



BOARD OF BEHAVIORAL SCIENCES
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MEETING NOTICE

Policy and Advocacy Committee April 4, 2007

Department of Consumer Affairs
1625 N. Market Boulevard
El Dorado Conference Room
Sacramento, CA 95834
(916) 574-7830

9:30 a.m. – 3:30 p.m.

- I. Introductions
- II. Review and Approval of the January 3, 2007 Policy and Advocacy Committee Meeting Minutes
- III. Presentation on Legislative Proposal to License Alcohol and Drug Abuse Counselors by the California Association of Alcohol and Drug Abuse Counselors
- IV. Discussion and Possible Action Regarding Proposal to License Substance Abuse Addiction Counselors
- V. Discussion and Possible Action to Allow Marriage and Family Therapist Interns to Receive Experience Credit for Client Centered Advocacy and to Revise the Definition of Client Centered Advocacy for Associate Clinical Social Workers.
- VI. Review of Legislation Introduced in the 2007 Legislative Session
- VII. Incorporation of Family Code Section 3110.5(e) in Unprofessional Conduct Definition for Marriage and Family Therapists and Licensed Clinical Social Workers
- VIII. Update on Results from the Board's Demographic Survey
- IX. Request to Recognize Doctorates in Social Work for Licensing Purposes
- X. Review of Progress on Strategic Plan Objectives 2, 4, 5 & 6
- XI. Budget Update
- XII. Update on Board Sponsored Legislation
- XIII. Rulemaking Update

XIV. Future Meeting Dates

XV. Suggestions for Future Agenda Items

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

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

NOTICE: The meeting facilities are accessible to persons with disabilities. Please make requests for accommodations to the attention of Christina Kitamura at the Board of Behavioral Sciences, 1625 N. Market Boulevard, Suite S-200, Sacramento, CA 95834, or by phone at 916-574-7835, no later than one week prior to the meeting. If you have any questions please contact the Board at (916) 574-7830.



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***DRAFT* MEETING MINUTES**

Policy and Advocacy Committee

January 3, 2007

Burbank Airport Marriott
2500 Hollywood Way
Burbank, CA 91505

9:30 a.m. – 3:30 p.m.

MEMBERS PRESENT

Gordonna DiGiorgio, Chair, Public Member
Dr. Ian Russ, MFT Member

MEMBERS ABSENT

Victor Law, Public Member
Karen Roye, Public Member

STAFF PRESENT

Paul Riches, Executive Officer
Mona Maggio, Assistant Executive Officer
Christy Berger, Legislative Analyst

GUEST LIST ON FILE

I. Introductions

The meeting was called to order at approximately 9:30 a.m. Ms. DiGiorgio called the roll and a quorum was established.

II. Review and Approval of the June 21, 2006 Budget and Efficiency Committee Meeting Minutes.

The Committee was asked to approve the June 21, 2006 Budget and Efficiency Committee meeting minutes.

THE COMMITTEE CONCURRED TO APPROVE THE JUNE 21, 2006 BUDGET AND EFFICIENCY COMMITTEE MEETING MINUTES.

III. Review and Approval of September 27, 2006 Committee Meeting Minutes.

The Committee was asked to approve the September 27, 2006 Policy and Advocacy Committee meeting minutes.

THE COMMITTEE CONCURRED TO APPROVE THE SEPTEMBER 27, 2006 POLICY AND ADVOCACY COMMITTEE MEETING MINUTES.

(Agenda item IV was moved to the afternoon just after item IX)

V. Discussion and Possible Action on Increasing Portability of Licensure for Marriage and Family Therapists.

Ms. Berger reported that through legislation, the Board recently improved portability of licensure for out-of-state licensed clinical social workers. Stakeholders requested the same be done for Marriage and Family Therapists (MFT). Staff prepared a report regarding MFT licensure requirements across the country, which showed the variations in experience and educational requirements. The Committee directed staff to work with stakeholders to come up with a proposal that they would support. The following proposal resulted from staff working with stakeholders:

1. Modify the requirement for a course in California law and ethics. Out-of-state applicants would still be required to have completed a course in law and ethics within their degree, but could take a continuing education in California law and ethics. CAMFT has proposed that the course be an 18-hour requirement. This is currently under consideration by AAMFT.
2. Clarify that the Board will count hours of experience gained in the 6-years prior to the issuance of the applicant's MFT license in another state. This is current Board practice, but the law could be interpreted as requiring the hours within the 6 years prior to applying for licensure with the BBS. This change would preserve the requirement that experience be substantially equivalent to California requirements.
3. Current law allows out-of-state applicants to make up coursework or units in the MFT core curriculum. The core MFT courses, including practicum, should be required as part of any qualifying degree, but any other units should be allowed to be made up.
4. Provide a method to allow documented practice experience while licensed in another state to count in place of supervised experience. This will help those who are unable to document their experience. This part of the proposal has not yet been fully developed.

Dr. Russ asked Mr. Riches about the status of the Bureau for Private, Postsecondary and Vocational Education (BPPVE). Mr. Riches stated that not much has changed, which is that barring legislative action, the BPPVE ceases to exist on July 1, 2007. Mr. Riches has been in contact with the Department of Consumer Affairs (Department) and the legislature, and it is a priority. The Department is going to roll out their communication about the BPPVE in January 2007. The Board recently sent a letter to schools asking about their planning. We have received responses from five schools so far, and expect to hear from more after the winter break. Mr. Riches hopes to have a better sense of what will happen by the February Board meeting.

Dr. Russ asked how the proposal under consideration would impact the work that the MFT Education Committee is doing. Mr. Riches explained that when the MFT curriculum is rewritten, these changes would be incorporated. Dr. Russ asked whether this proposal would make it easier for someone from another state to meet the educational requirements than a person who earned their degree in California. Mr. Riches responded that this flexibility is not available to California graduates. He explained that California has some very particular requirements, including specific degree titles, but we can't expect all 49 other states to have that same structure. Flexibility is required so that it is not a practical impossibility to come in from another state and get licensed.

Dr. Russ asked Ms. Riemersma her thoughts about this. She stated that it would seem unfair that people from another state have it easier, but she agreed that we can't expect people from another state to have a degree with a specific title and content named in

California law. So CAMFT has been okay with the flexibility, and they don't want to be nonreceptive to people coming in from out of state. It seems to have worked okay and is better than requiring people to come in and get a whole new degree.

Janlee Wong, Executive Director of the National Association of Social Workers, California Chapter (NASW-CA) asked whether there were any data regarding disciplinary actions on licensees from another state. Mr. Riches responded that our current system does not have that capability, though there is a project that should allow us to start querying our own data, possibly this year. It will in theory allow us to look at a number of different factors. Mr. Riches stated that from his own subjective look at cases over the past two years, the Board doesn't often get competency-based complaints, and that boundary issues and dual relationships are more common. Mr. Wong asked whether the proposed law and ethics course could be designed around the types of issues shown by the data. Olivia Loewy, Executive Director of the American Association of Marital and Family Therapy, California Division (AAMFT-CA) stated that she doesn't think it has much to do with training, it is a person who makes a decision who is often in denial or taking a risk. They know they are violating the standards.

Dr. Russ asked if it were known how many people would apply if this proposal were passed. Mr. Riches stated that we get 400 or 500 applications per year from out of state. Often the challenge is to get the law and ethics, psychopharmacology and psychological testing courses. A lot of schools don't like to offer single classes.

Dr. Russ asked the audience, many of who are educators, whether their schools would permit people to take single courses. One educator responded that it depends on the particular program, providing there is space and it doesn't prevent a student admitted to the program from taking that course. Another educator confirmed their school was the same way, and that there is often a waiting list for their own students to take these courses.

THE COMMITTEE CONCURRED TO RECOMMEND THE PROPOSAL TO INCREASE PORTABILITY OF LICENSURE FOR MFTS TO THE BOARD.

VI. Discussion and Possible Action to Repeal Business and Professions Code Section 4980.40(i).

Ms. Berger explained that on January 1, 1988 the educational requirements for registration as a MFT intern or for MFT licensure had some significant changes. The statute permitted those who would have qualified prior to January 1, 1988 but did not apply, to be granted an intern registration if they had a specific degree title and made up courses needed to meet the current requirements. In the past five years or more, the Board has had only one applicant under that provision. For this reason staff believes this law is outdated and recommends that this statute be deleted.

THE COMMITTEE CONCURRED TO RECOMMEND THE PROPOSAL TO REPEAL BUSINESS AND PROFESSIONS CODE SECTION 4980.40(i) TO THE BOARD.

VII. Presentation by Stephanie Clendenin of the Health Professions Education Foundation.

Mr. Riches introduced Ms. Clendenin, who is the Interim Director of the Health Professions Education Foundation (HPEF), an arm of the Office of Statewide Health Planning and Development (OSHDP). HPEF is the administrator of loan repayment

programs for health professionals. There is a law that places a \$10 surcharge on the Board's licensees at the time of renewal to fund this program, which is not yet in operation. Staff has been working with HPEF on this for the past two years

Ms. Clendenin stated that the main reason she was asked to come to HPEF was to work on this program and develop the regulations. She has been there since November 20. HPEF has received many phone calls from professionals and associations inquiring about the status of the program, especially since AB 1852 was passed. The regulations had been worked on by the prior administration, were pretty much drafted, but the definition of the publicly funded facility and a full-time workweek, 32 vs. 40 hours, were holding things up.

Ms. Clendenin brought a copy of the draft regulations, which were given to HPEF's legal office the prior day. She expects to have them back by the end of the week, and plans to send it to interested parties prior to beginning the formal regulatory process to determine any other issues. Their goal is to have the regulations implemented by summer of 2007 and implement the program for their fall funding cycle, which would have an application deadline of September 11. They plan to have the application ready to go at the same time the regulations are passed.

Dr. Russ expressed his hope that the professional associations would advertise this program when it becomes available, including a press release. Ms. Clendenin stated that part of their process is to call together an advisory group consisting of representatives from associations and affected Boards to help them develop the application. That should leave everybody very informed about the process.

Dr. Russ expressed his understanding that Ms. Clendenin is a new interim director, but that from this side it has been a bureaucratic nightmare. Ms. Clendenin responded that she is only an interim director, but the executive director is committed to this process so if she were to leave, the commitment remains.

Ms. Loewy inquired regarding the timelines for the application process. Ms. Clendenin explained that there is an 8-week processing deadline. Since she is new, she did not know exactly when the funds are released but offered to obtain that information.

Ms. Clendenin brought a handout showing the fund's condition. It shows the funds coming into the program and that those funds are being invested. The money has not been kept in separate pools for each license type as the law requires, but they are working to make that separation. The expenditures show the authorization of .8 personnel years which accounts for the salary being charged to that fund.

Dr. Russ stated his concerns regarding the high administrative costs. Ms. Clendenin responded that work has been done on the program, including developing regulations and accounting functions. Also, OSHPD is moving, so each program is being charged for its fair share of moving costs. Mr. Riches stated that it is frustrating that we are bearing expenses without a program in place, and that a lot of these concerns will go away once the program is up and running. Ms. Clendenin expressed her understanding regarding the frustration.

Dr. Russ asked what amount of awards might be available to applicants. Ms. Clendenin stated that this would be determined by the advisory committee, who will balance the cost of education and the amount of money available. Mr. Wong stated that we should all be aware that \$155,000 split among three professions would not be a lot of awards. Also, since there are more MFTs than anybody else, they would get the majority of those awards. He stated that the criteria should include financial need. Ms. Clendenin stated

that the advisory committee would look at those types of criteria. Mr. Riches stated that the Board is considering a proposal that will put more money into this fund, which will expand the amount available for grants.

The Committee adjourned briefly for a break.

VIII. Discussion of Fee Reduction Alternatives and Funding for Loan Repayment Program.

Mr. Riches explained that the Board has too much money in its reserve. There was a prior proposal for a temporary reduction of license renewal fees, which would have been redirected to the loan repayment program. The Department said no to that proposal, as they did not believe a temporary reduction of fees would be feasible, as it would eventually result in a fee increase. That sent staff back to the drawing Board. We had brought a new proposal to the September meeting of the Committee, but some reservations were expressed and it was decided to hold it over for one meeting.

Staff looked at the Board's fund condition and considered the reservations expressed regarding the budget. There is a law that the Board can't have more than two years of reserves, and we will be there within four years. At that point the law requires a mandatory fee reduction. So there is an abundance of revenue, and in order to spend any of that revenue authority is needed in the budget act. Staff projected that the Board could sustain a \$40 fee reduction over a 10-year period, and after that time we would still be left with a 4-month reserve. The general advice from the Department of Finance is 3-6 months. This proposal would put nearly one million dollars a year into the loan program. Licensees would see no change in their renewal fee, but there would be a redirection of \$40 dollars per renewal into the loan repayment program.

