Board of Behavioral Sciences

Memo

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To: Board Members

Date: August 1, 2022

From: Rosanne Helms
Legislative Manager

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Subject: **Discussion of Potential Telehealth Clarification for Trainee Practicum**

The Telehealth Committee has been examining a potential clarification of the "face-to-face" practicum requirement in statute for marriage and family therapist (MFT) and professional clinical counselor (PCC) trainees. (Business and Professions Code (BPC) §§ 4980.36 and 4999.33) With the use of video technology becoming widespread during the COVID-19 state of emergency, it has become unclear whether the term "face-to-face" is intended to refer to only in-person experience, or if it is also intended to include experience gained via videoconferencing.

Trainee Practicum Clarification: "Face-to-Face" Requirement

MFT and PCC trainees seeking an in-state degree must, as part of their qualifying degree program, gain a specified number of "face-to-face" practicum experience hours counseling individuals, families or groups. The requirement can be found in the current degree program requirements in BPC sections 4980.36(d)(1)(B)(ii) and (vi) for LMFT in-state applicants, and 4999.33(c)(3)(L) for LPCC in-state applicants.

The Board is in the process of pursuing legislation to clarify that trainees may provide services via telehealth, based on past discussions and direction of this Committee. (Previously, the law was silent on this.) Now that that issue has been decided, a question arises about the meaning of "face-to-face" practicum hours required as part of the degree programs leading to LMFT and LPCC licensure. Therefore, the Telehealth Committee directed staff to draft language amending the practicum "face-to-face" experience hours requirement as follows:

- Permit either all in-person experience hours, or a combination of both in-person and videoconference experience hours;

- Recommend that the telehealth regulations the Board has in place for associates and licensees be followed. (Since trainees are not under the jurisdiction of the Board yet, the Committee decided against amending the telehealth regulations to include trainees.); and

- Include a placeholder sunset date in the new language. (Sunset date should be selected by the Board if it approves the proposal to run as legislation.)

The draft language can be found in **Attachment A**.

Other Considerations

While considering this proposal, the Committee discussed the following:

1. **Videoconferencing Experience Optional Versus Required.** The way the proposal shown in **Attachment A** is written makes in-person experience required, and experience via videoconferencing optional. The Committee confirmed that this was its intent .

2. **Older Degrees.** The reference to "face-to-face" practicum experience hours can also be found in the degree program requirements for older LMFT and LPCC degrees: BPC sections 4980.37(c)(2) (LMFT in-state applicants) and 4999.32(c)(3)(J) (LPCC in-state applicants). To qualify for licensure under the degree program requirements of these sections, these degrees must have been begun before August 2012, and completed by December 2018.

   Staff recommended against clarifying the requirements in these sections, as these degrees have already been obtained. The Committee concurred.

3. **Applicants With Education Gained Out-of-State.** BPC sections 4980.78(b)(1)(C) (for LMFT out-of-state applicants) and 4999.62(b)(1)(C) (for LPCC out-of-state applicants) require face-to-face practicum experience for out-of-state degrees. Therefore, the Committee considered whether corresponding amendments should be made to these sections.

   In looking at research on national standards (shown below) it appears that the requirements for practicum being in person or via telehealth are still evolving. Staff suggested making no amendments to the out-of-state degree practicum requirements right now. The Committee agreed with this. By leaving in the more general "face-to-face" language and not getting more specific, the law can be interpreted to allow practicum to be either in-person, or via videoconferencing, avoiding eliminating out-of-state applicants from licensure if practicum standards vary elsewhere. If a national standard emerges at a later date, the Board can reconsider at that time.

   - **CACREP.** The most recent standards (2016) for CACREP, which accredits some LPCC programs nationwide, can be found here: http://www.cacrep.org/wp-content/uploads/2018/05/2016-Standards-with-Glossary-5.3.2018.pdf

     The required practicum requirements are discussed on page 15-16 of the link. Forty hours of direct services are required. In-person versus

videoconferencing does not appear to be addressed, although a definition of "direct service" is provided on page 44.

On its website, CACREP notes that it is in the process of working on a 2024 update to the standards.

- **COAMFTE.** The most recent standards for COAMFTE (January 1, 2022), which accredits some LMFT programs nationwide, can be found here.

