



Board of Behavioral Sciences



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

Gavin Newsom, Governor  
State of California

Business, Consumer Services and Housing Agency  
Department of Consumer Affairs

## **POLICY AND ADVOCACY COMMITTEE Meeting Notice and Agenda**

**February 7, 2020  
10:30 a.m.**

**Department of Consumer Affairs  
Lou Galiano Hearing Room  
1625 North Market Blvd., #S-102  
Sacramento, CA 95834**

*While the Board intends to webcast this meeting, it may not be possible to webcast the entire meeting due to technical difficulties or limitations on resources. If you wish to participate or to have a guaranteed opportunity to observe, please plan to attend at the physical location.*

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- I. Call to Order, Establishment of Quorum, and Introductions\*
  - II. Approval of August 2, 2019 Committee Meeting Minutes
  - III. Approval of October 11, 2019 Committee Meeting Minutes
  - IV. Discussion and Possible Recommendation Regarding Notice to Clients About Filing a Complaint: Business and Professions Code Sections 4980.01, 4980.32, 4989.17, 4996.14, 4996.75, 4999.22, and 4999.71
  - V. Discussion and Possible Recommendation Regarding Practice Setting Definitions Bill Proposal: Supervisor Work Setting Requirements: Business and Professions Code Sections 4980.43.4, 4996.23.3, and 4999.46.4
  - VI. Discussion and Possible Recommendation Regarding Custody of Client Records Due to Licensee Death or Incapacitation
  - VII. Update on Status of Board-Sponsored Legislation:
    - a. Practice Setting Definitions Bill Proposal
    - b. Fee Increase Bill Proposal
    - c. Omnibus Bill Proposal

- VIII. Update on Board Rulemaking Proposals
  - IX. Public Comment for Items Not on the Agenda
  - X. Suggestions for Future Agenda Items
  - XI. Adjournment
- 

*Note: The Board may not discuss or take action on any matter raised during this public comment section, except to decide whether to place the matter on the agenda of a future meeting. [Gov. Code §§ 11125, 1125.7(a)]*

*\*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](http://www.bbs.ca.gov).*

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

## Policy and Advocacy Committee Minutes

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This Policy and Advocacy Committee Meeting webcast is available at <https://www.youtube.com/watch?v=A-HdUtV2MzM&feature=youtu.be>.

**DATE** August 2, 2019

**LOCATION** Department of Consumer Affairs  
Lou Galiano Hearing Room  
1625 North Market Blvd., #S-102  
Sacramento, CA 95834

**TIME** 9:00 a.m.

### ATTENDEES

**Members Present:** Christina Wong, Chair, LCSW Member  
Deborah Brown, Public Member  
Betty Connolly, LEP Member

**Members Absent:** *All members present*

**Staff Present:** Kim Madsen, Executive Officer  
Steve Sodergren, Assistant Executive Officer  
Sabina Knight, Legal Counsel  
Rosanne Helms, Legislative Analyst  
Christy Berger, Regulatory Analyst  
Christina Kitamura, Administrative Analyst

**Other Attendees:** *See voluntary sign-in sheet (available upon request)*

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### I. Call to Order, Establishment of Quorum, and Introductions

Christina Wong, Chair of the Policy and Advocacy Committee (Committee), called the meeting to order at 9:02 a.m. Christina Kitamura called roll, and a quorum was established.

1 **II. Approval of April 5, 2019 Committee Meeting Minutes**

2  
3 An amendment was proposed on page 1, line 5.

4  
5 **MOTION:** Approve the April 5, 2019 meeting minutes as amended. Connolly  
6 moved; Wong seconded. Vote: 3 yea, 0 nay. Motion carried.

7  
8 Roll call vote:

Member	Yea	Nay	Abstain	Absent	Recusal
Deborah Brown	x				
Betty Connolly	x				
Christina Wong	x				

9  
10  
11 **III. Discussion and Possible Recommendation Regarding Practice Setting**  
12 **Definitions, Subsequent Registration Numbers, and Exam Limits.**

13 **Proposed Amendments to Business and Professions Code Sections**  
14 **4980.01, 4980.399, 4980.42, 4980.43, 4980.43.2, 4980.43.3, 4980.43.4,**  
15 **4980.46, 4980.50, 4980.54, 4980.01, 4992.09, 4992.1, 4992.10, 4996.13,**  
16 **4996.14, 4996.15, 4996.22, 4996.23, 4996.23.1, 4996.23.2, 4996.23.3,**  
17 **4996.28, 4999.22, 4999.36, 4999.46, 4999.46.1, 4999.46.2, 4999.46.3,**  
18 **4999.46.4, 4999.52, 4999.55, 4999.72, 4999.76, 4999.100: Add Business and**  
19 **Professions Code Sections 4980.05, 4980.06, 4996.141, 4996.142, 4999.25,**  
20 **4999.26: Amend and Renumber BPC Sections 4984.74 (4980.51), 4996.4**  
21 **(4992.11), 4999.24 (4999.27), 4999.64 (4999.54)**

22  
23 The Exempt Setting Committee met in June 2019 to discuss the following  
24 topics:

- 25 1. Clarifying practice setting definitions  
26 2. Extending registration numbers to 8 years; allowing private practice with  
27 a subsequent registration number  
28 3. Requiring continuing education for registrants

29  
30 **1. Clarifying Practice Setting Definitions**

31 The proposal:

- 32 • Classifies all settings into two categories: exempt settings and non-  
33 exempt settings. The definition of exempt settings remains the same.  
34 The definition of non-exempt settings is all settings that do not qualify as  
35 exempt settings.  
36  
37 • Carves out definitions of two specific types of non-exempt settings:  
38 private practices and professional corporations. These definitions are  
39 used to place certain limitations on these specific types of settings.  
40

- 1 • Reiterates that an individual working in an exempt setting who holds a  
2 Board-issued license or registration is under the jurisdiction of the Board.  
3
- 4 • Reiterates that an active license or registration number is required to  
5 provide psychotherapeutic services in any non-exempt setting with two  
6 exceptions:
  - 7 ○ A trainee may provide services in a non-exempt setting as long as it  
8 is not a private practice or a professional corporation, and the trainee  
9 is under the jurisdiction and supervision of their school.  
10
  - 11 ○ An applicant for associate registration following the 90-day rule may  
12 provide services in a non-exempt setting as long as it is not a private  
13 practice or a professional corporation, and they are in compliance  
14 with the laws pertaining to the 90-day rule.  
15
- 16 • Specifies that an entity that is licensed or certified by a government  
17 agency is not considered a private practice setting.  
18
- 19 • Limits supervisors in a private practice or professional corporation to six  
20 individual or triadic supervisees at a time.  
21
- 22 • Permits contracted supervisors in a private practice or professional  
23 corporation. A supervisor must provide psychotherapeutic services to  
24 clients at the same site as the associate.  
25
- 26 • Prohibits any licensee who owns a business utilizing a fictitious business  
27 name from using a false or misleading business name.  
28

## 29 **Discussion Points**

### 30 Definition of Exempt Settings

31 Business and Professions Code (BPC) §4980.01(c) specifies that certain  
32 settings are exempt if the employee or volunteer is supervised solely by the  
33 entity where he or she is working. However, staff believes that this provision is  
34 outdated. The Exempt Setting Committee recommended revising the language  
35 to state that a setting is exempt if the employee or volunteer’s work “is  
36 performed under the oversight and direction” of one of the specified exempt  
37 entities.  
38

39 No discussion from Committee members regarding §4980.01(c)  
40

### 42 Entities Licensed or Certified by a Government Entity

43 The Exempt Setting Committee wanted to specify that an entity licensed or  
44 certified by a government entity should not be considered a private practice  
45 setting. The Exempt Setting Committee believes that such a certification or

1 license provides a level of oversight that distinguishes the setting from a private  
2 practice. However, staff believes that the language originally proposed could  
3 be too vague and recommends the following language:  
4

5 *An entity that is licensed or certified by a government agency (OR an*  
6 *entity that is licensed or certified by a state or federal agency to provide*  
7 *health care services) shall not be considered a private practice setting.*  
8

9 Discussion

10 Ms. Connolly: Concerned about not including county agencies, unless all  
11 counties are registered by the state.  
12

13 Ms. Wong: Does not believe the county agencies will be excluded and feels  
14 this language should be sufficient.  
15

16 Lynn Thill, California Alliance of Child and Family Services: Via the California  
17 waiver with Centers for Medicare & Medicaid Services, they subcontract with  
18 the counties. The counties subcontract with other contractors. Therefore, the  
19 counties are the entities charged with ensuring that the mental health services  
20 are provided to beneficiaries eligible for it. She expressed concern to not  
21 include counties in the language.  
22

23 Board staff proposed the following edit:

24 *An entity that is licensed or certified by a government agency (OR an*  
25 *entity that is licensed or certified by a county, state or federal agency to*  
26 *provide health care services) shall not be considered a private practice*  
27 *setting.*  
28

29 Janlee Wong, National Association of Social Workers California Chapter  
30 (NASW-CA): In family court, juvenile dependency court, or juvenile  
31 delinquency court, the court frequently mandates therapy for its wards. At  
32 times, wards may see private practitioners that are contracted by the courts.  
33

34 The Committee and staff were comfortable that the language will not affect  
35 court-appointed private practitioners.  
36

37 Mr. Wong, NASW-CA: Although the city of Berkeley is in Alameda County,  
38 mental health services is provided by the city of Berkeley; concerned that cities  
39 will be excluded.  
40

41 Ann Tran, CAMFT: Suggested “government regulatory agency” instead of  
42 “county, state or federal agency”.  
43

44 The Committee and Board staff agreed to move forward with Ms. Tran’s  
45 suggestion.  
46

1  
2 Allowing Contract Supervisors in Private Practice

3 Current law requires supervisors in a private practice to practice at the same  
4 site as their supervisees or be an owner of a private practice. If a professional  
5 corporation, the supervisor must be employed full time for the corporation and  
6 be “actively engaged in providing professional services” there.

7  
8 This requirement leads to significant confusion about what is acceptable,  
9 especially for corporations. To clear up this confusion, the Committee  
10 discussed re-wording this section, and decided to allow contract supervisors in  
11 a private practice or professional corporation.

12  
13 Discussion regarding the issue of potential exploitation

14 Ms. Connolly: In order to protect against the possibility for exploitation,  
15 additional barriers would be created. Additional supervisory requirements will  
16 result in reduction of abuse; feels comfortable with the language as proposed.

17  
18 Discussion regarding the requirement that supervisors must provide services at  
19 the same site

20 The Committee was comfortable with the language as proposed.

21  
22  
23 Limit of Six Supervisees Per Supervisor in Private Practice/Professional  
24 Corporation

25 A recommendation was made to increase the limit to six supervisees per  
26 supervisor in private practice/professional corporations. The Committee was  
27 comfortable with the proposed recommendation.

28  
29  
30 Supervisee Limit: Should it Apply in Private Practice/Professional Corporations  
31 Only, or in all Non-Exempt Settings?

32 The number of supervisees per supervisor in private practices and professional  
33 corporations are limited; however, there are no limits in other non-exempt  
34 settings. Was this the intent?

35  
36 The proposed language was amended as follows:

37 *Supervisors of supervisees in a non-exempt setting shall not serve as an*  
38 *individual or triadic supervisor for more than a total of six supervisees at*  
39 *any time.*

40  
41 **MOTION:** Move to amended §4980.05, §4980.06, and §4980.43.4, and  
42 recommend amended and discussed items to the Board for consideration as a  
43 legislative proposal. Connolly moved; Wong seconded. Vote: 3 yea, 0 nay.  
44 Motion carried.

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Roll call vote:

Member	Yea	Nay	Abstain	Absent	Recusal
Deborah Brown	x				
Betty Connolly	x				
Christina Wong	x				

**2. Extending Registration Numbers to 8 Years (with Coursework Required for a Subsequent Number) and Allowing Private Practice with a Subsequent Number**

Staff recommended a solution that would extend the length of a registration number and eliminate the private practice prohibition on a subsequent registration number.

- The length of a registration number would increase from 6 years to 8 years.
- The allowable age of experience hours would increase from 6 years to 8 years.
- If a subsequent registration number is needed, the applicant must:
  - Obtain a passing score on the California law and ethics exam within the past two years; and
  - Demonstrate successful completion of 15 semester units of graduate level coursework within the past two years. Some of the graduate level coursework must cover specified topic areas.
- Removal of private practice prohibition on a subsequent registration.

Discussion

Ms. Wong: Concerned about consumer protection and oversight of those in private practice. There is no mechanism for oversight.

Ms. Connolly: Stakeholders were passionate about this issue and were willing to make any compromises to have the Board revisit this matter. The Committee heard that the few applicants who need the subsequent registrations tend to be underrepresented, come from disadvantaged backgrounds, have more life challenges and encounter more barriers.

Ms. Madsen: Stated that consumer protection is present because those applicants are still under normal supervision and have not taken their clinical exams yet.

Ms. Wong: Concerned about consumer protection regarding applicants who have completed their hours and cannot pass the examination.



1 Ms. Madsen: Those applicants must take additional coursework and pass  
2 the law and ethics exam with a specified time frame before they can  
3 practice.  
4

5 Ms. Wong: Concerned about the group that is in the exam cycle, obtaining  
6 one hour/week, because there is no regulatory mechanism for the  
7 supervision.  
8

9 Ms. Berger: Responded that there is some regulatory mechanism carved  
10 out in law.  
11

12 Ms. Madsen: Stated that this proposal is not intended to address  
13 supervision, which was addressed in AB 93; this is intended to address the  
14 number of exam attempts and motivate associates to become licensed.  
15

16 Mr. Wong, NASW-CA: Problem with proposal requiring graduate-level  
17 coursework: 1) cost of 15 units, 2) cannot take coursework in a degree  
18 program when the applicant already has a degree, 3) applicant can only  
19 attend extended studies to obtain additional coursework (the required  
20 coursework, if available, is very limited).  
21

22 Ms. Tran, CAMFT: Concerned about all points discussed. Recommended  
23 further discussions.  
24

25 Ms. Connolly: Agrees with Mr. Wong; impossible to enroll in university to  
26 take courses. Recommended tabling this issue and referring the matter to a  
27 subcommittee.  
28

29 This item will be referred to a subcommittee for further discussion.  
30  
31

### 32 **3. Requiring Continuing Education for Registrants**

33 This item will be referred to a subcommittee for further discussion.  
34  
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### 36 **4. Limiting Clinical Exam Attempts**

37 This item will be referred to a subcommittee for further discussion.  
38

1 **IV. Discussion and Possible Recommendations Regarding Proposal to**  
 2 **Increase Board Fees. Proposed Amendments to Business and**  
 3 **Professions Code Sections 4980.54, 4984.7, 4989.34, 4989.36, 4989.40,**  
 4 **4989.68, 4996.3, 4996.22, 4999.76, 4999.104, 4999.120, 4999.122. Proposed**  
 5 **Amendments to Title 16, California Code of Regulations Sections 1816,**  
 6 **1816.1, 1816.2, 1816.3, 1816.4, 1816.5, 1816.6, 1816.7**

7  
 8 The Board has not raised its licensing fees in at least 20 years. A recent audit  
 9 of the Board’s licensing fees found that they are no longer sufficient to recover  
 10 operating costs. Therefore, staff is proposing the following fee increases.

11  
 12 Marriage and Family Therapists

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Fee Type	Current Fee	Proposed Fee
Associate Registration	\$75	\$150
Associate Renewal	\$75	\$150
Application for Licensure	\$100	\$250
Law & Ethics Exam	\$100	\$150
Clinical Exam	\$100	\$250
Initial License Issuance	\$130	\$200
License Renewal	\$130	\$200

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 15  
 16 Licensed Educational Psychologists

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Fee Type	Current Fee	Proposed Fee
Application for Licensure	\$100	\$250
Written Exam	\$100	\$250
Initial License Issuance	\$80	\$200
License Renewal	\$80	\$200

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 19  
 20 Clinical Social Workers

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Fee Type	Current Fee	Proposed Fee
Associate Registration	\$75	\$150
Associate Renewal	\$75	\$150
Application for Licensure	\$100	\$250
Law & Ethics Exam	\$100	\$150
Clinical Exam	n/a	n/a
Initial License Issuance	\$100	\$200
License Renewal	\$100	\$200

22

1 Professional Clinical Counselors

2

Fee Type	Current Fee	Proposed Fee
Associate Registration	\$100	\$150
Associate Renewal	\$100	\$150
Application for Licensure	\$180	\$250
Law & Ethics Exam	\$100	\$150
Clinical Exam	n/a	n/a
Initial License Issuance	\$200	\$200
License Renewal	\$175	\$200

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5 Background

6 In August 2018, the Board contracted with CPS HR Consulting (CPS) to  
7 provide performance auditing and consulting services to review the Board's fee  
8 structure and staff workload to determine if fee levels are appropriate for the  
9 recovery of the actual cost of conducting its programs. In April 2019, CPS  
10 submitted the final report.

- 11
- 12 • 25 fees that represent approximately 90% of the Board's fee revenue:  
applications for registrations, licenses, examination and renewals.
  - 13 • During the last four years, revenues for 25 fees increased by nearly 39%;  
14 the Board's expenditures increased by approximately 42%.
  - 15 • Increases due to steady increase of application volume and  
16 registrant/licensee population.

17  
18 To determine appropriate fees, CPS used three years of average expenditures  
19 and staff hours. Dividing the average expenditures by staff hours for the three  
20 years resulted in a \$120 per hour/\$2.00 per minute fully absorbed cost rate.  
21 The resulting proposed fee increases ranged from \$0 to \$315. These proposed  
22 fees were used to make projections for the fund condition for the next five  
23 years. The fees proposed would increase the Board's revenue by \$6,016,000  
24 per full fiscal year and would result in a five-month reserve by fiscal year  
25 2023-2024.

26  
27 In developing the proposed fees, staff took into consideration the impact a fee  
28 increase may have on the registrants and licensees. Higher number of staff  
29 hours are typically spent on registrants; however, registrants earn less money  
30 than licensees. Therefore, proposed fees were adjusted from fees based solely  
31 on workload to achieve a more equitable result.

32  
33 Proposal

34 A two-step proposal for fee increase:  
35

- Step 1: Run legislation to increase the fees in statute, setting a baseline amount, and a maximum amount so that fees may be increased in the future via regulations if necessary.
- Step 2: Amend the Board's regulations relating to licensing fees. Initially, the regulations would reflect the baseline fees established in statute. If the Board wished to seek additional fee increases in the future, it could do so by solely running regulations, as long as the fee amounts did not exceed the maximum amounts specified in statute.

Staff is also proposing to delete obsolete language or clarify language in regulations:

- Delete certain references to inactive license fees because it is already specified in law;
- Delete language in LEP and LPCC law regarding payment of accrued renewal fees for expired licenses;
- Specify in statute that the delinquency fee equals half of the renewal fee;
- Delete language in LPCC law regarding start-up fund.

Discussion

Kenneth Edwards, California Association for Licensed Professional Clinical Counselors (CALPCC): Supports proposal to increase fees. Suggested implementing the increase in a graduated percentage amount. The fee increase, along with all other costs, may create a barrier to entry.

Mr. Wong, NASW-CA: Supports proposal to increase fees. Added that it is unfair that LPCCs and LCSWs subsidize the fees for LMFTs by making the fees equal across the board. The subsidizing of fees does not take workload into consideration; the staff's workload for LMFTs is much greater than LCSWs.

Mr. Sodergren: CPS presented a very aggressive approach to building the Board's reserve. Staff responded by slowing it down to gradually increase the reserve. In terms of incremental fee adjustments, the legislature would frown upon yearly legislation to increase fees.

A presentation regarding fee increases will be presented at the upcoming Board meeting.

**MOTION:** Recommend to the Board to support as a legislative proposal. Wong moved; Connolly seconded. The motion carried; 3 yea, 0 nay.

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Roll call vote:

Member	Yea	Nay	Abstain	Absent	Recusal
Deborah Brown	x				
Betty Connolly	x				
Christina Wong	x				

**V. Discussion and Possible Action Regarding Continuing Education Requirements: Title 16, California Code of Regulations: Add Section 1810.5; Amend Sections 1807, 1807.2, 1810, 1887, 1887.1, 1887.2, 1887.3, 1887.4.0, 1887.4.1 and 1887.4.3; Repeal Sections 1810.1, 1810.2, 1887.4, 1887.7, 1887.8, 1887.9, 1887.10, 1887.11 and 1887.15**

The purpose of this agenda item is to consider possible regulation changes pertaining to both continuing education (CE) and “additional training” requirements. This proposal would do all of the following:

- Delete the regulations that were necessary for the CE program’s 2015 transition away from Board-approval of individual CE providers
- Clarify and update provisions of the current regulations
- Propose several minor changes
- Amend the requirements to qualify for a CE waiver
- Update, clarify and streamline the regulations pertaining to “additional training” requirements (coursework required to be completed by applicants for licensure, as well as LEPs renewing for the first time).

A draft of this proposal was initially brought before the Policy and Advocacy Committee at its January 2018 meeting and has been revised based on feedback from the Committee as well as stakeholders.

Proposed Changes

The proposed language would do all of the following:

1. Update the list of acceptable providers for the following courses and streamline the lists of acceptable providers into one section:
  - Human Sexuality
  - Child Abuse Assessment and Reporting
  - Alcoholism and Other Chemical Substance Dependency
  - California Law and Ethics
  - Crisis or Trauma Counseling
2. Update the content required for the Human Sexuality course for consistency with statute, the DSM-V and to ensure currency (it has not been updated in over 30 years).

- 1 3. Update the content required for the Alcoholism and Other Chemical  
2 Substance Dependency class to clarify that it should also include  
3 substance abuse.  
4
- 5 4. Clarify that dual licensees must only complete a total of 36 hours per  
6 renewal period (as opposed to 36 hours per license type).  
7
- 8 5. Clarify that an individual who holds a retired license is exempt from CE  
9 requirements.  
10
- 11 6. Delete the requirement that LMFTs and LCSWs who began graduate study  
12 prior to January 1, 1986 take a CE course in Alcoholism and Other  
13 Chemical Substance Dependency. All applicants for LMFT and LCSW  
14 licensure must now meet this requirement prior to license issuance.  
15
- 16 7. Clarify that a CE course taught by a licensee may only count toward his or  
17 her CE if it is a course taught for a board-accepted provider.  
18
- 19 8. Specify that teaching a CE course may only count for 18 of the 36 hours of  
20 CE required to be taken every two-year renewal period. Current law  
21 specifies that the licensee may count the same number of hours as a  
22 licensee who took the course and may only claim a course once per  
23 renewal cycle. However, licensees may count the same class(es) taught  
24 each renewal period.  
25
- 26 9. Allow a licensee who completes a board occupational analysis survey to be  
27 awarded with six hours of CE.  
28
- 29 10. Update the list of approval agencies and acceptable providers.  
30
- 31 11. Delete outdated sections that pertained to the Board's former CE regulatory  
32 program and delineated the transition to the new program.  
33
- 34 12. Make other technical changes.  
35

#### 36 Additional Changes – CE Exceptions

37 This proposal would also update and clarify the requirements for obtaining an  
38 exception from (waiver of) CE requirements. CE waivers allow the licensee to  
39 renew in an active status without completing the required 36 hours of CE during  
40 the two-year renewal period.  
41

42 The proposed amendments are as follows:

- 43 • Strike the provision that allows a licensee in their initial renewal period to  
44 complete 18 hours of CE rather than 36 hours.  
45

- 1 • Update the CE waiver request forms and instructions, which are incorporated  
2 by reference into the Board’s regulations.  
3
- 4 • Clarify that a CE waiver is temporary and applies only to the current renewal  
5 cycle.  
6
- 7 • Delete the reference to “reasonable accommodation.”  
8
- 9 • Delete the waiver for active duty military members.  
10
- 11 • Delete the waiver for licensees who resided in another country for at least  
12 one year.  
13
- 14 • For licensees who were a primary caregiver of an immediate family member  
15 for at least one year during the renewal period, the proposal would provide a  
16 definition of a “total physical or mental disability” meaning the family member  
17 is both unable to work and unable to perform activities of daily living without  
18 substantial assistance.  
19
- 20 • For licensees who have a physical or mental disability of their own for at  
21 least one year during the renewal period, staff had originally proposed to  
22 require the evaluating professional to certify that the condition substantially  
23 limited the licensee’s ability to practice and complete the required CE.  
24 However, there were concerns expressed that this language was too vague  
25 and that professional evaluators would need more clarity. The current  
26 proposal would do the following:
  - 27 ○ No longer require “total disability”. Instead, require that the licensee had  
28 a condition that substantially limited one or more life activities, consistent  
29 with the wording of the Americans with Disabilities Act and California law;  
30 and,
  - 31 ○ Require the licensee to demonstrate that their condition caused earned  
32 income to drop below the “substantial gainful activity” (SGA) amount for  
33 non-blind individuals as set by the Social Security Administration (SSA).
  - 34 ○ Eligibility would be demonstrated through a combination of a physician or  
35 psychologist verification of disability, along with proof of income during  
36 the period of disability.  
37
- 38 • Require licensees who are granted a CE waiver to take the 6-hour law and  
39 ethics course despite the waiver.  
40

41 CAMFT Letter

42 The California Association of Marriage and Family Therapists sent a letter  
43 requesting consideration of the following:  
44

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- Discuss concerns that requiring 6 hours of law and ethics from those who were granted a temporary CE waiver would be an undue burden, due to a need to focus on the health and recovery for themselves or a family member.