This proposal has two parts. Our fees have a range set in statute. The first step is a rulemaking to reduce the fees. The second step would be legislation to increase the surcharge by a comparable amount. Passage of the legislative proposal is not a certainty as fees and surcharges are not a popular with legislators. We will have to make the argument that there is a neutral impact on our licensees. If everything goes well, it is possible that this could be implemented on July 1, 2008.

Mr. Riches asked Ms. Clendenin what impact this would have operationally on their program. She stated that most of their processes are fairly manual, so they would have to look at systems changes. Mr. Riches asked whether this would be similar in scale to their other programs. She said it would be significantly greater. Dr. Russ asked whether we could get support for this from the Department of Mental Health (DMH). Mr. Riches stated that they have had some discussions. Ms. Clendenin stated that the DMH did approach HPEF recently to see if they could transfer approximately two million dollars per year to HPEF to fund these types of programs. HPEF was not able to do it because of the large scale and time frames in which DMH wanted to do it. Dr. Russ asked if HPEF was the only governmental agency that could distribute these types of funds. Ms. Clendenin stated that they are one of a limited number of programs within the state. HPEF is able to solicit donations from private parties. Mr. Riches explained that HPEF is a nonprofit and charitable organization which is also a state agency, a bit unusual.

Mr. Riches asked whether HPEF has considered outsourcing to other entities, such as the private sector. Ms. Clendenin stated that they might have to as their programs grow. Dr. Russ expressed his concern that outside entities may have even higher administrative costs. Ms. Clendenin stated that they would look for entities with low administrative costs. Dr. Russ asked the professional organizations whether they would

have the facilities to create these types of scholarship funds. Mr. Riches stated that this is already being done by several social work organizations. Ms. Riemersma stated that CAMFT could do it on a contract basis, as they have a 501(c)(3). She stated that there are programs on the way for MFTs through different consortia.

THE COMMITTEE CONCURRED TO RECOMMEND THE PROPOSAL FOR FEE REDUCTION AND FUNDING FOR LOAN REPAYMENT TO THE BOARD.

IX. Discussion and Possible Action on Legislative Proposal for Licensure of Professional Counselors.

Mr. Riches stated that the California Coalition for Counselor Licensure (CCCL) has proposed legislation for licensure of professional counselors. The Board looked at a similar bill two years ago. Staff has been working with the sponsors over the past couple of years on drafting issues. The Board's analysis of the bill mostly addresses administrative issues. There are two very significant issues from a staff perspective, the provisions for grandparenting existing counselors and the source of startup funding for the program. There is one other question regarding the inclusion of career development in the scope of practice, and whether that activity should be regulated.

There are questions that need to be answered, such as whether there is a threat to public harm, and if so, whether that threat that is remedied by this proposal, the scope, need, and workforce considerations. These are some of the core philosophical questions. Staff has tried to whittle down the administrative and ministerial issues so that the Board can wrestle with the core issues. Staff has prepared an analysis that recommends a position of oppose unless amended based on the amendments we have requested. This reflects our extraordinary caution in taking on something like this rather than a reflection on the philosophical questions.

Dean Porter, the President of the CCCL explained that they are a coalition of 12 professional associations that have come together for the purpose of obtaining licensure for counselors in California. She introduced the other CCCL Board members, who are all nationally certified counselors. Dr. Gregory Jackson is a counselor educator at California State University (CSU) Northridge, Dr. Lea Brew is licensed in Texas as a Licensed Professional Counselor (LPC) and is a counselor educator at CSU Fullerton. Jan Cummings is a master's level counselor and has been attending some of the Mental Health Services Act (MHSA) and mental health planning council meetings.

Dr. Jackson explained that LPC licensure exists in 48 other states. There are more than 95,000 LPCs in the U.S. There is a national effort to improve the portability of counselors from state to state to improve conditions for practitioners and consumers. The bill reflects American Association of State Counseling Boards' (AASCB) standards. He described the U.S. Department of Human Services' definition of professional counseling, and explained what professional counselors often do and whom they work with. He explained that the ethical standards are set by the American Counseling Association (ACA), established in 1952. He described several pieces of federal legislation that would have provided opportunities to LPCs in California, but because this type of licensure does not exist, none of California's counselors were able to take advantage of these opportunities.

Dr. Brew described the Council for Accreditation of Counseling and Related Educational Programs (CACREP), an accrediting body that works with ACA and the National Board for Certified Counselors (NBCC), which develops the exams. CACREP creates rigorous standards for counselor education programs, consistent with the NBCC. There are

seven CACREP accredited programs in California even though there is not licensure. Dr. Brew explained that they are proposing a 48 unit program and in five years that would increase to 60 units. She described the core curriculum, and the practicum hours which would start at 150 and later increase to 280 hours.

Ms. Cummings explained that she has had a career-long interest in quality of mental health care issues. She believes that licensure of professional counselors would help to address the workforce shortage of mental health counselors in California, help with accessibility of mental health services to meet the increasing need of underserved populations, and have a role in protecting the consumer. She referred to a mental health workforce report which indicates that there is a large growth in need for such professionals and that there seems to be a disconnect with the population that is growing increasingly diverse and aging. She reported on a survey of counselor students in California and found that they are quite diverse. Unlicensed counselors are often found in exempt settings and are often underemployed. They often cannot be promoted or offer clinical services. She also explained that acute shortages of professionals are often found in rural areas, so California needs to broaden the accessibility in order to meet increasing needs. The MHSA is working to increase that access to the underserved.

Ms. Porter provided an overview of the legislation, including scope of practice, exemptions from licensure, educational requirements comparable to MFTs, 3000 hours of postgraduate supervised experience, and the examination requirement such as the national counseling examinations and possibly a California supplemental examination. She also described the grandparenting provisions which require core counseling courses, documentation of 1,000 hours of supervised postdegree direct client contact, and passage of an examination. MFTs could be grandparented if they have all of the core courses.

Ms. DiGiorgio asked what the counselors are doing who are currently practicing in California but are not licensed. Ms. Porter responded that they are working in exempt settings where they are not regulated, or they are underemployed as case managers, doing rehabilitation or career counseling, or working in the schools. Some from other states have had to change careers. Ms. DiGiorgio asked whether they all came from other states or did they get their education in California. Ms. Brew responded that both are true. Mr. Riches asked whether some of the counselor education programs qualify people for pupil personnel services credentials as a school counselor. Ms. Brew said many of them do, but in other states people could get this degree and work in schools or independently. There are approximately 3,500 graduates in these programs per year. Dr. Russ asked how many they expect to apply for grandparenting. Ms. Porter explained that there are approximately 1,000 certified counselors and approximately 1,000 rehabilitation counselors but beyond that it would be hard to estimate because many might come from out of state.

Dr. Russ asked about what rehabilitation counselors do. Dr. Brew explained that they counsel people with disabilities providing basic psychotherapy and career counseling. Dr. Russ asked whether LPCs could treat within the military. Ms. Porter responded that they could under supervision of a physician. Dr. Russ then asked about how this licensure would increase access to the underserved. Dr. Brew stated that there is greater ethnic diversity and social class backgrounds within the students of counselor education programs, and there are LPC-qualified people in rural areas. Dr. Russ asked why they draw a more culturally diverse group of students. Dr. Jackson stated that he has had a number of students of color who are concerned that the term "psychotherapist" is a western orientation, and the term "counselor" offers another framework that is not as threatening to other cultures. Dr. Brew stated that marriage and

family therapy traditionally takes a systemic view and tries to work with the whole family and acculturation issues are huge for many people and so they are more likely to look for individual therapy.

Dr. Russ asked about the staff implications to the Board from including MFTs in the grandparenting process. Mr. Riches replied that it would be one very busy year and explained the different processes that the Board would have to go through to get such a program up and running. Dr. Russ asked why grandparent MFTs and not LCSWs. Ms. Porter stated that the education for MFTs and LPCs were more similar, and that MFTs would be required to have particular coursework. Dr. Russ asked whether counselor education programs were teaching the recovery model. Dr. Brew stated that they do teach from a strengths-based, wellness perspective, which is similar.

Ms. Riemersma asked to clarify what MFTs do, which is not only treat couples, families and groups, but also individuals. It is often from a systems perspective, but they rarely have the family in the room. She stated her feeling that the workforce study is flawed regarding shortages. She believes that instead there is a disconnect where people aren't getting information about the available jobs. She does believe there are shortages of professionals who are culturally diverse or multilingual.

A member of the audience questioned the proposed scope of practice, and asked how it is different than what is currently available to consumers in California. If it is a matter of not having enough providers, why don't we increase the numbers of current licensees rather than adding a new license type, which makes things more complex and confusing for consumers. Dr. Brew stated that the training is from a different perspective, focusing on prevention and lifespan development. She stated that there are people who are qualified to provide psychotherapy but don't meet the specific requirements for licensure in California.

Dr. Russ stated his concern that this bill would newly regulate career counseling. Dr. Jackson stated that this depends. If you're talking about someone who writes resumes, helps with job searches and does some assessments, no. But those who counsel people with psychological problems and help them to make life transitions, yes. Mr. Riches stated that in terms of drafting a scope of practice, you need to be very careful about what to include, because anything included will be regulated. Dr. Jackson stated that there are people who currently provide straight career counseling without psychotherapy, and they do not intend to regulate those people. Ms. Porter offered to remove career counseling from the scope. She stated they had included it because it appears in the scope of practice for other states. Mr. Riches stated that the Board's other licensees do work that is not listed in their scope of practice and which doesn't require a license. He stated that it would be cleaner from his perspective to remove it.

Mr. Wong asked why the bill would grandparent MFTs but not LCSWs, as the work they do is very similar. He suggested that the ability to diagnose be included in the scope of practice. He questioned the diversity statistics provided by the sponsor, stating his belief that it is dangerous to use national statistics in California. He stated that LCSWs are just as diverse if not more diverse than counselors. He stated his belief that the number of different license types is already confusing to the public.

Ms. DiGiorgio stated that as a consumer she would love to see just one license type but with different specializations. It is really difficult for a consumer who has no knowledge, and as a first-generation American, she wouldn't know where to begin. She would like to see a pamphlet for consumers regarding the different license types.

Ms. Riemersma asked what the sponsor's relationship is, if any, with the alcohol and drug abuse counselors who will be attempting a licensure bill, or the expressive arts therapists. Ms. Porter stated there is no relationship with the alcohol and drug abuse counselors. As far as the art therapists, to become licensed as a LPC they would have to meet all of the requirements, just as they would to become a MFT.

The Committee adjourned for lunch.

Dr. Russ asked for feedback from those who think the LPC license is not a good idea. A member of the audience responded that it doesn't seem there has been a documented need for another license in California, the distinguishing scopes of practice between the three license types is not there. It is not clear about the financial impact on the existing professions and the system, adding another layer of bureaucracy and another level of complexity adding to different systems in California. Coming from Ventura County, there would have to be job descriptions and policies written to address this, taking a tremendous amount of resources.

Another audience member stated that with just the two license types, it is already a major struggle providing oversight in her agency for supervised hours. So if this went forward, it would be more of a struggle.

Ms. Loewy asked for clarification about the demographics relating to diversity, whether it is for students in California or nationwide. Ms. Cummings responded that they surveyed the students in California counseling programs, and about one-third of the schools responded. A member of the audience asked whether the Board had surveyed students. Mr. Riches responded that they had not, only registrants and licensees.

Dr. Russ stated he was not interested in regulating new areas, but if there is a qualified workforce that has substantially equivalent education, training, experience and ability who are available to serve in mental health, why shouldn't we license them. In terms of consumer protection, there are no significant issues. The Board could explain the history and orientation of each profession. It seems that more qualified people would be better for consumers. He recommended that this proposal be recommended to the Board.

A member of the audience asked how fiscal impact is determined to the state, counties and practitioners who would be competing for the same jobs with the other license types. Dr. Russ acknowledged that it could create more competition and may lower prices for consumers. He stated that the Board's job is to protect consumers but at the same time therapists should not be put out of business.

Mr. Wong stated his understanding that the Board's job is not to serve consumers, but to protect consumers, which is a big difference to him. He explained that depressed prices to increase access doesn't sound like consumer protection to him, it sounds like marketplace and business. He believes that lowering prices could have the opposite effect. This happened in Medi-Cal when the rates were lowered, creating a shortage of physicians willing to accept Medi-Cal. His belief is when a new license type is proposed, quantitative data and studies showing there is a consumer protection problem that needs to be remedied should be provided.

Mr. Riches responded that he has seen a lot of people fight for licensure or expansion of licensure, and rarely are there any reviewed, study level quantitative analysis to back up any of it. This includes the existing licenses in California, none of them have crossed that hurdle. The fact that LPCs would be joining an existing field is an unusual situation in Mr. Riches' experience. The kind of studies Mr. Wong is asking for would be relevant if we were looking at a field not already being regulated. It was determined a long time ago

that psychotherapists need to be licensed, so we are past the question of whether this profession needs regulation. The core question is whether the population seeking licensure is qualified to perform the service for which you need a license. You only need to demonstrate public harm when you are attempting to regulate a new field.