  Page 24 of the standards address teletherapy in practicum. Students are required to gain 300 hours of direct clinical contact hours. Programs that include teletherapy are required to have policies and procedures in place to support student teletherapy practice and supervision with attention to applicable legal and ethical requirements and current/emerging professional guidelines

4. **Social Work Interns Not Included.** This proposal does not make corresponding changes for social work interns (individuals who are in their social work master's degree program). Unlike LMFTs and LPCCs, LCSWs do not have their practicum requirements spelled out in statute because Council on Social Work Education (CSWE) sets the national standard for social work education programs via its accreditation requirements.

   The link below shows the accreditation standards for the Council on Social Work Education (CSWE)(2022). This document was just approved in June 2022. Requirements for practicum, which CSWE refers to as "field education," can be found on page 21 of the document. CSWE requires 900 hours of field education for master's programs.

   https://www.cswe.org/getmedia/8d7dade5-2683-4940-9587-5675f6ef5426/2022-EPAS.pdf

   The 2022 standards appear to support field education via telehealth as follows:

   Pg. 17: *"The explicit curriculum, including field education, fosters a learning environment and engaged learning methods informed by guidance from the professional practice community. Design and delivery of the explicit curriculum incorporate experientially based learning opportunities informed by teaching that includes digital and information literacy and technology-supported learning. The program's commitment to continuous curriculum improvement is guided by evolving contemporary science and interprofessional research."*

   Pg. 20 *"Field education programs develop field models to prepare students for contemporary and interprofessional social work practice, including the use of various forms of technology."*

   Staff recommends no changes be made for social work interns at this time.

Committee Recommendations

At its meeting on June 3, 2022, the Telehealth Committee reviewed the proposed language and directed staff to bring it to the Policy and Advocacy Committee for consideration as proposed legislation.

In conferring with the Board's legal counsel after the Telehealth Meeting, it was determined that a phase-in date would be needed, as it is possible that some applicants may have obtained all of their practicum via telehealth before or during the pandemic. Therefore, the language modifying the definition of "face-to-face" practicum experience was given a phase-in date. It is written to apply to practicum gained on or after January 1, 2024.

At its meeting on July 29, 2022, the Policy and Advocacy Committee directed staff to bring the proposal to the Board for consideration as a legislative proposal.

Recommendation

Conduct an open discussion regarding the proposed language shown in **Attachment A** and direct staff on how the Board wishes to proceed. If the Board decides to proceed with pursing legislation, a sunset day should be selected.

Attachments

Attachment A: Proposed Language

Attachment B: CAMFT and CALPCC Letter to Telehealth Committee and Board, dated May 27, 2022

Attachment C: Letter from Dr. Tony Rousmaniere, PsyD, dated August 4, 2022, regarding trainee telehealth requirements

ATTACHMENT A
PROPOSED LANGUAGE

<u>LMFTs</u>

BPC §4980.36

(a) This section shall apply to the following:

(1) Applicants for licensure or registration who begin graduate study before August 1, 2012, and do not complete that study on or before December 31, 2018.

(2) Applicants for licensure or registration who begin graduate study before August 1, 2012, and who graduate from a degree program that meets the requirements of this section.

(3) Applicants for licensure or registration who begin graduate study on or after August 1, 2012.

(b) To qualify for a license or registration, applicants shall possess a doctoral or master's degree meeting the requirements of this section in marriage, family, and child counseling, marriage and family therapy, couple and family therapy, psychology, clinical psychology, counseling psychology, or either counseling or clinical mental health counseling with an emphasis in either marriage, family, and child counseling or marriage and family therapy. The degree shall be obtained from a school, college, or university approved by the Bureau for Private Postsecondary Education, or accredited by either the Commission on Accreditation for Marriage and Family Therapy Education, or a regional or national institutional accrediting agency that is recognized by the United States Department of Education. The board has the authority to make the final determination as to whether a degree meets all requirements, including, but not limited to, course requirements, regardless of accreditation or approval.

(c) A doctoral or master's degree program that qualifies for licensure or registration shall be a single, integrated program that does the following:

(1) Integrate all of the following throughout its curriculum:

(A) Marriage and family therapy principles.

(B) The principles of mental health recovery-oriented care and methods of service delivery in recovery-oriented practice environments, among others.

(C) An understanding of various cultures and the social and psychological implications of socioeconomic position, and an understanding of how poverty and social stress impact an individual's mental health and recovery.