5

6 Discussion

7 No change to staff proposal.

8

- 9
- Consider allowing “microlearning”.

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11 Discussion

12 Microlearning is valuable; however, it is not practical to change the Board’s processes to accommodate that level of learning. The complexity to track the CE and increased staff demands to track the CE is impractical. Staff recommended that CE providers allow for modules less than one hour in length, and provide certification showing accumulation of modules equaling one hour.

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- Clarification on whether a course on “Law and Ethics for Supervisors” should be allowed to meet both of the following:
    - The 6-hour Law and Ethics course required for all licensees each renewal period, and
    - The 6-hour supervisor training refresher required of LMFT and LPCC supervisors each renewal period.

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26 Discussion

27 The Law and Ethics for Supervisors cannot be double-counted. Staff will develop clarifying language.

28

29

- 30
- Clarification of course content requirements.

31

32 Discussion

33 Staff proposed clarifying language.

34

- 35
- Streamline subsection (c) of the section on course content, and no longer require educational goals and specific learning objectives to be “measurable”.

36

37

38

39 Discussion

40 No changes were made.

41

- 42
- Retain the section pertaining to required content for course advertisements and make it applicable to CE providers operating under an approval agency. Since the Board no longer approves individual CE providers, and because
- 43
- 44



1 approval agencies are now responsible for setting standards for CE  
2 providers, this section is proposed to be deleted.

3  
4 Discussion

5 No change to staff proposal to delete this section.  
6

- 7
- 8 • Retain the section pertaining to course instructor qualifications and make it  
9 applicable to CE providers operating under an approval agency. Since the  
10 Board no longer approves individual CE providers, and because approval  
11 agencies are now responsible for setting standards for CE providers, this  
12 section is proposed to be deleted.

13 Discussion

14 No change to staff proposal to delete this section.  
15

16 **MOTION:** Direct staff to make any discussed changes and any non-  
17 substantive changes, and recommend to the full Board as a regulatory  
18 proposal. Wong moved; Brown seconded. The motion carried; 3 yea, 0 nay.  
19

20 Roll call vote:

Member	Yea	Nay	Abstain	Absent	Recusal
Deborah Brown	x				
Betty Connolly	x				
Christina Wong	x				

21  
22  
23 **VI. Update on Board-Sponsored and Board-Considered Legislation**  
24

25 **Board-Sponsored Legislation**

26 SB 679 Healing Arts: Therapists and Counselors: Licensing

27 Status: This bill is in the Assembly Appropriations Committee.  
28

29 AB 630 Board of Behavioral Sciences: Marriage and Family Therapists: Clinical  
30 Social Workers: Educational Psychologists: Professional Clinical Counselors:

31 Required Notice

32 Status: This bill is on its third reading in the Senate.  
33

34 SB 786 (Senate Business, Professions, and Economic Development  
35 Committee): Healing Arts (Omnibus Bill)

36 The Board requested eight items be included in the bill. One item was rejected  
37 for inclusion due to being too substantive. All other requested items were  
38 included.  
39

40 Status: This bill is in the Assembly Appropriations Committee.  
41

1 **Board-Supported Legislation**

2 AB 769 (Smith): Federally Qualified Health Centers and Rural Health Clinics:  
3 Licensed Professional Clinical Counselor

4 Status: This is a two-year bill. It is in the Senate Appropriations Committee.

5  
6 AB 1651 (Medina): Licensed Educational Psychologists: Supervision of  
7 Associates and Trainees

8 Status: This bill is on its third reading in the Senate.

9  
10 Many of the bills that the Board supported had substantial amendments;  
11 therefore, those bills lost the Board's positions until it meets again to discuss.

12  
13  
14 **VII. Update on Board Rulemaking Proposals**

15  
16 Substantial Relationship & Rehabilitation Criteria (AB 2138 Regulations)

17 Status: Submitted for notice to the public. Public comment period will begin on  
18 August 16<sup>th</sup>. The public hearing will be held on at September 30<sup>th</sup> in the DCA  
19 El Dorado Room.

20  
21 Enforcement Process

22 Status: On hold until passage of AB 2138 regulations.

23  
24 Examination Rescoring; Application Abandonment; APCC Subsequent  
25 Registration Fee

26 Status: Submitted to Office of Administrative Law for final approval.

27  
28 Supervision

29 Status: DCA Initial Review

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31  
32 **VIII. Public Comment for Items Not on the Agenda**

33  
34 No public comments

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36  
37 **IX. Suggestions for Future Agenda Items**

38  
39 No suggestions

40  
41  
42 **X. Adjournment**

43  
44 The Committee adjourned at 12:33 p.m.



Board of Behavioral Sciences

# Memo

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Sacramento, CA 95834  
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[www.bbs.ca.gov](http://www.bbs.ca.gov)

**To:** Committee Members  
**Date:** January 28, 2020  
**From:** Rosanne Helms  
Legislative Manager  
**Telephone:** (916) 574-7897  
**Subject:** Notice to Clients About Filing a Complaint

---

## Background

Last year, the Board sponsored AB 630 (Chapter 229, Statutes of 2019). The bill amended the law (effective July 1, 2020) to require that unlicensed or unregistered individuals providing psychotherapy services in exempt settings provide their clients with a notice about where to file a complaint about the therapist. AB 630 also requires Board licensed or registered therapists in any setting provide their clients with a similar notice stating that a complaint may be filed with the Board. These notices must be provided prior to initiating psychotherapy services.

The Board may wish to consider two clarifying amendments to the provisions of AB 630.

### **Amendment #1: Additional Information to Clients of Unlicensed or Unregistered Therapists (Amend BPC §§4980.01, 4996.14, and 4999.22)**

In its review of AB 630 last summer, the Senate Committee on Business, Professions, and Economic Development (Committee) suggested the following additional language be included in the notice provided to clients of unlicensed or unregistered practitioners:

*[The Board of Behavioral Sciences receives and responds to complaints regarding services provided by individuals licensed and registered by the Board. If you have a complaint and are unsure if your practitioner is licensed or registered, please contact the Board of Behavioral Sciences at 916-574-7830 for assistance or utilize the Board's online license verification feature by visiting \[www.bbs.ca.gov\]\(http://www.bbs.ca.gov\).](#)*

Adding this language would provide a consumer who is unsure about their therapist's license status with an additional resource (the Board's contact number and website) so that they can check if their therapist is licensed or registered.

At the time, it was too late in the legislative session to take this suggestion back to the Board for consideration without AB 630 becoming a two-year bill. The Committee let

the bill proceed, and staff agreed to take the amendment to the next Board meeting for consideration.

The Board discussed the amendment at its November 22, 2019 meeting and suggested some minor changes (which are included in the language in italics above and in **Attachment A**). However, during the discussion, stakeholders suggested that an additional clarification to the language in AB 630 might be helpful (see Amendment #2 below). Therefore, the Board directed staff to consider the new suggestion and bring proposed language back at a later date.

**Amendment #2: Timing of Providing the Notice to Clients (Amend BPC §§4980.01, 4980.32, 4989.17, 4996.14, 4996.75, 4999.22 and 4999.71)**

As written in AB 630, the law requires the practitioner to provide the notice to clients about where to file a complaint prior to initiating psychotherapy services.

In most cases when the practitioner is beginning session based-therapy, this requirement will not be difficult to fulfill. However, stakeholders raised the concern that in crisis situations, it may not be feasible or appropriate to stop the delivery of immediate services to provide and/or discuss the required notice.

Staff recommends that the Board consider clarifying the notice requirement (for both licensed and registered individuals and unlicensed and unregistered individuals). The proposed amendment states that the notice must be provided prior to initiating psychotherapy services, or as soon as practically possible thereafter. This provides clarity that in a crisis situation with a new patient, the practitioner does not need to stop urgent services to provide the notice. Instead, they can provide the notice as soon as possible after the crisis has been addressed.

The suggested amendment allowing the notice to be provided “as soon as practicably possible” is similar to language used in the law regarding mandated reporting of child abuse (see Penal Code §11166, **Attachment B**) and elder and dependent adult abuse (see Welfare and Institutions Code §15630).

The Committee also may wish to discuss whether or not it would be helpful to include language stating that the delivery of the notice shall be documented. The provision of law regarding telehealth (BPC §2290.5) requires a patient’s consent for telehealth to be documented.

Recommendation

Conduct an open discussion about the proposed amendments. Direct staff to make any discussed changes, and any non-substantive changes, and bring to the Board for consideration as a legislative proposal.

Attachments

**Attachment A:** Proposed Language

**Attachment B:** Example Language: Penal Code §11166

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**ATTACHMENT A  
PROPOSED LANGUAGE**

**AMEND §4980.01. (Includes Chaptered Language From AB 630)**

(a) This chapter shall not be construed to constrict, limit, or withdraw the Medical Practice Act, the Social Work Licensing Law, the Nursing Practice Act, the Licensed Professional Clinical Counselor Act, or the Psychology Licensing Law.

(b) This chapter shall not apply to any priest, rabbi, or minister of the gospel of any religious denomination when performing counseling services as part of their pastoral or professional duties, or to any person who is admitted to practice law in the state, or a physician and surgeon who provides counseling services as part of their professional practice.

(c) This chapter shall not apply to an unlicensed or unregistered employee or volunteer working in a governmental entity, a school, a college, a university, or an institution that is both nonprofit and charitable if both of the following apply:

(1) The work of the employee or volunteer is performed solely under the supervision of the entity.

(2) On and after July 1, 2020, the employee or volunteer provides a client, prior to initiating psychotherapy services, or as soon as practicably possible thereafter, a notice written in at least 12-point type that is in substantially the following form:

**NOTICE TO CLIENTS**

The (Name of office or unit) of the (Name of agency) receives and responds to complaints regarding the practice of psychotherapy by any unlicensed or unregistered ~~counselor~~ practitioner providing services at (Name of agency). To file a complaint, contact (Telephone number, email address, internet website, or mailing address of agency).

The Board of Behavioral Sciences receives and responds to complaints regarding services provided by individuals licensed and registered by the Board. If you have a complaint and are unsure if your practitioner is licensed or registered, please contact the Board of Behavioral Sciences at 916-574-7830 for assistance or utilize the Board's online license verification feature by visiting [www.bbs.ca.gov](http://www.bbs.ca.gov).

(3) The delivery of the notice to the client shall be documented.

(d) A marriage and family therapist licensed under this chapter is a licentiate for purposes of paragraph (2) of subdivision (a) of Section 805, and thus is a health care provider subject to the provisions of Section 2290.5 pursuant to subdivision (b) of that section.

(e) Notwithstanding subdivisions (b) and (c), all persons registered as associates or licensed under this chapter shall not be exempt from this chapter or the jurisdiction of the board.

**AMEND §4980.32.**

On and after July 1, 2020, a licensee or registrant shall provide a client with a notice written in at least 12-point type prior to initiating psychotherapy services, or as soon as practicably possible thereafter, that reads as follows:

NOTICE TO CLIENTS

The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of marriage and family therapists. You may contact the board online at [www.bbs.ca.gov](http://www.bbs.ca.gov), or by calling (916) 574-7830.

The delivery of the notice to the client shall be documented.

**AMEND §4989.17.**

On and after July 1, 2020, a licensee shall provide a client with a notice written in at least 12-point type prior to initiating psychological services, or as soon as practicably possible thereafter, that reads as follows:

NOTICE TO CLIENTS

The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of licensed educational psychologists. You may contact the board online at [www.bbs.ca.gov](http://www.bbs.ca.gov), or by calling (916) 574-7830.

The delivery of the notice to the client shall be documented.

**AMEND §4996.14. (Includes Chaptered Language From AB 630)**

(a) This chapter shall not be construed to constrict, limit, or withdraw the Medical Practice Act, the Licensed Marriage and Family Therapist Act, the Nursing Practice Act, the Licensed Professional Clinical Counselor Act, or the Psychology Licensing Law.

(b) This chapter shall not apply to an unlicensed or unregistered employee or volunteer working in a governmental entity, a school, a college, a university, or an institution that is both nonprofit and charitable if both of the following apply:

(1) The work of the employee or volunteer is performed solely under the supervision of the entity.

(2) On and after July 1, 2020, the employee or volunteer provides a client, prior to initiating psychotherapy services, or as soon as practicably possible thereafter, a notice written in at least 12-point type that is in substantially the following form:



## NOTICE TO CLIENTS

The (Name of office or unit) of the (Name of agency) receives and responds to complaints regarding the practice of psychotherapy by any unlicensed or unregistered ~~counselor~~ practitioner providing services at (Name of agency). To file a complaint, contact (Telephone number, email address, internet website, or mailing address of agency).

The Board of Behavioral Sciences receives and responds to complaints regarding services provided by individuals licensed and registered by the Board. If you have a complaint and are unsure if your practitioner is licensed or registered, please contact the Board of Behavioral Sciences at 916-574-7830 for assistance or utilize the Board's online license verification feature by visiting [www.bbs.ca.gov](http://www.bbs.ca.gov).

(3) The delivery of the notice to the client shall be documented.

(c) This chapter shall not apply to a person using hypnotic techniques if their client was referred by a physician and surgeon, dentist, or psychologist.

(d) This chapter shall not apply to a person using hypnotic techniques that offer vocational self-improvement, and the person is not performing therapy for emotional or mental disorders.

### **AMEND §4996.75.**

On and after July 1, 2020, a licensee or registrant shall provide a client with a notice written in at least 12-point type prior to initiating psychotherapy services, or as soon as practicably possible thereafter, that reads as follows:

## NOTICE TO CLIENTS

The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of clinical social workers. You may contact the board online at [www.bbs.ca.gov](http://www.bbs.ca.gov), or by calling (916) 574-7830.

The delivery of the notice to the client shall be documented.

### **AMEND §4999.22. CONSTRUCTION WITH OTHER LAWS; NONAPPLICATION TO CERTAIN PROFESSIONALS AND EMPLOYEES (Includes Chaptered Language From AB 630)**

(a) Nothing in this chapter shall prevent qualified persons from doing work of a psychosocial nature consistent with the standards and ethics of their respective professions. However, these qualified persons shall not hold themselves out to the public by any title or description of services incorporating the words "licensed professional clinical counselor" and shall not state that they are licensed to practice professional clinical counseling, unless they are otherwise licensed to provide professional clinical counseling services.

(b) Nothing in this chapter shall be construed to constrict, limit, or withdraw provisions of the Medical Practice Act, the Clinical Social Worker Practice Act, the Nursing Practice Act, the Psychology Licensing Law, or the Licensed Marriage and Family Therapist Act.

(c) This chapter shall not apply to any priest, rabbi, or minister of the gospel of any religious denomination who performs counseling services as part of their pastoral or professional duties, or to any person who is admitted to practice law in this state, or who is licensed to practice medicine, who provides counseling services as part of their professional practice.

(d) This chapter shall not apply to an unlicensed or unregistered employee or volunteer working in a governmental entity or a school, a college, a university, or an institution that is both nonprofit and charitable, if both of the following apply:

(1) The work of the employee or volunteer is performed solely under the supervision of the entity.

(2) On and after July 1, 2020, the employee or volunteer provides a client, prior to initiating psychotherapy services, or as soon as practicably possible thereafter, a notice written in at least 12-point type that is in substantially the following form:

#### NOTICE TO CLIENTS

The (Name of office or unit) of the (Name of agency) receives and responds to complaints regarding the practice of psychotherapy by any unlicensed or unregistered ~~counselor~~ practitioner providing services at (Name of agency). To file a complaint, contact (Telephone number, email address, internet website, or mailing address of agency).

The Board of Behavioral Sciences receives and responds to complaints regarding services provided by individuals licensed and registered by the Board. If you have a complaint and are unsure if your practitioner is licensed or registered, please contact the Board of Behavioral Sciences at 916-574-7830 for assistance or utilize the Board's online license verification feature by visiting [www.bbs.ca.gov](http://www.bbs.ca.gov).

(3) The delivery of the notice to the client shall be documented.

(e) All persons registered as associates or licensed under this chapter shall not be exempt from this chapter or the jurisdiction of the board.

#### **AMEND §4999.71.**

Effective July 1, 2020, a licensee or registrant shall provide a client with a notice written in at least 12-point type prior to initiating psychotherapy services, or as soon as practicably possible thereafter, that reads as follows:

## NOTICE TO CLIENTS

The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of professional clinical counselors. You may contact the board online at [www.bbs.ca.gov](http://www.bbs.ca.gov), or by calling (916) 574-7830.

[The delivery of the notice to the client shall be documented.](#)

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**ATTACHMENT B**  
**PENAL CODE §11166**

**Penal Code §11166.**

(a) Except as provided in subdivision (d), and in Section 11166.05, a mandated reporter shall make a report to an agency specified in Section 11165.9 whenever the mandated reporter, in the mandated reporter's professional capacity or within the scope of the mandated reporter's 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. The mandated reporter shall make an initial report by telephone to the agency immediately or as soon as is practicably possible, and shall prepare and send, fax, or electronically transmit a written followup report within 36 hours of receiving the information concerning the incident. The mandated reporter may include with the report any nonprivileged documentary evidence the mandated reporter possesses relating to the incident.

(1) For purposes of this article, "reasonable suspicion" means that it is objectively reasonable for a person to entertain a suspicion, based upon facts that could cause a reasonable person in a like position, drawing, when appropriate, on the person's training and experience, to suspect child abuse or neglect. "Reasonable suspicion" does not require certainty that child abuse or neglect has occurred nor does it require a specific medical indication of child abuse or neglect; any "reasonable suspicion" is sufficient. For purposes of this article, the pregnancy of a minor does not, in and of itself, constitute a basis for a reasonable suspicion of sexual abuse.

(2) The agency shall be notified and a report shall be prepared and sent, faxed, or electronically transmitted even if the child has expired, regardless of whether or not the possible abuse was a factor contributing to the death, and even if suspected child abuse was discovered during an autopsy.

(3) A report made by a mandated reporter pursuant to this section shall be known as a mandated report.

(b) If, after reasonable efforts, a mandated reporter is unable to submit an initial report by telephone, the mandated reporter shall immediately or as soon as is practicably possible, by fax or electronic transmission, make a one-time automated written report on the form prescribed by the Department of Justice, and shall also be available to respond to a telephone followup call by the agency with which the mandated reporter filed the report. A mandated reporter who files a one-time automated written report because the mandated reporter was unable to submit an initial report by telephone is not required to submit a written followup report.

(1) The one-time automated written report form prescribed by the Department of Justice shall be clearly identifiable so that it is not mistaken for a standard written followup report. In addition, the automated one-time report shall contain a section that allows the mandated reporter to state the reason the initial telephone call was not able to be completed. The reason for the submission of the one-time automated written report in

lieu of the procedure prescribed in subdivision (a) shall be captured in the Child Welfare Services/Case Management System (CWS/CMS). The department shall work with stakeholders to modify reporting forms and the CWS/CMS as is necessary to accommodate the changes enacted by these provisions.

(2) This subdivision shall not become operative until the CWS/CMS is updated to capture the information prescribed in this subdivision.

(3) This subdivision shall become inoperative three years after this subdivision becomes operative or on January 1, 2009, whichever occurs first.

(4) This section does not supersede the requirement that a mandated reporter first attempt to make a report via telephone, or that agencies specified in Section 11165.9 accept reports from mandated reporters and other persons as required.

(c) A mandated reporter who fails to report an incident of known or reasonably suspected child abuse or neglect as required by this section is guilty of a misdemeanor punishable by up to six months confinement in a county jail or by a fine of one thousand dollars (\$1,000) or by both that imprisonment and fine. If a mandated reporter intentionally conceals the mandated reporter's failure to report an incident known by the mandated reporter to be abuse or severe neglect under this section, the failure to report is a continuing offense until an agency specified in Section 11165.9 discovers the offense.

(d) (1) A clergy member who acquires knowledge or a reasonable suspicion of child abuse or neglect during a penitential communication is not subject to subdivision (a). For the purposes of this subdivision, "penitential communication" means a communication, intended to be in confidence, including, but not limited to, a sacramental confession, made to a clergy member who, in the course of the discipline or practice of the clergy member's church, denomination, or organization, is authorized or accustomed to hear those communications, and under the discipline, tenets, customs, or practices of the clergy member's church, denomination, or organization, has a duty to keep those communications secret.

(2) Nothing in this subdivision shall be construed to modify or limit a clergy member's duty to report known or suspected child abuse or neglect when the clergy member is acting in some other capacity that would otherwise make the clergy member a mandated reporter.

(3) (A) On or before January 1, 2004, a clergy member or any custodian of records for the clergy member may report to an agency specified in Section 11165.9 that the clergy member or any custodian of records for the clergy member, prior to January 1, 1997, in the clergy member's professional capacity or within the scope of the clergy member's employment, other than during a penitential communication, acquired knowledge or had a reasonable suspicion that a child had been the victim of sexual abuse and that the clergy member or any custodian of records for the clergy member did not previously report the abuse to an agency specified in Section 11165.9. The provisions of Section 11172 shall apply to all reports made pursuant to this paragraph.

(B) This paragraph shall apply even if the victim of the known or suspected abuse has reached the age of majority by the time the required report is made.

(C) The local law enforcement agency shall have jurisdiction to investigate any report of child abuse made pursuant to this paragraph even if the report is made after the victim has reached the age of majority.

(e) (1) A commercial film, photographic print, or image processor who has knowledge of or observes, within the scope of that person's professional capacity or employment, any film, photograph, videotape, negative, slide, or any representation of information, data, or an image, including, but not limited to, any film, filmstrip, photograph, negative, slide, photocopy, videotape, video laser disc, computer hardware, computer software, computer floppy disk, data storage medium, CD-ROM, computer-generated equipment, or computer-generated image depicting a child under 16 years of age engaged in an act of sexual conduct, shall, immediately or as soon as practicably possible, telephonically report the instance of suspected abuse to the law enforcement agency located in the county in which the images are seen. Within 36 hours of receiving the information concerning the incident, the reporter shall prepare and send, fax, or electronically transmit a written followup report of the incident with a copy of the image or material attached.

(2) A commercial computer technician who has knowledge of or observes, within the scope of the technician's professional capacity or employment, any representation of information, data, or an image, including, but not limited to, any computer hardware, computer software, computer file, computer floppy disk, data storage medium, CD-ROM, computer-generated equipment, or computer-generated image that is retrievable in perceivable form and that is intentionally saved, transmitted, or organized on an electronic medium, depicting a child under 16 years of age engaged in an act of sexual conduct, shall immediately, or as soon as practicably possible, telephonically report the instance of suspected abuse to the law enforcement agency located in the county in which the images or materials are seen. As soon as practicably possible after receiving the information concerning the incident, the reporter shall prepare and send, fax, or electronically transmit a written followup report of the incident with a brief description of the images or materials.

(3) For purposes of this article, "commercial computer technician" includes an employee designated by an employer to receive reports pursuant to an established reporting process authorized by subparagraph (B) of paragraph (43) of subdivision (a) of Section 11165.7.

(4) As used in this subdivision, "electronic medium" includes, but is not limited to, a recording, CD-ROM, magnetic disk memory, magnetic tape memory, CD, DVD, thumbdrive, or any other computer hardware or media.

(5) As used in this subdivision, "sexual conduct" means any of the following:

(A) Sexual intercourse, including genital-genital, oral-genital, anal-genital, or oral-anal, whether between persons of the same or opposite sex or between humans and animals.

(B) Penetration of the vagina or rectum by any object.

(C) Masturbation for the purpose of sexual stimulation of the viewer.

(D) Sadomasochistic abuse for the purpose of sexual stimulation of the viewer.

(E) Exhibition of the genitals, pubic, or rectal areas of a person for the purpose of sexual stimulation of the viewer.

(f) Any mandated reporter who knows or reasonably suspects that the home or institution in which a child resides is unsuitable for the child because of abuse or neglect of the child shall bring the condition to the attention of the agency to which, and at the same time as, the mandated reporter makes a report of the abuse or neglect pursuant to subdivision (a).