Ms. DiGiorgio stated she had no problem taking this proposal forward to the Board, since 48 other states have this classification of licensure. This would help with increasing access to services.

Mr. Riches stated that one of the primary issues in the analysis is where the startup funds would originate, because there are significant up front costs. He recommends that the Board oppose the bill because there are no visible means of support. This is one issue of several that need to be resolved before we take any other position. The larger question of whether licensure of LPCs is appropriate is a different issue, from his standpoint.

Dr. Russ clarified that the Board is not attempting to create a new license, it is a group of people who brought forth this proposal. It is just a question of whether the Board supports the proposal or not. The Board's mission statement has broadened in the past several years, including addressing quality and delivery of services and diverse consumers.

Mr. Riches stated that any time there is a new program, it is a significant undertaking for the organization, and this is a consideration for the Board.

THE COMMITTEE CONCURRED TO RECOMMEND THAT THE BOARD SUPPORT THE BILL IF STAFF CONCERNS ARE ADDRESSED.

IV. Presentation by Lindle Hatton of Hatton Management Consultants Regarding Strategic Planning Process.

Mr. Riches introduced Dr. Hatton, who worked with the Board on its previous strategic plan, and is now working with us to update our strategic plan. Dr. Hatton thanked the Committee for the opportunity to meet with them. He stated that he has worked with state government for the past 25 years working on strategic plans.

Dr. Hatton explained that he uses an expanded approach using multiple constituencies, engaging as many internal and external stakeholders as possible. To do that, the model approach is to follow the state's strategic planning guidelines, consistent with the Governor's office and the Department of Finance. That model consists of four driving questions. 1. Where are we now?; 2. Where do we want to go?; 3. How do we want to get there?; and, 4. How do we measure progress? We are now moving into the first phase of scanning the environment. Previous discussions with Mr. Riches and Ms. Maggio involved developing a list of key stakeholders who have an interest in the Board and with a working knowledge of the Board. Dr. Hatton received a list of 91 stakeholders, 52 of which are external. He asked the Committee whether they felt this was a good sample.

Mr. Riches stated there are a few more that they wish to add and he would provide that information soon. He explained that they were going to pull their attendance lists from Board events, with an emphasis on those who attended more than one meeting, as it is preferable to have people with a reasonable understanding of and familiarity with the Board. They are still working to track down some of the people on that list, which

includes people from agencies, schools, students, and consumers casting as broad of a net as possible.

Dr. Hatton stated that the strategic planning process was last performed 23 months ago and there was a very nominal response from stakeholders. They are working to get a greater response by expanding the list and using the Internet. The survey is designed in two primary segments. The first is regarding the Board's organizational effectiveness, consisting of approximately 25 questions rated on a scale of one to five, then five open-ended questions, the first asking about the accomplishments of the Board over the past two years, the other four speak to the SWOT Analysis, the strengths and weakness that may limit the Board's effectiveness, opportunities the Board should be prepared to pursue, and the threats that might limit the Board.

The survey will probably be sent out soon with a two-week response deadline. Dr. Hatton will be meeting with all Board staff on February 7th and 20th, where the survey responses will be reviewed. Management and Board members will initially review the responses and have the opportunity to provide feedback, then it will go to staff for prioritization of themes. Those themes should be able to fit into existing goals, or we will need to create new goals. This is also an appropriate time to revisit the mission statement. In May the Board will have a focused working session with Dr. Hatton to review vision, mission and themes based upon data collected from the surveys, and how they align with current goals, and taking new suggestions. The objectives this time are to have a more robust data and to have more staff involvement than last time.

Dr. Hatton explained that all information collected from stakeholders would be kept confidential. The Board has a two-year contract with him to allow training and assistance to staff for actualization and accountability on an ongoing basis, at least quarterly. He would have a more hands-on role in creating work action plans. As tasks are aligned with people responsible for those tasks, we will create a forum for them to return and report on progress. He would like to do that by having staff report personally to the Board, as he feels it is important to send a strong message to staff that the Board is interested in what they are doing. It also gives them an opportunity to interact with the Board in a more formal level, and for staff development purposes.

Mr. Riches stated that while the prior strategic planning process had its successes, one of the breakdowns in the prior process, partially due to his newness, were large gaps in reaching stakeholders, so we have been working very hard to develop that list. The other gap was giving staff more of a voice in where the Board is going, and giving them more of a leadership role. This will provide another tool in building staff capability and providing a professional development opportunity. Like any other organization we need to be mindful of building staff from within.

Dr. Hatton stated that our approach is to first train staff and then coach them. As their voice is heard, they will have ownership of the plan. Dr. Russ asked whether staff felt they had the opportunity to express concerns about internal issues without feeling they would get in trouble. Dr. Hatton responded that they could express concerns through open-ended questions in the survey, which would not be anonymous to Dr. Hatton, but would be to everybody else, and he will not edit content of the responses. Mr. Riches stated that in prior staff sessions, staff did express some concerns in an open forum. Dr. Hatton confirmed that they felt comfortable to express those concerns in the presence of the management team, but if they did not want to vocalize it in that setting, they can send us an email. Dr. Russ asked if outside stakeholders expressed significant concerns, how that would be handled. Dr. Hatton stated that they would bring them in for a group work session.

X. Discussion and Possible Action to Revise Board Policy on Succession of Officers.

Mr. Riches explained that the Board adopted a policy two years ago addressing the succession of Board officers, which is now outdated. The policy references a prior statutory requirement that the Board elect officers before March 1 of every year. That statute was changed in Senate Bill 1475 (Chapter 659, Statutes of 2006) to require election of officers before June 1, in alignment with the expiration of Board terms. The misalignment in the prior law caused the Board to lose three consecutive chairs due to reappointment issues. The policy needs to be updated to reflect the new statute.

THE COMMITTEE CONCURRED TO RECOMMEND THE PROPOSAL REGARDING UPDATING THE POLICY ON SUCCESSION OF OFFICERS TO THE BOARD.

XI. Update on Results from the Board's Demographic Survey.

Mr. Riches explained that at the February 2006 meeting, the Board directed staff to complete a demographic survey of its licensees to inform its deliberations on workforce issues. Staff developed the survey, mailed it in October and received a 38% response rate. This response rate is much higher than anticipated and about one-half of the responses have been entered.

Mr. Riches presented a summary of the data entered thus far, representing nearly 12,000 responses. He expects to have all surveys entered by the end of January. The responses show a very different response from registrants vs. licensees in terms of linguistic capabilities, racial and ethnic makeup, primary practice environment and gender. He plans to also solicit information from the schools to get pipeline data.

The average age in the license base is very high and the distribution is very high, but it seems we have the same baby boomer problem as everyone else if not worse. Ms. Riemersma stated her feeling that this won't be a problem for this profession, as they tend to keep practicing even after retirement.

XII. Review of Progress on Strategic Plan Objectives.

Mr. Riches stated that he did not have any major updates to provide as we are still on track across the Board. One area we will need to look at down the road is under Goal #5 where we are now getting detailed information from the Department about the iLicensing program. He just received the business requirements document that the Department released. There are a couple of places where our objectives don't line up with what they are going to provide so we will need to revisit those. Ms. DiGiorgio asked whether this would slow down the process. Mr. Riches responded that he is cautiously optimistic that we will be up on the web in early 2009 which is near our objective, but he is skeptical of whether that date will hold.

XIII. Budget Update

Mr. Riches reported that the Board has a budget change proposal for two new enforcement analysts, which he expected would be approved. The funding would be redirected from other enforcement-related lines. This will tighten up the enforcement budget, which is not a problem. We typically revert about \$400,000 per year to the Board's reserve, and this budget change proposal should reduce that by half. This year we are projecting an \$80,000 end of year reversion due to some one-time costs and

contracts, which is about as low as we should go. However, we are in a very comfortable budget situation. We expect to introduce some budget change proposals for next year.

XIV. Legislation Update

Ms. Berger stated that the legislature just came back into session so there is no new legislation to report on other than the draft bill for LPCs. She provided an update on the Board's proposals for 2007, including changes to the unprofessional conduct statute, elimination of extensions for associate clinical social worker registrations, a minor change to MFT out-of-state education requirements, reducing the license delinquency period for three years, addressing the use of fictitious business names for LCSWs in private practice, technical and structural changes relating to fee and renewal statutes, and continuing education credit for licensees to attend Board meetings.

Mr. Riches stated that we had a meeting with the California Association of Alcohol and Drug Abuse Counselors (CAADAC), who will be advancing legislation for licensure of alcohol and drug abuse counselors. We will be discussing that at the next meeting of the Committee, as it is a significant piece of legislation. Also, at the February Board meeting there will probably be an item on the agenda relating to the BPPVE. They have been working on ideas so that graduating students are not impacted by the potential sunset.

XV. Rulemaking Update

Ms. Berger provided an update on rulemaking proposals that are in process, including the delegation of authority to the executive officer to compel a physical or mental evaluation of a licensee, changes to supervisor qualifications, technical cleanup to LEP and Board administration regulations, consistency in time frames for abandonment of application files, delinquency fees for continuing education providers, technical changes regarding fees, and increasing the amount of self-study hours accepted for continuing education and citation and fine of continuing education providers.

XVI. Future Meeting Dates

Mr. Riches referred to the list of proposed meeting dates for the Committee for 2007 and asked whether there were any conflicts. None were stated.

XVII. Suggestions for Future Agenda Items

None were suggested.

The meeting adjourned at 2:04 p.m.

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State of California

Memorandum

To: Policy and Advocacy Committee

Date: March 21, 2007

From: Paul Riches
Executive Officer

Telephone: (916) 574-7847

Subject: **V. Client Centered Advocacy**

Background

To qualify for licensure as a marriage and family therapist intern (IMF) must, among other things, complete 3000 hours of supervised experience. This experience can/must be gained in a number of areas including:

- Individual Counseling
- Diagnosing and treating couples, families, and children
- Personal psychotherapy
- Administering and evaluating psychological tests
- Group therapy or group counseling
- Direct supervisor contact
- Telephone counseling
- Writing clinical reports, progress notes, or process notes
- Professional enrichment activities

These areas presume that marriage and family therapists (MFT) and IMFs would be employed in private practice settings which focus on direct therapy skills and expertise. These areas contrast sharply in some respects with those for associate clinical social workers (ASW).

ASWs must obtain 3200 hours of supervised experience in two areas:

- Clinical psychosocial diagnosis
- Clinical psychosocial Assessment
- Clinical psychosocial treatment (including psychotherapy or counseling)
- Client-centered advocacy, consultation, evaluation, and research***

These areas presume that licensed clinical social workers and ASWs would frequently work in public mental health settings (among others) and included the "client centered advocacy" experience because the clients in public mental health settings need assistance in obtaining other benefits and services to support progress in therapy.

While there is significant overlap in what experience accepted for both licenses, IMFs may not gain hours for "client centered advocacy" as can an ASW. The reality that IMFs and ASWs are increasingly working in the same settings and in the same jobs undermines the presumptions upon which these requirements are based. The blending of both professions in public mental health settings suggests that these requirements be revisited.

This issue was highlighted at a recent meeting of the MFT Education Committee by supervisors who commented on the resistance of IMFs to engage in client centered advocacy functions because they did not count towards the licensing requirement.

Proposed Text

The proposed text attached would allow IMFs to gain experience for “client centered advocacy” in much the same fashion as an ASW would. The proposal does not reduce the number of hours of direct patient contact required for licensure.

Attachments

Draft Proposal

§4980.03. BOARD; INTERN; TRAINEE; ADVERTISE

(a) "Board," as used in this chapter, means the Board of Behavioral Sciences.

(b) "Intern," as used in this chapter, means an unlicensed person who has earned his or her master's or doctor's degree qualifying him or her for licensure and is registered with the board.

(c) "Trainee," as used in this chapter, means an unlicensed person who is currently enrolled in a master's or doctor's degree program, as specified in Section 4980.40, that is designed to qualify him or her for licensure under this chapter, and who has completed no less than 12 semester units or 18 quarter units of coursework in any qualifying degree program.

(d) "Applicant" as used in this chapter, means an unlicensed person who has completed a master's or doctoral degree program, as specified in Section 4980.40, and whose application for registration as an intern is pending, or an unlicensed person who has completed the requirements for licensure as specified in this chapter, is no longer registered with the board as an intern, and is currently in the examination process.

(e) "Advertise," as used in this chapter, includes, but is not limited to, the issuance of any card, sign, or device to any person, or the causing, permitting, or allowing of any sign or marking on, or in, any building or structure, or in any newspaper or magazine or in any directory, or any printed matter whatsoever, with or without any limiting qualification. It also includes business solicitations communicated by radio or television broadcasting. Signs within church buildings or notices in church bulletins mailed to a congregation shall not be construed as advertising within the meaning of this chapter.

(f) "Experience," as used in this chapter, means experience in interpersonal relationships, psychotherapy, marriage and family therapy, and professional enrichment activities that satisfies the requirement for licensure as a marriage and family therapist pursuant to Section 4980.40.