(2) Allow for innovation and individuality in the education of marriage and family therapists.

(3) Encourage students to develop the personal qualities that are intimately related to effective practice, including, but not limited to, integrity, sensitivity, flexibility, insight, compassion, and personal presence.

(4) Permit an emphasis or specialization that may address any one or more of the unique and complex array of human problems, symptoms, and needs of Californians served by marriage and family therapists.

(5) Provide students with the opportunity to meet with various consumers and family members of consumers of mental health services to enhance understanding of their experience of mental illness, treatment, and recovery.

(d) The degree described in subdivision (b) shall contain no less than 60 semester or 90 quarter units of instruction that includes, but is not limited to, the following requirements:

(1) Both of the following:

(A) No less than 12 semester or 18 quarter units of coursework in theories, principles, and methods of a variety of psychotherapeutic orientations directly related to marriage and family therapy and marital and family systems approaches to treatment and how these theories can be applied therapeutically with individuals, couples, families, adults, including elder adults, children, adolescents, and groups to improve, restore, or maintain healthy relationships.

(B) Practicum that involves direct client contact, as follows:

(i) A minimum of six semester or nine quarter units of practicum in a supervised clinical placement that provides supervised fieldwork experience.

(ii) A minimum of 150 hours of face-to-face experience counseling individuals, couples, families, or groups.

(iii) A student must be enrolled in a practicum course while counseling clients, except as specified in subdivision (c) of Section 4980.42.

(iv) The practicum shall provide training in all of the following areas:

(I) Applied use of theory and psychotherapeutic techniques.

(II) Assessment, diagnosis, prognosis, and treatment planning.

(III) Treatment of individuals and premarital, couple, family, and child relationships, including trauma and abuse, dysfunctions, healthy functioning, health promotion, illness prevention, and working with families.

(IV) Professional writing, including documentation of services, treatment plans, and progress notes.

(V) How to connect people with resources that deliver the quality of services and support needed in the community.

(v) Educational institutions are encouraged to design the practicum required by this subparagraph to include marriage and family therapy experience in low income and multicultural mental health settings.

(vi) In addition to the 150 hours required in clause (ii), 75 hours of either of the following, or a combination thereof:

(I) Client centered advocacy, as defined in Section 4980.03.

(II) Face-to-face experience counseling individuals, couples, families, or groups.

(C) For purposes of paragraph (B), for practicum gained on or after January 1, 2024, “face-to-face experience” means in-person experience, or a combination of both in-person experience and experience via two-way, real time videoconferencing. If experience is gained via two-way, real time videoconferencing, the educational institution, supervisor, and employer are encouraged to comply with the standards of practice for telehealth for licensees and registrants specified by the board by regulation. This paragraph shall remain in effect only until January 1, xxxx, and of that date is repealed, unless further extended by the Legislature.

(2) Instruction in all of the following:

(A) Diagnosis, assessment, prognosis, treatment planning, and treatment of mental disorders, including severe mental disorders, evidence-based practices, psychological testing, psychopharmacology, and promising mental health practices that are evaluated in peer-reviewed literature.

(B) Developmental issues from infancy to old age, including instruction in all of the following areas:

(i) The effects of developmental issues on individuals, couples, and family relationships.

(ii) The psychological, psychotherapeutic, and health implications of developmental issues and their effects.

(iii) Aging and its biological, social, cognitive, and psychological aspects. This coursework shall include instruction on the assessment and reporting of, as well as treatment related to, elder and dependent adult abuse and neglect.

(iv) A variety of cultural understandings of human development.

(v) The understanding of human behavior within the social context of socioeconomic status and other contextual issues affecting social position.

(vi) The understanding of human behavior within the social context of a representative variety of the cultures found within California.

(vii) The understanding of the impact that personal and social insecurity, social stress, low educational levels, inadequate housing, and malnutrition have on human development.

(C) The broad range of matters and life events that may arise within marriage and family relationships and within a variety of California cultures, including instruction in all of the following:

(i) A minimum of seven contact hours of training or coursework in child abuse assessment and reporting as specified in Section 28, and any regulations promulgated thereunder.

(ii) Spousal or partner abuse assessment, detection, intervention strategies, and same gender abuse dynamics.

(iii) Cultural factors relevant to abuse of partners and family members.