(g) Any other person who has knowledge of or observes a child whom the person knows or reasonably suspects has been a victim of child abuse or neglect may report the known or suspected instance of child abuse or neglect to an agency specified in Section 11165.9. For purposes of this section, "any other person" includes a mandated reporter who acts in the person's private capacity and not in the person's professional capacity or within the scope of the person's employment.

(h) When two or more persons, who are required to report, jointly have knowledge of a known or suspected instance of child abuse or neglect, and when there is agreement among them, the telephone report may be made by a member of the team selected by mutual agreement and a single report may be made and signed by the selected member of the reporting team. Any member who has knowledge that the member designated to report has failed to do so shall thereafter make the report.

(i) (1) The reporting duties under this section are individual, and no supervisor or administrator may impede or inhibit the reporting duties, and no person making a report shall be subject to any sanction for making the report. However, internal procedures to facilitate reporting and apprise supervisors and administrators of reports may be established provided that they are not inconsistent with this article. An internal policy shall not direct an employee to allow the employee's supervisor to file or process a mandated report under any circumstances.

(2) The internal procedures shall not require any employee required to make reports pursuant to this article to disclose the employee's identity to the employer.

(3) Reporting the information regarding a case of possible child abuse or neglect to an employer, supervisor, school principal, school counselor, coworker, or other person shall not be a substitute for making a mandated report to an agency specified in Section 11165.9.

(j) (1) A county probation or welfare department shall immediately, or as soon as practicably possible, report by telephone, fax, or electronic transmission to the law enforcement agency having jurisdiction over the case, to the agency given the responsibility for investigation of cases under Section 300 of the Welfare and Institutions Code, and to the district attorney's office every known or suspected instance of child abuse or neglect, as defined in Section 11165.6, except acts or omissions coming within subdivision (b) of Section 11165.2, or reports made pursuant to Section 11165.13 based on risk to a child that relates solely to the inability of the parent to provide the child with regular care due to the parent's substance abuse, which shall be reported only to the county welfare or probation department. A county probation or welfare department also shall send, fax, or electronically transmit a written report thereof within



36 hours of receiving the information concerning the incident to any agency to which it makes a telephone report under this subdivision.

(2) A county probation or welfare department shall immediately, and in no case in more than 24 hours, report to the law enforcement agency having jurisdiction over the case after receiving information that a child or youth who is receiving child welfare services has been identified as the victim of commercial sexual exploitation, as defined in subdivision (d) of Section 11165.1.

(3) When a child or youth who is receiving child welfare services and who is reasonably believed to be the victim of, or is at risk of being the victim of, commercial sexual exploitation, as defined in Section 11165.1, is missing or has been abducted, the county probation or welfare department shall immediately, or in no case later than 24 hours from receipt of the information, report the incident to the appropriate law enforcement authority for entry into the National Crime Information Center database of the Federal Bureau of Investigation and to the National Center for Missing and Exploited Children.

(k) A law enforcement agency shall immediately, or as soon as practicably possible, report by telephone, fax, or electronic transmission to the agency given responsibility for investigation of cases under Section 300 of the Welfare and Institutions Code and to the district attorney's office every known or suspected instance of child abuse or neglect reported to it, except acts or omissions coming within subdivision (b) of Section 11165.2, which shall be reported only to the county welfare or probation department. A law enforcement agency shall report to the county welfare or probation department every known or suspected instance of child abuse or neglect reported to it which is alleged to have occurred as a result of the action of a person responsible for the child's welfare, or as the result of the failure of a person responsible for the child's welfare to adequately protect the minor from abuse when the person responsible for the child's welfare knew or reasonably should have known that the minor was in danger of abuse. A law enforcement agency also shall send, fax, or electronically transmit a written report thereof within 36 hours of receiving the information concerning the incident to any agency to which it makes a telephone report under this subdivision.

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www.bbs.ca.gov

**To:** Committee Members **Date:** January 13, 2020  
**From:** Rosanne Helms  
Legislative Manager **Telephone:** (916) 574-7897  
**Subject: Setting Definitions Bill Proposal: Discussion of Supervisor Work  
Setting Requirements**

At its November 22, 2019 meeting, the Board of Behavioral Sciences (Board) approved language for a bill proposal that provides concise definitions of the types of settings where its licensees and pre-licensees work.

The goal of the proposal is to reduce the confusion that often arises of where pre-licensees may or may not work based on how a business is structured. While the Board approved the bill and directed staff to pursue a legislative proposal, it determined one aspect should be brought back to a future meeting for further discussion.

### Proposed Language

The language approved by the Board can be found in **Attachment A** (for LMFTs), **Attachment B** (for LPCCs), and **Attachment C** (for LCSWs). Highlights of the bill proposal are as follows:

1. The proposal classifies all settings into two main types: exempt settings and non-exempt settings. The definition of exempt settings remains the same. Non-exempt settings are all settings that do not qualify as exempt settings.
2. The proposal carves out definitions of two special types of non-exempt settings: private practices and professional corporations. These definitions are used to place certain limitations on pre-licensees working in these specific types of settings.
3. The proposal limits supervisors in any non-exempt setting to **six** individual or triadic supervisees at a time. (In current law, the limit is **three** associates per supervisor in a **private practice or a corporation, and no limitation in all other types of settings.**)

4. The proposal requires that **in a private practice or a professional corporation**, the supervisor of an associate must be employed or contracted by the associate's employer, or be an owner of the practice; and they must also provide psychotherapeutic services to clients at the same site. (In current law, associates in a private practice must be supervised by a supervisor who is employed by and practices at the same site as them (or the supervisor may be an owner). If the site is incorporated, the supervisor must be employed at the site full time and be actively engaged in performing professional services there.)

#### Item for Further Discussion

Today's discussion is intended to focus on item #4 of the list above.

*The proposal requires that **in a private practice or a professional corporation**, the supervisor of an associate must be employed or contracted by the associate's employer, or be an owner of the practice; and they must also provide psychotherapeutic services to clients at the same site.*

The question that arose is whether it would be appropriate to extend this requirement to supervisors of associates and trainees in all non-exempt settings, not just those in a private practice or professional corporation.

Currently, the law does not place any such restrictions on a setting that does not qualify as a private practice or a professional corporation. Some items for consideration include the following:

- It is possible these sites (non-exempt settings that are not private practices or professional corporations) may have additional internal or government oversight that makes such a requirement less necessary.
- Some businesses that employ pre-licensed therapists may have a number of different sites or branches, and may have individuals employed just to supervise (not see clients) that travel from site-to-site. Therefore, the effects of requiring practice at the same site for these settings should be weighed against the often-limited supply of supervisors. (As noted in item #3 above, this bill proposal is already newly limiting the number of supervisees to supervisor in all non-exempt settings to six.)
- The effect on trainees should also be considered. Since trainees are not permitted to work in a private practice or professional corporation, the proposed supervisor restrictions in item #4 currently do not apply to them. However, if the proposed restrictions were extended to apply to all non-exempt settings, they would be affected, as the bill permits trainees to work in non-exempt settings that are not a private practice or a professional corporation. (This similarly would also affect applicants for registration who are utilizing the 90-day rule.)

Due to the uncertainty of how extending this limitation to all non-exempt settings would affect the supply of supervisors available to associates and trainees, staff suggests leaving the proposal as written for now (i.e. the restriction on requiring the supervisor to practice psychotherapeutic services at the same site would only apply to private practice and professional corporations). If concerns arose in the future, this topic could be reconsidered.

### Recommendation

Conduct an open discussion about the provision in BPC §§4980.43.4(b) (LMFTs), 4996.23.3(b) (LCSWs), and 4999.46.4(b) (LPCCs) to determine if any amendments are needed.

### Attachments

**Attachment A:** Proposed Language: LMFT

**Attachment B:** Proposed Language: LPCC

**Attachment C:** Proposed Language: LCSW

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**ATTACHMENT A  
PROPOSED LANGUAGE: LMFT**

**AMEND §4980.01. CONSTRUCTION WITH OTHER LAWS; NONAPPLICATION TO CERTAIN PROFESSIONALS AND EMPLOYEES (Incorporates AB 630 Amendments)**

(a) This chapter shall not be construed to constrict, limit, or withdraw the Medical Practice Act, the Social Work Licensing Law, the Nursing Practice Act, the Licensed Professional Clinical Counselor Act, or the Psychology Licensing Law.

(b) This chapter shall not apply to any priest, rabbi, or minister of the gospel of any religious denomination when performing counseling services as part of their pastoral or professional duties, or to any person who is admitted to practice law in the state, or a physician and surgeon who provides counseling services as part of their professional practice.

(c) This chapter shall not apply to an unlicensed or unregistered employee or volunteer working in a governmental entity, a school, a college, a university, or an institution that is both nonprofit and charitable if both of the following apply:

(1) The work of the employee or volunteer is performed ~~solely under the supervision~~ under the oversight and direction of the entity.

(2) On and after July 1, 2020, the employee or volunteer provides a client, prior to initiating psychotherapy services, a notice written in at least 12-point type that is in substantially the following form:

**NOTICE TO CLIENTS**

The (Name of office or unit) of the (Name of agency) receives and responds to complaints regarding the practice of psychotherapy by any unlicensed or unregistered counselor providing services at (Name of agency). To file a complaint, contact (Telephone number, email address, internet website, or mailing address of agency).

(d) A marriage and family therapist licensed under this chapter is a licentiate for purposes of paragraph (2) of subdivision (a) of Section 805, and thus is a health care provider subject to the provisions of Section 2290.5 pursuant to subdivision (b) of that section.

(e) Notwithstanding subdivisions (b) and (c), all persons registered as associates or licensed under this chapter shall not be exempt from this chapter or the jurisdiction of the board.

## ADD §4980.05 EXEMPT SETTINGS

The settings described in section 4980.01 are exempt settings and do not fall under the jurisdiction of this chapter or the Board except as specified in section 4980.01, and with the following exceptions:

- (a) Any individual working or volunteering in an exempt setting who is licensed or registered under this chapter shall fall under the jurisdiction of the Board and is not exempt from this chapter.
- (b) An entity that is **licensed or certified by a government regulatory agency to provide health care services** shall not be considered an exempt setting unless it directly meets the criteria described in section 4980.01.

## ADD §4980.06 OTHER TYPES OF PRACTICE SETTINGS

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

1. A “non-exempt setting” is any type of setting that does not qualify as an exempt setting, as specified in section 4980.01.
  2. A “private practice” is a type of non-exempt setting that meets the following criteria:
    - (A) The practice is owned by a health professional who is licensed under Division 2 of the Code, either independently or jointly with one or more other health professionals who are licensed under Division 2 of the Code;
    - (B) The practice provides clinical mental health services, including psychotherapy, to clients; and
    - (C) One or more licensed health professionals are responsible for the practice and for the services provided and set conditions of client payment or reimbursement for the provision of services.
  3. A “professional corporation” is a type of non-exempt setting and private practice that has been formed pursuant to Part 4 of Division 3 of Title 1 of the Corporations Code (commencing with section 13400).
  4. An entity that is **licensed or certified by a government regulatory agency to provide health care services** shall not be considered a private practice setting.
- (b) An active license or registration number shall be required to engage in the practice of marriage and family therapy as defined in section 4980.02, in non-exempt settings at all times with the following exceptions:



1. A trainee may engage in the practice of marriage and family therapy in a non-exempt setting that is not a private practice or a professional corporation while they are gaining supervised experience that meets the requirements of this chapter under the jurisdiction and supervision of their school as specified in section 4980.42.
2. An applicant for registration as an associate may engage in the practice of marriage and family therapy in a non-exempt setting that is not a private practice or a professional corporation before the registration number is issued if they are in compliance with subdivision (b) of section 4980.43 and are gaining supervised experience that meets the requirements of this chapter.

**AMEND §4980.43. SUPERVISED EXPERIENCE: ASSOCIATES OR TRAINEES  
(Incorporates AB 1651 Amendments)**

(a) Except as provided in subdivision (b), all applicants shall have an active associate registration with the board in order to gain postdegree hours of supervised experience.

(b) (1) ~~Preregistered postdegree hours~~ Post-degree hours of experience gained prior to issuance of an associate registration shall be credited toward licensure if all of the following apply:

(A) The registration applicant applies for the associate registration and the board receives the application within 90 days of the granting of the qualifying master's degree or doctoral degree.

(B) For applicants completing graduate study on or after January 1, 2020, the experience is obtained at a workplace that, prior to the registration applicant gaining supervised experience hours, requires completed Live Scan fingerprinting. The applicant shall provide the board with a copy of that completed State of California "Request for Live Scan Service" form with the application for licensure.

(C) The board subsequently grants the associate registration.

(2) The applicant shall not be employed or volunteer in a private practice or a professional corporation until the applicant has been issued an associate registration by the board.

(c) Supervised experience that is obtained for purposes of qualifying for licensure shall be related to the practice of marriage and family therapy and comply with the following:

(1) A minimum of 3,000 hours completed during a period of at least 104 weeks.

(2) A maximum of 40 hours in any seven consecutive days.

(3) A minimum of 1,700 hours obtained after the qualifying master's or doctoral degree was awarded.

(4) A maximum of 1,300 hours obtained prior to the award date of the qualifying master's or doctoral degree.

- (5) A maximum of 750 hours of counseling and direct supervisor contact prior to the award date of the qualifying master's or doctoral degree.
- (6) Hours of experience shall not be gained prior to completing either 12 semester units or 18 quarter units of graduate instruction.
- (7) Hours of experience shall not have been gained more than six years prior to the date the application for licensure was received by the board, except that up to 500 hours of clinical experience gained in the supervised practicum required by subdivision (c) of Section 4980.37 and subparagraph (B) of paragraph (1) of subdivision (d) of Section 4980.36 shall be exempt from this six-year requirement.
- (8) A minimum of 1,750 hours of direct clinical counseling with individuals, groups, couples, or families, that includes not less than 500 total hours of experience in diagnosing and treating couples, families, and children.
- (9) A maximum of 1,200 hours gained under the supervision of a licensed educational psychologist providing educationally related mental health services that are consistent with the scope of practice of an educational psychologist, as specified in Section 4989.14.
- (10) A maximum of 1,250 hours of nonclinical practice, consisting of direct supervisor contact, administering and evaluating psychological tests, writing clinical reports, writing progress or process notes, client centered advocacy, and workshops, seminars, training sessions, or conferences directly related to marriage and family therapy that have been approved by the applicant's supervisor.
- (11) It is anticipated and encouraged that hours of experience will include working with elders and dependent adults who have physical or mental limitations that restrict their ability to carry out normal activities or protect their rights.

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

(d) An individual who submits an application for licensure between January 1, 2016, and December 31, 2020, may alternatively qualify under the experience requirements of this section that were in place on January 1, 2015.

#### **AMEND §4980.43.2. DIRECT SUPERVISOR CONTACT**

- (a) Except for experience gained by attending workshops, seminars, training sessions, or conferences, as described in paragraph (9) of subdivision (a) of Section 4980.43, direct supervisor contact shall occur as follows:
- (1) Supervision shall include at least one hour of direct supervisor contact in each week for which experience is credited in each work setting.
  - (2) A trainee shall receive an average of at least one hour of direct supervisor contact for every five hours of direct clinical counseling performed each week in each setting. For experience gained on or after January 1, 2009, no more than six

hours of supervision, whether individual, triadic, or group, shall be credited during any single week.

- (3) An associate gaining experience who performs more than 10 hours of direct clinical counseling in a week in any setting shall receive at least one additional hour of direct supervisor contact for that setting. For experience gained on or after January 1, 2009, no more than six hours of supervision, whether individual, triadic, or group, shall be credited during any single week.
- (4) Of the 104 weeks of required supervision, 52 weeks shall be individual supervision, triadic supervision, or a combination of both.

(b) For purposes of this chapter, “one hour of direct supervisor contact” means any of the following:

- (1) Individual supervision, which means one hour of face-to-face contact between one supervisor and one supervisee.
- (2) Triadic supervision, which means one hour of face-to-face contact between one supervisor and two supervisees.
- (3) Group supervision, which means two hours of face-to-face contact between one supervisor and no more than eight supervisees. Segments of group supervision may be split into no less than one continuous hour. A supervisor shall ensure that the amount and degree of supervision is appropriate for each supervisee.

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

(d) Alternative supervision may be arranged during a supervisor’s vacation or sick leave if the alternative supervision meets the requirements in this chapter and regulation.

(de) Notwithstanding subdivision (b), an associate a supervisee working in a governmental entity, school, college, university, or an institution that is nonprofit and charitable an exempt setting described in section 4980.01 may obtain the required weekly direct supervisor contact via two-way, real-time videoconferencing. The supervisor shall be responsible for ensuring compliance with federal and state laws relating to confidentiality of patient health information.

(ef) Notwithstanding any other law, once the required number of experience hours are gained, associates and applicants for licensure shall receive a minimum of one hour of direct supervisor contact per week for each practice setting in which direct clinical counseling is performed. Once the required number of experience hours are gained, further supervision for nonclinical practice, as defined in paragraph (9) of subdivision (a) of Section 4980.43, shall be at the supervisor’s discretion.

**AMEND §4980.43.3. SUPERVISED EXPERIENCE: ACCEPTABLE SETTINGS;  
ACCEPTABLE SUPERVISION PRACTICES**

- (a) A trainee, associate, or applicant for licensure shall only perform mental health and related services as an employee or volunteer, and not as an independent contractor. The requirements of this chapter regarding hours of experience and supervision shall apply equally to employees and volunteers. A trainee, associate, or applicant for licensure shall not perform any services or gain any experience within the scope of practice of the profession, as defined in Section 4980.02, as an independent contractor. While an associate may be either a paid employee or a volunteer, employers are encouraged to provide fair remuneration.
- (1) If employed, an associate shall provide the board, upon application for licensure, with copies of the W-2 tax forms for each year of experience claimed.
- (2) If volunteering, an associate shall provide the board, upon application for licensure, with a letter from his or her employer verifying the associate's status as a volunteer during the dates the experience was gained.
- (b) (1) A trainee shall not perform services in a private practice or a professional corporation. A trainee may be credited with supervised experience completed in a setting that meets all of the following:
- (A) Is not a private practice or a professional corporation.
- (B) Lawfully and regularly provides mental health counseling or psychotherapy.
- (C) Provides oversight to ensure that the trainee's work at the setting meets the experience and supervision requirements in this chapter and is within the scope of practice for the profession, as defined in Section 4980.02.
- (2) Only experience gained in the position for which the trainee volunteers or is employed shall qualify as supervised experience.
- (c) (1) An associate may be credited with supervised experience completed in any setting that meets both of the following:
- (1)(A) Lawfully and regularly provides mental health counseling or psychotherapy.
- (2)(B) Provides oversight to ensure that the associate's work at the setting meets the experience and supervision requirements in this chapter and is within the scope of practice for the profession, as defined in Section 4980.02.
- (3)(2) Only experience gained in the position for which the associate volunteers or is employed shall qualify as supervised experience.

- (4)(3) An applicant for registration as an associate shall not be employed or volunteer in a private practice or a professional corporation until he or she has been issued an associate registration by the board.
- (d) Any experience obtained under the supervision of a spouse, relative, or domestic partner shall not be credited toward the required hours of supervised experience. Any experience obtained under the supervision of a supervisor with whom the applicant has had or currently has a personal, professional, or business relationship that undermines the authority or effectiveness of the supervision shall not be credited toward the required hours of supervised experience.
- (e) A trainee, associate, or applicant for licensure shall not receive any remuneration from patients or clients and shall only be paid by his or her employer, if an employee.
- (f) A trainee, associate, or applicant for licensure shall have no proprietary interest in his or her employer's business and shall not lease or rent space, pay for furnishings, equipment, or supplies, or in any other way pay for the obligations of his or her employer.
- (g) A trainee, associate, or applicant for licensure who provides voluntary services in any lawful work setting ~~other than a private practice~~ and who only receives reimbursement for expenses actually incurred shall be considered an employee. The board may audit an applicant for licensure who ~~receives~~received reimbursement for expenses and the applicant for licensure shall have the burden of demonstrating that the payment received was for reimbursement of expenses actually incurred.
- (h) A trainee, associate, or applicant for licensure who receives a stipend or educational loan repayment from a program designed to encourage demographically underrepresented groups to enter the profession or to improve recruitment and retention in underserved regions or settings shall be considered an employee. The board may audit an applicant who receives a stipend or educational loan repayment and the applicant shall have the burden of demonstrating that the payment received was for the specified purposes.
- (i) An associate or a trainee may provide services via telehealth that are in the scope of practice outlined in this chapter.
- (j) Each educational institution preparing applicants pursuant to this chapter shall consider requiring, and shall encourage, its students to undergo individual, marital, conjoint, family, or group counseling or psychotherapy, as appropriate. Each supervisor shall consider, advise, and encourage his or her associates and trainees regarding the advisability of undertaking individual, marital, conjoint, family, or group counseling or psychotherapy, as appropriate. Insofar as it is deemed appropriate and is desired by the applicant, educational institutions and supervisors are

encouraged to assist the applicant to locate counseling or psychotherapy at a reasonable cost.

**AMEND §4980.43.4. SUPERVISEES: LOCATION OF SERVICES; MAXIMUM NUMBER OF SUPERVISEES; OVERSIGHT AGREEMENT (Incorporates SB 786 Amendments)**

(a) A trainee, associate, or applicant for licensure shall only perform mental health and related services at the places where their employer permits business to be conducted.

(b) An associate who is employed by or volunteering in a private practice or a professional corporation shall be supervised by an individual who: is employed by, and shall practice at the same site as, the associate's employer. Alternatively, the supervisor may be an owner of the private practice. However, if the site is incorporated, the supervisor must be employed full-time at the site and be actively engaged in performing professional services at the site.

(1) Is employed by or contracted by the associate's employer, or is an owner of the private practice or professional corporation, and

(2) Provides psychotherapeutic services to clients at the same site as the associate.

~~(c) A supervisor at a private practice or a corporation shall not supervise more than a total of three supervisees at any one time. Supervisees may be registered as an associate marriage and family therapist, an associate professional clinical counselor, or an associate clinical social worker.~~

(c) Supervisors of supervisees in a non-exempt setting shall not serve as an individual or triadic supervisor for more than a total of six supervisees at any time. Supervisees may be registered as associate marriage and family therapists, associate professional clinical counselors, associate clinical social workers, or any combination of these.

~~(d) In a setting that is not a private practice:~~

~~(1) A written oversight agreement, as specified by regulation, shall be executed between the supervisor and employer when the supervisor is not employed by the supervisee's employer or is a volunteer.~~

~~(2) A supervisor shall evaluate the site or sites where a trainee or associate will be gaining experience to determine that the site or sites comply with the requirements set forth in this chapter.~~

(d) A written oversight agreement, as specified by regulation, shall be executed between the supervisor and employer when the supervisor is not employed by the supervisee's employer or is a volunteer. The supervisor shall evaluate the site or

sites where the supervisee will be gaining experience to determine that the site or sites comply with the requirements set forth in this chapter.

~~(e) Alternative supervision may be arranged during a supervisor's vacation or sick leave if the alternative supervision meets the requirements in this chapter and regulation.~~

#### **AMEND §4980.46. FICTITIOUS BUSINESS NAMES**

Any licensed marriage and family therapist who ~~conducts a private practice~~ owns a business under utilizing a fictitious business name shall not use any name which is false, misleading, or deceptive, and shall inform the patient, prior to the commencement of treatment, of the name and license designation of the owner or owners of the practice.

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**ATTACHMENT B  
PROPOSED LANGUAGE: LPCC**

**AMEND §4999.22. CONSTRUCTION WITH OTHER LAWS; NONAPPLICATION TO CERTAIN PROFESSIONALS AND EMPLOYEES (Incorporates AB 630 Amendments)**

(a) Nothing in this chapter shall prevent qualified persons from doing work of a psychosocial nature consistent with the standards and ethics of their respective professions. However, these qualified persons shall not hold themselves out to the public by any title or description of services incorporating the words “licensed professional clinical counselor” and shall not state that they are licensed to practice professional clinical counseling, unless they are otherwise licensed to provide professional clinical counseling services.

(b) Nothing in this chapter shall be construed to constrict, limit, or withdraw provisions of the Medical Practice Act, the Clinical Social Worker Practice Act, the Nursing Practice Act, the Psychology Licensing Law, or the Licensed Marriage and Family Therapist Act.

(c) This chapter shall not apply to any priest, rabbi, or minister of the gospel of any religious denomination who performs counseling services as part of their pastoral or professional duties, or to any person who is admitted to practice law in this state, or who is licensed to practice medicine, who provides counseling services as part of their professional practice.

(d) This chapter shall not apply to an unlicensed or unregistered employee or volunteer working in a governmental entity or a school, a college, a university, or an institution that is both nonprofit and charitable, if both of the following apply:

(1) The work of the employee or volunteer is performed ~~solely under the supervision of~~ under the oversight and direction of the entity.