(g) "Supervisor," as used in this chapter, means an individual who meets all of the following requirements:

(1) Has been licensed for at least two years as a marriage and family therapist, licensed clinical social worker, licensed psychologist, or licensed physician certified in psychiatry by the American Board of Psychiatry and Neurology.

(2) Has not provided therapeutic services to the trainee or intern.

(3) Has been licensed or certified for at least two years prior to acting as a supervisor.

(4) Has a current and valid license that is not under suspension or probation.

(5) Complies with supervision requirements established by board regulations.

(h) "Professional enrichment activities," as used in this chapter, include both of the following:

(1) Workshops, seminars, training sessions, or conferences directly related to marriage and family therapy attended by the applicant that are approved by the applicant's supervisor.

(2) Participation by the applicant in group, marital or conjoint, family, or individual psychotherapy by an appropriately licensed professional.

(i) “Client centered advocacy” as used in this chapter includes researching, identifying, and accessing resources, or other activities, related to obtaining or providing services and supports for clients or groups of clients receiving psychotherapy or counseling services.

§4980.43. PROFESSIONAL EXPERIENCE; INTERNS OR TRAINEES

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

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

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

(3) Not less than 1,700 hours of supervised experience completed subsequent to the granting of the qualifying master's or doctor's degree.

(4) Not more than 1,300 hours of experience obtained prior to completing a master's or doctor's degree. This experience shall be composed as follows:

(A) Not more than 750 hours of counseling and direct supervisor contact.

(B) Not more than 250 hours of professional enrichment activities excluding personal psychotherapy, and client centered advocacy.

(C) Not more than 100 hours of personal psychotherapy. The applicant shall be credited for three hours of experience for each hour of personal psychotherapy.

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

(6) No hours of experience gained more than six years prior to the date the application for licensure was filed, except that up to 500 hours of clinical experience gained in the supervised practicum required by subdivision (b) of Section 4980.40 shall be exempt from this six-year requirement.

(7) Not more than ~~4000~~ 1250 hours of experience for ~~direct supervisor contact~~ and related professional activities as follows :-

(A) Not more than 250 hours of professional enrichment activities.

(B) Not more than 250 hours of administering and evaluating psychological tests, writing clinical reports, progress notes, or process notes.

(C) Direct supervisor contact

(D) Client centered advocacy.

(E) Personal psychotherapy.

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

~~(9) Not more than 250 hours of experience administering and evaluating psychological tests of counselees, writing clinical reports, writing progress notes, or writing process notes.~~

(10) Not more than 250 hours of experience providing counseling or crisis counseling on the telephone.

(11) Not less than 500 total hours of experience in diagnosing and treating couples, families, and children.

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

(c) Supervision shall include at least one hour of direct supervisor contact in each week for which experience is credited in each work setting, as specified:

(1) A trainee shall receive an average of at least one hour of direct supervisor contact for every five hours of client contact in each setting.

(2) Each individual supervised after being granted a qualifying degree shall receive an average of at least one hour of direct supervisor contact for every 10 hours of client contact in each setting in which experience is gained.

(3) For purposes of this section, "one hour of direct supervisor contact" means one hour of face-to-face contact on an individual basis or two hours of face-to-face contact in a group of not more than eight persons.

(4) All experience gained by a trainee shall be monitored by the supervisor as specified by regulation. The 5-to-1 and 10-to-1 ratios specified in this subdivision shall be applicable to all hours gained on or after January 1, 1995.

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

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

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

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

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

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

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

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

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

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

(4) Except for periods of time during a supervisor's vacation or sick leave, an intern who is employed or volunteering in private practice shall be under the direct supervision of a licensee enumerated in subdivision (f) of Section 4980.40. The supervising licensee shall either be employed by and practice at the same site as the intern's employer, or shall be an owner or shareholder of the private practice. Alternative supervision may be arranged during a supervisor's vacation or sick leave if the supervision meets the requirements of this section.

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

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

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

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

(i) Trainees, interns, and applicants shall only perform services at the place where their employers regularly conduct business, which may include performing services at other locations, so long as the services are performed under the direction and control of their employer and supervisor, and in compliance with the laws and regulations pertaining to supervision. Trainees and interns shall have no proprietary interest in the employer's business.

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

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

CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES

BILL ANALYSIS

BILL NUMBER: AB 164 **VERSION:** AMENDED MARCH 5, 2007

AUTHOR: SMYTH **SPONSOR:** CAMFT

RECOMMENDED POSITION: SUPPORT

SUBJECT: CHILD CUSTODY: CHILD'S RECORDS

Existing Law:

- 1) Prohibits denying a parent with access to medical, dental and school records and information pertaining to a minor because that parent is not the custodial parent. (Family Code § 3025)
- 2) Allows a mental health provider to deny access to psychotherapy notes. (45 CFR § 164.524)
- 3) Prohibits a minor's representative from inspecting or obtaining copies of the minor's patient records when: (HSC § 123115(a))
 - The minor is legally able to consent for treatment
 - The health care provider determines that access to the records requested would have a detrimental effect on the provider's professional relationship with the minor
- 4) Allows a health care provider to prepare a summary of the patient's record for inspection and copying by a patient within 10 working days from the date of the patient's request, or within 30 days if the record is of extraordinary length. (HSC § 123130(a))
- 5) Defines "Mental health records" as patient records or a portion of a record, specifically relating to evaluation or treatment of a mental disorder. (HSC § 123105(b))

This Bill:

- 1) Adds mental health records to the types of records that cannot be denied to a parent. (Family Code § 3025)
- 2) Prohibits denying a parent with access to mental health and other types of records and information pertaining to a minor unless that parent has been any of the following: (Family Code § 3025)
 - Denied legal custody based on a threat to the safety of the child or custodial parent.
 - Denied visitation.
 - Ordered to supervised visitation.
 - Restricted in access to the child or custodial parent by a temporary or permanent protective order, unless that protective order, or a subsequent order that modifies the protective order specifically allows access to the records.

Comment:

- 1) **Author's Intent.** According to the sponsor, the California Association of Marriage and Family Therapists (CAMFT), this section of law is often cited and has been the source of some confusion on the part of therapists and attorneys. The law's intent is to allow a parent with legal custody of a minor child access to his or her child's medical record information. This cannot be denied merely because the parent does not have physical custody. As currently worded, Section 3025 uses the phrase "not the child's custodial parent" which can be misinterpreted to mean that a parent who does not even have legal custody of a minor can have access to the child's health records. This bill would clarify that a parent's access to records and information shall not be denied because that parent does not have physical custody so long as the parent has not been denied legal custody for certain reasons or has not been denied visitation, etc. This bill also adds mental health records to make clear that this law applies to both medical and mental health records.
- 2) **Mental Health Records.** This bill would provide clarification and additional specificity regarding provision of records to parents who do not have physical or legal custody of a child. It would provide a parent who does not have custody with the ability to access the child's health records, except in situations where there court has restricted access to the child (i.e., denied or supervised visitation, etc.). It would also provide clarification that this also applies to mental health records.
- 3) **Enforcement.** When the Board receives a complaint regarding a child's psychotherapist, staff attempts to obtain a signed release from both parents. If that attempt is unsuccessful, staff will request a copy of the custody agreement to see the terms. Staff also will write to the therapist in an attempt to obtain the records. Typically, if a custodial parent will not sign a release, staff cannot obtain records from the therapist. If staff is unable to obtain records, the Board often cannot pursue the case. This bill may assist the Board in pursuing some cases by providing greater access to records.
- 4) **Support and Opposition.**
Not yet known
- 5) **History**
2007
Mar. 6 Re-referred to Com. on JUD.
Mar. 5 From committee chair, with author's amendments: Amend, and re-refer to Com. on JUD. Read second time and amended.
Feb. 9 Referred to Com. on JUD.
Jan. 23 From printer. May be heard in committee February 22.
Jan. 22 Read first time. To print.

AMENDED IN ASSEMBLY MARCH 5, 2007

CALIFORNIA LEGISLATURE—2007—08 REGULAR SESSION

ASSEMBLY BILL

No. 164

Introduced by Assembly Member Smyth

January 22, 2007

An act to amend Section 3025 of the Family Code, relating to child custody.

LEGISLATIVE COUNSEL'S DIGEST

AB 164, as amended, Smyth. Child custody: child's records.

Under existing law, a parent shall not be denied access to records and information pertaining to a minor child, including, but not limited to, medical, dental, and school records, because that parent is not the child's custodial parent.

This bill would provide, instead, that a parent shall not be denied access to the child's records because he or she does not have physical custody of the child, ~~so long as that parent has legal custody, whether sole or joint unless that parent has been denied legal custody of the child based on a threat to the safety of the child or custodial parent, denied visitation, ordered to supervised visitation, or restricted in access to the child or custodial parent by a temporary or permanent protective order, as specified.~~ The bill would add mental health records of the minor child among those records subject to this provision.

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

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

1 SECTION 1. Section 3025 of the Family Code is amended to
2 read:

3 3025. Notwithstanding any other law, access to records and
4 information pertaining to a minor child, including, but not limited
5 to, medical, mental health, dental, and school records, shall not be
6 denied to a parent because that parent does not have physical
7 custody of the child, ~~so long as that parent has legal custody,~~
8 ~~whether sole or joint.~~ *unless that parent has been any of the*
9 *following:*

- 10 (a) *Denied legal custody of the child based on a threat to the*
11 *safety of the child or custodial parent.*
- 12 (b) *Denied visitation.*
- 13 (c) *Ordered to supervised visitation.*
- 14 (d) *Restricted in access to the child or custodial parent by a*
15 *temporary or permanent protective order, unless that protective*
16 *order, or a subsequent order that modifies the protective order,*
17 *specifically allows access to the records.*

CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES

BILL ANALYSIS

BILL NUMBER: AB 234 **VERSION:** AMENDED MARCH 15, 2007

AUTHOR: ENG **SPONSOR:** CAMFT

RECOMMENDED POSITION: NONE

SUBJECT: MARRIAGE AND FAMILY THERAPY

Existing Law:

- 1) Defines "Supervisor," as an individual who meets all of the following requirements: (Business and Professions Code [BPC] § 4980.03(g))
 - Has been licensed for at least two years as a marriage and family therapist (MFT), licensed clinical social worker, licensed psychologist, or licensed physician certified in psychiatry by the American Board of Psychiatry and Neurology.
 - Has not provided therapeutic services to the trainee or intern.
 - Has been licensed or certified for at least two years prior to acting as a supervisor.
 - Has a current and valid license that is not under suspension or probation.
 - Complies with supervision requirements established by board regulations.
- 2) Permits MFT Trainees (pre-degree) to gain a maximum of 1,300 hours of experience as follows: (BPC § 4980.43)
 - Not more than 750 hours of counseling and direct supervisor contact
 - Not more than 250 hours of professional enrichment activities excluding personal psychotherapy.
 - Not more than 100 hours of personal psychotherapy, which shall be triple-credited.
- 3) Permits MFT Interns (post-degree) to gain a minimum of 1,700 hours of supervised experience as follows: (BPC § 4980.43)
 - Not more than 1000 hours of direct supervisor contact and professional activities.
 - Not more than 500 hours providing group therapy or group counseling.
 - Not more than 250 hours administering and evaluating psychological tests of counselees, writing clinical reports, writing progress notes, or writing process notes.
 - Not more than 250 hours providing counseling or crisis counseling on the telephone.
 - Not less than 500 total hours diagnosing and treating couples, families, and children.
- 4) Prohibits MFT trainees and interns from having a proprietary interest in their employer's business. (BPC § 4980.43(i))
- 5) Requires education gained outside of California to be accepted toward MFT licensure requirements if it is substantially equivalent. (BPC § 4980.90(b))
- 6) Defines "telemedicine" as the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. (BPC § 2290.5(a))

- This does not include a telephone conversation nor an electronic mail message between a health care practitioner and patient.
- Defines "interactive" as an audio, video, or data communication involving a real time or near real time two-way transfer of medical data and information.

This Bill:

- 1) Requires a supervisor to be licensed or certified by a state agency for a minimum of two years prior to acting as a supervisor of MFT Interns or Trainees. (BPC § 4980.03(g))
- 2) Limits MFT Interns to a maximum of 125 hours of experience providing personal psychotherapy services via telemedicine. (BPC § 4980.43(a)(12))
- 3) Prohibits MFT Trainees and Interns from leasing or renting space, paying for furnishings, equipment or supplies, or in any other way paying for the obligations of their employers. (BPC § 4980.43(i))
- 4) Deletes an obsolete provision permitting supervision of MFT Interns and Trainees by a physician who has completed a residency in psychiatry. (BPC § 4980.45(a))
- 5) Requires education gained while residing outside of California to be accepted toward the MFT licensure requirements if it is substantially equivalent. (BPC § 4980.90(b))
- 6) Makes technical changes in MFT statutes referring to the definitions of “supervisor” and “professional enrichment activities.”

