro University Worldwide - Masters of Arts in Marriage and Family Therapy			
MFT 611 Foundation of Psychopathology	5 hours	Covers suicide assessment, treatment, and management	
University of La Verne - Marriage and Family Therapy MS			
PSY 512 Clinical Psychopathology	6 hours	Suicide assessment for high risk diagnostic categories	
PSY 544 Trauma Focused Treatment	2 hours	Trauma response and harm assessment, hospitalization, collaboration of care	
PSY 509 Psychological Testing	3 hours	Suicide assessment/interview techniques	
PSY 550 Community Mental Health Counseling	2 hours	Disaster/trauma response. Harm assessment.	
PSY 580 Fieldwork I	6 hours	Discussion of clinical cases, suicide assessment techniques/steps needed when clients require hospitalization	
PSY 581 Fieldwork II	6 hours		
University of Phoenix (Southern California Campus) - MSC/MFCT			
Legal and Ethical Issues in MFT	3 hours	Duty to warn/protect in cases of danger to self and others	Students can take additional seminars that are offered on MFT related topics. One of these is a 4 hour suicide assessment workshop.
Introduction to Clinical Assessment	4 hours	Prevalence of suicidal behavior in individuals with mental disorders, evaluation criteria, assessment techniques and strategies for suicidal clients, interventions with suicidal clients.	
Pre-practicum	2 hours	Suicide prevention; strategies of risk assessment of self harm.	
University of San Diego - MA in Marital and Family Therapy			
MFTS 528 Psychopathology	1 hour	Video and discussion on suicide assessment.	
MFTS 529 Ethical and Legal Issues in Family Therapy	2 hours	interviewing techniques for suicidal clients, assessment, risk factors, and treatment options.	
EDU 704i Treatment of Severe Mental Illness	5 hours	Suicide risk assessment, treatment, and intervention. Final assignment is treatment plan based on vignette for suicidal patient.	

Required Courses in Degree Covering Topic	Units or Hours Courses Spend on Topic	Topic Areas Covered	Additional Elective Courses (Not Required)
USC - Masters in Marriage and Family Therapy			
EDUC 507 Professional Identity and Law and Ethics for Counselors	3 hours	Duties around suicide assessment, suicide assessment practices, suicidal ideation intervention Suicidality discussed throughout fieldwork; hours shown is an estimate.	
EDUC 644 Practicum in Counseling	3 hours		
Other: Fieldwork A and B	Approx. 9 hours		
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.	<ul style="list-style-type: none"> -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.)
Vanguard University - Graduate Program in Clinical Psychology			
PSYG 601, 603, 604, 626, 724, and 726	Lectured in these courses, but no required number of hours. Also discussed in clinical work in practicum course.		PSYG 618 - This course changes each semester, but one offering of this course is specifically on suicide assessment, treatment, and management.
Western Seminary (Sacramento Campus) - Master of Arts in Marriage and Family Therapy			
Tests and Measurements	2 hours	Uses a book teaching clinical and legal standards of care for suicidal patients; students learn instruments for assessment of suicidal clients.	
Psychopathology	5 hours	Studies the dangers of suicide with mentally ill clients, students develop a treatment plan regarding suicide and mental illness.	
Legal and Ethical Issues	3 hours	Studies legal and ethical issues around a suicide crisis, breaking confidentiality, reporting, & hospitalization when patient is a danger to themselves.	
Counseling for Addictions	3 hours	Discussion of drugs & alcohol use/abuse/addiction as risk factors for suicide.	
Emergency Preparedness: Crisis Management	12 hours	Suicide crisis, assessment, prevention, and treatment. Text is focused on developing clinical skills in these areas.	

[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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To: Board Members

Date: May 6, 2015

From: Marc Mason
Administrative Manager

Telephone: (916) 574-7828

**Subject: Consider English as a Second Language as a Possible Testing
Accommodation**

Issue

The Board does not currently offer special accommodations for examinees who speak English as a Second language (ESL). A growing number of Board examinees have approached the Board and requested some sort of ESL accommodation.

Background

Board records indicate that from at least 2000 up to July 1, 2011, candidates who requested an ESL accommodation were granted extra time to take the board examinations. However, ESL is not identified as a disability under the Americans with Disabilities Act (ADA).

Prior to making the decision to end the ESL accommodation, the Board contacted the Office of Professional Examination Services (OPES) for information. OPES indicated that they reviewed the readability of the Board's examination as well as other ESL issues. OPES considered that prior to entering a bachelor's program or master's program, ESL candidates take the Test of English as a Foreign Language (TOEFL). Further, the candidate receives the master's degree in English. Based on this information, it is reasonable to conclude that a candidate should be proficient enough to take the examination in English.