(2) On and after July 1, 2020, the employee or volunteer provides a client, prior to initiating psychotherapy services, a notice written in at least 12-point type that is in substantially the following form:

**NOTICE TO CLIENTS**

The (Name of office or unit) of the (Name of agency) receives and responds to complaints regarding the practice of psychotherapy by any unlicensed or unregistered counselor providing services at (Name of agency). To file a complaint, contact (Telephone number, email address, internet website, or mailing address of agency).

(e) Notwithstanding subdivisions (c) and (d), all A# persons registered as associates or licensed under this chapter shall not be exempt from this chapter or the jurisdiction of the board.

## ADD §4999.25 EXEMPT SETTINGS

The settings described in section 4999.22 are exempt settings and do not fall under the jurisdiction of this chapter or the board except as specified in section 4980.01, and with the following exceptions:

- (a) Any individual working or volunteering in an exempt setting who is licensed or registered under this chapter shall fall under the jurisdiction of the board and is not exempt from this chapter.
- (b) An entity that is **licensed or certified by a government regulatory agency to provide health care services** shall not be considered an exempt setting unless it directly meets the criteria described in section 4980.01.

## ADD §4999.26 OTHER TYPES OF PRACTICE SETTINGS

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

1. A “non-exempt setting” is any type of setting that does not qualify as an exempt setting, as specified in section 4999.22.
2. A “private practice” is a type of non-exempt setting that meets the following criteria:
  - (A) The practice is owned by a health professional who is licensed under Division 2 of the Code, either independently or jointly with one or more other health professionals who are licensed under Division 2 of the Code;
  - (B) The practice provides clinical mental health services, including psychotherapy, to clients; and
  - (C) One or more licensed health professionals are responsible for the practice and for the services provided and set conditions of client payment or reimbursement for the provision of services.
3. A “professional corporation” is a type of non-exempt setting and private practice that has been formed pursuant to Part 4 of Division 3 of Title 1 of the Corporations Code (commencing with section 13400).
4. An entity that is **licensed or certified by a government regulatory agency to provide health care services** shall not be considered a private practice setting.

(b) An active license or registration number shall be required to engage in the practice of professional clinical counseling as defined in section 4999.20, in non-exempt settings at all times with the following exceptions:

1. A trainee may engage in the practice of professional clinical counseling in a non-exempt setting that is not a private practice or a professional corporation while they are gaining supervised experience that meets the requirements of this chapter under the jurisdiction and supervision of their school as specified in section 4999.36.
2. An applicant for registration as an associate may engage in the practice of professional clinical counseling in a non-exempt setting that is not a private practice or a professional corporation before the registration number is issued if they are in compliance with subdivision (b) of section 4999.46 and are gaining supervised experience that meets the requirements of this chapter.

### **RENUMBER AND AMEND ~~§4999.24~~4999.27 TRAINEE SERVICES**

(a) Nothing in this chapter shall restrict or prevent activities of a psychotherapeutic or counseling nature on the part of persons employed by accredited or state-approved academic institutions, public schools, government agencies, or nonprofit institutions ~~engaged in the training of graduate students or clinical counselor trainees pursuing a course of study leading to~~ who train graduate students pursuing a degree that qualifies for professional clinical counselor licensure at an accredited or state-approved college or university, ~~or working in a recognized training program,~~ provided that these activities and services constitute a part of a supervised course of study and that those persons are designated by a title such as “clinical counselor trainee” or other title clearly indicating the training status appropriate to the level of training.

(b) Notwithstanding subdivision (a), a graduate student shall not perform professional clinical counseling in a private practice or a professional corporation.

### **AMEND §4999.46. SUPERVISED POST-MASTER’S EXPERIENCE (Includes AB 1651 Amendments)**

(a) Except as provided in subdivision (b), all applicants shall have an active associate registration with the board in order to gain postdegree hours of supervised experience.

(b) (1) ~~Preregistered postdegree~~ Post-degree hours of experience gained prior to issuance of an associate registration shall be credited toward licensure if all of the following apply:

(A) The registration applicant applies for the associate registration and the board receives the application within 90 days of the granting of the qualifying master’s degree or doctoral degree.

(B) For applicants completing graduate study on or after January 1, 2020, the experience is obtained at a workplace that, prior to the registration applicant gaining supervised experience hours, requires completed Live Scan fingerprinting. The applicant shall provide the board with a copy of that completed State of California “Request for Live Scan Service” form with their application for licensure.

(C) The board subsequently grants the associate registration.

(2) The applicant shall not be employed or volunteer in a private practice or a professional corporation until they have been issued an associate registration by the board.

(c) Supervised experience that is obtained for the purposes of qualifying for licensure shall be related to the practice of professional clinical counseling and comply with the following:

(1) A minimum of 3,000 postdegree hours performed over a period of not less than two years (104 weeks).

(2) Not more than 40 hours in any seven consecutive days.

(3) Not less than 1,750 hours of direct clinical counseling with individuals, groups, couples, or families using a variety of psychotherapeutic techniques and recognized counseling interventions.

(4) Not less than 150 hours of clinical experience in a hospital or community mental health setting, as defined in Section 4999.12.

(5) A maximum of 1,250 hours of nonclinical practice, consisting of direct supervisor contact, administering and evaluating psychological tests, writing clinical reports, writing progress or process notes, client centered advocacy, and workshops, seminars, training sessions, or conferences directly related to professional clinical counseling that have been approved by the applicant’s supervisor.

(6) A maximum of 1,200 hours gained under the supervision of a licensed educational psychologist providing educationally related mental health services that are consistent with the scope of practice of an educational psychologist, as specified in Section 4989.14.

(d) An individual who submits an application for licensure between January 1, 2016, and December 31, 2020, may alternatively qualify under the experience requirements of this section that were in place on January 1, 2015.

(e) Experience hours shall not have been gained more than six years prior to the date the application for licensure was received by the board.

## AMEND §4999.46.2. DIRECT SUPERVISOR CONTACT

- (a) Except for experience gained by attending workshops, seminars, training sessions, or conferences, as described in paragraph (5) of subdivision (c) of Section 4999.46, direct supervisor contact shall occur as follows:
- (1) Supervision shall include at least one hour of direct supervisor contact in each week for which experience is credited in each work setting.
  - (2) A trainee shall receive an average of at least one hour of direct supervisor contact for every five hours of direct clinical counseling performed each week in each setting. For experience gained after January 1, 2009, no more than six hours of supervision, whether individual, triadic, or group, shall be credited during any single week.
  - (3) An associate gaining experience who performs more than 10 hours of direct clinical counseling in a week in any setting shall receive at least one additional hour of direct supervisor contact for that setting. For experience gained after January 1, 2009, no more than six hours of supervision, whether individual supervision, triadic supervision, or group supervision, shall be credited during any single week.
  - (4) Of the 104 weeks of required supervision, 52 weeks shall be individual supervision, triadic supervision, or a combination of both.
- (b) For purposes of this chapter, “one hour of direct supervisor contact” means any of the following:
- (1) Individual supervision, which means one hour of face-to-face contact between one supervisor and one supervisee.
  - (2) Triadic supervision, which means one hour of face-to-face contact between one supervisor and two supervisees.
  - (3) Group supervision, which means two hours of face-to-face contact between one supervisor and no more than eight supervisees. Segments of group supervision may be split into no less than one continuous hour. The supervisor shall ensure that the amount and degree of supervision is appropriate for each supervisee.
- (c) Direct supervisor contact shall occur within the same week as the hours claimed.
- (d) Alternative supervision may be arranged during a supervisor’s vacation or sick leave if the alternative supervision meets the requirements in this chapter and regulation.
- ~~(d)~~(e) Notwithstanding subdivision (b), an associate working in a governmental entity, school, college, university, or institution that is both nonprofit and charitable an exempt setting described in section 4999.22 may obtain the required weekly direct supervisor contact via two-way, real-time videoconferencing. The supervisor shall be responsible for ensuring compliance with federal and state laws relating to confidentiality of patient health information.
- ~~(e)~~(f) Notwithstanding any other law, once the required number of experience hours are gained, associates and applicants for licensure shall receive a minimum of one hour of direct supervisor contact per week for each practice setting in which direct clinical counseling is performed. Once the required number of experience hours are gained, further supervision for nonclinical practice, as defined in paragraph (5) of subdivision (c) of Section 4999.46, shall be at the supervisor’s discretion.

**AMEND §4999.46.3. SUPERVISED EXPERIENCE: ACCEPTABLE SETTINGS;  
ACCEPTABLE SUPERVISION PRACTICES**

- (a) A clinical counselor trainee, associate, or applicant for licensure shall only perform mental health and related services as an employee or volunteer, and not as an independent contractor. The requirements of this chapter regarding hours of experience and supervision shall apply equally to employees and volunteers. A clinical counselor trainee, associate, or applicant for licensure shall not perform any services or gain any experience within the scope of practice of the profession, as defined in Section 4999.20, as an independent contractor. While an associate may be either a paid employee or a volunteer, employers are encouraged to provide fair remuneration.
- (1) If employed, an associate shall provide the board, upon application for licensure, with copies of the corresponding W-2 tax forms for each year of experience claimed.
  - (2) If volunteering, an associate shall provide the board, upon application for licensure, with a letter from his or her employer verifying the associate's status as a volunteer during the dates the experience was gained.
- (b) A clinical counselor trainee shall not perform services in a private practice or a professional corporation.
- (c) A trainee shall complete the required predegree supervised practicum or field study experience in a setting that meets all of the following requirements:
- (1) Is not a private practice or a professional corporation.
  - (2) Lawfully and regularly provides mental health counseling or psychotherapy.
  - (3) Provides oversight to ensure that the clinical counselor trainee's work at the setting meets the experience and supervision requirements in this chapter and is within the scope of practice of the profession, as defined in Section 4999.20.
  - (4) Only experience gained in the position for which the clinical counselor trainee volunteers or is employed shall qualify as supervised practicum or field study experience.
- (d) (1) An associate may be credited with supervised experience completed in any setting that meets both of the following:
- (A) Lawfully and regularly provides mental health counseling or psychotherapy.
  - (B) Provides oversight to ensure that the associate's work at the setting meets the experience and supervision requirements in this chapter and is within the scope of practice for the profession, as defined in Section 4999.20.
- (2) Only experience gained in the position for which the associate volunteers or is employed shall qualify as supervised experience.
  - (3) An applicant for registration as an associate shall not be employed or volunteer in a private practice or a professional corporation until he or she has been issued an associate registration by the board.

- (e) Any experience obtained under the supervision of a spouse, relative, or domestic partner shall not be credited toward the required hours of supervised experience. Any experience obtained under the supervision of a supervisor with whom the applicant has had or currently has a personal, professional, or business relationship that undermines the authority or effectiveness of the supervision shall not be credited toward the required hours of supervised experience.
- (f) A clinical counselor trainee, associate, or applicant for licensure shall not receive any remuneration from patients or clients and shall only be paid by his or her employer, if an employee.
- (g) A clinical counselor trainee, associate, or applicant for licensure shall have no proprietary interest in his or her employer's business and shall not lease or rent space, pay for furnishings, equipment, or supplies, or in any other way pay for the obligations of his or her employer.
- (h) A clinical counselor trainee, associate, or applicant for licensure who provides voluntary services in any lawful work setting ~~other than a private practice~~ and who only receives reimbursement for expenses actually incurred shall be considered an employee. The board may audit an applicant for licensure who ~~receives~~received reimbursement for expenses and the applicant for licensure shall have the burden of demonstrating that the payments received were for reimbursement of expenses actually incurred.
- (i) A clinical counselor trainee, associate, or applicant for licensure who receives a stipend or educational loan repayment from a program designed to encourage demographically underrepresented groups to enter the profession or to improve recruitment and retention in underserved regions or settings shall be considered an employee. The board may audit an applicant who receives a stipend or educational loan repayment and the applicant shall have the burden of demonstrating that the payments were for the specified purposes.
- (j) Each educational institution preparing applicants pursuant to this chapter shall consider requiring, and shall encourage, its students to undergo individual, marital, conjoint, family, or group counseling or psychotherapy, as appropriate. Each supervisor shall consider, advise, and encourage his or her associates and trainees regarding the advisability of undertaking individual, marital, conjoint, family, or group counseling or psychotherapy, as appropriate. Insofar as it is deemed appropriate and is desired by the applicant, educational institutions and supervisors are encouraged to assist the applicant to locate that counseling or psychotherapy at a reasonable cost.

**§4999.46.4. SUPERVISEES: LOCATION OF SERVICES; MAXIMUM NUMBER OF REGISTRANTS; OVERSIGHT AGREEMENT (Includes SB 786 Amendments)**

- (a) A clinical counselor trainee, associate, or applicant for licensure shall only perform mental health and related services at the places where their employer permits business to be conducted.

- (b) An associate who is employed by or volunteering in a private practice or a professional corporation shall be supervised by an individual who is employed by, and shall practice at the same site as, the associate's employer. Alternatively, the supervisor may be an owner of the private practice. However, if the site is incorporated, the supervisor must be employed full-time at the site and be actively engaged in performing professional services at the site.
- (1) Is employed by or contracted by the associate's employer, or is an owner of the private practice or professional corporation, and
- (2) Provides psychotherapeutic services to clients at the same site as the associate.
- (c) ~~A supervisor at a private practice or a corporation shall not supervise more than a total of three supervisees at any one time. A supervisee may be registered as an associate marriage and family therapist, an associate professional clinical counselor, or an associate clinical social worker.~~
- (c) Supervisors of supervisees in a non-exempt setting shall not serve as an individual or triadic supervisor for more than a total of six supervisees at any time. Supervisees may be registered as associate marriage and family therapists, associate professional clinical counselors, associate clinical social workers, or any combination of these.
- (d) ~~In a setting that is not a private practice:~~
- ~~(1) A written oversight agreement, as specified in regulation, shall be executed between the supervisor and employer when the supervisor is not employed by the supervisee's employer or is a volunteer.~~
- ~~(2) A supervisor shall evaluate the site or sites where an associate will be gaining experience to determine that the site or sites provide experience that is in compliance with the requirements set forth in this chapter.~~
- (d) A written oversight agreement, as specified by regulation, shall be executed between the supervisor and employer when the supervisor is not employed by the supervisee's employer or is a volunteer. The supervisor shall evaluate the site or sites where the supervisee will be gaining experience to determine that the site or sites comply with the requirements set forth in this chapter.
- (e) ~~Alternative supervision may be arranged during a supervisor's vacation or sick leave if the alternative supervision meets the requirements in this chapter and regulation.~~

## §4999.72. FICTITIOUS BUSINESS NAME

Any licensed professional clinical counselor who conducts a private practice owns a business under utilizing a fictitious business name shall not use any name that is false, misleading, or deceptive, and shall inform the patient, prior to the commencement of treatment, of the name and license designation of the owner or owners of the practice.



**ATTACHMENT C**  
**PROPOSED LANGUAGE: LCSW**

**AMEND §4992.10. FICTITIOUS BUSINESS NAME**

A licensed clinical social worker who ~~conducts a private practice~~ owns a business under utilizing a fictitious business name shall not use a name that is false, misleading, or deceptive, and shall inform the patient, prior to the commencement of treatment, of the name and license designation of the owner or owners of the practice.

**§4996.13. OTHER PROFESSIONAL GROUPS; WORK OF PSYCHOSOCIAL NATURE; IMPERMISSIBLE REPRESENTATIONS**

Nothing in this article shall prevent qualified members of other professional groups from doing work of a psychosocial nature consistent with the standards and ethics of their respective professions. However, they shall not hold themselves out to the public by any title or description of services incorporating the words psychosocial, or clinical social worker, or that they shall not state or imply that they are licensed to practice clinical social work. These qualified members of other professional groups include, but are not limited to, the following:

- (a) A physician and surgeon certified pursuant to Chapter 5 (commencing with Section 2000).
- (b) A psychologist licensed pursuant to Chapter 6.6 (commencing with Section 2900).
- (c) Members of the State Bar of California.
- (d) Marriage and family therapists licensed pursuant to Chapter 13 (commencing with Section 4980).
- (e) Licensed professional clinical counselors pursuant to Chapter 16 (commencing with Section 4999.10).
- (f) A priest, rabbi, or minister of the gospel of any religious denomination.

**AMEND §4996.14. EMPLOYEES OF CERTAIN ORGANIZATIONS; ACTIVITIES OF PSYCHOSOCIAL NATURE (Incorporates AB 630 Amendments)**

- (a) This chapter shall not be construed to constrict, limit, or withdraw the Medical Practice Act, the Licensed Marriage and Family Therapist Act, the Nursing Practice Act, the Licensed Professional Clinical Counselor Act, or the Psychology Licensing Law.
- (b) This chapter shall not apply to an unlicensed or unregistered employee or volunteer working in a governmental entity, a school, a college, a university, or an institution that is both nonprofit and charitable if both of the following apply:

(1) The work of the employee or volunteer is performed solely under the supervision of the under the oversight and direction of the entity.

(2) On and after July 1, 2020, the employee or volunteer provides a client, prior to initiating psychotherapy services, a notice written in at least 12-point type that is in substantially the following form:

#### NOTICE TO CLIENTS

The (Name of office or unit) of the (Name of agency) receives and responds to complaints regarding the practice of psychotherapy by any unlicensed or unregistered counselor providing services at (Name of agency). To file a complaint, contact (Telephone number, email address, internet website, or mailing address of agency).

(c) This chapter shall not apply to a person using hypnotic techniques if their client was referred by a physician and surgeon, dentist, or psychologist.

(d) This chapter shall not apply to a person using hypnotic techniques that offer vocational self-improvement, and the person is not performing therapy for emotional or mental disorders.

(e) Notwithstanding subdivisions (b) and (c), and notwithstanding section 4996.13, all persons registered as associates or licensed under this chapter shall not be exempt from this chapter or the jurisdiction of the board.

#### **ADD §4996.14.1 EXEMPT SETTINGS**

The settings described in section 4996.14 are exempt settings and do not fall under the jurisdiction of this chapter or the Board except as specified in section 4996.14, and with the following exceptions:

(a) Any individual working or volunteering in an exempt setting who is licensed or registered under this chapter shall fall under the jurisdiction of the Board and is not exempt from this chapter.

(b) An entity that is licensed or certified by a government regulatory agency to provide health care services shall not be considered an exempt setting unless it directly meets the criteria described in section 4996.14.

#### **ADD §4996.14.2 OTHER TYPES OF PRACTICE SETTINGS**

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

1) A “non-exempt setting” is any type of setting that does not qualify as an exempt setting, as specified in section 4996.14.

2) A “private practice” is a type of non-exempt setting that meets the following

criteria:

(A) The practice is owned by a health professional who is licensed under Division 2 of the Code, either independently or jointly with one or more other health professionals who are licensed under Division 2 of the Code;

(B) The practice provides clinical mental health services, including psychotherapy, to clients; and

(C) One or more licensed health professionals are responsible for the practice and for the services provided and set conditions of client payment or reimbursement for the provision of services.

3) A “professional corporation” is a type of non-exempt setting and private practice that has been formed pursuant to Part 4 of Division 3 of Title 1 of the Corporations Code (commencing with section 13400).

4) An entity that is licensed or certified by a government regulatory agency to provide health care services shall not be considered a private practice setting.

(b) An active license or registration number shall be required to engage in the practice of clinical social work, as defined in section 4996.9, in non-exempt settings at all times, with the following exceptions:

1) A social work intern may engage in the practice of clinical social work in a non-exempt setting that is not a private practice or a professional corporation, while pursuing a course of study leading to a master’s degree in social work pursuant to section 4996.15.

2) An applicant for registration as an associate may engage in the practice of clinical social work in a non-exempt setting that is not a private practice or a professional corporation before the registration number is issued if they are in compliance with subdivision (b) of section 4996.23 and are gaining supervised experience that meets the requirements of this chapter.

**§4996.15. PERFORMANCE OF PSYCHOSOCIAL WORK BY PERSONS IN ACADEMIC INSTITUTIONS, GOVERNMENT AGENCIES OR NONPROFIT ORGANIZATIONS; SOCIAL WORK INTERN (Incorporates AB 630 Amendments)**

(a) Nothing in this article shall restrict or prevent psychosocial activities by employees of accredited academic institutions, public schools, government agencies, or nonprofit institutions who train graduate students pursuing a master’s degree in social work in an accredited college or university. Any psychosocial activities by the employee shall be part of a supervised course of study and the graduate students shall be designated by such titles as social work interns, social work trainees, or other titles clearly indicating the training status appropriate to their level of training. The term “social work intern,”

however, shall be reserved for persons enrolled in a master's or doctoral training program in social work in an accredited school or department of social work.

(b) Notwithstanding subdivision (a), a graduate student shall not perform clinical social work in a private practice or a professional corporation.

**AMEND §4996.23. SUPERVISED POST-MASTER'S EXPERIENCE (Includes AB 1651 Amendments)**

(a) To qualify for licensure, each applicant shall complete 3,000 hours of post-master's degree supervised experience related to the practice of clinical social work. Except as provided in subdivision (b), experience shall not be gained until the applicant is registered as an associate clinical social worker.

(b) ~~Preregistered postdegree~~ Post-degree hours of experience gained prior to issuance of an associate registration shall be credited toward licensure if all of the following apply:

(1) The registration applicant applies for the associate registration and the board receives the application within 90 days of the granting of the qualifying master's or doctoral degree.

(2) For applicants completing graduate study on or after January 1, 2020, the experience is obtained at a workplace that, prior to the registration applicant gaining supervised experience hours, requires completed Live Scan fingerprinting. The applicant shall provide the board with a copy of that completed "State of California Request for Live Scan Service" form with the application for licensure.

(3) The board subsequently grants the associate registration.

(c) The applicant shall not be employed or volunteer in a private practice or a professional corporation until the applicant has been issued an associate registration by the board.

(d) The experience shall be as follows:

(1) (A) At least 1,700 hours shall be gained under the supervision of a licensed clinical social worker. The remaining required supervised experience may be gained under the supervision of a physician and surgeon who is certified in psychiatry by the American Board of Psychiatry and Neurology, licensed professional clinical counselor, licensed marriage and family therapist, psychologist licensed pursuant to Chapter 6.6 (commencing with Section 2900), licensed educational psychologist, or licensed clinical social worker.

(B) A maximum of 1,200 hours gained under the supervision of a licensed educational psychologist providing educationally related mental health services that are consistent

with the scope of practice of an educational psychologist, as specified in Section 4989.14.

(2) A minimum of 2,000 hours in clinical psychosocial diagnosis, assessment, and treatment, including psychotherapy or counseling; however, at least 750 hours shall be face-to-face individual or group psychotherapy provided in the context of clinical social work services.

(3) A maximum of 1,000 hours in client centered advocacy, consultation, evaluation, research, direct supervisor contact, and workshops, seminars, training sessions, or conferences directly related to clinical social work that have been approved by the applicant's supervisor.

(4) A minimum of two years of supervised experience is required to be obtained over a period of not less than 104 weeks and shall have been gained within the six years immediately preceding the date on which the application for licensure was received by the board.

(5) No more than 40 hours of experience may be credited in any seven consecutive days.

(6) For hours gained on or after January 1, 2010, no more than six hours of supervision, whether individual, triadic, or group supervision, shall be credited during any single week.

(e) An individual who submits an application for licensure between January 1, 2016, and December 31, 2020, may alternatively qualify under the experience requirements of this section that were in place on January 1, 2015.

#### **AMEND §4996.23.1 DIRECT SUPERVISOR CONTACT**

(a) Except for experience gained by attending workshops, seminars, training sessions, or conferences, as described in paragraph (3) of subdivision (d) of Section 4996.23, direct supervisor contact shall occur as follows:

(1) Supervision shall include at least one hour of direct supervisor contact each week for which experience is credited in each work setting.

(2) An associate gaining experience who performs more than 10 hours of direct clinical counseling in a week in any setting shall receive at least one additional hour of direct supervisor contact for that setting.

(b) For purposes of this chapter, "one hour of direct supervisor contact" means any of the following:

(1) Individual supervision, which means one hour of face-to-face contact between one supervisor and one supervisee.

- (2) Triadic supervision, which means one hour of face-to-face contact between one supervisor and two supervisees.
- (3) Group supervision, which means two hours of face-to-face contact between one supervisor and no more than eight supervisees. Segments of group supervision may be split into no less than one continuous hour. A supervisor shall ensure that the amount and degree of supervision is appropriate for each supervisee.
- (c) Direct supervisor contact shall occur within the same week as the hours claimed.
- (d) Of the 104 weeks of required supervision, 52 weeks shall be individual supervision, triadic supervision, or a combination of both.
- (e) Of the 52 weeks of required individual or triadic supervision, no less than 13 weeks shall be supervised by a licensed clinical social worker.
- (f) Alternative supervision may be arranged during a supervisor's vacation or sick leave if the alternative supervision meets the requirements in this chapter and by regulation.