Comment:

- 1) **Author’s Intent.** The sponsor, the California Association of Marriage and Family Therapists (CAMFT) states that this bill would make a number of clarifying changes and updates to the MFT licensing law.
- 2) **Telemedicine.** This bill would clarify that interns may earn supervised experience providing services via telemedicine, and place a 125-hour cap on counting such hours toward licensure.
- 3) **Employer Obligations.** This bill would newly prohibit trainees and interns from leasing or renting space, paying for furnishings, equipment or supplies, or in any other way paying for the obligations of their employers. This amendment would be in conformity with the intent of current law, which prohibits trainees and interns from having a proprietary interest in their employer’s business.
- 4) **Out-of-State Education.** The law is currently unclear regarding persons who **live in** California while attending a school located **outside of** California, such as an online school. Such persons are currently subject to the same educational requirements as those who both live **and** attend school outside of California – meaning the degree must be “substantially equivalent.” However, a person who resided in and attended a school located in California must meet more stringent requirements, such as possessing a degree with a specific title named in law, and the inability to make up deficient units. The MFT educational requirements should be the same for everybody who completes their education while residing in California. Out-of-state schools that take students who reside in California should not be exempt from the same standards that apply to California schools.

At its meeting in November 2006, the Board agree to sponsor legislation to effect this change. This proposal has been submitted to the Senate Business and Professions Committee for inclusion in their annual omnibus bill.

5) Suggested Amendment. Section 4980.03(g) currently defines a “supervisor,” in part, as an individual who “Has been licensed or certified for at least two years prior to acting as a supervisor.” This bill would recast that provision to add that the license or certification must have been issued by “a state regulatory agency.” This addition is fine, but it brought to our attention that the statute permits a person with only a certification to supervise, which should not be permissible. The Board is not aware of any certification issued by a state agency, or any agency for that matter, that would qualify an individual to supervise. The intent is for a licensed person to supervise. Therefore, we suggest the following amendment:

(g) “Supervisor,” as used in this chapter, means an individual who meets all of the following requirements:

- (1) Has been licensed ~~or certified~~ by a state regulatory agency for at least two years as a marriage and family therapist, licensed clinical social worker, licensed psychologist, or licensed physician certified in psychiatry by the American Board of Psychiatry and Neurology.
- (2) Has not provided therapeutic services to the trainee or intern.
- (3) Has a current and valid license that is not under suspension or probation.
- (4) Complies with supervision requirements established by this chapter and by board regulations.

6) Support and Opposition.

Not yet known

7) History

2007

- Mar. 15 From committee chair, with author's amendments: Amend, and re-refer to Com. on B. & P. Read second time and amended.
- Mar. 15 Referred to Com. on B. & P.
- Jan. 31 From printer. May be heard in committee March 2.
- Jan. 30 Read first time. To print.

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AMENDED IN ASSEMBLY MARCH 15, 2007

CALIFORNIA LEGISLATURE—2007—08 REGULAR SESSION

ASSEMBLY BILL

No. 234

Introduced by Assembly Member Eng

January 30, 2007

~~An act to amend Section 11011.15 of the Government Code, relating to state property.~~ *An act to amend Sections 4980.03, 4980.43, 4980.45, and 4980.90 of the Business and Professions Code, relating to marriage and family therapy.*

LEGISLATIVE COUNSEL'S DIGEST

AB 234, as amended, Eng. ~~State property; inventory.~~ *Marriage and family therapy.*

Existing law makes the Board of Behavioral Sciences responsible for licensing and regulating the practice of marriage and family therapy and makes a violation of these provisions a crime.

Existing law requires an applicant for the marriage and family therapist licensure examination to complete specified experience, with limits on the amount of experience that may be earned in certain areas of emphasis, including professional enrichment activities, and subject to various hourly limitations.

This bill would impose a 125-hour limitation on experience earned providing personal psychotherapy services via telemedicine, as defined, and would modify the definition of professional enrichment activities for these purposes.

Under existing law, trainees and interns may have no proprietary interest in their employer's business.

This bill would additionally provide that trainees and interns may not lease or rent space, pay for furnishings, equipment or supplies, or

in any other way pay for the obligations of their employers. By revising this provision, this bill would expand the scope of an existing crime, thereby imposing a state-mandated local program.

Existing law provides that education gained outside of California applies toward the marriage and family therapist licensure requirements.

This bill would instead specify that education gained while residing outside of California applies toward the licensure requirements.

The bill would make other technical and conforming changes.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

~~Existing law requires the Department of General Services to maintain a complete and accurate statewide inventory of all real property held by the state and to update it annually, and to categorize that inventory by agency and geographical location. This inventory is required to include specified information furnished by state agencies and the University of California.~~

~~This bill would require that this inventory be completed and updated by January 1 of each year.~~

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

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

- 1 SECTION 1. Section 4980.03 of the Business and Professions
- 2 Code is amended to read:
- 3 4980.03. (a) “Board,” as used in this chapter, means the Board
- 4 of Behavioral Sciences.
- 5 (b) “Intern,” as used in this chapter, means an unlicensed person
- 6 who has earned his or her master’s or doctor’s degree qualifying
- 7 him or her for licensure and is registered with the board.
- 8 (c) “Trainee,” as used in this chapter, means an unlicensed
- 9 person who is currently enrolled in a master’s or doctor’s degree
- 10 program, as specified in Section 4980.40, that is designed to qualify
- 11 him or her for licensure under this chapter, and who has completed

1 no less than 12 semester units or 18 quarter units of coursework
2 in any qualifying degree program.

3 (d) "Applicant," as used in this chapter, means an unlicensed
4 person who has completed a master's or doctoral degree program,
5 as specified in Section 4980.40, and whose application for
6 registration as an intern is pending, or an unlicensed person who
7 has completed the requirements for licensure as specified in this
8 chapter, is no longer registered with the board as an intern, and is
9 currently in the examination process.

10 (e) "Advertise," as used in this chapter, includes, but is not
11 limited to, the issuance of any card, sign, or device to any person,
12 or the causing, permitting, or allowing of any sign or marking on,
13 or in, any building or structure, or in any newspaper or magazine
14 or in any directory, or any printed matter whatsoever, with or
15 without any limiting qualification. It also includes business
16 solicitations communicated by radio or television broadcasting.
17 Signs within church buildings or notices in church bulletins mailed
18 to a congregation shall not be construed as advertising within the
19 meaning of this chapter.

20 (f) "Experience," as used in this chapter, means experience in
21 interpersonal relationships, psychotherapy, marriage and family
22 therapy, and professional enrichment activities that satisfies the
23 requirement for licensure as a marriage and family therapist
24 pursuant to Section 4980.40.

25 (g) "Supervisor," as used in this chapter, means an individual
26 who meets all of the following requirements:

27 (1) Has been licensed *or certified by a state regulatory agency*
28 for at least two years as a marriage and family therapist, licensed
29 clinical social worker, licensed psychologist, or licensed physician
30 certified in psychiatry by the American Board of Psychiatry and
31 Neurology.

32 (2) Has not provided therapeutic services to the trainee or intern.

33 ~~(3) Has been licensed or certified for at least two years prior to~~
34 ~~acting as a supervisor.~~

35 ~~(4)~~

36 (3) Has a current and valid license that is not under suspension
37 or probation.

38 ~~(5)~~

39 (4) Complies with supervision requirements established by *this*
40 *chapter and by* board regulations.

1 (h) ~~“Professional enrichment activities,” as used in this chapter,~~
2 ~~include both of the following:~~

3 ~~(1) Workshops, seminars, training sessions, or conferences~~
4 ~~directly related to marriage and family therapy attended by the~~
5 ~~applicant that are approved by the applicant’s supervisor.~~

6 ~~(2) Participation by the applicant in group, marital or conjoint,~~
7 ~~family, or individual psychotherapy by an appropriately licensed~~
8 ~~professional.~~

9 *SEC. 2. Section 4980.43 of the Business and Professions Code*
10 *is amended to read:*

11 4980.43. (a) Prior to applying for licensure examinations, each
12 applicant shall complete experience that shall comply with the
13 following:

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

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

17 (3) Not less than 1,700 hours of supervised experience
18 completed subsequent to the granting of the qualifying master’s
19 or doctor’s degree.

20 (4) Not more than 1,300 hours of experience obtained prior to
21 completing a master’s or doctor’s degree. This experience shall
22 be composed as follows:

23 (A) Not more than 750 hours of counseling and direct supervisor
24 contact.

25 (B) Not more than 250 hours of professional enrichment
26 activities, excluding personal psychotherapy *as described in*
27 *paragraph (2) of subdivision (1).*

28 (C) Not more than 100 hours of personal psychotherapy *as*
29 *described in paragraph (2) of subdivision (1).* The applicant shall
30 be credited for three hours of experience for each hour of personal
31 psychotherapy.

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

35 (6) No hours of experience gained more than six years prior to
36 the date the application for licensure was filed, except that up to
37 500 hours of clinical experience gained in the supervised practicum
38 required by subdivision (b) of Section 4980.40 shall be exempt
39 from this six-year requirement.

1 (7) Not more than ~~1000~~ *a total of 1,000* hours of experience for
2 direct supervisor contact and professional *enrichment* activities.

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

5 (9) Not more than 250 hours of *postdegree* experience
6 administering and evaluating psychological tests of counselees,
7 writing clinical reports, writing progress notes, or writing process
8 notes.

9 (10) Not more than 250 hours of experience providing
10 counseling or crisis counseling on the telephone.

11 (11) Not less than 500 total hours of experience in diagnosing
12 and treating couples, families, and children.

13 (12) *Not more than 125 hours of experience providing personal*
14 *psychotherapy services via telemedicine in accordance with Section*
15 *2290.5.*

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

28 (c) Supervision shall include at least one hour of direct
29 supervisor contact in each week for which experience is credited
30 in each work setting, as specified:

31 (1) A trainee shall receive an average of at least one hour of
32 direct supervisor contact for every five hours of client contact in
33 each setting.

34 (2) Each individual supervised after being granted a qualifying
35 degree shall receive an average of at least one hour of direct
36 supervisor contact for every 10 hours of client contact in each
37 setting in which experience is gained.

38 (3) For purposes of this section, “one hour of direct supervisor
39 contact” means one hour of face-to-face contact on an individual

1 basis or two hours of face-to-face contact in a group of not more
 2 than eight persons.

3 (4) All experience gained by a trainee shall be monitored by the
 4 supervisor as specified by regulation. The 5-to-1 and 10-to-1 ratios
 5 specified in this subdivision shall be applicable to all hours gained
 6 on or after January 1, 1995.

7 ~~(d) (1)~~

8 ~~A~~

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

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

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

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

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

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

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

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

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

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

37 (4) Except for periods of time during a supervisor’s vacation or
 38 sick leave, an intern who is employed or volunteering in private
 39 practice shall be under the direct supervision of a licensee
 40 enumerated in subdivision (f) of Section 4980.40 that has satisfied

1 *the requirements of subdivision (g) of Section 4980.03.* The
2 supervising licensee shall either be employed by and practice at
3 the same site as the intern's employer, or shall be an owner or
4 shareholder of the private practice. Alternative supervision may
5 be arranged during a supervisor's vacation or sick leave if the
6 supervision meets the requirements of this section.

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

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

12 (g) Except when employed in a private practice setting, all
13 postdegree hours of experience shall be credited toward licensure
14 so long as the applicant applies for the intern registration within
15 90 days of the granting of the qualifying master's or doctor's
16 degree and is thereafter granted the intern registration by the board.

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

20 (i) Trainees, interns, and applicants shall only perform services
21 at the place where their employers regularly conduct business,
22 which may include performing services at other locations, so long
23 as the services are performed under the direction and control of
24 their employer and supervisor, and in compliance with the laws
25 and regulations pertaining to supervision. Trainees and interns
26 shall have no proprietary interest in ~~the employer's business~~ *their*
27 *employers' businesses and shall not lease or rent space, pay for*
28 *furnishings, equipment or supplies, or in any other way pay for*
29 *the obligations of their employers.*

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

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

12 (l) For purposes of this section, “professional enrichment
13 activities” includes the following:

14 (1) Workshops, seminars, training sessions, or conferences
15 directly related to marriage and family therapy attended by the
16 applicant that are approved by the applicant’s supervisor.

17 (2) Participation by the applicant in personal psychotherapy
18 which includes group, marital or conjoint, family, or individual
19 psychotherapy by an appropriately licensed professional.

20 SEC. 3. Section 4980.45 of the Business and Professions Code
21 is amended to read:

22 4980.45. (a) A licensed professional in private practice who
23 ~~is a marriage and family therapist, a psychologist, a clinical social~~
24 ~~worker, a licensed physician certified in psychiatry by the~~
25 ~~American Board of Psychiatry and Neurology, or a licensed~~
26 ~~physician who has completed a residency in psychiatry and who~~
27 ~~is described in subdivision (f) of Section 4980.40 has satisfied the~~
28 ~~requirements of subdivision (g) of Section 4980.03~~ may supervise
29 or employ, at any one time, no more than two unlicensed marriage
30 and family therapist registered interns in that private practice.