Possible ESL Accommodations

There are two possible accommodations that the Board could make. The first accommodation that could be made is to translate the Board's exams into languages other than English. According to OPES when a licensing board, bureau, or committee under DCA is faced with the decision whether or not to adapt an examination, the following must be taken into consideration:

- If a language survey has been conducted and a target language group has been identified to have a substantial number (5%) of non- or limited English-speaking candidates, an examination may be adapted.
- If English is an essential aspect of a profession, an examination will not be adapted.

A translated examination must adhere to the current standards and guidelines for testing. Further, the cost to translate an examination ranges from \$25,000 up to \$75,000 per exam, per language. The Board currently develops 6 examinations; two different versions of each examination. The option to translate an examination would require a language survey, but at the outset, this option is cost prohibitive.

The second option for an ESL accommodation is giving candidates extra time to take the exam. This is the option the Board has used in the past. If the Board did choose this option a criteria for how to decide who would be granted an ESL accommodation would need to be developed and likely placed in regulations. For instance, the Board of Psychology has proposed regulations that require the following for an ESL accommodation of extra time:

- The candidate submits a signed request for an ESL accommodation of extra time under penalty of perjury that English is his or her second language.
- A TOEFL IBT certification score of 85 or below must be sent by Educational Testing Service directly to the Board. The TOEFL must have been taken within the previous two years prior to the application.

Their TOEFL IBT is composed of four parts that measure an individual's reading, listening, speaking, and writing skills in English. The test can be taken online or in person at a testing center and the fee for taking the test is \$185. A score of 85 would indicate that an individual has "low" to "intermediate" proficiency in English.

At the last Board meeting Board members expressed some concern over the cost and availability of the TOEFL IBT and about the methods used to arrive at the needed score. Another option could be using a TOEFL IBT score that the applicant obtained at any time during the applicant's university career. The Board would not look at the score or evaluate it but simply deem having taken the TOEFL IBT as sufficient reason to offer a special accommodation. In addition to this, the Board could accept proof that an applicant obtained his or her university education in a country outside of the United States as an additionally sufficient reason to offer an ESL accommodation.

Recommendation

Conduct an open discussion regarding whether or not the Board would like to offer a testing accommodation for ESL. And if so, what criteria should be established and direct staff to draft regulatory language for consideration.

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To: Board Members

Date: May 4, 2015

From: Kim Madsen
Executive Officer

Telephone: (916) 574-7841

Subject: Signature on Licensee's Wall Certification

Background

A license is issued to a candidate who satisfies all of the licensure requirements and successfully passes both required examinations. The new licensee receives a license that reflects the issue and expiration date and the State of California seal, the Department of Consumer Affairs (DCA) logo, and the Board of Behavioral Sciences (Board) address. The license is approximately 4x8 inches in size and is the license that is required to be displayed in a conspicuous place in the licensee's primary place of practice (Business and Professions Code section 4980.31, 4996.7, 4989.48, 4999.70). Upon renewal, a new license is issued. (Attachment A)

A second license, typically referred to as a Wall Certification, is also issued to the licensee. The Wall Certification is issued once, bears the State of California seal, the DCA logo, the title Board of Behavioral Sciences, and is approximately 8x10 inches. The Wall Certification is not required to be displayed in the licensee's primary place of practice. The Wall Certification is the official certificate of licensure which confers the rights and privileges under the specific licensure chapter with the date of issuance and name of the individual. The Wall Certification is signed by the Board Chair and Executive Officer using their electronic signatures (Attachment B).

Issue

Several months ago Board staff became aware that Wall Certifications were being issued with the prior Board Chair signature. Prior to BreEZe, the process to change signatures on the Wall Certification could be done internally and quickly. However, since BreEZe, this modification now requires a change request that is submitted to the BreEZe team. The change is not immediate and in fact, can take several months to implement.

Further research revealed that the seal that appears on both the smaller license and Wall Certification are not in compliance with law. Specifically, Business and Professions Code section 107.5 specifies that if the Board is to use an official seal, the seal shall contain the words "State of California" and "Department of Consumer Affairs" in addition to the title of the Board.

Although all of this language is on license and Wall Certification, the seal only bears the words “The Great Seal of the State of California.”

The document’s design has been in place for a number of years. Board records do not reflect any discussion regarding the design of the seal or layout of both documents. However, staff recalls that as the Board transitioned to BreEZe, the current layout was discussed and implemented.

Discussion

Wall Certifications

Each May, the Board elects officers. In the past few years, the Board has opted to elect the incumbent for a second or third term. So a change in Board Chairs has occurred every two or three years, although there is the potential that a change in Board Chair could occur every year. The Executive Officer serves at the pleasure of the Board, however, changes in this position occur less frequently. The last change in Executive Officers was in 2010.

Board Members should discuss what signature or signatures should be on the Wall Certification considering the following options.