(iv) Childbirth, child rearing, parenting, and stepparenting.

(v) Marriage, divorce, and blended families.

(vi) Long-term care.

(vii) End-of-life and grief.

(viii) Poverty and deprivation.

(ix) Financial and social stress.

(x) Effects of trauma.

(xi) The psychological, psychotherapeutic, community, and health implications of the matters and life events described in clauses (i) to (x), inclusive.

(D) Cultural competency and sensitivity, including a familiarity with the racial, cultural, linguistic, and ethnic backgrounds of persons living in California.

(E) Multicultural development and cross-cultural interaction, including experiences of race, ethnicity, class, spirituality, sexual orientation, gender, and disability, and their incorporation into the psychotherapeutic process.

(F) The effects of socioeconomic status on treatment and available resources.

(G) Resilience, including the personal and community qualities that enable persons to cope with adversity, trauma, tragedy, threats, or other stresses.

(H) Human sexuality, including the study of physiological, psychological, and social cultural variables associated with sexual behavior and gender identity, and the assessment and treatment of psychosexual dysfunction.

(I) Substance use disorders, co-occurring disorders, and addiction, including, but not limited to, instruction in all of the following:

(i) The definition of substance use disorders, co-occurring disorders, and addiction. For purposes of this subparagraph, “co-occurring disorders” means a mental illness and substance abuse diagnosis occurring simultaneously in an individual.

(ii) Medical aspects of substance use disorders and co-occurring disorders.

(iii) The effects of psychoactive drug use.

(iv) Current theories of the etiology of substance abuse and addiction.

(v) The role of persons and systems that support or compound substance abuse and addiction.

(vi) Major approaches to identification, evaluation, and treatment of substance use disorders, co-occurring disorders, and addiction, including, but not limited to, best practices.

(vii) Legal aspects of substance abuse.

(viii) Populations at risk with regard to substance use disorders and co-occurring disorders.

(ix) Community resources offering screening, assessment, treatment, and follow up for the affected person and family.

(x) Recognition of substance use disorders, co-occurring disorders, and addiction, and appropriate referral.

(xi) The prevention of substance use disorders and addiction.

(J) California law and professional ethics for marriage and family therapists, including instruction in all of the following areas of study:

(i) Contemporary professional ethics and statutory, regulatory, and decisional laws that delineate the scope of practice of marriage and family therapy.

(ii) The therapeutic, clinical, and practical considerations involved in the legal and ethical practice of marriage and family therapy, including, but not limited to, family law.

(iii) The current legal patterns and trends in the mental health professions.

(iv) The psychotherapist-patient privilege, confidentiality, the patient dangerous to self or others, and the treatment of minors with and without parental consent.

(v) A recognition and exploration of the relationship between a practitioner's sense of self and human values and the practitioner's professional behavior and ethics.

(vi) The application of legal and ethical standards in different types of work settings.

(vii) Licensing law and licensing process.

(e) The degree described in subdivision (b) shall, in addition to meeting the requirements of subdivision (d), include instruction in case management, systems of care for the severely mentally ill, public and private services and supports available for the severely mentally ill, community resources for persons with mental illness and for victims of abuse, disaster and trauma response, advocacy for the severely mentally ill, and collaborative treatment. This instruction may be provided either in credit level coursework or through extension programs offered by the degree-granting institution.

(f) The changes made to law by this section are intended to improve the educational qualifications for licensure in order to better prepare future licentiates for practice, and are not intended to expand or restrict the scope of practice for marriage and family therapists.

LPCCs

BPC §4999.33

(a) This section shall apply to the following:

(1) Applicants for licensure or registration who begin graduate study before August 1, 2012, and do not complete that study on or before December 31, 2018.

(2) Applicants for licensure or registration who begin graduate study before August 1, 2012, and who graduate from a degree program that meets the requirements of this section.

(3) Applicants for licensure or registration who begin graduate study on or after August 1, 2012.

(b) To qualify for licensure or registration, applicants shall possess a master's or doctoral degree that is counseling or psychotherapy in content and that meets the requirements of this section, obtained from an accredited or approved institution, as defined in Section 4999.12. For purposes of this subdivision, a degree is "counseling or psychotherapy in content" if it contains the supervised practicum or field study experience described in paragraph (3) of subdivision (c) and, except as provided in subdivision (f), the coursework in the core content areas listed in subparagraphs (A) to (M), inclusive, of paragraph (1) of subdivision (c).