31 (b) A marriage and family therapy corporation may employ, at
32 any one time, no more than two registered interns for each
33 employee or shareholder who ~~is qualified to provide supervision~~
34 ~~pursuant to subdivision (f) of Section 4980.40 has satisfied the~~
35 ~~requirements of subdivision (g) of Section 4980.03~~. In no event
36 shall any corporation employ, at any one time, more than 10
37 registered interns. In no event shall any supervisor supervise, at
38 any one time, more than two registered interns. Persons who
39 supervise interns shall be employed full time by the professional
40 corporation and shall be actively engaged in performing

1 professional services at and for the professional corporation.
2 Employment and supervision within a marriage and family therapy
3 corporation shall be subject to all laws and regulations governing
4 experience and supervision gained in a private practice setting.

5 *SEC. 4. Section 4980.90 of the Business and Professions Code*
6 *is amended to read:*

7 4980.90. (a) Experience gained outside of California shall be
8 accepted toward the licensure requirements if it is substantially
9 equivalent to that required by this chapter and if the applicant has
10 gained a minimum of 250 hours of supervised experience in direct
11 counseling within California while registered as an intern with the
12 board.

13 (b) Education gained *while residing* outside of California shall
14 be accepted toward the licensure requirements if it is substantially
15 equivalent to the education requirements of this chapter, and if the
16 applicant has completed all of the following:

17 (1) A two semester- or three quarter-unit course in California
18 law and professional ethics for marriage, family, and child
19 counselors that shall include areas of study as specified in Section
20 4980.41.

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

24 (3) A minimum of 10 contact hours of training or coursework
25 in sexuality as specified in Section 25 and any regulations
26 promulgated thereunder.

27 (4) A minimum of 15 contact hours of training or coursework
28 in alcoholism and other chemical substance dependency as
29 specified by regulation.

30 (5) (A) Instruction in spousal or partner abuse assessment,
31 detection, and intervention. This instruction may be taken either
32 in fulfillment of other educational requirements for licensure or
33 in a separate course.

34 (B) On and after January 1, 2004, a minimum of 15 contact
35 hours of coursework or training in spousal or partner abuse
36 assessment, detection, and intervention strategies.

37 (6) On and after January 1, 2003, a minimum of a two semester-
38 or three quarter-unit survey course in psychological testing. This
39 course may be taken either in fulfillment of other requirements for
40 licensure or in a separate course.

1 (7) On and after January 1, 2003, a minimum of a two semester-
 2 or three quarter-unit survey course in psychopharmacology. This
 3 course may be taken either in fulfillment of other requirements for
 4 licensure or in a separate course.

5 (8) With respect to human sexuality, alcoholism and other
 6 chemical substance dependency, spousal or partner abuse
 7 assessment, detection, and intervention, psychological testing, and
 8 psychopharmacology, the board may accept training or coursework
 9 acquired out of state.

10 (c) For purposes of this section, the board may, in its discretion,
 11 accept education as substantially equivalent if the applicant has
 12 been granted a degree in a single integrated program primarily
 13 designed to train marriage, family, and child counselors and if the
 14 applicant’s education meets the requirements of Sections 4980.37
 15 and 4980.40. The degree title and number of units in the degree
 16 program need not be identical to those required by subdivision (a)
 17 of Section 4980.40. If the applicant’s degree does not contain the
 18 number of units required by subdivision (a) of Section 4980.40,
 19 the board may, in its discretion, accept the applicant’s education
 20 as substantially equivalent if the applicant’s degree otherwise
 21 complies with this section and the applicant completes the units
 22 required by subdivision (a) of Section 4980.40.

23 *SEC. 5. No reimbursement is required by this act pursuant to*
 24 *Section 6 of Article XIII B of the California Constitution because*
 25 *the only costs that may be incurred by a local agency or school*
 26 *district will be incurred because this act creates a new crime or*
 27 *infraction, eliminates a crime or infraction, or changes the penalty*
 28 *for a crime or infraction, within the meaning of Section 17556 of*
 29 *the Government Code, or changes the definition of a crime within*
 30 *the meaning of Section 6 of Article XIII B of the California*
 31 *Constitution.*

32 ~~SECTION 1. Section 11011.15 of the Government Code is~~
 33 ~~amended to read:~~

34 ~~11011.15. (a) The Department of General Services shall~~
 35 ~~maintain a complete and accurate statewide inventory of all real~~
 36 ~~property held by the state and categorize that inventory by agency~~
 37 ~~and geographical location. The inventory shall include all~~
 38 ~~information furnished by agencies pursuant to subdivision (b) and~~
 39 ~~the University of California pursuant to Section 11011.17. The~~

1 inventory shall be completed and updated by January 1 of each
2 year.

3 (b) Each agency shall furnish the department, in the format
4 specified by the department, a record of each parcel of real property
5 that it possesses. Each agency shall update its real property
6 holdings, reflecting any changes, by July 1 of each year. This
7 record shall include, but is not limited to, all of the following
8 information:

9 (1) The location of the property within the state and the county,
10 the size of the property, including its acreage, and any other
11 relevant property data that the department deems necessary. This
12 latter requirement shall be uniformly applied to all agencies.

13 (2) The date of the acquisition of the real property, if available.

14 (3) The manner in which the property was acquired and the
15 purchase price, if available.

16 (4) A description of the current uses of the property and any
17 projected future uses during the next three years. In the case of
18 land held for state park use whose projected use would exceed a
19 three-year period, the projected use and estimated date of
20 construction or use shall be furnished.

21 (5) A concise description of each major structure located on the
22 property.

23 (6) The estimated value of real property declared surplus by the
24 agency and real property where the agency has not identified a
25 current or potential use.

26 (e) The department shall prepare a separate report and shall
27 update the report annually of all properties declared surplus or
28 properties with no identified current or projected use. The report
29 shall be made available upon request.

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CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES

BILL ANALYSIS

BILL NUMBER: AB 249 **VERSION:** INTRODUCED FEBRUARY 1, 2007

AUTHOR: ENG **SPONSOR:** AUTHOR

RECOMMENDED POSITION: SUPPORT

SUBJECT: REGULATORY GAG CLAUSES

Existing Law:

- 1) Permits the Board of Behavioral Sciences (BBS) to take enforcement action against a licensee or registrant for unprofessional conduct or other violations of BBS law.
- 2) Requires every settlement or arbitration award against a Marriage and Family Therapist (MFT) or Licensed Clinical Social Worker (LCSW) over \$10,000 resulting from a claim or action for damages for death or personal injury caused by negligence, error or omission, or by providing unauthorized services, to be reported by the insurer to the BBS within 30 days. (B&P § 801(c), 802(b))

This Bill:

- 1) Prohibits a “healing arts” licensee, including LCSWs, MFTs, and Licensed Educational Psychologists, or an entity acting as an authorized agent of a licensee, from including any of the following provisions, known as “gag clauses” in a civil settlement: (B&P Code § 809.10(a))
 - Prohibiting the other party from contacting the Department of Consumer Affairs (DCA) or the board
 - Prohibiting the other party from cooperating with the DCA or the board
 - Prohibiting the other party from filing a complaint with the DCA or the board
 - Requiring the other party to withdraw a complaint the DCA or the board
- 2) Declares that gag clauses are void as against public policy. (B&P Code § 809.10(a))
- 3) Specifies that a licensee who includes or permits a gag clause to be included in a civil settlement agreement is subject to disciplinary action by the appropriate board. (B&P Code § 809.10(b))

Comment:

- 1) **Author’s Intent.** According to the author, the state has created regulatory agencies to license healthcare professionals in order to protect patients, but those same practitioners can use gag clauses in malpractice settlements to prevent the licensing agency from finding out about their abuses. That makes absolutely no sense. Licensed healthcare professionals should not be able to misuse the civil justice system to conceal evidence of misconduct from their regulators.

Regulatory gag clauses currently are prohibited in legal malpractice, and medical malpractice settlements involving physicians and surgeons, and there have been numerous court decisions that describe a compelling public interest in voiding regulatory gag clauses in other professions so that the regulator can best protect the public from harm. However, in spite of court rulings, the use of regulatory gag clauses persists. Gag clauses are sometimes used to intimidate injured victims so they refuse to testify against a licensee in investigations. Gag clauses cause delay and thwart regulatory agency efforts to investigate possible cases of misconduct, thereby preventing the regulatory agency from performing its most basic function - protecting the public.

Regulatory gag clauses increase costs to taxpayers, delay action by regulators, and tarnish the reputation of competent and reputable licensed professionals. California should not allow repeat offenders who injure patients to hide their illegal acts from the authority that grants them their license to practice as a healthcare professional.

- 2) **Gag Clauses.** This bill is intended to close a loophole in current law that allows a healing arts licensee under the DCA to prohibit a consumer who settles a civil suit from also filing a complaint or otherwise cooperating with a regulatory agency. Such an agreement is known as a regulatory "gag clause." A regulatory gag clause requires a plaintiff to agree, as a condition of a malpractice or misconduct settlement with the licensee, to a provision prohibiting the plaintiff from contacting or cooperating with the defendant's regulator, or requiring the plaintiff to withdraw a pending complaint before that regulator.

As an example, under current law, a physician who settles a malpractice complaint with an injured patient might require, as a condition of receiving the settlement payment, that the consumer not report the malpractice to the Medical Board of California (MBC) or otherwise speak regarding the case, even if the patient is contacted by DCA investigators or private attorneys who are looking into separate complaints against the physician.

Former California Attorney General Bill Lockyer has commented, "We have long maintained that such contracts and settlement provisions are void as against public policy. These kinds of agreements undermine public protection and delay investigation of misconduct.

- 3) **Medical Board.** According to an investigation by the MBC, such gag clauses have stymied a number of investigations, many of which involved allegations of sexual misconduct. The most common result of such clauses seems to be delay. Cases can be slowed by several months or even years due to fear on the part of patients who sometimes require a court order before they will cooperate. The legal burden of overcoming gag clauses can also add thousands of dollars in legal costs for the state. Legislation was passed in 2006 (see item #6 "Prior Legislation") that prohibits a physician and surgeon from including a gag clause within a civil settlement.
- 4) **BBS.** The BBS receives notification of civil settlements from insurance carriers, and then contacts the potential complainant by sending a complaint form and a letter that provides information about pursuing administrative action. The majority does not file a complaint. It is not clear whether the lack of response to BBS contact is due to use of gag clauses or whether consumers typically feel satisfied with the outcome of civil settlements and do not wish to take further action. However, it is safe to assume that gag clauses are used in some civil settlements with BBS licensees, and that their use at times may frustrate the BBS' ability to protect consumers.

This bill establishes that any licensee who includes or permits a gag clause to be included in a settlement agreement is subject to disciplinary action by a board. It is not clear from this

bill that the BBS would be able to deny a registration or a license on this basis. Amendments to the following sections would assist the BBS in pursuing disciplinary action by clearly defining the use of a gag clause as unprofessional conduct, and by allowing the BBS to deny a registration or license for the use of a gag clause:

B&P Code § § 4982, 4989.54, and 4992.3

5) Attorneys. This bill is modeled on an existing statute that prohibits attorneys from including gag clauses in legal malpractice settlements, and is in line with a number of court decisions that describe a compelling public interest in voiding regulatory gag clauses to allow the regulator to best protect the public from harm.

6) Prior Legislation. AB 2260 (Negrete McLeod), Chapter 565, Statutes of 2006, prohibits physicians and surgeons licensed by MBC from including a gag clause in a civil settlement agreement. This bill took effect January 1, 2007. AB 320 (2004) and AB 446 (2005) would have prohibited all DCA professions from using regulatory gag clauses. The Board took a position of “support” on AB 446. These bills were both vetoed by the Governor.

7) Support and Opposition.

Support:

California Nurses Association
Center for Public Interest Law

Opposition:

None on file

8) History

2007

Mar. 6 From committee: Do pass, and re-refer to Com. on JUD. Re-referred.
(Ayes 10. Noes 0.) (March 6).

Feb. 20 Referred to Coms. on B. & P. and JUD.

Feb. 2 From printer. May be heard in committee March 4.

Feb. 1 Read first time. To print.

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ASSEMBLY BILL

No. 249

Introduced by Assembly Member Eng

February 1, 2007

An act to add Section 809.10 to, and to repeal Section 2220.7 of, the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 249, as introduced, Eng. Licensees: healing arts: settlement agreements.

Existing law prohibits a physician and surgeon from including or permitting to be included specified provisions in a settlement agreement arising from his or her practice regardless of whether the agreement is made before or after filing the civil action. Under existing law, a physician and surgeon who violates this requirement is subject to disciplinary action by the Medical Board of California.

This bill would continue to impose that prohibition on physicians and surgeons and would additionally impose it on other healing arts practitioners and would also make them subject to disciplinary action.