~~(f)(g)~~ Notwithstanding subdivision (b), ~~an associate clinical social worker a supervisee working in a governmental entity, school, college, university, or an institution that is nonprofit and charitable an exempt setting described in section 4996.14~~ may obtain the required weekly direct supervisor contact via two-way, real-time videoconferencing. The supervisor shall be responsible for ensuring compliance with state and federal laws relating to confidentiality of patient health information.

~~(g)(h)~~ Notwithstanding any other law, once the required number of experience hours are gained, an associate clinical social worker or applicant for licensure shall receive a minimum of one hour of direct supervisor contact per week for each practice setting in which direct clinical counseling is performed. Once the required number of experience hours are gained, further supervision for nonclinical practice, as described in paragraph (3) of subdivision (d) of Section 4996.23, shall be at the supervisor's discretion.

#### **AMEND §4996.23.2. SUPERVISED EXPERIENCE: ACCEPTABLE SETTINGS; ACCEPTABLE SUPERVISION PRACTICES**

(a) An associate clinical social worker or applicant for licensure shall only perform mental health and related services as an employee or as a volunteer, not as an independent contractor. The requirements of this chapter regarding hours of experience and supervision shall apply equally to employees and volunteers. An associate or applicant for licensure shall not perform any services or gain any experience within the scope of practice of the profession, as defined in Section 4996.9, as an independent contractor. While an associate may be either a paid employee or a volunteer, employers are encouraged to provide fair remuneration.

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

(2) If volunteering, an associate shall provide the board, upon application for licensure, with a letter from his or her employer verifying the associate's status as a volunteer during the dates the experience was gained.

~~(b)~~ "Private practice," for purposes of this chapter, is defined as a setting owned by a licensed clinical social worker, a licensed marriage and family therapist, a psychologist licensed pursuant to Chapter 6.6 (commencing with Section 2900), a licensed professional clinical counselor, a licensed physician and surgeon, or a professional corporation of any of these licensed professions.

~~(c)~~(b) Employment in a private practice or a professional corporation shall not commence until the applicant has been registered as an associate clinical social worker.

~~(d)~~(c) Experience shall only be gained in a setting that meets both of the following:

(1) Lawfully and regularly provides clinical social work, mental health counseling, or psychotherapy.

(2) Provides oversight to ensure that the associate's work at the setting meets the experience and supervision requirements set forth in this chapter and is within the scope of practice for the profession as defined in Section 4996.9.

~~(e)~~(d) Only experience gained in the position for which the associate clinical social worker volunteers or is employed shall qualify as supervised experience.

~~(f)~~(e) Any experience obtained under the supervision of a spouse or relative by blood or marriage shall not be credited toward the required hours of supervised experience. Any experience obtained under the supervision of a supervisor with whom the applicant has had or currently has a personal, professional, or business relationship that undermines the authority or effectiveness of the supervision shall not be credited toward the required hours of supervised experience.

~~(g)~~(f) An associate clinical social worker or applicant for licensure who provides voluntary services in any lawful work setting ~~other than a private practice~~ and who only receives reimbursement for expenses actually incurred shall be considered an employee. The board may audit an applicant for licensure who ~~receives~~ received reimbursement for expenses and the applicant shall have the burden of demonstrating that the payments received were for reimbursement of expenses actually incurred.

~~(h)~~(g) An associate clinical social worker or applicant for licensure who receives a stipend or educational loan repayment from a program designed to encourage demographically underrepresented groups to enter the profession or to improve recruitment and retention in underserved regions or settings shall be considered an employee. The board may audit an applicant who receives a stipend or educational loan repayment and the applicant shall have the burden of demonstrating that the payments received were for the specified purposes.

~~(i)~~(h) An associate or applicant for licensure shall not receive any remuneration from patients or clients and shall only be paid by his or her employer, if an employee.

~~(i)~~(i) An associate or applicant for licensure shall have no proprietary interest in his or her employer's business and shall not lease or rent space, pay for furnishings, equipment, or supplies, or in any other way pay for the obligations of his or her employer.

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

**AMEND §4996.23.3. SUPERVISEES: LOCATION OF SERVICES; MAXIMUM NUMBER OF REGISTRANTS; OVERSIGHT AGREEMENT (Includes SB 786 Amendments)**

(a) An associate clinical social worker or an applicant for licensure shall only perform mental health and related services at the places where their employer permits business to be conducted.

(b) An associate who is employed by or volunteering in a private practice or a professional corporation shall be supervised by an individual who is employed by, and shall practice at the same site as, the associate's employer. Alternatively, the supervisor may be an owner of the private practice. However, if the site is incorporated, the supervisor must be employed full-time at the site and be actively engaged in performing professional services at the site.

(1) Is employed by or contracted by the associate's employer, or is an owner of the private practice or professional corporation, and

(2) Provides psychotherapeutic services to clients at the same site as the associate.

~~(c)~~ A supervisor at a private practice or a corporation shall not supervise more than a total of three supervisees at any one time. A supervisee may be registered as an associate marriage and family therapist, an associate professional clinical counselor, or an associate clinical social worker.

~~(c)~~ Supervisors of supervisees in a non-exempt setting shall not serve as an individual or triadic supervisor for more than a total of six supervisees at any time. Supervisees may be registered as associate marriage and family therapists, associate professional clinical counselors, associate clinical social workers, or any combination of these.

~~(d)~~ In a setting that is not a private practice:

~~(1)~~ A written oversight agreement, as specified by regulation, shall be executed between the supervisor and employer when the supervisor is not employed by the supervisee's employer or is a volunteer.



- ~~(2) A supervisor shall evaluate the site or sites where an associate clinical social worker will be gaining experience to determine that the site or sites are in compliance with the requirements set forth in this chapter and regulations.~~
- ~~(d) A written oversight agreement, as specified by regulation, shall be executed between the supervisor and employer when the supervisor is not employed by the supervisee's employer or is a volunteer. The supervisor shall evaluate the site or sites where the supervisee will be gaining experience to determine that the site or sites comply with the requirements set forth in this chapter.~~
- ~~(e) Alternative supervision may be arranged during a supervisor's vacation or sick leave if the alternative supervision meets the requirements in this chapter and by regulation.~~

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**To:** Committee Members **Date:** January 28, 2020

**From:** Rosanne Helms  
Legislative Manager **Telephone:** (916) 574-7897

**Subject: Custody of Client Records Due to Licensee Death or Incapacitation**

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From time to time, the Board receives inquiries about what should happen to client records if the therapist dies or becomes incapacitated.

Currently, the Board's statutes and regulations do not address this. At its October 2019 meeting, the Board's Policy and Advocacy Committee discussed the possibility of amending statutes or regulations to provide further clarity. It asked staff to explore the issue further, including providing additional information about informed consent and coverage of the topic in the ethical guidelines of the professions.

### Informed Consent

The Policy and Advocacy Committee discussed the possibility of utilizing an informed consent document to provide clients with information about the transfer of records in the case of the therapist's death or incapacitation. Currently, the Board's licensing laws do not specifically require a single comprehensive informed consent document prior to the beginning of therapy. However, the law does require certain information be disclosed to the client, including the following:

- The fee to be charged for services, or the basis used to compute that fee (prior to beginning treatment). (BPC §§4982(n), 4989.54(o), 4992.3(o), 4999.90(n))
- Prior to providing services via telehealth, the client must be informed about the use of telehealth and verbal or written consent must be obtained and documented. The client must also be informed of potential risks and limitations of receiving treatment via telehealth, and must be informed of the therapist's license or registration number and the type of license or registration. (BPC §2290.5, California Code of Regulations (CCR) Title 16 §1815.5)

- Unlicensed associates and trainees must inform the client that they are unlicensed and under supervision (prior to performing services). (BPC §§4980.44, 4980.48, 4996.18(g), 4999.36, 4999.46.1)
- All clients must be provided with a notice about where a complaint may be filed about the therapist (beginning July 1, 2020 prior to initiating services). (BPC §§4980.32, 4989.17, 4996.75, 4999.71)

Although the Board does not currently require a single informed consent document, many of the required disclosures are required at the beginning of the therapeutic relationship, so it may not necessarily be burdensome to add another disclosure.

Some states do have specific requirements in law for a comprehensive informed consent:

In Texas, professional counselors are specifically required by law to obtain a signed informed consent form from their clients that covers certain topics, including fees, limits on confidentiality, counseling purposes and goals, and the plan for custody and control of the client's records in the event of the licensee's death or incapacity (**Attachment A**).

The state of Colorado requires what it calls a "mandatory disclosure" of information to clients. This is a document that all professional counselor licensees and registrants must provide to their clients during initial client contact. The law requires very specific information be included in this document, including an explanation of levels of regulation of mental health professionals, degrees, certifications, and licenses held by the practitioner, contact information for the regulating board, and information about confidentiality (**Attachment B**). However, it does not require any disclosure information about custody of records in the event of the practitioner's death or incapacitation.

The California Association of Marriage and Family Therapists (CAMFT) published a detailed article about informed consent and its applicability to Board licensees. This article is provided in **Attachment C**.

### Professional Associations

Several relevant professional associations touch on the importance of preparing a practice for the therapist's death or incapacitation in their codes of ethics.

#### National Association of Social Workers (NASW) Code of Ethics (2017)

- Section 1.07(t) – Privacy and Confidentiality: Social workers should take reasonable precautions to protect client confidentiality in the event of the social worker's termination of practice, incapacitation, or death.

- Section 1.15 – Interruption of Services: Social workers should make reasonable efforts to ensure continuity of services in the event that services are interrupted by factors such as unavailability, disruptions in electronic communication, relocation, illness, mental or physical ability, or death.

California Association of Marriage and Family Therapists (CAMFT) Code of Ethics (2019)

- Section 1.3 Treatment Disruption: Marriage and family therapists are aware of their professional and clinical responsibilities to provide consistent care to clients/patients and to maintain practices and procedures that are intended to provide uninterrupted care. Such practices and procedures may include, but are not limited to, providing contact information and specified procedures in case of emergency or therapist absence, conducting appropriate terminations, and providing for a professional will.
- Section 1.4 Termination: Marriage and family therapists use sound clinical judgment when terminating therapeutic relationships. Reasons for termination may include, but are not limited to, the client/patient is not benefiting from treatment, continuing treatment is not clinically appropriate, the therapist is unable to provide treatment due to the therapist's incapacity or extended absence, or due to an otherwise unresolvable ethical conflict or issue.

The American Counseling Association's 2014 ACA Code of Ethics

- Section B.6.i.: Reasonable Precautions: Counselors take reasonable precautions to protect client confidentiality in the event of the counselor's termination of practice, incapacity, or death and appoint a records custodian when identified as appropriate.
- Section C.2.h.: Counselor Incapacitation, Death, Retirement, or Termination of Practice: Counselors prepare a plan for the transfer of clients and the dissemination of records to an identified colleague or records custodian in the case of the counselor's incapacitation, death, retirement, or termination of practice.

American Psychological Association's (APA's) Ethical Principles of Psychologists and Code of Conduct (2017)

- APA Ethics Code Section 6.02(c): Psychologists make plans in advance to facilitate the appropriate transfer and to protect the confidentiality of records and data in the event of psychologists' withdrawal from positions or practice.
- APA Ethics Code Section 3.12: Unless otherwise covered by contract, psychologists make reasonable efforts to plan for facilitating services in the event that psychological services are interrupted by factors such as the psychologist's

illness, death, unavailability, relocation, or retirement or by the client's/patient's relocation or financial limitations.

In addition to the above guidelines, some professional associations have also provided outreach via articles to advise their members on how to prepare for the end of their practice. See **Attachments D** and **E** for examples from NASW and APA, respectively.

### Other States

In addition to Texas (mentioned above), some other states have taken steps to require that their licensed mental health professionals take action to ensure safekeeping of client records in the event of their death. For example:

- **Florida:** Florida has a regulation for its licensed mental health professionals that requires that if client termination was due to the licensee's death, records must be maintained for at least two years. After that, the executor, administrator, or survivor must publish a notice once a week for 4 consecutive weeks in the highest circulated newspaper in each county of practice. The notice must state that the records will be disposed of or destroyed 4 weeks or later from the notice publication. (Florida Administrative Code §64B4-9.001(4)) (Shown in **Attachment F.**)
- **Oregon:** The Oregon Board of Licensed Professional Counselors and Therapists requires its licensed marriage and family therapists and professional counselors to arrange for the maintenance of and access to records in the event of the death or incapacity of the licensee. Oregon licensees must file the name of a custodian of record with the board, along with that person's (or organization's) contact information. The custodian of record must be an Oregon-licensed mental health professional, a licensed medical professional, a health care or mental health organization, and attorney, a school, or a medical records company. (Oregon Administrative Rules Chapter 833, §833-075-0080) (Shown in **Attachment G.**)
- **Washington:** The state of Washington requires its licensed mental health counselors, marriage and family therapists, and social workers to make provisions for retaining or transferring records in the event of going out of business, death, or incapacitation. The provisions may be made in the practitioner's will, an office policy, or by ensuring another licensed counselor is available to review records with a client, or other appropriate means. (Washington Administrative Code §246-809-035(5)) (Shown in **Attachment H.**)

### HIPAA and Client Records

One logical question to ask is how establishing a plan to transfer client records to another practitioner upon a therapist's death interacts with the federal Health Insurance

Portability and Accountability Act (HIPAA). The U.S. Department of Health and Human Services (HHS) has an FAQ about HIPAA for professionals on its web site. It states that health care providers are allowed to use health information for treatment purposes without the patient's authorization, including to consult with other providers or to refer the patient. **Attachment I** shows HHS's response to the FAQ question, as well as the federal regulation code section cited in its response.

### Recommendation

Conduct an open discussion about whether the Board should consider pursuing legislation or regulations to address safekeeping of client records in the event that a licensee dies or becomes incapacitated.

### Attachments

**Attachment A:** State of Texas Regulation: Texas Administrative Code Title 22, Chapter 681, §681.41(e)(8)

**Attachment B:** Colorado Revised Statutes Section 12-245-216

**Attachment C:** CAMFT Article: "Revisiting Informed Consent" by Michael Griffin, J.D., LCSW. Originally printed in "The Therapist" September/October 2006; Revised October 2017.

**Attachment D:** NASW Article: "Clinical Social Work Practice Update: When a Clinical Social Worker in Solo or Group Practice Dies" by Mirean Coleman, MSW, LICSW, CT; November 2009.

**Attachment E:** American Psychological Association "Ask our Attorney: Handling Records of a Deceased Psychologist" January 17, 2013.

**Attachment F:** State of Florida Regulation: Florida Administrative Code §64B4-9.001(4)

**Attachment G:** State of Oregon Regulation: Oregon Administrative Rules Chapter 833, §833-075-0080

**Attachment H:** State of Washington Regulation: Washington Administrative Code §246-809-035(5)

**Attachment I:** U.S. Department of Health and Human Services FAQ about HIPAA and Information Sharing, and Federal Code of Regulations Title 45, §164.506

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# ATTACHMENT A

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## Texas Administrative Code

<a href="#">TITLE 22</a>	EXAMINING BOARDS
<a href="#">PART 30</a>	TEXAS STATE BOARD OF EXAMINERS OF PROFESSIONAL COUNSELORS
<a href="#">CHAPTER 681</a>	PROFESSIONAL COUNSELORS
<a href="#">SUBCHAPTER C</a>	CODE OF ETHICS
RULE §681.41	General Ethical Requirements

(a) A licensee must not make any false, misleading, deceptive, fraudulent or exaggerated claim or statement about the licensee's services, including, but not limited to:

- (1) the effectiveness of services;
- (2) the licensee's qualifications, capabilities, background, training, experience, education, professional affiliations, fees, products, or publications; or
- (3) the practice or field of counseling.

(b) A licensee must not make any false, misleading, deceptive, fraudulent or exaggerated claim or statement about the services of a mental health organization or agency, including, but not limited to, the effectiveness of services, qualifications, or products.

(c) A licensee must discourage a client from holding exaggerated or false ideas about the licensee's professional services, including, but not limited to, the effectiveness of the services, practice, qualifications, associations, or activities. If a licensee learns of exaggerated or false ideas held by a client or other person, the licensee must take immediate and reasonable action to correct the ideas held.

(d) A licensee must make reasonable efforts to discourage others whom the licensee does not control from making misrepresentations; exaggerated or false claims; or false, deceptive, or fraudulent statements about the licensee's practice, services, qualifications, associations, or activities. If a licensee learns of a misrepresentation; exaggerated or false claim; or false, deceptive, or fraudulent statement made by another, the licensee must take immediate and reasonable action to correct the statement.

(e) Regardless of setting, a licensee must provide counseling only in the context of a professional relationship. Prior to providing services, a licensee must obtain from an individual a signed informed consent, signed written receipt of information, or in the case of involuntary treatment a copy of the appropriate court order, including the following:

- (1) fees and arrangements for payment;
- (2) counseling purposes, goals, and techniques;
- (3) any restrictions placed on the license by the board;
- (4) the limits on confidentiality;
- (5) any intent of the licensee to use another individual to provide counseling treatment intervention to the client; and
- (6) supervision of the licensee by another licensed health care professional including the name, address, contact information and qualifications of the supervisor;
- (7) the name, address and telephone number of the board for the purpose of reporting violations of the Act or this chapter; and
- (8) the established plan for the custody and control of the client's mental health records in the event of the licensee's death or incapacity, or the termination of the licensee's counseling practice.

(f) A licensee must inform the client in writing of any changes to the items in subsection (e) of this section prior to initiating the change.

(g) Technological means of communication may be used to facilitate the therapeutic counseling process.

(h) In accordance with §503.401(a)(4) of the Act, a licensee must not intentionally or knowingly offer to pay or agree to accept any remuneration directly or indirectly, overtly or covertly, in cash or in kind, to or from any person, firm, association of persons, partnership, corporation, or entity for securing or soliciting clients or patronage.

(i) A licensee employed or under contract with a chemical dependency facility or a mental health facility must comply with the

requirements in the Texas Health and Safety Code, §164.006, relating to soliciting and contracting with certain referral sources. Compliance with the Treatment Facilities Marketing Practices Act, Texas Health and Safety Code Chapter 164, will not be considered as a violation of state law relating to illegal remuneration.

(j) A licensee must not engage in activities for the licensee's personal gain at the expense of a client.

(k) A licensee may promote the licensee's personal or business activities to a client if such activities, services or products are to facilitate the counseling process or help achieve the client's counseling goals. Prior to engaging in any such activities, services or product sales with the client, the licensee must first inform the client of the licensee's personal and/or business interest therein. A licensee must not exert undue influence in promoting such activities, services or products.

(l) A licensee must set and maintain professional boundaries.

(m) Except as provided by this subchapter, non-therapeutic relationships with clients are prohibited.

(1) A non-therapeutic relationship is any non-counseling activity initiated by either the licensee or client that results in a relationship unrelated to therapy.

(2) A licensee may not engage in a non-therapeutic relationship with a client if the relationship begins less than two (2) years after the end of the counseling relationship; the non-therapeutic relationship must be consensual, not the result of exploitation by the licensee, and is not detrimental to the client.

(3) A licensee may not engage in sexual contact with a client if the contact begins less than five (5) years after the end of the counseling relationship; the non-therapeutic relationship must be consensual, not the result of exploitation by the licensee, and is not detrimental to the client.

(4) For purposes of paragraphs (2) and (3) of this subsection, the licensee must be able to demonstrate there has been no exploitation and the non-therapeutic relationship is not detrimental to the client in light of all relevant factors, including, but not limited to, the factors set forth in §681.42(b)(4)(A) - (G) of this title (relating to Sexual Misconduct).

(5) The licensee must not provide counseling services to previous or current:

(A) family members;

(B) personal friends;

(C) educational associates; or

(D) business associates.

(6) The licensee must not give or accept a gift from a client or a relative of a client valued at more than \$50, borrow or lend money or items of value to clients or relatives of clients, or accept payment in the form of goods or services rendered by a client or relative of a client.

(7) The licensee must not enter into a non-professional relationship with a client's family member or any person having a personal or professional relationship with a client if the licensee knows or reasonably should have known such a relationship could be detrimental to the client.

(n) The licensee must not knowingly offer or provide counseling to an individual concurrently receiving counseling treatment intervention from another mental health services provider except with that provider's knowledge. If a licensee learns of such concurrent therapy, the licensee must request release from the client to inform the other professional and strive to establish positive and collaborative professional relationships.

(o) A licensee may take reasonable action to inform medical or law enforcement personnel if the licensee determines there is a probability of imminent physical injury by the client to the client or others, or there is a probability of immediate mental or emotional injury to the client.

(p) The licensee must take reasonable precautions to protect clients from physical or emotional harm resulting from interaction:

(1) within a group; or

(2) individual counseling.

(q) For each client, a licensee must keep accurate records of:

(1) signed informed consent, signed written receipt of information, or, in the case of involuntary treatment, a copy of the appropriate court order

(2) intake assessment;

(3) dates of counseling treatment intervention;

(4) principal treatment methods;

(5) progress notes;

(6) treatment plan; and

(7) billing information.

(r) Records held by a licensee must be kept for a minimum of six (6) years from the date of the last contact with the client.

(s) Records created by licensees during the scope of their employment by agencies or institutions that maintain client records are not required to comply with (q) and (r) of this section.

(t) Billing Requirements.

(1) A licensee must bill clients or third parties for only those services actually rendered or as agreed to by mutual understanding at the beginning of services or as later modified by mutual written agreement.

(2) Relationships between a licensee and any other person used by the licensee to provide services to a client must be so reflected on billing documents.

(3) Pursuant to Texas Health and Safety Code Chapter 611, on the written request of a client, a client's guardian, or a client's parent (sole managing, joint managing or possessory conservator) if the client is a minor, a licensee must provide, in plain language, a written explanation of the types of treatment and charges for counseling treatment intervention previously made on a bill or statement for the client. This requirement applies even if the charges are to be paid by a third party.

(4) A licensee may not knowingly overcharge a client.

(5) With the exception of an unkept appointment, a licensee may not submit to a client or a third party payor a bill for counseling treatment intervention the licensee knows or should know is improper, unreasonable, or unnecessary.

(u) A licensee must comply with all requirements of Texas Health and Safety Code Chapters 611 and 181 concerning the release of mental health records and confidential information.

(v) Prior to the commencement of counseling services to a minor client who is named in a custody agreement or court order, a licensee must obtain and review a current copy of the custody agreement or court order as well as any applicable part of the divorce decree. A licensee must maintain these documents in the client's record and abide by the documents at all times. When federal or state statutes provide an exemption to secure consent of a parent or guardian prior to providing services to a minor, a licensee must follow the protocol set forth in such federal or state statutes.

(w) A licensee must terminate a professional counseling relationship when it is reasonably clear the client is not benefiting from the relationship.

(x) Upon termination of a relationship, if professional counseling is still necessary, the licensee must take reasonable steps to facilitate the transfer to appropriate care.

(y) A licensee must not evaluate any individual's mental, emotional, or behavioral condition unless the licensee has personally interviewed the individual or the licensee discloses in the evaluation the licensee has not personally interviewed the individual.

(z) A licensee must not knowingly overtreat a client.

(aa) A licensee must not aid or abet the unlicensed practice of professional counseling by a person required to be licensed under the Act.

(bb) A licensee must report to the board knowledge of any unlicensed practice of counseling.

(cc) A licensee or an applicant must not participate in the falsification of any materials submitted to the board.

(dd) A licensee must not provide services while impaired.