- Option One - Remain with the current format; recognizing that changes to any signature will require some time. Thus, some Wall Certifications will be issued with the signatures that may not reflect the current leadership of the Board.
- Option Two - Remove the Board Chair signature and keep the Executive Officer signature. Historically, the Executive Officer position does not change as frequently as the Board Chair position. This option would eliminate a potential yearly or every other year request to change to the signature block.
- Option Three – Require that all Wall Certifications are issued with “wet” signatures. On average the Board issues approximately 220 new licenses per month. Currently, both the smaller license and Wall Certifications are printed and mailed directly to the licensee from the printing vendor. If this option is selected, all smaller licenses and the Wall Certifications would be returned to the Board so that the Wall Certification could be signed. Board staff would subsequently mail out both documents when the signatures on the Wall Certification are complete. This option would negate the Board’s effort to streamline this process; new licensees would see an increased delay in receiving their smaller license and their Wall Certification.

Board Seal

DCA Publications Unit redesigned the Board’s seal to include the requirements specified in law. Attached are three versions (light, dark, and color) of the seal that will be sent to DCA Director Kidane for approval. Once the seal is approved, Board staff will initiate the action to replace the existing seals on the smaller license and wall certificates.

Attachment A	Small license
Attachment B	Wall Certification
Attachment C	Board Seal



LICENSED PROFESSIONAL CLINICAL COUNSELOR

License No. LPCC [REDACTED]

Receipt No. 128

Valid Until: 02/28/2015

Issue Date: 11/26/2013



In accordance with the provisions of Division 2 Chapter 16 of the Business and Professions Code, the person named hereon is issued a Licensed Professional Clinical Counselor original license.

-----NON-TRANSFERABLE-----

-----POST IN PUBLIC VIEW-----





State of California

Board of Behavioral Sciences

Pursuant to Chapter 13.5 of Division 2 of the Business and Professions Code, this license as a

Licensed Educational Psychologist

is issued to:



and confers upon the holder all of the rights and privileges under said Chapter, including the right to engage in the business, advertise to the public, and use the title of Licensed Educational Psychologist.

In witness thereof the Chairperson and the Executive Officer affix their signatures hereto and the Seal of the State of California this 13th day of October, 2014, at Sacramento, California.



Chairperson:

Christie M. Wiethebaal

Executive Officer:

Kim Madson

License No.



License Holder:

BBS State Seal Design



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To: Board Members

Date: April 28, 2015

From: Kim Madsen
 Executive Officer

Telephone: (916) 574-7841

Subject: Election of Officers

Section 4990 of the Business and Professions Code requires the Board to elect a Chair and Vice-Chair prior to June 1 of each year. Currently, Christina Wong serves as the Board Chair, and Deborah Brown is the Vice-Chair.

In order to comply with existing law, the Board members should elect both a chair and a vice-chair at this meeting for 2015-2016.

Below is a list of board members and the date on which their term will expire:

Board Member	Type	Authority	Date Appointed	Reappointed	Term Expires	Grace Expires
Dr. Christine Wietlisbach	Public	Senate	2/4/2010	5/2011	6/1/2015	6/1/2016
Samara Ashley	Public	Governor	1/21/2010	7/12/2013	6/1/2017	8/1/2017
Betty Connolly	LEP	Governor	8/22/2012		6/1/2016	8/1/2016
Sarita Kohli	LMFT	Governor	6/7/2011	6/13/2014	6/1/2018	8/1/2018
Patricia Lock-Dawson	Public	Governor	1/13/2010	7/12/2013	6/1/2017	8/1/2017
Renee Lonner	LCSW	Governor	1/17/2007	7/25/2014	6/1/2018	8/1/2018
Karen Pines	LMFT	Governor	4/5/2011	7/2/2013	6/1/2017	8/1/2017
Christina Wong	LCSW	Governor	5/18/2011	7/2/2013	6/1/2017	8/1/2017
Dr. Leah Brew	LPCC	Governor	8/28/2012		6/1/2016	8/1/2016
Deborah Brown	Public	Governor	8/23/2012	7/2/2013	6/1/2017	8/1/2017
Dr. Scott Bowling	Public	Governor	9/11/2014		6/1/2018	8/1/2018
Dr. Peter Chiu	Public	Governor	10/30/2013		6/1/2015	8/1/2015
Vacancy (Douglas)	Public	Assembly			6/1/2015	6/1/2016

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To: Board Members

Date: May 4, 2015

From: Kim Madsen
Executive Officer

Telephone: (916) 574-7841

Subject: Sunset Oversight Review

On April 30, 2015, the Senate Committee on Business, Professions, and Economic Development and Assembly Committee on Business and Professions (Committee) sent notification to the Board that Committee will begin its Sunset Oversight Review in the Fall of 2015. The Board is one of ten Boards that will participate in this review.