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

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

- 1 SECTION 1. Section 809.10 is added to the Business and
- 2 Professions Code, to read:
- 3 809.10. (a) No person who is licensed, certified, or registered
- 4 by a board under this division, nor an entity or person acting as an
- 5 authorized agent of that person, shall include or permit to be

1 included any of the following provisions in an agreement to settle
2 a civil dispute, whether the agreement is made before or after the
3 commencement of a civil action:

4 (1) A provision that prohibits the other party in that dispute
5 from contacting or cooperating with the department or board.

6 (2) A provision that prohibits the other party in that dispute
7 from filing a complaint with the department or board.

8 (3) A provision that requires the other party in that dispute to
9 withdraw a complaint from the department or board. This type of
10 provision is void as against public policy.

11 (b) A licensed, certified, or registered person who violates this
12 section is subject to disciplinary action by the appropriate board.

13 SEC. 2. Section 2220.7 of the Business and Professions Code
14 is repealed.

15 ~~2220.7. (a) A physician and surgeon shall not include or permit
16 to be included any of the following provisions in an agreement to
17 settle a civil dispute arising from his or her practice, whether the
18 agreement is made before or after filing the action:~~

19 ~~(1) A provision that prohibits another party to the dispute from
20 contacting or cooperating with the board.~~

21 ~~(2) A provision that prohibits another party to the dispute from
22 filing a complaint with the board.~~

23 ~~(3) A provision that requires another party to the dispute to
24 withdraw a complaint he or she has filed with the board.~~

25 ~~(b) A provision described in subdivision (a) is void as against
26 public policy.~~

27 ~~(c) A physician and surgeon who violates this section is subject
28 to disciplinary action by the board.~~

CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES

BILL ANALYSIS

BILL NUMBER: AB 423 **VERSION:** AMENDED MARCH 19, 2007

AUTHOR: BEALL **SPONSOR:** AUTHOR

RECOMMENDED POSITION: SUPPORT

SUBJECT: MENTAL HEALTH PARITY

Existing Law:

- 1) Prohibits a health plan which provides mental health benefits from placing an annual or lifetime limit on mental health benefits if the plan does not include a limit for substantially all medical and surgical benefits. (42 USCS § 300gg-5)
- 2) Requires health care service plan contracts and disability insurance policies which cover hospital, medical, or surgical benefits to provide coverage for the following under the same terms and conditions as other medical conditions beginning July 1, 2000: (HSC § 1374.72(a), IC § 10144.5(a))
 - The diagnosis and treatment of severe mental illnesses
 - A child's serious emotional disturbance
- 3) Defines severe mental illness as any of the following: (HSC § 1374.72(d), IC § 10144.5(d))
 - Schizophrenia.
 - Schizoaffective disorder.
 - Bipolar disorder (manic-depressive illness).
 - Major depressive disorders.
 - Panic disorder.
 - Obsessive-compulsive disorder.
 - Pervasive developmental disorder or autism.
 - Anorexia nervosa.
 - Bulimia nervosa.
- 4) Defines "health insurance" as a disability insurance policy that provides coverage for hospital, medical, or surgical benefits in statutes effective on or after January 1, 2002. (IC § 106(b))

This Bill:

- 1) Requires health care service plan contracts which provide hospital, medical, or surgical coverage, and health insurance policies issued, amended or renewed on or after January 1, 2008 provide coverage for the diagnosis and treatment of a mental illness of a person of any age under the same terms and conditions applied to other medical conditions: (HSC § 1374.73(a), IC § 10144.7(a))
 - The diagnosis and treatment of mental illnesses
 - A child's serious emotional disturbance
- 2) Defines "mental illness" as mental disorders defined in the Diagnostic and Statistical Manual IV or subsequent editions, including substance abuse. (HSC § 1374.73(a), IC § 10144.7(a))

- 3) Does not apply to contracts entered into between the Department of Health Care Services (DHCS) and a health care service plan for enrolled Medi-Cal beneficiaries. (HSC § 1374.73(b))
- 4) Permits a plan or insurer to provide coverage for all or part of the mental health services required through a separate specialized health care service plan or mental health plan. (HSC § 1374.73(c)(1), IC § 10144.7(b)(1))
 - Does not require a plan or insurer to obtain an additional or specialized license for this purpose.
- 5) Requires a plan or insurer to provide mental health coverage in its entire service area and in emergency situations as required by law. (HSC § 1374.73(c)(2), IC § 10144.7(b)(2))
- 6) Does not preclude health care service plans that provide benefits through preferred provider contracting arrangements from requiring enrollees who reside or work in geographic areas served by specialized health care service plans or mental health plans to secure all or part of their mental health services within those geographic areas served by specialized health care service plans or mental health plans. (HSC § 1374.73(c)(2), IC § 10144.7(b)(2))
- 7) Permits a health care service plan to use case management, network providers, utilization review techniques, prior authorization, co-payments, or other cost sharing when providing treatment for mental illness except as permitted by law. (HSC § 1374.73(c)(3))
- 8) Does not deny or restrict the DHCS' authority to ensure plan compliance when a plan provides coverage for prescription drugs. (HSC § 1374.73(d))
- 9) Permits a health insurer to use case management, managed care or utilization review when providing treatment for mental illness except as permitted by law. (IC § 10144.7(b)(3))
- 10) Prohibits any action that a health insurer takes to implement mental health parity, including but not limited to contracting with preferred provider organizations, to be deemed as an action that would otherwise require licensure as a health care service plan. (IC § 10144.7(b)(4))
- 11) Does not require mental health parity laws to apply to accident-only, specified disease, hospital indemnity, Medicare supplement, dental-only or vision-only insurance policies. (IC § 10144.7(c))

Comment:

- 1) **Author's Intent.** According to the author, many health plans do not provide coverage for mental disorders, and those that do impose much stricter limits on mental health care than on other medical care. Individuals struggling with mental illness quickly deplete limited coverage and personal savings and become dependent upon taxpayer-supported benefits. This bill would correct a serious discrimination problem while resulting in premium increases of less than one dollar per member per month. Nearly all health plans discriminate against patients with biological brain disorders such as schizophrenia, depression and posttraumatic stress disorders. Additionally, an alarming number of mentally ill persons end up incarcerated because they lack access to appropriate care. This forces law enforcement officers to serve as the mental health providers of last resort, which costs state taxpayers roughly \$1.8 billion per year.
- 2) **Mental Health Parity.** AB 88, California's mental health parity law, was enacted in 2000. This bill required health plans to provide coverage for mental health services that are equal to medical services. AB 88 covered only particular diagnoses considered to be a severe mental illness or a serious emotional disturbance of a child, and therefore is sometimes referred to as "partial parity." An evaluative study conducted by Mathematica Policy Research for the California Health Care

Foundation¹ identified so called partial parity as an ongoing challenge related to the implementation of AB 88.

Federal mental health parity legislation has been introduced this year in both the House and the Senate. Such legislation is anticipated to have a reasonable chance of being signed into law. For general information about mental health parity, please see the attached paper from Carnegie Mellon's *Heinz School Review*.

- 3) **Cost and Access.** According to an analysis by the American Psychiatric Association², "Legislating diagnostic criteria for impairment on the basis of political and economic factors may limit treatment efforts and ultimately fail those most in need of care," and "Definitions of mental illness in state parity laws have important implications for access, cost, and reimbursement; they determine which populations receive a higher level of mental health services." This bill would substantially expand the types of diagnoses which must be covered, which would help to alleviate a problem that clinicians may face regarding diagnosis. Some clinicians may submit an inaccurate diagnosis, but one which is covered by current parity laws to ensure that the client is able to receive treatment.

The expansion of mental health parity should ensure that the costs are balanced with access to care. Any time costs are increased to insurers, the cost of insurance tends to increase. This is a problem for people who cannot afford an increase to insurance rates or co-payments. This could lead to a decrease in insured residents and an increase in use of public mental health programs, increasing costs to the state. However, one study found that the elimination of caps on mental health coverage might not lead to increased spending.³

- 4) **Board Position.** Staff has suggested a position of "support" for this bill. However, mental health parity is a large and complex issue, and this recommendation is grounded in the general idea that people should have access to mental health care. The recommendation represents the belief that the concept of mental health parity should be supported.
- 5) **CHBRP Analysis.** The California Health Benefits Review Program (CHBRP), created by AB 1996 in 2003, is required to analyze all legislation proposing mandated health care benefits. This analysis will be available on April 21, 2007.

- 6) **Support and Opposition.**
Not yet known

7) **History**
2007

Feb. 26	Referred to Com. on HEALTH.
Feb. 20	From printer. May be heard in committee March 22.
Feb. 16	Read first time. To print.

ATTACHMENT

"Mental Health Parity," *Heinz School Review*

¹ Lake, et. al. (2002)

² "An Analysis of the Definitions of Mental Illness Used in State Parity Laws." *APA Journal*. (2002)

³ "Behavioral Health Insurance for Federal Employees," *New England Journal of Medicine*, H. Goldman et. al. Volume 354:1378-1386, March 30, 2006.

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Mental Health Parity

Legislation and Implications for Insurers and Providers by Joseph Peters

Introduction

In 2003 in the United States, outpatient visits to physicians' offices for treatment of mental disorders numbered over 40 million, and visits to hospital emergency rooms numbered close to 4 million.¹ Clearly, treatment of mental health represents a large and significant portion of the health care system as a whole. Yet mental health coverage within insurance plans has been treated differently from physical conditions. Within the last 10 years, the debate over mental health parity with other medical and surgical benefits has taken place both at the federal and state level, starting with Congress's passage of the Mental Health Parity Act of 1996. After five subsequent extensions of the Act's sunset provision (with the current sunset provision taking effect December 31st of this year), parity remains on the Congressional agenda, although it is overshadowed by other pressing policy concerns such as the War in Iraq, Medicare, and federal budget cuts.

The issue of mental health parity is far reaching and involves many stakeholders. In this paper I will focus on the implications of mental health parity for insurers and providers. My analysis will show that the interests of providers and insurers are at odds with one another, with providers (both physicians and hospital groups) siding with patient advocacy groups.

Defining Mental Health Parity

Mental health parity refers to equivalence of coverage for mental health treatment and clinical visits compared to regular medical and surgical benefits within an insurance plan². In other words, it is the requirement that mental health coverage be subject to the same dollar limits as the medical and surgical benefits that are covered in a health insurance plan (whether it is traditional indemnity insurance or managed care insurance). In recent debates, "parity" has also been taken to include mandatory coverage of mental health services (both inpatient and outpatient); however, federal legislation has only up to this point reflected the narrower definition of equivalent coverage within existing insurance plans that already cover mental health services. Currently, advocacy groups such as the National Mental Health Association (NMHA) and the National Alliance on Mental Illness (NAMI) consider parity in its expanded form to include mandatory mental health coverage.

Legislative Overview

The Mental Health Parity Act of 1996

The major piece of federal legislation regarding mental health parity, The Mental Health Parity Act of 1996 (MHPA) was passed on Sept. 26th of 1996 as an amendment to the Health Insurance Portability and Accountability Act (HIPAA).³ At the time, numerous states had already enacted different types of parity legislation, but advocacy groups pressed for national legislation that would address the lack of parity in those states where laws had not been passed.⁴ The 1996 Act required that annual or lifetime dollar limits applying to mental health benefits be no lower than any such dollar limits applying to medical or surgical benefits offered by a group health plan or any health insurance carrier associating itself with a group plan. The law applied to those health plans' enrollment/coverage years commencing on or after January 1, 1998.⁵ Other key items included:

- A sunset provision that the requirements for parity would not apply to benefits covering specific services on or after Sept. 30, 2001. (This has been extended on five separate occasions, with the last provision expiring Dec. 31st, 2006.)
- Employers could retain discretion with respect to the extent of coverage for mental health services offered to employees and their dependents. This included cost sharing, limits on the numbers of visits or days of coverage, or requirements addressing medical necessity.⁶

The Act excluded benefits for substance abuse and chemical dependency. There were also exemptions provided to companies with a small number of employees or in cases where costs rose as a result of the mandate. The Parity Act did not mandate that benefits for mental health services be offered—only that if these benefits were offered, they have parity with the annual and lifetime dollar amounts for medical and surgical benefits. Patient advocacy groups saw problems with this legislation and argued that it was weak.⁷ They pointed out that the legislation didn't mandate parity or require that it be universal in its application. The weakness of the legislation can be partially attributed to the political climate surrounding the creation of the bill at that particular point in time; the insurance industry played a role in applying pressure to influence the outcome. After the bill was passed, employers took advantage of loopholes. Some employers placed restrictions on health benefits by limiting the number of inpatient days for mental health services covered or the number of outpatient office visits covered.