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**Source Note:** The provisions of this §681.41 adopted to be effective September 1, 2003, 28 TexReg 4134; amended to be effective November 21, 2004, 29 TexReg 10512; amended to be effective September 1, 2005, 30 TexReg 4978; amended to be effective April 27, 2008, 33 TexReg 3268; amended to be effective September 1, 2010, 35 TexReg 7801; amended to be effective May 20, 2012, 37 TexReg 3591; amended to be effective December 12, 2013, 38 TexReg 8889; amended to be effective January 12, 2015, 40 TexReg 233; amended to be effective July 14, 2016, 41 TexReg 5057; amended to be effective July 16, 2017, 42 TexReg 3487; amended to be effective February 28, 2019, 44 TexReg 844

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**Attachment B**  
**Colorado Revised Statutes**  
**Section 12-245-216**

**12-245-216. Mandatory disclosure of information to clients.**

(1) Except as otherwise provided in subsection (4) of this section, every licensee, registrant, or certificate holder shall provide the following information in writing to each client during the initial client contact:

- (a) The name, business address, and business phone number of the licensee, registrant, or certificate holder;
- (b) (I) An explanation of the levels of regulation applicable to mental health professionals under this article 245 and the differences between licensure, registration, and certification, including the educational, experience, and training requirements applicable to the particular level of regulation; and  
(II) A listing of any degrees, credentials, certifications, registrations, and licenses held or completed by the licensee, registrant, or certificate holder, including the education, experience, and training the licensee, registrant, or certificate holder was required to satisfy in order to complete the degree, credential, certification, registration, or license;
- (c) A statement indicating that the practice of licensed or registered persons in the field of psychotherapy is regulated by the division, and an address and telephone number for the board that regulates the licensee, registrant, or certificate holder;
- (d) A statement indicating that:
  - (I) A client is entitled to receive information about the methods of therapy, the techniques used, the duration of therapy, if known, and the fee structure;
  - (II) The client may seek a second opinion from another therapist or may terminate therapy at any time;
  - (III) In a professional relationship, sexual intimacy is never appropriate and should be reported to the board that licenses, registers, or certifies the licensee, registrant, or certificate holder;
  - (IV) The information provided by the client during therapy sessions is legally confidential in the case of licensed marriage and family therapists, social workers, professional counselors, and psychologists; licensed or certified addiction counselors; and registered psychotherapists, except as provided in section 12-245-220 and except for certain legal exceptions that will be identified by the licensee, registrant, or certificate holder should any such situation arise during therapy; and
- (e) If the mental health professional is a registered psychotherapist, a statement indicating that a registered psychotherapist is a psychotherapist listed in the state's database and is authorized by law to practice psychotherapy in Colorado but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state.

(2) If the client is a child who is consenting to mental health services pursuant to section 27-65-103, disclosure shall be made to the child. If the client is a child whose parent or legal guardian is consenting to mental health services, disclosure shall be made to the parent or legal guardian.

(3) In residential, institutional, or other settings where psychotherapy may be provided by multiple providers, disclosure shall be made by the primary therapist. The institution shall also provide a statement to the patient containing the information in subsections (1)(c) and (1)(d) of this section and a statement that the patient is entitled to the information listed in subsections (1)(a) and (1)(b) of this section concerning any psychotherapist in the employ of the institution who is providing psychotherapy services to the patient.

(4) The disclosure of information required by subsection (1) of this section is not required when psychotherapy is being administered in any of the following circumstances:

(a) In an emergency;

(b) Pursuant to a court order or involuntary procedures pursuant to sections 27-65-105 to 27-65-109;

(c) The sole purpose of the professional relationship is for forensic evaluation;

(d) The client is in the physical custody of either the department of corrections or the department of human services and such department has developed an alternative program to provide similar information to the client and the program has been established through rule;

(e) The client is incapable of understanding the disclosure and has no guardian to whom disclosure can be made;

(f) By a social worker practicing in a hospital that is licensed or certified under section 25-1.5-103 (1)(a)(I) or (1)(a)(II);

(g) By a person licensed or certified pursuant to this article 245, or by a registered psychotherapist practicing in a hospital that is licensed or certified under section 25-1.5-103(1)(a)(I) or (1)(a)(II).

(5) If the client has no written language or is unable to read, an oral explanation shall accompany the written copy.

(6) Unless the client, parent, or guardian is unable to write, or refuses or objects, the client, parent, or guardian shall sign the disclosure form required by this section not later than the second visit with the psychotherapist.

Source: L. 2019: Entire title R&RE with relocations, (HB 19-1172), ch. 136, p. 1233, § 1, effective October 1.

## Attachment C

# Revisiting Informed Consent

- 
- September 1, 2006 |
- [Michael Griffin, JD, Staff Attorney](#) |

Although most therapists consider informed consent to treatment to be an important principle in healthcare, some question whether informed consent differs from ordinary consent to treatment and if so, how it applies to the practice of psychotherapy.

By Michael Griffin, J.D., LCSW

CAMFT Attorney

*The Therapist*

(September/October 2006)

Revised October, 2017 by Michael Griffin, JD, LCSW, CAMFT Attorney

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Although most therapists consider informed consent to treatment to be an important principle in healthcare, some question whether informed consent differs from ordinary consent to treatment and if so, how it applies to the practice of psychotherapy. Therapists also raise a variety of related questions, such as: Are there specific legal requirements for informed consent in California? If so, do they apply to medical professionals and to non-medical mental health providers alike? Are therapists legally and/or ethically required to make certain disclosures to their patients at a particular time in the treatment process? Are ethical standards related to informed consent the same for marriage and family therapists, psychologists, and clinical social workers? Should therapists address informed consent differently under special or unique treatment circumstances, such as on-line therapy? Is informed consent any different for children than it is for adults? Are there special considerations to be aware of when treating couples or families? Is informed consent actually a process?

In an effort to address these and other questions, this article provides a general discussion of informed consent, examines the relevant legal and ethical standards, addresses the issue of mandated disclosures and reviews a number of special circumstances involving informed consent.

### **What is Informed Consent?**

#### ***The Legal Doctrine of Informed Consent***

Informed consent to treatment should be distinguished from simple consent to treatment. In the latter, an adult simply agrees to accept treatment for him or herself, or for his or her minor child. To be effective, consent must be provided knowingly and voluntarily. In other words, the patient must be at least generally informed about his or her treatment and understand that he or she has a

right to decline the treatment. In addition, the patient must possess the legal capacity to provide consent. For example, a minor (with certain exceptions) lacks the legal capacity to provide consent to his or her own treatment. Alternately, an intoxicated person may lack the capacity to provide effective consent due to impaired mental condition.

In the 1960s, the legal doctrine known as informed consent emerged in various case law decisions that concerned the failure of a physician to provide his or her patient with adequate information about the possible or known risks associated with a particular medical treatment or procedure.<sup>1</sup> Informed consent doctrine ultimately required a physician to disclose meaningful information to his or her patient about the proposed treatment, and to offer a discussion of the relevant risks and benefits of that treatment.<sup>2</sup> A patient was thereby provided with an opportunity to make an informed decision about whether or not to accept the particular treatment.<sup>3</sup>

It is important to note that the element of risk that is associated with a given treatment is an important consideration in determining whether informed consent is applicable. As the likelihood of potential harm increases, there is a corresponding increase in risk. As risk increases, the need to inform the patient increases in importance. This principle is further illustrated by the fact that the informed consent doctrine is generally inapplicable to routine or simple treatments, or to treatments that present little or no risk to the patient.

### **Informed Consent Doctrine in California**

The specific requirements for informed consent vary from state to state and from profession to profession.<sup>4</sup> In the 1972 case, *Cobbs v. Grant*, the California Supreme Court established a medical doctor's duty of reasonable disclosure for the purposes of informed consent, stating that physicians must disclose "all information relevant to a meaningful decisional process."<sup>5</sup> In their opinion, the Court articulated four "primary postulates" of informed consent,<sup>6</sup> as paraphrased here:

- Patients do not ordinarily possess the same technical knowledge as a physician.
- A person has the right to exercise control over him or herself and to determine whether or not to submit to treatment.
- A patient's consent to treatment must be informed to be effective.
- A patient relies upon his or her provider for important information regarding the treatment.<sup>7</sup>

The definition of informed consent expressed in *Cobbs v. Grant* and in subsequent California cases, is evident in the California Civil (jury) Instructions (CACI), which state:<sup>8</sup>

"...A [medical professional] must give the patient as much information as he/she needs to make an informed decision, including any risk that a reasonable person would consider important in deciding to have the proposed treatment or procedure, and any other information skilled practitioners would disclose to the patient under the same or similar circumstances..."<sup>9</sup>

Because psychotherapy is not an inherently risky form of treatment, it is reasonable to question whether informed consent doctrine is truly applicable to psychotherapy under most



circumstances. In fact, many therapists may be surprised to learn that, with the exception of telehealth, California law does not specifically require psychotherapists to obtain their patients<sup>10</sup> informed consent for treatment. Section 1815.5(c)(1) of the California Code of Regulations requires a licensee or registrant to obtain informed consent from the client consistent with Section 2290.5 of the Business and Professions Code, upon initiation of telehealth services.

While the language of section 532 of the California Civil jury instructions CACI concerns the conduct of “medical professionals,” that doesn’t mean that psychotherapists are, or should be, nonchalant about the underlying principles of informed consent. For example, a number of ethical guidelines directly refer to, and in some cases require, the specific application of informed consent.<sup>11</sup> Furthermore, many therapists believe that issues of informed consent arise during the course of treatment when the therapist and his or her patient consider significant changes or modifications to the treatment plan.

### **Therapist Disclosures**

California law does require psychotherapists to disclose specific information to their patients.<sup>12</sup> Because the law does not require that such disclosures be made in a particular manner, some therapists provide their disclosures verbally, while others prefer to furnish the information in writing, which may or may not be in the form of a signed agreement. Regardless of the method selected, therapists should strive to provide their patients with clear information, in plain English.<sup>13</sup>

The following information identifies the various disclosures that California law either requires or encourages of marriage and family therapists, licensed clinical social workers, and psychologists. The disclosure requirements are similar, but by no means identical, for these professional groups.

The California Business and Professions Code and the California Code of Regulations govern the conduct of numerous professional groups in California, including marriage and family therapists, clinical social workers and psychologists. Violations of these laws generally constitute unprofessional conduct and may subject the individual to disciplinary action by their respective licensing board(s).

### **Telehealth-Related Disclosures**

Section 1815.5 of the Code of Regulations, and Section 2290.5 of the Business and Professions Code require a number of specific disclosures to the client prior to rendering telehealth services. Additional information regarding this topic is available in “Regulatory and Legal Considerations for Telehealth,” by Ann Tran-Lien, JD, in the September, 2016 issue of *The Therapist*, and “The Basics of Telehealth,” by Alain Montgomery, JD, in the February, 2015 issue of *The Therapist*.)

### **Marriage and family therapists<sup>14</sup> must disclose the following information to their patients:**

- Prior to the commencement of treatment, information concerning the fee to be charged for the professional services, or the basis upon which that fee will be computed, must be disclosed to the client or prospective client.<sup>15</sup>

- If the therapist is a Registered MFT Associate or trainee, he or she must inform each client or patient prior to performing any professional services that he or she is unlicensed and under the supervision of a licensed marriage and family therapist, licensed clinical social worker, licensed professional clinical counselor, licensed psychologist, or a licensed physician and surgeon certified in psychiatry by the American Board of Psychiatry and Neurology.<sup>16 17</sup>
- Any licensed marriage and family therapist who conducts a private practice under a fictitious business name shall not use any name which is false, misleading, or deceptive, and shall inform the patient, prior to the commencement of treatment, of the name and license designation of the owner or owners of the practice.<sup>18</sup>
- The name of a marriage and family therapy corporation shall contain one or more of the words “marriage,” “family,” or “child” together with one or more of the words “counseling,” “counselor,” “therapy,” or “therapist,” and wording or abbreviations denoting corporate existence. A marriage and family therapy corporation that conducts business under a fictitious business name shall not use any name that is false, misleading or deceptive, and shall inform the patient, prior to the commencement of treatment, that the business is conducted by a marriage and family therapy corporation.<sup>19</sup>
- The therapist is required to conspicuously display his or her professional license in his or her primary place of business.<sup>20</sup>
- California law encourages, (but doesn’t require) marriage and family therapists to disclose the following: “...all marriage and family therapists are encouraged to provide to each client, at an appropriate time and within the context of the psychotherapeutic relationship, an accurate and informative statement of the therapist’s experience, education, specialties, professional orientation, and any other information deemed appropriate by the licensee.”<sup>21 22</sup>
- While this article does not specifically discuss professional clinical counselors, it is worth mentioning that under California law, their disclosure requirements are very similar to those which are applicable to marriage and family therapists, clinical social workers and psychologists. Information regarding the legal requirements applicable to professional clinical counselors is available on the BBS website at: [www.bbs.ca.gov](http://www.bbs.ca.gov).

**Clinical social workers<sup>23</sup> must disclose the following information to their patients:**

- The licensee is required to conspicuously display his or her professional license in his or her primary place of business.<sup>24</sup>
- The registrant shall inform each client or patient prior to performing any professional services that he or she is unlicensed and is under the supervision of a licensed professional.<sup>25</sup>
- Prior to the commencement of treatment, information concerning the fee to be charged for the professional services, or the basis upon which that fee will be computed, must be disclosed to the client or prospective client.<sup>26</sup>
- The name of a licensed clinical social worker corporation and any name or names under which it may be rendering professional services shall contain the words “licensed clinical social worker” and wording or abbreviations denoting corporate existence. A licensed clinical social worker corporation that conducts business under a fictitious business name shall not use any name which is false, misleading, or deceptive, and shall inform the

patient, prior to the commencement of treatment, that the business is conducted by a licensed clinical social worker corporation.<sup>27</sup>

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### **Psychologists must disclose the following information to their patients:**

- All licensees and registrants are required to post the following notice in a conspicuous location in their principal psychological business office: “NOTICE TO CONSUMERS: The Department of Consumer Affairs Board of Psychology receives and responds to questions and complaints regarding the practice of psychology. If you have questions or complaints, you may contact the board on the Internet at [www.psychboard.ca.gov](http://www.psychboard.ca.gov), by calling 1-866-503-3221, or by writing to the following address: Board of Psychology 2005 Evergreen Street, Suite 1400, Sacramento, California, 95815-3894.”<sup>28</sup>
- The name of a psychological corporation and any name or names under which it may render professional services shall contain one of the words specified in subdivision (c) of Business and Prof. Code, § 2902, (such as “psychologist,” “psychology,” etc.) and wording or abbreviations denoting corporate existence.<sup>29</sup>
- Every licensed psychologist shall include his or her number in any advertising, public directory or solicitation, regardless of whether such a presentment is made under the licensee’s own name, a fictitious business or group name or a corporate name.<sup>30</sup>
- Primary supervisors shall ensure that each client or patient is informed, prior to the rendering of services by the trainee; (1) that the trainee is unlicensed and is functioning under the direction and supervision of the supervisor; (2) that the primary supervisor shall have full access to the treatment records in order to perform supervision responsibilities and (3) that any fees paid for the services of the trainee must be paid directly to the primary supervisor or employer.<sup>31</sup>
- The supervisor shall inform each client or patient prior to the rendering of services by the psychological assistant that the assistant is unlicensed and is under the direction and supervision of the supervisor as an employee and that the supervisor shall have full access to the patient’s chart in fulfilling his/her supervision duties.<sup>32</sup>

### **“Covered Entities” Under HIPAA**

All therapists who are covered entities according to HIPAA must provide a copy of their Notice of Privacy Practices.<sup>33</sup> The therapist is not required to obtain the patient’s signature on the Notice, but must make a good faith effort to obtain the patient’s written acknowledgment of receipt of the Notice.”<sup>34</sup>

### **Optional Disclosures:**

Therapists are certainly not limited to the disclosures mandated by California law. However, because of their unique backgrounds, training and theoretical approaches, no single list will address all of their needs. The following is a list of commonly utilized disclosures. Individual therapists may pick and choose those items that are meaningful to him or her, eliminate those that aren’t and modify or add content as needed.

- Information regarding the use of health insurance, charges for missed sessions and any policies concerning the use of collection services for unpaid fees.
- Information describing the therapist's policies regarding scheduling and cancellations.
- Information regarding therapist availability, including "on-call" availability for after-hours emergencies.
- The therapist's policies concerning termination of treatment for lack of cooperation (client no-shows, unpaid fees, etc.)
- Information regarding the limitations of psychotherapy, including the fact that therapists cannot guarantee a particular outcome.
- Information regarding the value of patient cooperation and collaborative participation in the treatment process.
- Information about the limits of confidentiality<sup>35</sup>, including the mandated reporting of child abuse,<sup>36</sup> elder abuse, the therapist's "duty to warn / protect"<sup>37</sup> and the Patriot Act.<sup>38</sup>
- The therapist's clinical impressions and treatment recommendations regarding the application of particular therapeutic modalities (e.g., individual therapy, family therapy, marital therapy, group therapy, play therapy); specific treatment methods or techniques (e.g., EMDR, hypnosis, art therapy, music therapy, etc.); frequency of sessions, and length of treatment.<sup>39</sup>

### **Ethical Standards**

The ethical standards promulgated by professional associations such as CAMFT,<sup>40</sup> AAMFT,<sup>41</sup> NASW,<sup>42</sup> APA,<sup>43</sup> and others, are an important source of guidance to therapists. The following selected examples of ethical standards from each of these organizations pertain to the issue of informed consent:

### **CAMFT Code of Ethics for Marriage and Family Therapists**

1. "Marriage and family therapists respect the right of patients to make decisions and help them to understand the consequences of those decisions. When clinically appropriate, MFTs advise their patients that decisions on the status of their relationships, including dissolution, are the responsibilities of the patient."<sup>44</sup>
2. "Marriage and family therapists inform patients of the potential risks and benefits of service of therapy when utilizing novel or experimental techniques or when there is risk of harm that could result from the utilization of any techniques."<sup>45</sup>
3. "Marriage and family therapists inform patients of the extent of their availability for emergencies and for other contacts between sessions. When a marriage and family therapist is not located in the same geographic area as the patient, he/she shall provide the patient with appropriate resources in the patient's locale for contact in case of emergency."<sup>46</sup>
4. "Marriage and family therapists discuss appropriate treatment alternatives with patients.<sup>47</sup> Marriage and family therapists do not limit their discussions of treatment alternatives to what is covered by third-party payers."<sup>48</sup>
5. "Marriage and family therapists are encouraged to inform patients as to certain exceptions to confidentiality such as child abuse reporting, elder and dependent adult abuse reporting, and patients dangerous to themselves or others."<sup>49</sup>

6. “Marriage and family therapists are encouraged to inform patients at an appropriate time and within the context of the psychotherapeutic relationship of their experience, education, specialties, theoretical and professional orientation and any other information deemed appropriate by the therapist.”<sup>50</sup>
7. “Marriage and family therapists disclose, in advance, their fees and the basis upon which they are computed, including, but not limited to, charges for canceled or missed appointments and any interest to be charged on unpaid balances, at the beginning of treatment and give reasonable notice of any changes in fees or other charges.”<sup>51</sup>
8. “Marriage and family therapists obtain written informed consent from clients before videotaping, audio recording, or permitting third party observation.”<sup>52</sup>
9. “When therapy occurs by electronic means, marriage and family therapists inform patients of the potential risks and benefits, including but not limited to, issues of confidentiality, clinical limitations, transmission difficulties, and ability to respond to emergencies.”<sup>53</sup>

### **AAMFT Code of Ethics**

1. “Marriage and family therapists obtain appropriate informed consent to therapy or related procedures as early as feasible in the therapeutic relationship, and use language that is reasonably understandable to clients. The content of informed consent may vary depending upon the client and treatment plan; however, informed consent generally necessitates that the client: (a) has the capacity to consent; (b) has been adequately informed of significant information concerning treatment processes and procedures; (c) has been adequately informed of potential risks and benefits of treatments for which generally recognized standards do not yet exist; (d) has freely and without undue influence expressed consent; and (e) has provided consent that is appropriately documented. When persons, due to age or mental status, are legally incapable of giving informed consent, marriage and family therapists obtain informed permission from a legally authorized person, if such substitute consent is legally permissible.”<sup>54</sup> 2. “Marriage and family therapists obtain written informed consent from clients before videotaping, audio recording, or permitting third-party observation.”<sup>55</sup>

### **NASW Code of Ethics**

1. “Social workers should provide services to clients only in the context of a professional relationship based, when appropriate, on valid informed consent. Social workers should use clear and understandable language to inform clients of the purpose of the services, risks related to the services, limits to services because of the requirements of a third-party payer, relevant costs, reasonable alternatives, clients’ right to refuse or withdraw consent, and the time frame covered by the consent. Social workers should provide clients with an opportunity to ask questions.”<sup>56</sup>
2. “In instances when clients are not literate or have difficulty understanding the primary language used in the practice setting, social workers should take steps to ensure clients’ comprehension. This may include providing clients with a detailed verbal explanation or arranging for a qualified interpreter or translator whenever possible.”<sup>57</sup>

3. “In instances when clients lack the capacity to provide informed consent, social workers should protect clients’ interests by seeking permission from an appropriate third party, informing clients consistent with the clients’ level of understanding. In such instances social workers should seek to ensure that the third party acts in a manner consistent with clients’ wishes and interests. Social workers should take reasonable steps to enhance such clients’ ability to give informed consent.”<sup>58</sup>
4. “In instances when clients are receiving services involuntarily, social workers should provide information about the nature and extent of services and about the extent of clients’ right to refuse service.”<sup>59</sup>
5. “Social workers who provide services via electronic media (such as computer, telephone, radio, and television) should inform recipients of the limitations and risks associated with such services.”<sup>60</sup>
6. “Social workers should obtain clients’ informed consent before audio taping or videotaping clients or permitting observation of services to clients by a third party.”<sup>61</sup>

### **APA Principles of Psychologists and Code of Conduct:**

1. “When psychologists conduct research or provide assessment, therapy, counseling, or consulting services in person or via electronic transmission or other forms of communication, they obtain the informed consent of the individual or individuals using language that is reasonably understandable to that person or persons except when conducting such activities without consent is mandated by law or governmental regulation or as otherwise provided in this Ethics code.”<sup>62</sup>
2. For persons who are legally incapable of giving informed consent, psychologists nevertheless (1) provide an appropriate explanation, (2) seek the individual’s assent, (3) consider such persons’ preferences and best interests, and (4) obtain appropriate permission from a legally authorized person, if such substitute consent is permitted or required by law. When consent by a legally authorized person is not permitted or required by law, psychologists take reasonable steps to protect the individual’s rights and welfare.”<sup>63</sup>
3. “When psychological services are court ordered or otherwise mandated, psychologists inform the individual of the nature of the anticipated services, including whether the services are court ordered or mandated and any limits of confidentiality, before proceeding.”<sup>64</sup>
4. “Psychologists appropriately document written or oral consent, permission, and assent.”<sup>65</sup>
5. “When obtaining informed consent to therapy as required in Standard 3.10, Informed Consent, psychologists inform clients/patients as early as is feasible in the therapeutic relationship about the nature and anticipated course of therapy, fees, involvement of third parties, and limits of confidentiality and provide sufficient opportunity for the client/patient to ask questions and receive answers.”<sup>66</sup>
6. “When obtaining informed consent for treatment for which generally recognized techniques and procedures have not been established, psychologists inform their clients/patients of the developing nature of the treatment, the potential risks involved,

alternative treatments that may be available, and the voluntary nature of their participation.”<sup>67</sup>

7. “When the therapist is a trainee and the legal responsibility for the treatment provided resides with the supervisor, the client/patient, as part of the informed consent procedure, is informed that the therapist is in training and is being supervised and is given the name of the supervisor.”<sup>68</sup>
8. “Before recording the voices or images of individuals to whom they provide services, psychologists obtain permission from all such persons or their legal representatives.”<sup>69</sup>

### **Special Treatment Circumstances**

In California, the Business and Professions Code requires the documentation of verbal informed consent for the use of Telehealth (on-line therapy).<sup>70</sup> Also, as noted earlier, the ethical standards for marriage and family therapists, clinical social workers and psychologists all require that the patient’s informed consent be obtained prior to audio and video-taping treatment and/or for third party observation.<sup>71</sup> The standards for marriage and family therapists further require that the patient’s informed consent be provided in writing prior to any of those same activities.

A therapist should also consider the use of a written informed consent document when the nature of the treatment is likely to be unfamiliar to his or her patient, and/or when the treatment is novel, experimental, is particularly unique or presents an unusual element of risk. In such instances, the patient is likely to benefit by a description of the treatment, including its intended benefits and if applicable, the relevant risks. For example, when the proposed therapy includes outdoor hiking, there may be an increased likelihood of accident or injury. Additional examples might include the use of hypnosis, EMDR, biofeedback, bodywork, art therapy, music therapy, drama therapy, Christian counseling, confrontational group therapies, and others.

### **Required Procedures**

The Telehealth statute requires that prior to the delivery of health care via telehealth, the health care provider at the originating site shall verbally inform the patient that telehealth may be used and obtain verbal consent from the patient for this use. The verbal consent shall be documented in the patient's medical record.<sup>75</sup>

### **Optional Disclosures**

Because Telehealth is a relatively new, innovative and non-traditional method of providing therapy, therapists are encouraged to disclose information that provides the patient with a description of the particular form of telehealth offered.<sup>76</sup> For example, telehealth with audio/video features may be distinguished from telehealth using text-only communications.<sup>77</sup> Such disclosures will vary, depending on the facts of the case, and the experience of the therapist, similar to the manner in which nonmandatory disclosures vary from therapist to therapist in other treatment scenarios.<sup>78</sup> Audio taping, videotaping and third-party observation: written informed consent required.