The Sunset Oversight Review process affords the legislature the opportunity to review Board operations and performance as well as discuss current issues facing the Board. The purpose of the Sunset Oversight Review is to determine if the Board should continue to license and regulate LCSWs, LMFTs, LEPs, LPCCs, ASWs, MFTIs, and PCIs. The Committee will also determine the extension time period granted to the Board. During the 2012 Sunset Oversight Review, the Board received a four year extension. A copy of the Board's 2012 Sunset Review Report is available on the Board's website.

The Committee requested the Board submit a comprehensive report that responds to 12 sections with over 60 questions regarding Board operations, performance, and past issues. This comprehensive report will include statistics, procedural information, and essentially detail the work of the Board since 2012. Board staff and members of the Board's Sunset Review Committee will work together to prepare the report.

A draft report will be available at the August Board meeting for the Board members to review. A final report will be presented at the November meeting to the Board members for approval and submission to the Committee. The Board's Sunset Review Report is due December 1, 2015. The public hearing dates will be announced sometime in January.

Attached for your reference is the report format that will be used for the Sunset Review Report.

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[BOARD NAME]
BACKGROUND INFORMATION AND OVERVIEW OF THE CURRENT REGULATORY PROGRAM
As of [date]

Section 1
Background and Description of the Board and Regulated Profession

Provide a short explanation of the history and function of the board.¹ Describe the occupations/profession that are licensed and/or regulated by the board (Practice Acts vs. Title Acts).

1. Describe the make-up and functions of each of the board’s committees (cf., Section 12, Attachment B).

Table 1a. Attendance			
[Enter board member name]			
Date Appointed:	[Enter date appointed]		
Meeting Type	Meeting Date	Meeting Location	Attended?
Meeting 1	[Enter Date]	[Enter Location]	[Y/N]
Meeting 2	[Enter Date]	[Enter Location]	[Y/N]
Meeting 3	[Enter Date]	[Enter Location]	[Y/N]
Meeting 4	[Enter Date]	[Enter Location]	[Y/N]

Table 1b. Board/Committee Member Roster					
Member Name (Include Vacancies)	Date First Appointed	Date Re-appointed	Date Term Expires	Appointing Authority	Type (public or professional)

2. In the past four years, was the board unable to hold any meetings due to lack of quorum? If so, please describe. Why? When? How did it impact operations?
3. Describe any major changes to the board since the last Sunset Review, including:
 - Internal changes (i.e., reorganization, relocation, change in leadership, strategic planning)
 - All legislation sponsored by the board and affecting the board since the last sunset review.

¹ The term “board” in this document refers to a board, bureau, commission, committee, department, division, program, or agency, as applicable. Please change the term “board” throughout this document to appropriately refer to the entity being reviewed.

- All regulation changes approved by the board the last sunset review. Include the status of each regulatory change approved by the board.
4. Describe any major studies conducted by the board (cf. Section 12, Attachment C).
 5. List the status of all national associations to which the board belongs.
 - Does the board’s membership include voting privileges?
 - List committees, workshops, working groups, task forces, etc., on which board participates.
 - How many meetings did board representative(s) attend? When and where?
 - If the board is using a national exam, how is the board involved in its development, scoring, analysis, and administration?

**Section 2
Performance Measures and Customer Satisfaction Surveys**

6. Provide each quarterly and annual performance measure report for the board as published on the DCA website
7. Provide results for each question in the board’s customer satisfaction survey broken down by fiscal year. Discuss the results of the customer satisfaction surveys.

**Section 3
Fiscal and Staff**

Fiscal Issues

8. Describe the board’s current reserve level, spending, and if a statutory reserve level exists.
9. Describe if/when a deficit is projected to occur and if/when fee increase or reduction is anticipated. Describe the fee changes (increases or decreases) anticipated by the board.

Table 2. Fund Condition						
(Dollars in Thousands)	FY 2011/12	FY 2012/13	FY 2013/14	FY 2014/15	FY 2015/16	FY 2016/17
Beginning Balance						
Revenues and Transfers						
Total Revenue	\$	\$	\$	\$	\$	\$
Budget Authority						
Expenditures						
Loans to General Fund						
Accrued Interest, Loans to General Fund						
Loans Repaid From General Fund						
Fund Balance	\$	\$	\$	\$	\$	\$
Months in Reserve						

10. Describe the history of general fund loans. When were the loans made? When have payments been made to the board? Has interest been paid? What is the remaining balance?
11. Describe the amounts and percentages of expenditures by program component. Use *Table 3. Expenditures by Program Component* to provide a breakdown of the expenditures by the board in each program area. Expenditures by each component (except for pro rata) should be broken out by personnel expenditures and other expenditures.

Table 3. Expenditures by Program Component (list dollars in thousands)								
	FY 2011/12		FY 2012/13		FY 2013/14		FY 2014/15	
	Personnel Services	OE&E	Personnel Services	OE&E	Personnel Services	OE&E	Personnel Services	OE&E
Enforcement								
Examination								
Licensing								
Administration *								
DCA Pro Rata								
Diversion (if applicable)								
TOTALS	\$	\$	\$	\$	\$	\$	\$	\$

*Administration includes costs for executive staff, board, administrative support, and fiscal services.