(c) The degree described in subdivision (b) shall be a single, integrated program that contains not less than 60 graduate semester units or 90 graduate quarter units of instruction, which shall, except as provided in subdivision (f), include all of the following:

(1) The equivalent of at least three semester units or four quarter units of graduate study in all of the following core content areas:

(A) Counseling and psychotherapeutic theories and techniques, including the counseling process in a multicultural society, an orientation to wellness and prevention, counseling theories to assist in selection of appropriate counseling interventions, models of counseling consistent with current professional research and practice, development of a personal model of counseling, and multidisciplinary responses to crises, emergencies, and disasters.

(B) Human growth and development across the lifespan, including normal and abnormal behavior and an understanding of developmental crises, disability, psychopathology, and situational and environmental factors that affect both normal and abnormal behavior.

(C) Career development theories and techniques, including career development decisionmaking models and interrelationships among and between work, family, and other life roles and factors, including the role of multicultural issues in career development.

(D) Group counseling theories and techniques, including principles of group dynamics, group process components, group developmental stage theories, therapeutic factors of group work, group leadership styles and approaches, pertinent research and literature, group counseling methods, and evaluation of effectiveness.

(E) Assessment, appraisal, and testing of individuals, including basic concepts of standardized and nonstandardized testing and other assessment techniques, norm-referenced and criterion-referenced assessment, statistical concepts, social and cultural factors related to assessment and evaluation of individuals and groups, and ethical strategies for selecting, administering, and interpreting assessment instruments and techniques in counseling.

(F) Multicultural counseling theories and techniques, including counselors' roles in developing cultural self-awareness, identity development, promoting cultural social justice, individual and community strategies for working with and advocating for diverse populations, and counselors' roles in eliminating biases and prejudices, and processes of intentional and unintentional oppression and discrimination.

(G) Principles of the diagnostic process, including differential diagnosis, and the use of current diagnostic tools, such as the current edition of the Diagnostic and Statistical Manual of Mental Disorders, the impact of co-occurring substance use disorders or medical psychological disorders, established diagnostic criteria for mental or emotional disorders, and the treatment modalities and placement criteria within the continuum of care.

(H) Research and evaluation, including studies that provide an understanding of research methods, statistical analysis, the use of research to inform evidence-based practice, the importance of research in advancing the profession of counseling, and statistical methods used in conducting research, needs assessment, and program evaluation.

(I) Professional orientation, ethics, and law in counseling, including California law and professional ethics for professional clinical counselors, professional ethical standards and legal considerations, licensing law and process, regulatory laws that delineate the profession's scope of practice, counselor-client privilege, confidentiality, the client dangerous to self or others, treatment of minors with or without parental consent, relationship between practitioner's sense of self and human values, functions and relationships with other human service providers, strategies for collaboration, and advocacy processes needed to address institutional and social barriers that impede access, equity, and success for clients.

(J) Psychopharmacology, including the biological bases of behavior, basic classifications, indications, and contraindications of commonly prescribed psychopharmacological medications so that appropriate referrals can be made for medication evaluations and so that the side effects of those medications can be identified.

(K) Addictions counseling, including substance abuse, co-occurring disorders, and addiction, major approaches to identification, evaluation, treatment, and prevention of substance abuse and addiction, legal and medical aspects of substance abuse, populations at risk, the role of support persons, support systems, and community resources.

(L) Crisis or trauma counseling, including crisis theory; multidisciplinary responses to crises, emergencies, or disasters; cognitive, affective, behavioral, and neurological effects associated with trauma; brief, intermediate, and long-term approaches; and assessment strategies for clients in crisis and principles of intervention for individuals with mental or emotional disorders during times of crisis, emergency, or disaster.

(M) Advanced counseling and psychotherapeutic theories and techniques, including the application of counseling constructs, assessment and treatment planning, clinical interventions, therapeutic relationships, psychopathology, or other clinical topics.

(2) In addition to the course requirements described in paragraph (1), 15 semester units or 22.5 quarter units of advanced coursework to develop knowledge of specific treatment issues or special populations.

(3) Not less than six semester units or nine quarter units of supervised practicum or field study experience that involves direct client contact in a clinical setting that provides a range of professional clinical counseling experience, including the following:

(A) Applied psychotherapeutic techniques.