Therapists have numerous uses for audiotaping and videotaping in their clinical work. Audiotapes and videotapes are an excellent source of feedback to the therapist about the efficacy of his or her efforts with a particular patient. Recordings can also be extremely helpful to patients by providing them with the opportunity to review important content from their sessions. And as

any clinical supervisor knows, audio and videotapes are fundamental tools for use in supervising and training therapists.

Patients generally offer little or no objection to the use of audio taping or videotaping equipment. That may be due in part to the fact that current technology permits the use of recording devices that are small, quiet and relatively unobtrusive. However, the therapist should consider his or her patient's particular sensitivity to being recorded when contemplating the use of audio and or video tape recording. Prior to the use of any recording devices, the therapist should insure that his or her patient has provided explicit consent for their use. Informed consent documents should be signed and dated by the patient, documenting his or her permission for the use of audio tape and/or videotape, for a stated purpose, e.g., treatment review and/or planning, or clinical supervision, etc. Because audio and/or videotapes, and digital video recordings contain confidential and privileged content, they should be subjected to the same protections and security measures that are applicable to other clinical records.

### **Third-Party Observation**

There are a number of circumstances where a therapist may wish to permit a third party to observe their patient's treatment. As an example, the use of one-way mirrors that permit the observation of therapy sessions by a clinical supervisor is a long-standing method used in the training of therapists. Although the use of third-party observation is hardly rare, many patients may be unfamiliar with its use. Therefore, therapists should consider the suitability and appropriateness of its use on a case by case basis. As in the use of audio taping and videotaping, the therapist should consider his or her patient's individual needs and sensitivities ahead of all other concerns. As in the use of audio taping and videotaping, therapists should obtain a written informed consent from his or her patient prior to the use of third-party observation.

### **Hypnosis**

It is suggested that informed consent be obtained prior to the use of hypnosis. One rather unique example of mandatory informed consent under California law involves the use of hypnosis for the purpose of helping a witness to recall events which are the subject of their testimony in a criminal case. The California Evidence Code requires that a witness must have given their informed consent to the use of hypnosis for this purpose, as one condition of admissibility for his or her testimony.<sup>79</sup>

### **Family Therapy/Couples Therapy**

Therapists who work with families and couples sometimes utilize a "no-secrets" policy, which permits them to use their professional discretion in the disclosure of information obtained from a family member's individual session. Because such a policy is a significant departure from the typical parameters of confidentiality, therapists are advised to consider the use of a written informed consent.

### **Children and Informed Consent**

It is easy for therapists and families alike to overlook the relevance of informed consent to the treatment of children and adolescents. Although minors, under the age of 12 lack the legal capacity to provide legal consent to their treatment, they certainly can, and should, provide input to their therapist regarding their treatment. Clinicians who treat children are often witnesses to



the fact that children feel powerless and/or helpless in the face of traumatic events, such as the divorce of their parents, a change in the composition of their family, or the physical relocation of their family. In these and other circumstances, children are often particularly grateful for the opportunity to express their opinions about the direction of the therapy and they appreciate the fact that someone asked. Therapists who work with children have an opportunity to acknowledge the child's need to understand and participate in their own treatment plan.

## **Informed Consent as a Process**

### **Addressing Informed Consent Prior to Treatment**

The issues of consent and/or informed consent for treatment are typically addressed during the initial interview(s). Depending on the nature of the case and the type of treatment being sought or provided, a patient either agrees to accept treatment, e.g., provides his or her ordinary/simple consent to treatment, and/or, the therapist initiates the process of obtaining his or her patient's informed consent. Whereas simple consent is basically a static event involving a patient's agreement to participate in treatment, informed consent is often described as a process that includes the therapist's initial assessment and any subsequent dialogue(s) between the therapist and his or her patient about the treatment plan.<sup>80</sup>

### **Addressing Informed Consent During the Course of Treatment**

By addressing informed consent at the start of treatment, the patient is provided with an opportunity to determine whether he or she agrees with the therapist's assessment and his or her related treatment recommendations. However, issues of informed consent are not confined to the beginning of therapy. They may also arise during the course of treatment. At the beginning of treatment, the patient and therapist have had limited opportunity to establish a therapeutic relationship. Consequently, initial treatment plans are crafted with the understanding that therapist and patient alike are expected to engage in a process of regular review of the efficacy of their collaborative treatment efforts. This process of review is founded upon the premise that changes in treatment plans will be contemplated should therapeutic progress fail to materialize.

The therapist's duty of care requires him or her to maintain an appropriate awareness of therapeutic progress and to make or suggest the appropriate changes to the treatment plan.<sup>81</sup> Regardless of the precision of the initial treatment plan, neither therapist nor patient can possibly know what the precise outcome of treatment will be. A good practice is to inform new patients that treatment plans are subject to an ongoing process of review by patient and therapist and that such reviews are intended to insure their input into, and agreement with, the treatment plan.

In one example, a patient may resist his or her therapist's suggestion to explore certain traumatic experiences, preferring instead that his or her therapist address present-day issues that were identified during the intake. Alternately, a therapist may ask an individual psychotherapy patient to invite his or her spouse to a session. To the extent that the patient's individual therapy becomes conjoint marital therapy and the patient has not explicitly assented to the change, the therapist may have exceeded the bounds of the originally agreed-upon treatment plan.

In order to avoid confusion, and as a measure of respect for the patient's autonomy, a therapist should definitely consider the use of informed consent any time that a significant change in the original treatment plan is contemplated. Significant decision points in the treatment, such as those referred to in the foregoing examples, are a logical time to consider the use of informed consent. As stated earlier, informed consent is applicable in situations where the patient is unlikely to be familiar with the particular treatment. In this situation, a patient may not have prior familiarity with the fact that more than one treatment modality may have relevance to his or her needs. It also cannot be assumed that a patient is in agreement with, or aware of, his or her therapist's reasoning. Furthermore, some patients may be reluctant to question their therapist about a proposed change or may be confused, in light of the preceding therapeutic process. Consequently, significant decision points in the treatment offer a valuable opportunity to discuss the nature of proposed changes and the reasons for (or if applicable, against) making the change(s).

### **The Use of Forms**

For the sake of consistency, therapists are advised to develop clear and reliable procedures<sup>82</sup> for the purpose of providing information to their patients and to address issues of informed consent. Such procedures and the use of related forms or documents should be incorporated into the therapist's regular intake and assessment process.

Therapists often focus on the utility or language of a particular document or form, created for the purpose of obtaining consent. That's understandable, as the use of various "intake," "client information" or "therapist disclosure" statements, etc., as a means to provide new patients with information has become standard practice.<sup>83</sup> Similarly, many therapists are trained in bureaucratic settings where the use of forms for patient consent is ubiquitous. However, just because an individual signs a form, it doesn't mean that he or she understands its contents. Consent forms are often confusing, poorly worded and filled with technical jargon. Because patients are reliant on the clarity of information provided to them, therapists must take care to provide patients with clear and complete information on any form they select for the purpose of obtaining informed consent. Yet, regardless of the therapist's diligence to this matter, misunderstandings are inevitable. It is therefore recommended that informed consent documents contain a clear expression of the therapist's willingness to respond to the patient's questions and concerns as they may arise.

### **REFERENCES:**

<sup>1</sup> Berner, Marilyn, "Informed Consent," In, Lifson, Lawrence and Simon, Robert, *The Mental Health Practitioner and the Law* Harvard Univ. Press, 1999

<sup>2</sup> Id.

<sup>3</sup> Id.

<sup>4</sup> See generally, Leslie, Richard, S., J.D., (2006) "Informed Consent," CPH & Associates, *Avoiding Liability Bulletin*, July, (1).

<sup>5</sup> *Cobbs v. Grant*, (1972) 8 Cal.3d 229

<sup>6</sup> Id.

<sup>7</sup> Id.

<sup>8</sup> CACI No. 532. CACI is used by California judges to instruct jurors regarding the law

<sup>9</sup> Id.

<sup>10</sup> The terms “patient” and “client” are used interchangeably in this article.

<sup>11</sup> See CAMFT Code of Ethics, AAMFT Code of Ethics, NASW Ethical Standards, and APA Ethical Principles.

<sup>12</sup> The required disclosures are not identical for Marriage and Family Therapists, Clinical Social Workers and Psychologists.

<sup>13</sup> Plain English should not be confused with the verbiage commonly employed by therapists and lawyers.

<sup>14</sup> References in this article to marriage and family therapists are to licensees, associates and trainees.

<sup>15</sup> California Business & Professions Code, §§ 4982.(n)

<sup>16</sup> California Business & Professions Code, § 4980.44 (a)(4)

<sup>17</sup> California Business & Professions Code, § 4980.48

<sup>18</sup> California Business & Professions Code, § 4980.46

<sup>19</sup> California Business & Professions Code, § 4987.7.

<sup>20</sup> California Business & Professions Code, § 4980.31

<sup>21</sup> California Business & Professions Code, § 4980.55.

<sup>22</sup> A therapist should exercise caution when describing their areas of special interest and skill. Holding oneself out as an “expert” imposes the standard of care applicable to that of a reasonable and prudent expert providing treatment under same or similar circumstances.

<sup>23</sup> References in this article to clinical social workers are to licensees and associate clinical social workers.

<sup>24</sup> California Business & Professions Code, § 4996.7.

<sup>25</sup> California Business & Professions Code, § 4996.18.(e) The term “registrant” refers to an associate clinical social worker.

<sup>26</sup> California Business & Professions Code, §§4992.3.(n);1881.(j)

<sup>27</sup> California Business & Professions Code, §4998.2.

<sup>28</sup> California Business & Professions Code, § 2936.

<sup>29</sup> California Business & Professions Code, § 2998.

<sup>30</sup> California Administrative Code, title 16, § 1380.6

<sup>31</sup> California Administrative Code, title 16, § 1387.1

<sup>32</sup> California Administrative Code, title 16, § 1391.6

<sup>33</sup> The Health Insurance Portability and Accountability Act of 1996

<sup>34</sup> Id.

<sup>35</sup> Therapists should advise couples regarding confidentiality between the partners. For example, in the absence of a “no secrets” policy, each member of the couple has an expectation of confidentiality when speaking to the therapist outside the presence of their partner.

<sup>36</sup> Calif. Penal Code, §§11164-11174.3; Calif. Welf. & Instit. Code, §§ 15630-15632

<sup>37</sup> Calif. Civil Code, § 43.92; *Tarasoff v. Regents of Univ. of Calif.*, (1976), 17 Cal.3d 425; *Ewing v. Goldstein*, (2004), 120 Cal.App.4th 807; *Ewing v. Northridge Hospital Center* (2004), 120 App. 4th 807

<sup>38</sup> The US Patriot Act of 2001 requires therapists (and others) in certain circumstances, to provide FBI agents with books, records, papers and documents and prohibits the therapist from disclosing to the patient that the FBI sought or obtained the items under the Act.

<sup>39</sup> A therapist’s clinical impressions and recommendations will obviously vary, depending on the nature of the case and the information then available to the therapist.

<sup>40</sup> California Association of Marriage and Family Therapists  
<sup>41</sup> American Association of Marriage and Family Therapists  
<sup>42</sup> National Association of Social Workers  
<sup>43</sup> American Psychological Association  
<sup>44</sup> CAMFT Code of Ethics 1.4  
<sup>45</sup> Id., 1.5.2  
<sup>46</sup> Id., 1.5.3  
<sup>47</sup> Id., 1.4  
<sup>48</sup> Id., 1.13  
<sup>49</sup> Id., 1.5.5  
<sup>50</sup> Id., 1.5.6  
<sup>51</sup> Id., 9.3  
<sup>52</sup> Id., 1.5.4  
<sup>53</sup> Id., 1.4.2  
<sup>54</sup> 4 AAMFT Code of Ethics 1.2  
<sup>55</sup> Id., 1.12  
<sup>56</sup> NASW Ethical Standard 1.03 (a)  
<sup>57</sup> Id., 1.03 (b)  
<sup>58</sup> Id., 1.03 (c)  
<sup>59</sup> Id., 1.03 (d)  
<sup>60</sup> Id., 1.03 (e)  
<sup>61</sup> Id., 1.03 (f)  
<sup>62</sup> APA Ethical Standard 3.10 (a)  
<sup>63</sup> Id., 3.10 (b)  
<sup>64</sup> Id., 3.10 (c)  
<sup>65</sup> Id., 3.10 (d)  
<sup>66</sup> Id.,10.01 (a); See also, APA Ethical Standards regarding informed consent to research and informed consent to assessments.  
<sup>67</sup> Id.,10.01 (b)  
<sup>68</sup> Id.,10.01(c)  
<sup>69</sup> Id., 4.03  
<sup>70</sup> California Business and Professions Code, §2290.5  
<sup>71</sup> See id.; CAMFT Code of Ethics 1.4.2; AAMFT Code of Ethics, 1.12; NASW Code of Ethics 1.03 (f) APA Ethical Principles 4.03  
<sup>72</sup> See id., § 2290.5  
<sup>73</sup> See, Leslie, Richard, S., J.D., (2002) “ Practicing Via the Internet-the Legal View,” Family Therapy Magazine, Sept/Oct. (1); Benitez, Bonnie R., Jensen, David, G.,(2002)“ Telemedicine: AKA On-Line Therapy & Mandatory Informed Consent,” The Therapist, Sept./Oct., vol. 14, (5).  
<sup>74</sup> See id., § 2290.5 The failure to comply with the provisions of this statute constitutes unprofessional conduct.  
<sup>75</sup> California Business & Professions Code, §2290.5(b)  
<sup>76</sup> See Leslie, Richard, S., JD., (2002) “Practicing Via the Internet-the Legal View”  
<sup>77</sup> Id.  
<sup>78</sup> Id.; See also, Riemersma, Mary, (2002) “Informed Consent/Disclosure Online Therapy Statement,” The Therapist, Sept. /Oct., vol. 14, (5). Provides a sample form illustrating optional disclosures.

<sup>79</sup> California Evidence Code, §795.

<sup>80</sup> Pomerantz, Andrew M. (2005). "Increasingly Informed Consent: Discussing Distinct Aspects of Psychotherapy at Different Points in Time," *Ethics & Behavior* 15(4), 351-360; Berg, J.W Appelbaum, P.S., Lidz, C.W., & Parker, L.S., *Informed consent: Legal theory and clinical Practice* (2nd ed.), New York: Oxford University Press; O'Neill, P. (1998) *Negotiating consent in Psychotherapy*, New York: New York University Press.

<sup>81</sup> See, CAMFT Code of Ethics, 1.7 Marriage and family therapists continually monitor their effectiveness and take steps to improve when necessary. Marriage and family therapists continue therapeutic relationships only so long as it is reasonably clear that patients are benefiting from the relationship.

<sup>82</sup> Having a written procedure, and following it, helps to insure that all patients are treated professionally and consistently. It also serves as documentary evidence of the therapist's care and attention to the matter of consent.

<sup>83</sup> See generally, Leslie, Richard, S., J.D., "Information/ Disclosure Statements: Informed Consent," *The Therapist*, March/April, 1992

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## WHEN A CLINICAL SOCIAL WORKER IN SOLO OR GROUP PRACTICE DIES

NASW has received numerous telephone calls from co-workers and family members of NASW members seeking assistance with the estate of a clinical social worker in solo or group practice who has died. In many situations, death and disability occur unexpectedly; therefore, it is important for clinical social workers to prepare their private practice for such circumstances by preparing a professional will. Doing so allows for a smooth transition of services for patients during a difficult period and provides important guidance for the person designated to close the practice and resolve paperwork.

### Preparing Your Practice

Although you may not like to think about death, it is important for clinical social workers to consider provisions for their practice in the event of their death. Preparation of your practice for your death is the best practice to allow for a continuum of services. A recommended list of options includes the following:

- Seek legal counsel and discuss options for the estate of your practice with an attorney skilled and experienced in mental health law.
- Prepare a professional will that includes directions for your solo or group practice including instructions on how to access patient records and how business-related expenses should be paid.

- Select an appropriate colleague or designee familiar with the practice of social work to handle the transfer or closing of patient matters.
- On your office's intake form and/or contract with patient, include provisions about services in the event of your death.
- Make a list of referrals for patients to receive on-going services in the event you are unable to continue providing services.
- Make provisions for the disposition of the patient records, including identification of a storage place.
- Keep all records and claims up to date.

### Lack of Preparation

Should there be no preparation for the clinical social worker's death, the executor of the estate or designee should consider the following options:

- Consult with an attorney about the estate of the clinical social worker who has died.
- Ensure confidentiality of patient records. No one may be privy to the contents.
- Mail a letter to all of the clinical social worker's patients to inform them of his or her death.

- Inform patients how they may obtain their files if needed.
- Give patients referral options to continue services if needed.
- Place a brief message on the office's voicemail and e-mail for several months.
- Locate a safe, secure place to store locked files. Check state laws regarding record retention after the death of a provider.
- Notify the professional liability insurance agency of the clinical social worker's death. (NASW's agency is the American Professional Agency, 1-800-421-6694.) Should the clinical social worker be insured under the NASW program, the Extended Reporting Period coverage may be available at no cost or for a nominal fee. This coverage is essential because it protects the estate from future malpractice suits that may qualify for coverage.
- Contact appropriate managed care companies and insurance companies to inform them of the clinical social worker's death.
- When appropriate, submit outstanding claim forms.
- Follow tips in the NASW brochure *Retiring or Closing a Private Practice?* available online from NASW Press at [www.naswpress.org](http://www.naswpress.org).

A professional will provides others with basic guidance for taking care of the unfinished business of a solo or group practice. Clinical social workers should prepare a professional will, review it on a regular basis, and make immediate updates when changes occur.

### Resources

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National Association of Social Workers. (2003). *Clinical Social Workers in Private Practice: A Reference Guide*. Available online at [www.naswpress.org](http://www.naswpress.org).

Pope, K., & Vasquez, M. (2005). *How to survive and thrive as a therapist*. Washington, DC: American Psychological Association.

Zuckerman, E. (2008). *The paper office*. New York: Guilford Press.



## ATTACHMENT E



AMERICAN PSYCHOLOGICAL ASSOCIATION  
Services, Inc.

**PracticeUpdate** (</practice/update/index>) | **January 17, 2013** (</practice/update/2013/01-17/index>)

# Ask our attorney: Handling records of a deceased psychologist

Guidance on disposition of patient records in the absence of a professional will

**By Legal & Regulatory Affairs and APA Ethics Office staff**

**Jan. 17, 2013**—APA Practice’s Office of Legal and Regulatory Affairs often receives calls from family members, executors, colleagues or office staff of deceased psychologists, asking what to do about that psychologist’s patient records. This issue can be complicated, particularly if the practitioner had not planned for disposition of the records through a professional will (</practice/good-practice/prepared.pdf>) (PDF, 657KB).

One source of difficulty is the fact that many laws and practices regarding record keeping and patient access to records were developed with the assumption that the psychologist would always be around to retain the records and to determine when it is appropriate for a patient to have access to his or her record.

Most of the tough issues discussed below are avoided when a practitioner has planned ahead for the disposition of records through a professional will. A professional will makes virtually every aspect of the transition process more efficient and helpful to those responsible for determining what to do with the psychologist’s records, and also to those who may be responsible for continued clinical care.

APA Record Keeping Guidelines (</practice/ce/guidelines/record-keeping>) and the Ethics Code (<http://www.apa.org/ethics/code/index.aspx>) offer relevant guidance. Section 6.02 of the Ethics Code provides: “Psychologists make plans in advance to facilitate the appropriate transfer and to protect the confidentiality of records and data in the event of psychologists’ withdrawal from positions or practice.” (See also Standard 3.12, Interruption of Psychological Services.) Similarly, Guideline 13 of the APA Recordkeeping Guidelines recommends that psychologists plan for the transfer of records to ensure continuity of treatment and appropriate access to care when the psychologist is no longer in direct control.

The remainder of this article provides answers to questions frequently asked by callers when a deceased psychologist has not left a professional will.

## To whom should records be transferred?

The matter is clear cut if the psychologist has a professional will that specifies arrangements for another mental health professional to take over the records. Absent a professional will, the individual handling this issue (for example, the executor of the deceased psychologist’s estate or a family member) must figure out what to do with records. State law may directly address who has control over

the records — for example, the executor of the estate.

The person handling the issue can determine if the psychologist had a colleague who covered for the psychologist while on vacation, or who took referrals. If so, that psychologist might be asked to take over care of the records. One benefit of this approach is that another mental health professional should know the law, procedures and issues related to giving patients access to their records and retaining records. Another professional should already have a place and system for storing records, and may have staff familiar with responding to record requests.

This solution is particularly appropriate if any of the former patients are transitioning to this other psychologist.

As to patients for whom the other psychologist is *not* assuming care, it is important to note that this arrangement imposes some burdens on the other psychologist. First, there are potential HIPAA or other liability concerns for failure to secure records of another psychologist's patients. And the arrangement entails additional expense and burden for the other psychologist, which is particularly problematic if they do not have spare storage space. These burdens may be balanced, however, by the possibility that patients will want to receive treatment from the psychologist who has assumed custody of their records.

## What issues arise if records are retained by family members or the executor of the psychologist's estate?

Family members and executors usually understand the importance of protecting patient confidentiality and access to records. If they wind up with the records, however, some states' record keeping laws will not apply to them because they are not mental health professionals. Even in those states, the family or executor should be aware of potential liability to the estate if the psychologist's records are not properly maintained.

## What if the family/estate cannot transfer records to another psychologist and has issues with retaining the records? Should records be transferred to the patients?

Sometimes a family or estate of the deceased psychologist cannot identify an appropriate psychologist to assume control of the records, and does not have the resources or capability to store the records for the retention period and assure their security. Particularly after the estate is closed, there may be no legal or liability reasons for retaining the records and the family may consider destroying the records.

In this situation, giving patients the opportunity to take their records before they are destroyed is preferable (see last question regarding notice to former patients). Yet it is difficult to predict how a patient will react to seeing his or her record. For this reason, directly providing records to a former patient should be done with caution. If records are being provided directly to former patients, it may be helpful to provide a cover letter stating that the patient should speak with a mental health professional if there is anything in the record he or she finds distressing.

If records are destroyed, it should be done in a manner that will protect the records' privacy, such as by

shredding. Guideline 13 in the APA Record Keeping Guidelines discusses safe disposal and the particular concerns associated with electronic records.

## How long should records be retained?

How long records must be kept is governed by state record keeping law. In those few states that do not specify how long to keep psychology records, the suggested retention period in APA Record Keeping Guidelines (</practice/ce/guidelines/record-keeping>) should be considered. Guideline 7 of the record keeping guidelines recommends “retaining full records until 7 years after the last date of service delivery for adults or until 3 years after a minor reaches the age of majority, whichever is later.” (These Guidelines are also an excellent source of guidance on many record keeping issues beyond how long to retain records.)

If the person keeping the deceased psychologist’s records wishes to keep records for a longer period of time, he or she should weigh the benefits of longer retention against the risks associated with privacy loss or security breaches, and with obsolete or outdated information.

## How should patients be alerted about accessing their records?

Some psychology patients have not told their spouses or family members that they are seeking care, which complicates the process of notifying former patients. Some psychologists have a file, or a place in their files, indicating how patients want to be contacted. If the psychologist had an administrative assistant or secretary, he or she may know how patients prefer to be contacted. Some alternatives for notifying patients without alerting their family members include posting a notice at the office of the deceased psychologist, on the office’s voicemail, on the practice’s website or in the local newspaper. The office-based solutions are particularly applicable if the psychologist had been practicing at or shortly before the time of his/her death.

Some state psychology boards, like the Florida Board of Psychology, keep track of who has records after a psychologist retires or dies. In such cases, the relevant psychology board should be given notice of who is assuming custody of the records.

## Conclusion

The thorny issues discussed above are a good reminder that practitioners can spare their family members, executors, colleagues and/or office staff much heartache if they plan ahead and execute a professional will (</practice/good-practice/prepared.pdf>) (PDF, 657KB).

**Legal issues are complex and highly fact specific and require legal expertise that cannot be provided by any single article. In addition, laws change over time and vary by jurisdiction. The information in this article does not constitute legal advice and should not be used as a substitute for obtaining personal legal advice and consultation prior to making decisions regarding individual circumstances.**

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### **ⓘ DATED CONTENT**

*APA maintains an archive of our published material throughout our websites. From time to*

*time, you may come across a page that includes outdated science or missing details that could be improved. If you believe that this is one of those pages, please let us know.*

The content I just read:

 **IS RELEVANT**

 **MAY NEED AN UPDATE**

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**Find this article at:**

<https://www.apaservices.org/practice/update/2013/01-17/deceased-psychologist>

**ATTACHMENT F  
STATE OF FLORIDA**

**CHAPTER 64B4-9  
CLIENT RECORDS**

- 64B4-9.001 Requirements for Client Records
- 64B4-9.002 Definitions

**64B4-9.001 Requirements for Client Records.**

(1) A licensed clinical social worker, marriage and family therapist, or mental health counselor, including any registered intern or provisional licensee, shall maintain responsibility for all records relating to his clients as provided in section 456.057, F.S. All such records shall remain confidential except as provided by law or as allowed pursuant to a written and signed authorization by the client specifically requesting or authorizing release or disclosure of records in his office or possession.