12. Describe license renewal cycles and history of fee changes in the last 10 years. Give the fee authority (Business and Professions Code and California Code of Regulations citation) for each fee charged by the board.

Table 4. Fee Schedule and Revenue (list revenue dollars in thousands)							
Fee	Current Fee Amount	Statutory Limit	FY 2011/12 Revenue	FY 2012/13 Revenue	FY 2013/14 Revenue	FY 2014/15 Revenue	% of Total Revenue

13. Describe Budget Change Proposals (BCPs) submitted by the board in the past four fiscal years.

Table 5. Budget Change Proposals (BCPs)								
BCP ID #	Fiscal Year	Description of Purpose of BCP	Personnel Services				OE&E	
			# Staff Requested (include classification)	# Staff Approved (include classification)	\$ Requested	\$ Approved	\$ Requested	\$ Approved

Staffing Issues

14. Describe any board staffing issues/challenges, i.e., vacancy rates, efforts to reclassify positions, staff turnover, recruitment and retention efforts, succession planning.
15. Describe the board's staff development efforts and how much is spent annually on staff development (cf., Section 12, Attachment D).

Section 4 Licensing Program

16. What are the board's performance targets/expectations for its licensing² program? Is the board meeting those expectations? If not, what is the board doing to improve performance?
17. Describe any increase or decrease in the board's average time to process applications, administer exams and/or issue licenses. Have pending applications grown at a rate that exceeds completed applications? If so, what has been done by the board to address them? What are the performance barriers and what improvement plans are in place? What has the board done and what is the board going to do to address any performance issues, i.e., process efficiencies, regulations, BCP, legislation?
18. How many licenses or registrations does the board issue each year? How many renewals does the board issue each year?

Table 6. Licensee Population					
		FY 2011/12	FY 2012/13	FY 2013/14	FY 2014/15
[Enter License Type]	Active				
	Out-of-State				
	Out-of-Country				
	Delinquent				
[Enter License Type]	Active				
	Out-of-State				
	Out-of-Country				
	Delinquent				
[Enter License Type]	Active				
	Out-of-State				
	Out-of-Country				
	Delinquent				
[Enter License Type]	Active				
	Out-of-State				
	Out-of-Country				
	Delinquent				

² The term "license" in this document includes a license certificate or registration.

Table 7a. Licensing Data by Type											
	Application Type	Received	Approved	Closed	Issued	Pending Applications			Cycle Times		
						Total (Close of FY)	Outside Board control*	Within Board control*	Complete Apps	Incomplete Apps	combined, IF unable to separate out
FY 2011/12	(Exam)					-	-	-	-	-	-
	(License)					-	-	-	-	-	-
	(Renewal)			n/a		-	-	-	-	-	-
FY 2012/13	(Exam)										
	(License)										
	(Renewal)			n/a							
FY 2013/14	(Exam)										
	(License)										
	(Renewal)			n/a							

* Optional. List if tracked by the board.

Table 7b. Total Licensing Data				
	FY 2012/13	FY 2013/14	FY 2014/15	
Initial Licensing Data:				
Initial License/Initial Exam Applications Received				
Initial License/Initial Exam Applications Approved				
Initial License/Initial Exam Applications Closed				
License Issued				
Initial License/Initial Exam Pending Application Data:				
Pending Applications (total at close of FY)				
Pending Applications (outside of board control)*				
Pending Applications (within the board control)*				
Initial License/Initial Exam Cycle Time Data (WEIGHTED AVERAGE):				
Average Days to Application Approval (All - Complete/Incomplete)				
Average Days to Application Approval (incomplete applications)*				
Average Days to Application Approval (complete applications)*				
License Renewal Data:				
License Renewed				

* Optional. List if tracked by the board.

19. How does the board verify information provided by the applicant?

- a. What process does the board use to check prior criminal history information, prior disciplinary actions, or other unlawful acts of the applicant?
- b. Does the board fingerprint all applicants?
- c. Have all current licensees been fingerprinted? If not, explain.

- d. Is there a national databank relating to disciplinary actions? Does the board check the national databank prior to issuing a license? Renewing a license?
 - e. Does the board require primary source documentation?
20. Describe the board's legal requirement and process for out-of-state and out-of-country applicants to obtain licensure.
21. Describe the board's process, if any, for considering military education, training, and experience for purposes of licensing or credentialing requirements, including college credit equivalency.
- a. Does the board identify or track applicants who are veterans? If not, when does the board expect to be compliant with BPC § 114.5?
 - b. How many applicants offered military education, training or experience towards meeting licensing or credentialing requirements, and how many applicants had such education, training or experience accepted by the board?
 - c. What regulatory changes has the board made to bring it into conformance with BPC § 35?
 - d. How many licensees has the board waived fees or requirements for pursuant to BPC § 114.3, and what has the impact been on board revenues?
 - e. How many applications has the board expedited pursuant to BPC § 115.5?
22. Does the board send No Longer Interested notifications to DOJ on a regular and ongoing basis? Is this done electronically? Is there a backlog? If so, describe the extent and efforts to address the backlog.