(B) Assessment.

(C) Diagnosis.

(D) Prognosis.

(E) Treatment planning.

(F) Treatment.

(G) Issues of development, adjustment, and maladjustment.

(H) Health and wellness promotion.

(I) Professional writing including documentation of services, treatment plans, and progress notes.

(J) How to find and use resources.

(K) Other recognized counseling interventions.

(L) A minimum of 280 hours of face-to-face supervised clinical experience counseling individuals, families, or groups.

(M) For purposes of paragraph (L), for practicum gained on or after January 1, 2024, “face-to-face supervised clinical experience” means in-person supervised clinical experience, or a combination of both in-person supervised clinical experience and supervised clinical experience via two-way, real time videoconferencing. If supervised clinical experience is gained via two-way, real time videoconferencing, the educational institution, supervisor, and employer are encouraged to comply with the standards of practice for telehealth for licensees and registrants specified by the board by regulation. This paragraph shall remain in effect only until January 1, xxxx, and of that date is repealed, unless further extended by the Legislature.

(d) The 60 graduate semester units or 90 graduate quarter units of instruction required pursuant to subdivision (c) shall, in addition to meeting the requirements of subdivision (c), include instruction in all of the following:

(1) The understanding of human behavior within the social context of socioeconomic status and other contextual issues affecting social position.

(2) The understanding of human behavior within the social context of a representative variety of the cultures found within California.

(3) Cultural competency and sensitivity, including a familiarity with the racial, cultural, linguistic, and ethnic backgrounds of persons living in California.

(4) An understanding of the effects of socioeconomic status on treatment and available resources.

(5) Multicultural development and cross-cultural interaction, including experiences of race, ethnicity, class, spirituality, sexual orientation, gender, and disability and their incorporation into the psychotherapeutic process.

(6) Case management, systems of care for the severely mentally ill, public and private services for the severely mentally ill, community resources for victims of abuse, disaster and trauma response, advocacy for the severely mentally ill, and collaborative treatment. The instruction required in this paragraph may be provided either in credit level coursework or through extension programs offered by the degree-granting institution.

(7) Human sexuality, including the study of the physiological, psychological, and social cultural variables associated with sexual behavior, gender identity, and the assessment and treatment of psychosexual dysfunction.

(8) Spousal or partner abuse assessment, detection, intervention strategies, and same gender abuse dynamics.

(9) A minimum of seven contact hours of training or coursework in child abuse assessment and reporting, as specified in Section 28, and any regulations promulgated thereunder.

(10) Aging and long-term care, including biological, social, cognitive, and psychological aspects of aging. This coursework shall include instruction on the assessment and reporting of, as well as treatment related to, elder and dependent adult abuse and neglect.

(e) A degree program that qualifies for licensure under this section shall do all of the following:

(1) Integrate the principles of mental health recovery-oriented care and methods of service delivery in recovery-oriented practice environments.

(2) Integrate an understanding of various cultures and the social and psychological implications of socioeconomic position.

(3) Provide the opportunity for students to meet with various consumers and family members of consumers of mental health services to enhance understanding of their experience of mental illness, treatment, and recovery.

(f) (1) (A) An applicant whose degree is deficient in no more than three of the required areas of study listed in subparagraphs (A) to (M), inclusive, of paragraph (1) of subdivision (c) may satisfy those deficiencies by successfully completing post-master’s or postdoctoral degree coursework at an accredited or approved institution, as defined in Section 4999.12.

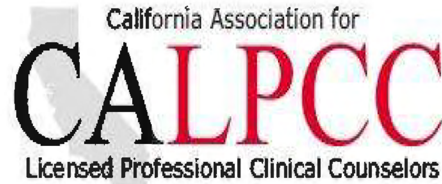
(B) Notwithstanding subparagraph (A), an applicant shall not be deficient in the required areas of study specified in subparagraphs (E) or (G) of paragraph (1) of subdivision (c) unless the applicant meets one of the following criteria and remediates the deficiency:

(i) The application for licensure was received by the board on or before August 31, 2020.

(ii) The application for registration was received by the board on or before August 31, 2020, and the registration was subsequently issued by the board.

(2) Coursework taken to meet deficiencies in the required areas of study listed in subparagraphs (A) to (M), inclusive, of paragraph (1) of subdivision (c) shall be the equivalent of three semester units or four quarter units of study.