(2) A full record of services shall be maintained for 7 years after the date of the last contact with the client or user.

(3) When a clinical social worker, marriage and family therapist, or mental health counselor terminates practice or relocates and is no longer available to clients or users, the clients or users shall be notified of such termination or relocation and unavailability by the licensee's causing to be published in the newspaper of greatest general circulation in the county in which the licensee practices or practiced, a notice which shall contain the date of termination or relocation and an address at which the licensee's client or user records are available to the client, user, or to a licensed mental health professional designated by the client or user. The notice shall appear at least once a week for 4 consecutive weeks. The records shall be retained for 2 years after the termination or relocation of the practice.

(4) If the termination was due to the death of a licensee, records shall be maintained at least two years after the licensee's death. At the conclusion of a 22 month period from the date of the licensee's death, the executor, administrator, personal representative, or survivor shall cause to be published once during each week for 4 consecutive weeks, in the newspaper of greatest general circulation in each county in which the licensee practiced, a notice indicating to the clients or users of the deceased licensee that the licensee's records will be disposed of or destroyed 4 weeks or later from the last day of the final week of publication of the notice.

*Rulemaking Authority 456.058, 491.004(5), 491.0148 FS. Law Implemented 456.058, 491.0148 FS. History—New 5-8-90, Formerly 21CC-9.001, 61F4-9.001, 59P-9.001, Amended 2-11-98, 6-13-07.*

**64B4-9.002 Definitions.**

Psychotherapy records are chronicles of a dynamic psychotherapeutic relationship and are to be accorded the dignity and respect due such a relationship. Psychotherapy is for the client and all records constructed shall respect the integrity and privacy of that relationship.

(1) A psychotherapy report is a summary of information derived from the psychotherapy records which addresses a specific request as authorized by the client.

(2) A psychotherapy record shall contain basic information about the client including name, address and telephone number, dates of therapy sessions, treatment plan and results achieved, diagnosis if applicable, and financial transactions between therapist and client including fees assessed and collected. A record shall also include notes or documentation of the client's consent to all aspects of treatment, copies of all client authorizations for release of information, any legal forms pertaining to the client, and documentation of any contact the therapist has with other professionals regarding the client.

(3) Regardless of who pays for the services of the psychotherapist, a client is that individual who, by virtue of private consultation with the psychotherapist, has reason to expect that the individual's communication with the psychotherapist during that private consultation will remain confidential.

*Rulemaking Authority 491.004(5), 491.0148 FS. Law Implemented 491.0148 FS. History—New 12-11-91, Formerly 21CC-9.002, 61F4-9.002, 59P-9.002, Amended 2-11-98.*

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**ATTACHMENT G**  
**OREGON ADMINISTRATIVE RULES CHAPTER 833**

**833-075-0080 Custodian of Record**

- (1) A licensee or registered intern must:
  - (a) Arrange for the maintenance of and access to client records that ensure the client's right to confidentiality and access to records in the event of the death or incapacity of the licensee;
  - (b) Register with the Board the name and contact information of a custodian of record that will have case files and can make necessary referrals if licensee becomes incapacitated or dies; and
  - (c) Notify the Board of changes of the custodian of record.
- (2) If the licensee or registered intern is an employee of an organization, the organization may be named as the custodian of record.
- (3) The Board will not release the name of the custodian of record except in the following cases:
  - (a) The death or incapacity of the licensee; or
  - (b) When a client is unable to locate the licensee.
- (4) A custodian of record under this rule must be a licensed mental health professional licensed under Oregon law, a licensed medical professional, a health care or mental health organization, an attorney, a school, or a medical records company.

**Source: Oregon Board of Licensed Professional Counselors and Therapists *Oregon Revised Statutes Chapter 675 (2017) & Oregon Administrative Rules Chapter 833 (Revised 08/18)***

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**ATTACHMENT H**  
**WASHINGTON ADMINISTRATIVE CODE**

**WAC 246-809-035**

**Recordkeeping and retention.**

(1) The licensed counselor or associate providing professional services to a client or providing services billed to a third-party payor, must document services, except as provided in subsection (2) of this section. The documentation includes:

(a) The following business information:

(i) Client name;

(ii) The fee arrangement and record of payments;

(iii) Dates counseling was received;

(iv) Disclosure statement, signed and dated by licensed counselor and client or associate and client on or before the initial session.

(b) The following treatment information:

(i) The presenting problem(s), purpose or diagnosis;

(ii) Notation and results of formal consults, including information obtained from other persons or agencies through a release of information;

(iii) Progress notes sufficient to support responsible clinical practice for the type of theoretical orientation/therapy the licensed counselor or associate uses; and

(iv) The associate must also provide all relevant information about their clinical work to the approved supervisor. This includes session notes, case discussions/analysis, or reports from collaborating professionals. The approved supervisor must have a thorough understanding of the clinical work that the associate is doing.

(2) If a client being treated by the licensed counselor requests in writing that no treatment records be kept, and the licensed counselor agrees to the request, then the licensed counselor must retain only the following documentation:

(a) The following business information:

(i) Client name;

(ii) The fee arrangement and record of payments;

(iii) Dates counseling was received; and

(iv) Disclosure statement, signed and dated by licensed counselor or associate and client.

(b) The client's written request that no treatment records be kept.

(3) The licensed counselor shall not agree to the request if maintaining client records is required by other state or federal law.

(4) The licensed counselor or associate or the associate's supervisor must keep all client records for a period of five years following the last visit. Within this five-year period, all records must be maintained safely, with properly limited access.

(5) The licensed counselor or associate or the associate's supervisor shall make provisions for retaining or transferring records in the event of going out of business, death or incapacitation. These provisions may be made in the practitioner's will, an office policy, or by ensuring another licensed counselor is available to review records with a client and recommend a course of action; or other appropriate means as determined by the licensed counselor or associate.

[Statutory Authority: RCW **18.225.040**. WSR 17-13-082, § 246-809-035, filed 6/16/17, effective 7/17/17.

Statutory Authority: Chapter **18.225** RCW. WSR 09-15-039, § 246-809-035, filed 7/8/09, effective 7/8/09.

Statutory Authority: RCW **18.225.040**, **18.130.050**. WSR 06-09-032, § 246-809-035, filed 4/12/06, effective 5/13/06.]

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# ATTACHMENT I

[hhs.gov](https://www.hhs.gov)

## **481-Does HIPAA permit health care providers to share information for treatment purposes without authorization**

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### **Answer:**

Yes. The Privacy Rule allows those doctors, nurses, hospitals, laboratory technicians, and other health care providers that are covered entities to use or disclose protected health information, such as X-rays, laboratory and pathology reports, diagnoses, and other medical information for treatment purposes without the patient's authorization. This includes sharing the information to consult with other providers, including providers who are not covered entities, to treat a different patient, or to refer the patient. See [45 CFR 164.506](#).

Date Created: 11/03/2003

Content created by Office for Civil Rights (OCR)

Content last reviewed on July 26, 2013

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## Code of Federal Regulations

Title 45 - Public Welfare Volume: 1 Date: 2003-10-01 Original Date: 2003-10-01 Title:  
Section 164.506 - Uses and disclosures to carry out treatment, payment, or health care  
operations. Context:

Title 45 - Public Welfare. SUBTITLE A - DEPARTMENT OF HEALTH AND HUMAN  
SERVICES. SUBCHAPTER C - ADMINISTRATIVE DATA STANDARDS AND  
RELATED REQUIREMENTS. PART 164 - SECURITY AND PRIVACY. Subpart E -  
Privacy of Individually Identifiable Health Information.

### § 164.506

Uses and disclosures to carry out treatment, payment, or health care operations.

(a) Standard: Permitted uses and disclosures. Except with respect to uses or disclosures that require an authorization under § 164.508(a)(2) and (3), a covered entity may use or disclose protected health information for treatment, payment, or health care operations as set forth in paragraph (c) of this section, provided that such use or disclosure is consistent with other applicable requirements of this subpart.

(b) Standard: Consent for uses and disclosures permitted. (1) A covered entity may obtain consent of the individual to use or disclose protected health information to carry out treatment, payment, or health care operations.

(2) Consent, under paragraph (b) of this section, shall not be effective to permit a use or disclosure of protected health information when an authorization, under § 164.508, is required or when another condition must be met for such use or disclosure to be permissible under this subpart.

(c) Implementation specifications: Treatment, payment, or health care operations.

(1) A covered entity may use or disclose protected health information for its own treatment, payment, or health care operations.

(2) A covered entity may disclose protected health information for treatment activities of a health care provider.

(3) A covered entity may disclose protected health information to another covered entity or a health care provider for the payment activities of the entity that receives the information.

(4) A covered entity may disclose protected health information to another covered entity for health care operations activities of the entity that receives the information, if each entity either has or had a relationship with the individual who is the subject of the protected health information being requested, the protected health information pertains to such relationship, and the disclosure is:

(i) For a purpose listed in paragraph (1) or (2) of the definition of health care operations; or

(ii) For the purpose of health care fraud and abuse detection or compliance.

(5) A covered entity that participates in an organized health care arrangement may disclose protected health information about an individual to another covered entity that participates in the organized health care arrangement for any health care operations activities of the organized health care arrangement.

[67 FR 53268, Aug. 14, 2002]



Board of Behavioral Sciences

# Memo

1625 North Market Blvd., Suite S-200  
Sacramento, CA 95834  
(916) 574-7830, (916) 574-8625 Fax  
www.bbs.ca.gov

**To:** Committee Members

**Date:** January 28, 2020

**From:** Rosanne Helms  
Legislative Manager

**Telephone:** (916) 574-7897

**Subject: Legislative Update**

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Board staff is currently pursuing the following legislative proposals:

**1. Practice Setting Definitions (No Bill Number Assigned at This Time)**

This bill proposal seeks to eliminate the confusion about where pre-licensees may work by providing specific definitions of private practice, professional corporation, and non-exempt settings. The Board approved this proposal at its November 22, 2019 meeting.

**2. Fee Increase Proposal (No Bill Number Assigned at This Time)**

This bill proposal would increase the licensing, registration, and examination fees charged by the Board. The Board has not increased its fees in over 20 years. The proposal was approved by the Board at its November 22, 2019 meeting.

**3. Omnibus Proposal (Senate Business, Professions, and Economic Development Committee) (No Bill Number Assigned at This Time)**

This bill proposal, approved by the Board at its November 22, 2019 meeting, makes minor, technical, and non-substantive amendments to add clarity and consistency to current licensing law.

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Sacramento, CA 95834  
(916) 574-7830, (916) 574-8625 Fax  
www.bbs.ca.gov

**To:** Board Members **Date:** January 28, 2020  
**From:** Christy Berger, Regulatory Analyst **Telephone:** (916) 574-7817  
**Subject:** **Status of Board Rulemaking Proposals**

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### **Substantial Relationship & Rehabilitation Criteria (AB 2138 Regulations)**

#### **Status: DCA Final Review Process**

This proposal would result in changes necessary in order to meet the requirements of Assembly Bill (AB) 2138 (Chapter 995, Statutes of 2018). This proposal includes modifying the Board's substantial relationship criteria, which helps to evaluate whether a crime or act was substantially related to the profession, as well as criteria to evaluate the rehabilitation of an individual when considering denying, suspending or revoking a license. The proposal was approved by the Board at its meeting in February 2019. See Attachment B for regulation timeline.

### **Enforcement Process**

#### **Status: On Hold**

This proposal would result in updates to the Board's disciplinary process. It would also make updates to the Board's "Uniform Standards Related to Substance Abuse and Disciplinary Guidelines (Revised October 2015)," which are incorporated by reference into the Board's regulations. The proposed changes fall into three general categories:

1. Amendments seeking to strengthen certain penalties that are available to the Board;
2. Amendments seeking to update regulations or the Uniform Standards/Guidelines in response to statutory changes to the Business and Professions Code; and
3. Amendments to clarify language that has been identified as unclear or needing further detail.

The proposal was approved by the Board at its meeting in February 2017 and was submitted to DCA to begin the initial review process in July 2017. This regulation package was placed on hold due to the passage of AB 2138 and remains on hold pending passage of the AB 2138 regulations.

## **Examination Rescoring; Application Abandonment; APCC Subsequent Registration Fee**

Status: Submitted to OAL for Final Approval

This proposal would amend the Board's examination rescoring provisions to clarify that rescoring pertains only to exams taken via paper and pencil, since all other taken electronically are automatically rescored. This proposal would also make clarifying, non-substantive changes to the Board's application abandonment criteria, and clarify the fee required for subsequent Associate Professional Clinical Counselor registrations. The proposal was approved by the Board at its meeting in November 2017. See Attachment B for regulation timeline.

## **Supervision**

Status: To be Noticed on February 7, 2020; Public Hearing on March 23, 2020

This proposal would:

- Revise the qualifications to become supervisor;
- Require supervisors to perform a self-assessment of qualifications and submit the self-assessment to the Board;
- Set forth requirements for substitute supervisors;
- Update and strengthen supervisor training requirements;
- Strengthen supervisor responsibilities, including provisions pertaining to monitoring and evaluating supervisees;
- Strengthen requirements pertaining to documentation of supervision;
- Make supervision requirements consistent across the three licensed professions;
- Address supervision gained outside of California; and
- Address documentation when a supervisor is incapacitated or deceased.
- Set forth terms relating to registrant placement by temporary staffing agencies.

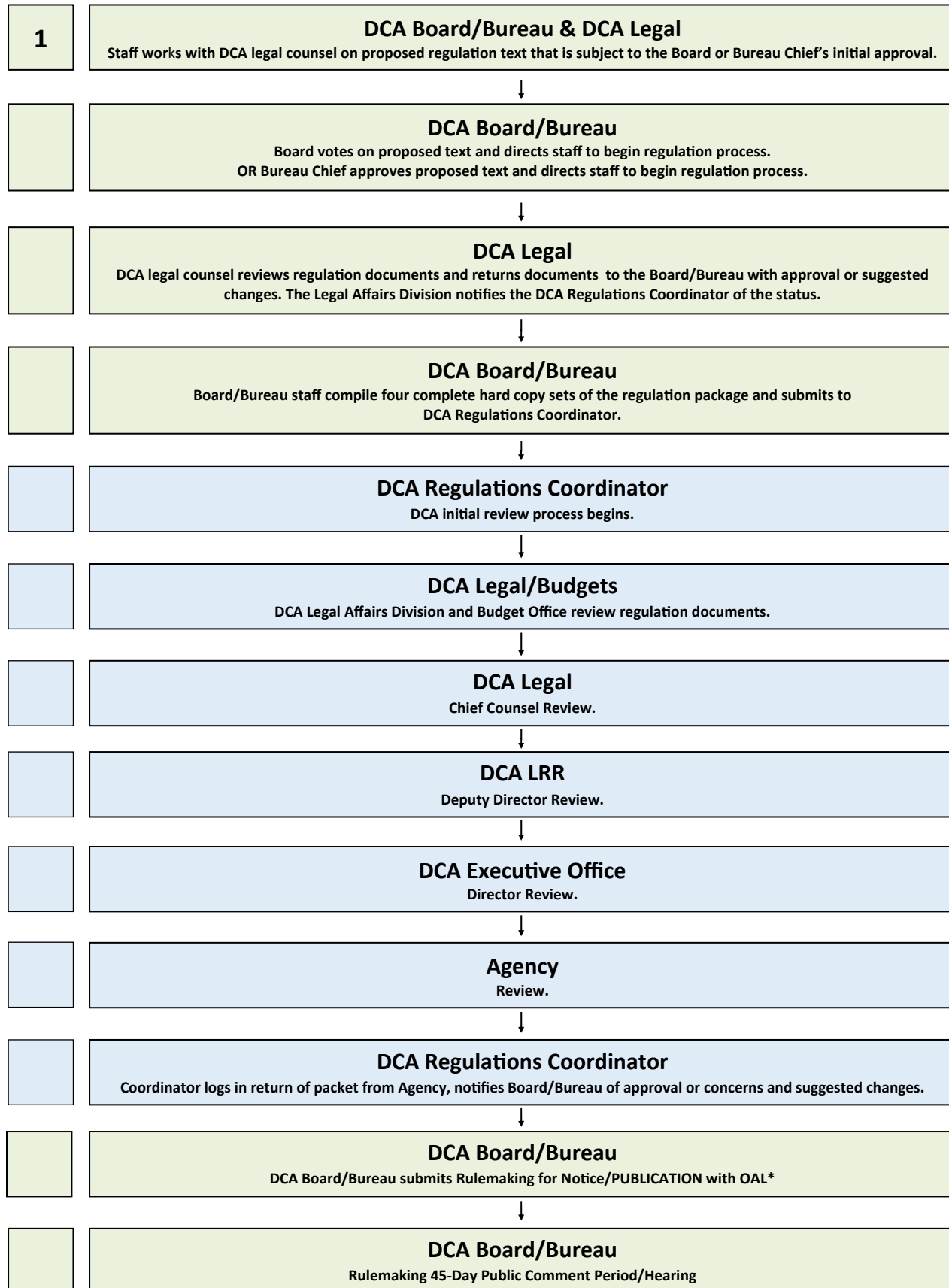
The proposal was approved by the Board at its meeting in November 2016 and was held aside while awaiting passage of AB 93 (Chapter 743, Statutes of 2018), the Board's supervision legislation. See Attachment B for regulation timeline.

## **Attachments**

**Attachment A:** DCA Regulation Process

**Attachment B:** BBS Regulation Timeline

**INITIAL PHASE**



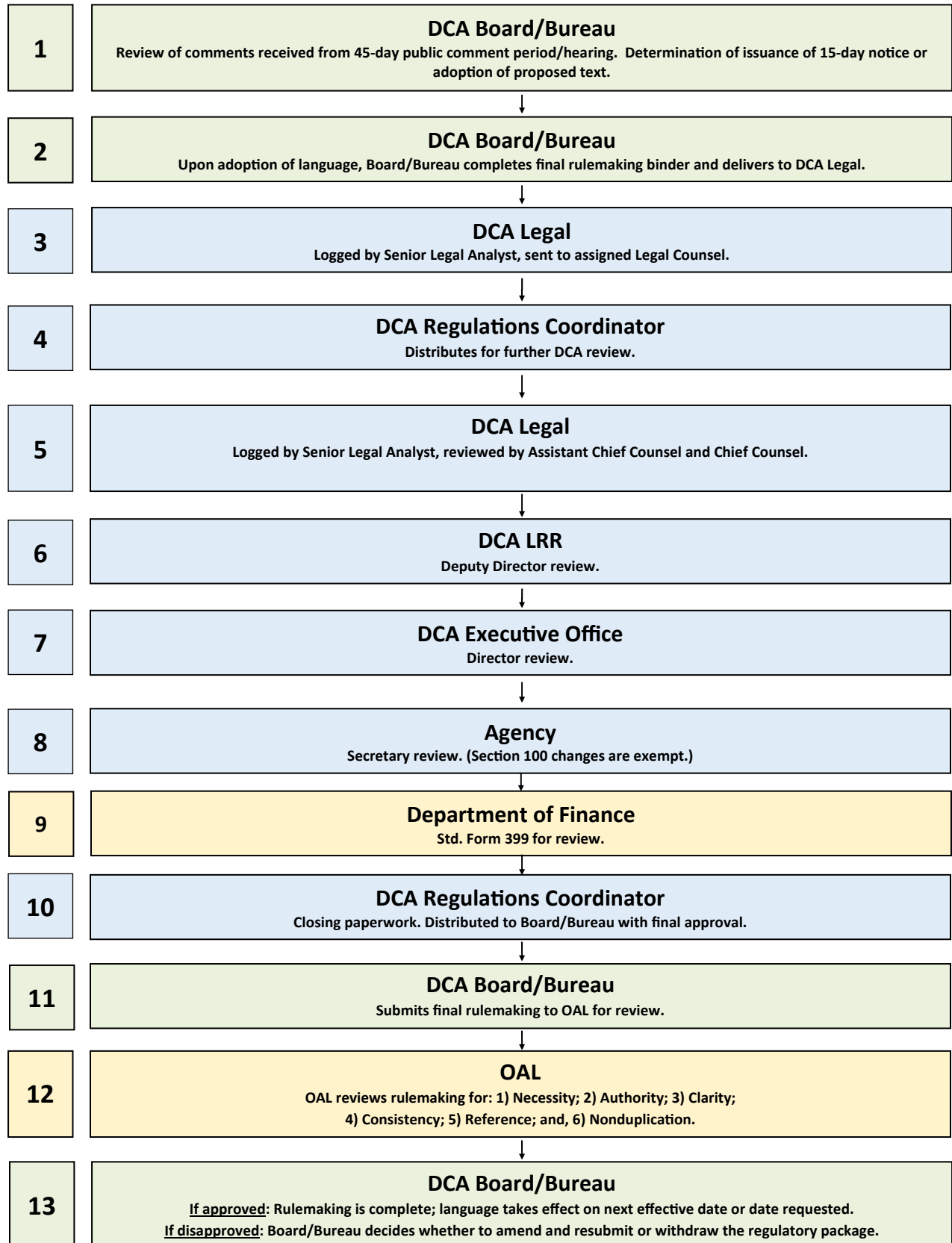
**Legend**

DCA – Department of Consumer Affairs  
 LRR – Division of Legislative Regulatory Review  
 OAL – Office of Administrative Law

\* If any changes to language last approved by the Board are needed, a vote by the Board may be necessary.

# REGULAR RULEMAKING PROCESS—DCA BOARDS/BUREAUS

## FINAL PHASE



### Legend

DCA – Department of Consumer Affairs  
LRR – Division of Legislative Regulatory Review  
OAL – Office of Administrative Law

DOF – Department of Finance  
Std. Form 399 – Economic and Fiscal Impact Statement

**ATTACHMENT B**

**BBS REGULATION TIMELINE**

**JANUARY 24, 2020**

Regulation Package Name	Board Approval	Submitted to DCA: Initial Review	Submitted to Agency: Initial Review/Date Agency Approved	Noticed	Public Hearing	Submitted to DCA: Final Review	Approved by Agency: Final Review	Submitted to DOF for Approval	Date Submitted to OAL/ Date OAL Approved
<b>Substantial Relationship &amp; Rehabilitation Criteria (AB 2138 Regs)</b>	3/1/19	4/18/19	6/25/19/ 7/30/19	8/8/19	9/30/19	11/25/19			
<b>Enforcement Update to Disciplinary Guidelines</b>	3/3/17	7/11/17	9/13/18*						
<b>Examination Rescoring; Application Abandonment; APCC Subsequent Registration Fee</b>	11/2/17	4/6/18	9/12/18/ 1/11/19**	2/22/19	4/8/19	4/30/19	6/10/19	6/13/19	Submitted 1/24/2020***
<b>Supervision</b>	11/4/16****	4/18/19	8/8/19/ 10/28/19	2/7/20	3/23/20				

\*This package was held due to the passage of AB 2138 and continues to be on hold pending approval of AB 2138 regulations.

\*\*Returned to Board meeting for Agency-requested changes during this time.

\*\*\*Originally submitted on 7/22/19 and withdrawn for approval of language changes.

\*\*\*\*This package was held pending passage of AB 93.

DCA and Agency Initial Review Process: Following review by the Board's attorney and required document preparation (Notice, Initial Statement of Reasons, Fiscal Impact), the package is submitted to the Department of Consumer Affairs' (DCA) Legal Affairs Office, who routes it for approvals from the budget office, the DCA Executive Office and the State Business, Consumer Services and Housing Agency (Agency). Once approved by Agency, the Board can submit the package to the Office of Administrative Law (OAL) to publicly notice the proposed regulation change. There may be changes requested to documents during this time and the timeline includes processing time for those changes.

Notice and Public Hearing: The public notice initiates the 45-day public comment period and a public hearing. The Board must consider all comments submitted. If any substantive changes to the text of the proposal, the Board must approve the language again, and provide a 15-day public comment period. If no changes are made to the proposal, the package goes to DCA for final review.

DCA and Agency Final Review: The initial review process is repeated.

Submission to DOF and OAL for Final Approval: Both the Department of Finance (DOF) and OAL must approve the regulation package. The review may occur at the same time. However, OAL is the final approval. Once OAL approves the regulation package, the proposal is adopted, and it is assigned an effective date.