Examinations

Table 8. Examination Data			
California Examination (include multiple language) if any:			
	License Type		
	Exam Title		
FY 2011/12	# of 1 st Time Candidates		
	Pass %		
FY 2012/13	# of 1 st Time Candidates		
	Pass %		
FY 2013/14	# of 1 st Time Candidates		
	Pass %		
FY 2014/15	# of 1 st time Candidates		
	Pass %		
	Date of Last OA		
	Name of OA Developer		
	Target OA Date		
National Examination (include multiple language) if any:			
	License Type		
	Exam Title		
FY 2011/12	# of 1 st Time Candidates		
	Pass %		
FY 2012/13	# of 1 st Time Candidates		

	Pass %			
FY 2013/14	# of 1 st Time Candidates			
	Pass %			
FY 2014/15	# of 1 st time Candidates			
	Pass %			
Date of Last OA				
Name of OA Developer				
Target OA Date				

23. Describe the examinations required for licensure. Is a national examination used? Is a California specific examination required?
24. What are pass rates for first time vs. retakes in the past 4 fiscal years? (*Refer to Table 8: Examination Data*)
25. Is the board using computer based testing? If so, for which tests? Describe how it works. Where is it available? How often are tests administered?
26. Are there existing statutes that hinder the efficient and effective processing of applications and/or examinations? If so, please describe.

School approvals

27. Describe legal requirements regarding school approval. Who approves your schools? What role does BPPE have in approving schools? How does the board work with BPPE in the school approval process?
28. How many schools are approved by the board? How often are approved schools reviewed? Can the board remove its approval of a school?
29. What are the board's legal requirements regarding approval of international schools?

Continuing Education/Competency Requirements

30. Describe the board's continuing education/competency requirements, if any. Describe any changes made by the board since the last review.
- How does the board verify CE or other competency requirements?
 - Does the board conduct CE audits of licensees? Describe the board's policy on CE audits.
 - What are consequences for failing a CE audit?
 - How many CE audits were conducted in the past four fiscal years? How many fails? What is the percentage of CE failure?
 - What is the board's course approval policy?
 - Who approves CE providers? Who approves CE courses? If the board approves them, what is the board application review process?
 - How many applications for CE providers and CE courses were received? How many were approved?
 - Does the board audit CE providers? If so, describe the board's policy and process.
 - Describe the board's effort, if any, to review its CE policy for purpose of moving toward performance based assessments of the licensee's continuing competence.

Section 5
Enforcement Program

31. What are the board’s performance targets/expectations for its enforcement program? Is the board meeting those expectations? If not, what is the board doing to improve performance?
32. Explain trends in enforcement data and the board’s efforts to address any increase in volume, timeframes, ratio of closure to pending cases, or other challenges. What are the performance barriers? What improvement plans are in place? What has the board done and what is the board going to do to address these issues, i.e., process efficiencies, regulations, BCP, legislation?

Table 9a. Enforcement Statistics			
	FY 2012/13	FY 2013/14	FY 2014/15
COMPLAINT			
Intake (Use CAS Report EM 10)			
Received			
Closed			
Referred to INV			
Average Time to Close			
Pending (close of FY)			
Source of Complaint (Use CAS Report 091)			
Public			
Licensee/Professional Groups			
Governmental Agencies			
Other			
Conviction / Arrest (Use CAS Report EM 10)			
CONV Received			
CONV Closed			
Average Time to Close			
CONV Pending (close of FY)			
LICENSE DENIAL (Use CAS Reports EM 10 and 095)			
License Applications Denied			
SOIs Filed			
SOIs Withdrawn			
SOIs Dismissed			
SOIs Declined			
Average Days SOI			
ACCUSATION (Use CAS Report EM 10)			
Accusations Filed			
Accusations Withdrawn			
Accusations Dismissed			
Accusations Declined			
Average Days Accusations			
Pending (close of FY)			