(3) The board shall make the final determination as to whether a degree meets all requirements, including, but not limited to, course requirements, regardless of accreditation.



May 27, 2022

Board of Behavioral Sciences
1625 N Market Blvd S-200
Sacramento, CA 95834

RE: Practicum Face-to-Face Requirements

Dear Members of the Behavioral Sciences Board and Telehealth Committee:

The California Association of Marriage and Family Therapists (CAMFT) and the California Association of Licensed Professional Clinical Counselors (CALPCC), would like to express our serious concerns on the sweeping changes that the Board of Behavioral Sciences (BBS) is considering on how a California Licensed Marriage and Family Therapist (LMFT) and Licensed Professional Clinical Counselor (LPCC) are trained to become a qualified, competent, and safe health care provider.

CAMFT and CALPCC appreciate the hard work of the BBS staff, the Telehealth Committee, and the BBS Board in addressing and discussing telehealth and its impact on the future of psychotherapy and the psychotherapist. We recognize determining how prelicensees provide services via telehealth in post-pandemic California is complicated, and there are important considerations to be taken into account.

In March 2022, the Telehealth Committee directed staff to draft legislative language redefining the concept of “face to face” and in essence, eliminating any requirement that LMFT and LPCC applicants in California have any training with a patient in person. We find this very concerning for the proficiency of the provider, and safety of the patient.

Currently, licensing laws require LMFT trainees to obtain 150 hours of “face-to-face” counseling experience[1] and LPCC applicants to obtain 280 hours of “face-to-face” counseling experience in their practicum.[2] During the COVID-19 state of emergency, BBS staff allowed “face-to-face” to include videoconferencing counseling to help continued access to mental health services during the crisis. That was a reasonable and appropriate allowance given the health and safety of both the provider and the patient. Now, as the state of California move out of the pandemic, we need to assess what worked, what did not, and make intentional and well-reasoned decisions on where to make policy change.

Apart from the required “face-to-face” practicum, there is no requirement in statute or regulations that ensures the therapist/counselor in training has any in-person interaction with their patients. Removing this requirement without substantially more research is problematic, and places harmful risks on consumer protection, as well as the integrity of the license.

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[1] BPC §§4980.36(d)(1)(B)(ii)
[2] BPC §4999.33(c)(3)(L)

All modifications to education and training will shape providers' skill sets moving forward, and this change would allow newly licensed providers to have no in-person clinical experience. Instead, there is a foreseeable and likely outcome where a provider would be seeing and interacting with a patient in-person for the first time *after* acquiring their license (and thus, without supervision and any relevant training).

To underscore the necessity to properly and effectively train future providers, the BBS in their wisdom determined it was necessary for providers to learn how to interact and work with patients via telehealth. Some providers may never use telehealth; yet, the BBS is ensuring training in this mode to establish sufficient knowledge regarding the use of technology, patient privacy, and ethical use of telehealth *in case* that provider does move forward with telehealth treatment. However, with this motion, the pendulum has swung in the opposite and will remove any guarantee that budding providers have any proficiency or skill with in-person treatment.

Telehealth was never intended to replace in-person care in its entirety but to improve access and provide an alternative option to in-person visits. If both modes of therapy are permitted, then training should be comprehensive to include requisite training in both modes of therapy.

CAMFT and CALPCC recommend that providers be educated and trained to ensure that they are proficient in providing therapy/counseling, *regardless of the mode of treatment*. **Legislation sponsored by the BBS this year requires all applicants and licensees under the BBS to have telehealth training. If telehealth training is going to be required, then in-person training should also be required.** An educational framework that requires in-person and telehealth experience is necessary to ensure providers are experienced and skilled in all treatment methods, including evaluating to determine if telehealth is appropriate for a patient.[3]

Concerns raised by association members include the lack of evidence that clinicians trained solely using telehealth are proficient in providing in-person care (anecdotal feedback indicating such things as physical cues are missed in telehealth.) Other feedback is that it is unclear how telehealth-only-trained clinicians will know how to assess patients and recognize that not all clients are suited for telehealth. If the clinician has only conducted telehealth services and has never provided in-person counseling, how would the clinician know what to look for when making this assessment?

The Pacific Southwest Mental Health Technology Transfer Center released the "Telehealth Clinical and Technical Considerations for Mental Health Providers,"[4] which was supported by the U.S. Department of Health and Human Services/the Substance Abuse and Mental Health Services Administration, which

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[3] Standards of Practice for Telehealth, 16 CCR 1815.5(d)(2)

[4] *Telehealth Clinical and Technical Considerations for Mental Health Providers*, which can be accessed at: https://cars-rp.org/_MHTTC/docs/Telehealth%20Clinical%20Considerations.pdf

addressed our concerns regarding the assessment and training limited to telehealth. The document recognizes that in-person assessments of a patient may differ from those done via telehealth, and that a clinician's senses they use in diagnosing are limited in remote settings:

> "**The assessment process must be adjusted in the telehealth context. Several of the clinician's senses that they often use in diagnosis (e.g., visual, auditory, olfactory) are limited in remote settings. Be creative with the Mental Status Exam (MSE) assessment to ensure that no aspect of an in-person assessment is omitted in the telemedicine context**. Pay attention to volume, diction, and speech content. Ask a client to walk across the room in view of the camera to assess gait and appearance. **Beyond the MSE, there are many tools created for in-person assessments that require special consideration when conducted remotely.** Cognitive, neuropsychological, and autism assessments are informed by the manipulation of physical materials, standardized interactions between assessor and client, and clinical observation of the person in a physical environment may or may not be appropriate for telehealth."

The paper also mentions the risks associated with Telehealth that could be exacerbated if clinicians lack in-person experience:

- Difficulty developing therapeutic alliance across distance. For example, clients with psychosis and dementia may feel discomfort with technology and experience emotional distance from provider.
- Difficulties managing intense client emotions during remote sessions. For example, clinicians have fewer ways to provide comfort and containment from a distance when they cannot hand the client a tissue or look directly into someone's eyes.

CAMFT and CALPCC are in strong support of the allowance of telehealth and the usage of telehealth towards licensure hours, as well as the necessity of requisite in-person training. Without any experience of delivering clinical services in-person prior to licensure, would a provider recognize whether they or their patient is experiencing these difficulties addressed above?

We supported the BBS telehealth survey conducted in 2021 to gather information to inform the BBS before making changes to the telehealth policy framework. The survey results were intended to guide the discussions regarding training and supervision and should be included in the decision to remove the face-to-face clinical hour training requirements.

The Telehealth survey responses from supervisors regarding a cap on counting telehealth hours towards licensure were close, with 47% responding that there should be a cap on the number of telehealth hours that supervisees can count towards licensure.

Supervisor Survey Question 8: Cap on Telehealth Hours (TH) Supervisees Can Count Towards Licensure?

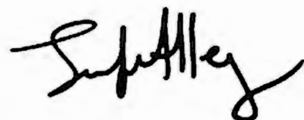
No Cap: 53.17%
Telehealth Capped at 75% of Hours: 12.34%
Telehealth Capped at 50% of Hours: 24.22%
Telehealth Capped at 25% of Hours: 9.37%
Telehealth Capped No hours counted: 0.90%

This close margin helps demonstrate *existing supervisors'* concerns regarding pre-licensed individuals' potential lack of in-person experience.

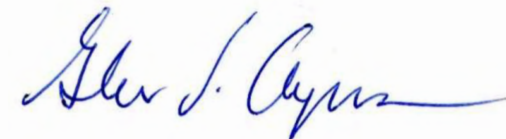
CAMFT and CALPCC recommend that a minimum of in-person experience hours be established, but are open to stakeholder input and BBS assessment as to what the minimum should be. A required minimum of in-person hours will help ensure applicants obtain requisite training in both modes of treatment. CAMFT and CALPCC support the use of telehealth, requirements to train providers in telehealth, and remote supervision of prelicensees because such requirements increase access and training opportunities. We also advocate strengthening the qualifications and maintaining high standards of professional ethics and accountability of LMFTs and LPCCs. The proposed change to “face-to-face” counseling requirements does not move the profession forward, nor does it maintain high educational standards for LMFTs and LPCCs.

For these reasons, CAMFT and CALPCC respectfully request the Committee to reject any proposal or language that eliminates a minimum requirement of in-person counseling experience during practicum.

Sincerely,



Jennifer Alley
California Association of Marriage and Family Therapists
State Government Affairs Specialist



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