Table 9b. Enforcement Statistics (continued)			
	FY 2012/13	FY 2013/14	FY 2014/15
DISCIPLINE			
Disciplinary Actions (Use CAS Report EM 10)			
Proposed/Default Decisions			
Stipulations			
Average Days to Complete			
AG Cases Initiated			
AG Cases Pending (close of FY)			
Disciplinary Outcomes (Use CAS Report 096)			
Revocation			
Voluntary Surrender			
Suspension			
Probation with Suspension			
Probation			
Probationary License Issued			
Other			
PROBATION			
New Probationers			
Probations Successfully Completed			
Probationers (close of FY)			
Petitions to Revoke Probation			
Probations Revoked			
Probations Modified			
Probations Extended			
Probationers Subject to Drug Testing			
Drug Tests Ordered			
Positive Drug Tests			
Petition for Reinstatement Granted			
DIVERSION			
New Participants			
Successful Completions			
Participants (close of FY)			
Terminations			
Terminations for Public Threat			
Drug Tests Ordered			
Positive Drug Tests			

Table 9c. Enforcement Statistics (continued)			
	FY 2012/13	FY 2013/14	FY 2014/15
INVESTIGATION			
All Investigations (Use CAS Report EM 10)			
First Assigned			
Closed			
Average days to close			
Pending (close of FY)			
Desk Investigations (Use CAS Report EM 10)			
Closed			
Average days to close			
Pending (close of FY)			
Non-Sworn Investigation (Use CAS Report EM 10)			
Closed			
Average days to close			
Pending (close of FY)			
Sworn Investigation			
Closed (Use CAS Report EM 10)			
Average days to close			
Pending (close of FY)			
COMPLIANCE ACTION (Use CAS Report 096)			
ISO & TRO Issued			
PC 23 Orders Requested			
Other Suspension Orders			
Public Letter of Reprimand			
Cease & Desist/Warning			
Referred for Diversion			
Compel Examination			
CITATION AND FINE (Use CAS Report EM 10 and 095)			
Citations Issued			
Average Days to Complete			
Amount of Fines Assessed			
Reduced, Withdrawn, Dismissed			
Amount Collected			
CRIMINAL ACTION			
Referred for Criminal Prosecution			

Table 10. Enforcement Aging						
	FY 2011/12	FY 2012/13	FY 2013/14	FY 2014/15	Cases Closed	Average %
Attorney General Cases (Average %)						
Closed Within:						
1 Year						
2 Years						
3 Years						
4 Years						
Over 4 Years						
Total Cases Closed						
Investigations (Average %)						
Closed Within:						
90 Days						
180 Days						
1 Year						
2 Years						
3 Years						
Over 3 Years						
Total Cases Closed						

33. What do overall statistics show as to increases or decreases in disciplinary action since last review.
34. How are cases prioritized? What is the board's compliant prioritization policy? Is it different from DCA's *Complaint Prioritization Guidelines for Health Care Agencies* (August 31, 2009)? If so, explain why.
35. Are there mandatory reporting requirements? For example, requiring local officials or organizations, or other professionals to report violations, or for civil courts to report to the board actions taken against a licensee. Are there problems with the board receiving the required reports? If so, what could be done to correct the problems?
36. Does the board operate with a statute of limitations? If so, please describe and provide citation. If so, how many cases have been lost due to statute of limitations? If not, what is the board's policy on statute of limitations?
37. Describe the board's efforts to address unlicensed activity and the underground economy.

Cite and Fine

38. Discuss the extent to which the board has used its cite and fine authority. Discuss any changes from last review and describe the last time regulations were updated and any changes that were made. Has the board increased its maximum fines to the \$5,000 statutory limit?
39. How is cite and fine used? What types of violations are the basis for citation and fine?
40. How many informal office conferences, Disciplinary Review Committees reviews and/or Administrative Procedure Act appeals of a citation or fine in the last 4 fiscal years?
41. What are the 5 most common violations for which citations are issued?
42. What is average fine pre- and post- appeal?
43. Describe the board's use of Franchise Tax Board intercepts to collect outstanding fines.

Cost Recovery and Restitution

44. Describe the board's efforts to obtain cost recovery. Discuss any changes from the last review.
45. How many and how much is ordered by the board for revocations, surrenders and probationers? How much do you believe is uncollectable? Explain.
46. Are there cases for which the board does not seek cost recovery? Why?
47. Describe the board's use of Franchise Tax Board intercepts to collect cost recovery.
48. Describe the board's efforts to obtain restitution for individual consumers, any formal or informal board restitution policy, and the types of restitution that the board attempts to collect, i.e., monetary, services, etc. Describe the situation in which the board may seek restitution from the licensee to a harmed consumer.

Table 11. Cost Recovery (list dollars in thousands)				
	FY 2011/12	FY 2012/13	FY 2013/14	FY 2014/15
Total Enforcement Expenditures				
Potential Cases for Recovery *				
Cases Recovery Ordered				
Amount of Cost Recovery Ordered				
Amount Collected				

* "Potential Cases for Recovery" are those cases in which disciplinary action has been taken based on violation of the license practice act.

Table 12. Restitution (list dollars in thousands)				
	FY 2011/12	FY 2012/13	FY 2013/14	FY 2014/15
Amount Ordered				
Amount Collected				

Section 6

Public Information Policies

49. How does the board use the internet to keep the public informed of board activities? Does the board post board meeting materials online? When are they posted? How long do they remain on the board's website? When are draft meeting minutes posted online? When does the board post final meeting minutes? How long do meeting minutes remain available online?
50. Does the board webcast its meetings? What is the board's plan to webcast future board and committee meetings? How long to webcast meetings remain available online?
51. Does the board establish an annual meeting calendar, and post it on the board's web site?
52. Is the board's complaint disclosure policy consistent with DCA's *Recommended Minimum Standards for Consumer Complaint Disclosure*? Does the board post accusations and disciplinary actions consistent with DCA's *Web Site Posting of Accusations and Disciplinary Actions* (May 21, 2010)?
53. What information does the board provide to the public regarding its licensees (i.e., education completed, awards, certificates, certification, specialty areas, disciplinary action, etc.)?
54. What methods are used by the board to provide consumer outreach and education?

Section 7

Online Practice Issues

55. Discuss the prevalence of online practice and whether there are issues with unlicensed activity. How does the board regulate online practice? Does the board have any plans to regulate internet business practices or believe there is a need to do so?

Section 8

Workforce Development and Job Creation

56. What actions has the board taken in terms of workforce development?
57. Describe any assessment the board has conducted on the impact of licensing delays.
58. Describe the board's efforts to work with schools to inform potential licensees of the licensing requirements and licensing process.
59. Provide any workforce development data collected by the board, such as:
- Workforce shortages
 - Successful training programs.

Section 9

Current Issues

60. What is the status of the board's implementation of the Uniform Standards for Substance Abusing Licensees?
61. What is the status of the board's implementation of the Consumer Protection Enforcement Initiative (CPEI) regulations?
62. Describe how the board is participating in development of BreEZe and any other secondary IT issues affecting the board.

Section 10

Board Action and Response to Prior Sunset Issues

Include the following:

- Background information concerning the issue as it pertains to the board.
- Short discussion of recommendations made by the Committees/Joint Committee during prior sunset review.
- What action the board took in response to the recommendation or findings made under prior sunset review.
- Any recommendations the board has for dealing with the issue, if appropriate.

Section 11 New Issues

This is the opportunity for the board to inform the Committees of solutions to issues identified by the board and by the Committees. Provide a short discussion of each of the outstanding issues, and the board's recommendation for action that could be taken by the board, by DCA or by the Legislature to resolve these issues (i.e., policy direction, budget changes, legislative changes) for each of the following:

1. Issues that were raised under prior Sunset Review that have not been addressed.
2. New issues that are identified by the board in this report.
3. New issues not previously discussed in this report.
4. New issues raised by the Committees.

Section 12 Attachments

Please provide the following attachments:

- A. Board's administrative manual.
- B. Current organizational chart showing relationship of committees to the board and membership of each committee (cf., Section 1, Question 1).
- C. Major studies, if any (cf., Section 1, Question 4).
- D. Year-end organization charts for last four fiscal years. Each chart should include number of staff by classifications assigned to each major program area (licensing, enforcement, administration, etc.) (cf., Section 3, Question 15).

Section 13 Board Specific Issues

THIS SECTION ONLY APPLIES TO SPECIFIC BOARDS, AS INDICATED BELOW.

Diversion

Discuss the board's diversion program, the extent to which it is used, the outcomes of those who participate, the overall costs of the program compared with its successes

Diversion Evaluation Committees (DEC) (for BRN, Dental, Osteo and VET only)

1. DCA contracts with a vendor to perform probation monitoring services for licensees with substance abuse problems, why does the board use DEC? What is the value of a DEC?
2. What is the membership/makeup composition?

3. Did the board have any difficulties with scheduling DEC meetings? If so, describe why and how the difficulties were addressed.
4. Does the DEC comply with the Open Meetings Act?
5. How many meetings held in each of the last three fiscal years?
6. Who appoints the members?
7. How many cases (average) at each meeting?
8. How many pending? Are there backlogs?
9. What is the cost per meeting? Annual cost?
10. How is DEC used? What types of cases are seen by the DEC?
11. How many DEC recommendations have been rejected by the board in the past four fiscal years (broken down by year)?

Disciplinary Review Committees (Board of Barbering and Cosmetology and BSIS only)

1. What is a DRC and how is a DRC used? What types of cases are seen by the DRCs?
2. What is the membership/makeup composition?
3. Does the DRC comply with the Open Meetings Act?
4. How many meeting held in last three fiscal years?
5. Did the board have any difficulties with scheduling DRC meetings? If so, describe why and how the difficulties were addressed.
6. Who appoints the members?
7. How many cases (average) at each meeting?
8. How many pending? Are there backlogs?
9. What is the cost per meeting? Annual cost?
10. Provide statistics on DRC actions/outcomes.

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