State Parity Legislation

Most legislative activity regarding parity has taken place at the state level. To date, thirty-six states have passed parity legislation, and twelve states and the District of Columbia have made mental health benefits mandatory. Two states, Idaho and Wyoming, have no parity or mandate laws. There is a wide degree of variation among state parity laws. Some states (i.e. North Carolina and Kansas) mandate specifically that only the offering of mental health coverage be included in insurance plans, and this coverage, if accepted by enrollees, be subjected to some, but not all, terms/conditions with physical benefits. In other words, if mental health coverage is taken up, there is not complete parity. Other states, such as Kentucky and Connecticut mandate that insurance companies offer mental health benefits, and if the benefits are chosen then full parity is required; therefore, there is no difference between the terms of coverage between physical and mental health services. Finally, some states recently have passed legislation mandating coverage of mental health services in all group policies and additionally require the terms and conditions, breadth, and any cost restrictions for the coverage to be no more limiting than those conditions for physical illness. Some states even extend the mandates to individual as well as group insurance plans. There is also variation in the different types of mental health services that apply to state parity legislation. Some states restrict parity requirements to "severe" mental illness, while others extend to "serious" cases, and some include full parity for all mental illnesses addressed in the DSMIV, as well as services for substance abuse and alcoholism.⁸

Why such variation across the states? Are there any solid successes for patients? The answers to these questions revolve around the issue of utilization. Two years after the federal Parity Act was passed, Roland Sturm and Liccardo Pacula conducted a study that found that states with parity laws tended to have lower rates of utilization of mental health services. This remained the case even after controlling for confounding variables such as age, gender, income, ethnicity or region of the country.⁹ Sturm and Pacula also found that before and after the passage of state parity legislation, rates of utilization for mental health services were largely unchanged. These results, if accepted as prima facie evidence, suggest that parity legislation does not increase utilization, and hence not increase costs.

The study goes further to suggest that since parity legislation was passed in states without high rates of utilization, the resulting legislation was the result of a "political process" in which patient advocacy groups and insurance companies/employer organizations battled it out; patient advocacy groups and provider organizations were drawn to states with a small number of people receiving (or using) mental health services and saw it as an opportunity to affect a change in policy. The low numbers of patients utilizing services also allowed little opposition to the parity legislation.¹⁰

Implications for Insurers and Providers

Insurers

The Health Insurance Association of America (HIAA) has from the beginning of the parity debate argued that any legislation, state or federal, mandating mental health benefits would increase health costs, and increase the rolls of the uninsured. The organization has claimed that roughly 20 to 25 percent of the uninsured are not covered as a result of mandates.¹¹ Other studies conducted by academic institutions and non-profit research organizations have had contrary findings.

Managed care, specifically within the context of Managed Behavioral Healthcare Organizations (MBHO's), offers the chance to offset the purported increased costs of parity. Research by the RAND Corporation conducted shortly after the passage of the 1996 federal parity legislation concluded that given unlimited mental health benefits, under managed care, benefits cost "virtually the same" as those benefits that were capped; the typical increase was found to be \$1 per employee when compared with benefits falling under a \$25,000 limit.¹² During the national debate over parity legislation, insurance groups argued that even under managed care parity would drive up costs; the RAND study disputed that claim. In the end, it becomes difficult to discern the true effects of parity legislation on costs, with a large body of research split and attached to both parity's proponents and its dissenters.

A final implication for insurers has been the need after any state parity legislation and after the federal 1996 law to redesign benefit schemes to reflect compliance. During the period between passage of the federal 1996 parity legislation and its enforcement date, RAND conducted a study of 4,000 firms and found that 90% of these firms' mental health plans were not consistent with the parity legislation and hence necessitated revision. At the same time, research found that inefficiencies and unnecessary complexities could be eliminated under such a benefit redesign.¹³

Providers

Providers, composed of both physician groups such as the American Medical Association (AMA) and hospital groups such as the American Hospital Association (AHA) have on the other hand expressed positions that parallel those of patient advocacy groups (i.e. NAMI and NMHA). The American Medical Association has called for state medical associations to press for mental health parity at the state level. The AMA also supports parity with respect to coverage of substance abuse and alcoholism-treatment programs. The AMA has allied itself with the American Psychiatric Association (APA) in its lobbying efforts.¹⁴

The AHA sent a letter to Senator Pete Domenici, co-sponsor of current legislation that will expand provisions of the federal parity act of 1996, affirming its support of the legislation. They wrote that they admired Domenici's "leadership in promoting nondiscriminatory insurance coverage for those that suffer mental illness..."¹⁵ The justification for the support from both physician and hospital groups of parity legislation is not clearly stated in their respective professional publications. However, hospitals—both for-profit and non-profit—ultimately serve the community as well as a board of directors. So they have a vested interest in ensuring access to their services—specifically if the costs of these services (mainly mental health services) are placed on insurance plans. Physician groups also have a vested interest in the issue of access, especially if they are reimbursed under capitation or fee schedules instead of being paid a set salary. Several studies have confirmed that financial incentives may have an impact on mental health providers' courses of treatment.¹⁶[17]

Conclusion

In the debate over mental health parity the incentives facing insurers are quite the opposite of those facing provider groups. Insurers face the imperative of compliance with state and federal parity legislation, while at the same time trying to offset costs. Providers must act in accordance with professional expectations (the AMA) and those of the community (in the case of the AHA). In the end, the outcomes of mental health parity legislation have reflected the various concerns of both insurance and provider groups. The debate continues with the same concerns. Ultimately, as seen at the state level, what proved to be successful was the fact that

patient advocacy groups worked in states with low rates of utilization, thus encountering few opposition groups. States with large rates of utilization must overcome the legislative obstacles that exist to see any lasting results of parity legislation.

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³ Ibid.

⁴ From this point, I will refer to Mental Health Parity Legislation simply as “parity legislation” and Mental Health Parity simply as “parity.”

⁵ Centers for Medicare and Medicaid Services, “The Mental Health Parity Act,” HIPAA Insurance Reform: Health Insurance Portability and Accountability Act, Department of Health and Human Services, 09 Feb. 2005, <http://www.cms.hhs.gov/hipaa/hipaa1/content/mhpa.asp>.

⁶ Ibid.

⁷ Jacobi, John V, “Parity and Difference: The Value of Parity Legislation for the Seriously Mentally Ill,” *American Journal of Law and Medicine* 29, no. 2–3 (2003): 185–201. Accessed through LexisNexis™ Academic Universe: <http://web.lexis-nexis.com/universe> November 13, 2005.

⁸ Ibid.

⁹ Ibid.

¹⁰ Ibid.

¹¹ Ziegler, Jan, “The Realities of Mental Health Parity in the U.S.” *Business & Health* 18, no. 7 (2000): 16–21.

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¹³ Ibid.

¹⁴ American Medical Association, “D-180.998: Insurance Parity for Mental Health and Psychiatry,” Policy Finder, 24 Sept. 2005, http://www.ama-assn.org/apps/pf_new/pf_online?f_n=browser&doc=p.

¹⁵ American Hospital Association, “Letters to the Hill: To the Honorable Pete V. Domenici,” 10 July 2001, <http://www.aha.org/aha/advocacy-grassroots/advocacy/hillletters/Hill>.

¹⁶ Agency for Healthcare Research and Quality, “Mental health visits are cut by one-fourth when providers are paid a fixed rate per patient,” *Research Activities*, Feb. 2001, <http://www.ahrq.gov/research/feb01/201RA16.htm>.

¹⁷ —, “Financial Incentives May Influence Health Care Providers’ Mental Health Treatment Decisions.” *Research Activities*, Dec. 1999, <http://www.ahrq.gov/research/dec99/1299ra11.htm>
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AMENDED IN ASSEMBLY MARCH 22, 2007

CALIFORNIA LEGISLATURE—2007—08 REGULAR SESSION

ASSEMBLY BILL

No. 423

Introduced by Assembly Member Beall

February 16, 2007

An act to add Section 1374.73 to the Health and Safety Code and to add Section 10144.7 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 423, as amended, Beall. Health care coverage: mental health services.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act), provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Under existing law, a health care service plan contract and a health insurance policy are required to provide coverage for the diagnosis and treatment of severe mental illnesses of a person of any age. Existing law does not define "severe mental illnesses" for this purpose but describes it as including several conditions.

This bill would expand this coverage requirement for a health care service plan contract and a health insurance policy issued, amended, or renewed on or after January 1, 2008, to include the diagnosis and treatment of a mental illness of a person of any age and would define mental illness for this purpose, ~~with certain exceptions~~, as a mental disorder defined in the Diagnostic and Statistical Manual IV.

Because the bill would expand coverage requirements under the Knox-Keene Act, the willful violation of which is a crime, it would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

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

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

1 SECTION 1. Section 1374.73 is added to the Health and Safety
2 Code, to read:

3 1374.73. (a) A health care service plan contract issued,
4 amended, or renewed on or after January 1, 2008, that provides
5 hospital, medical, or surgical coverage shall provide coverage for
6 the diagnosis and medically necessary treatment of a mental illness
7 of a person of any age, including a child, under the same terms
8 and conditions applied to other medical conditions as specified in
9 subdivision (c) of Section 1374.72. The benefits provided under
10 this section shall include all those set forth in subdivision (b) of
11 Section 1374.72. "Mental illness" for the purposes of this section
12 means a mental disorder defined in the Diagnostic and Statistical
13 Manual IV, or subsequent editions, published by the American
14 Psychiatric Association, ~~except those codes defining substance~~
15 ~~abuse disorders (291.0 to 292.9, inclusive, and 303.0 to 305.9,~~
16 ~~inclusive) and the "V" codes. Psychiatric Association, and includes~~
17 *substance abuse.*

18 (b) This section shall not apply to contracts entered into pursuant
19 to Chapter 7 (commencing with Section 14000) or Chapter 8
20 (commencing with Section 14200) of Part 3 of Division 9 of the
21 Welfare and Institutions Code, between the State Department of
22 Health Care Services and a health care service plan for enrolled
23 Medi-Cal beneficiaries.

24 (c) (1) For the purpose of compliance with this section, a plan
25 may provide coverage for all or part of the mental health services
26 required by this section through a separate specialized health care

1 service plan or mental health plan, and shall not be required to
2 obtain an additional or specialized license for this purpose.

3 (2) A plan shall provide the mental health coverage required by
4 this section in its entire service area and in emergency situations
5 as may be required by applicable laws and regulations. For
6 purposes of this section, health care service plan contracts that
7 provide benefits to enrollees through preferred provider contracting
8 arrangements are not precluded from requiring enrollees who reside
9 or work in geographic areas served by specialized health care
10 service plans or mental health plans to secure all or part of their
11 mental health services within those geographic areas served by
12 specialized health care service plans or mental health plans.

13 (3) Notwithstanding any other provision of law, in the provision
14 of benefits required by this section, a health care service plan may
15 utilize case management, network providers, utilization review
16 techniques, prior authorization, copayments, or other cost sharing.

17 (d) Nothing in this section shall be construed to deny or restrict
18 in any way the department's authority to ensure plan compliance
19 with this chapter when a plan provides coverage for prescription
20 drugs.

21 SEC. 2. Section 10144.7 is added to the Insurance Code, to
22 read:

23 10144.7. (a) A policy of health insurance that covers hospital,
24 medical, or surgical expenses in this state that is issued, amended,
25 or renewed on or after January 1, 2008, shall provide coverage for
26 the diagnosis and medically necessary treatment of a mental illness
27 of a person of any age, including a child, under the same terms
28 and conditions applied to other medical conditions as specified in
29 subdivision (c) of Section 10144.5. The benefits provided under
30 this section shall include all those set forth in subdivision (b) of
31 Section 10144.5. "Mental illness" for the purposes of this section
32 means a mental disorder defined in the Diagnostic and Statistical
33 Manual IV, or subsequent editions, published by the American
34 Psychiatric Association, ~~except those codes defining substance~~
35 ~~abuse disorders (291.0 to 292.9, inclusive, and 303.0 to 305.9,~~
36 ~~inclusive) and the "V" codes. Psychiatric Association, and includes~~
37 *substance abuse.*

38 (b) (1) For the purpose of compliance with this section, a health
39 insurer may provide coverage for all or part of the mental health
40 services required by this section through a separate specialized

1 health care service plan or mental health plan, and shall not be
2 required to obtain an additional or specialized license for this
3 purpose.

4 (2) A health insurer shall provide the mental health coverage
5 required by this section in its entire in-state service area and in
6 emergency situations as may be required by applicable laws and
7 regulations. For purposes of this section, health insurers are not
8 precluded from requiring insureds who reside or work in
9 geographic areas served by specialized health care service plans
10 or mental health plans to secure all or part of their mental health
11 services within those geographic areas served by specialized health
12 care service plans or mental health plans.

13 (3) Notwithstanding any other provision of law, in the provision
14 of benefits required by this section, a health insurer may utilize
15 case management, managed care, or utilization review.

16 (4) Any action that a health insurer takes to implement this
17 section, including, but not limited to, contracting with preferred
18 provider organizations, shall not be deemed to be an action that
19 would otherwise require licensure as a health care service plan
20 under the Knox-Keene Health Care Service Plan Act of 1975
21 (Chapter 2.2 (commencing with Section 1340) of Division 2 of
22 the Health and Safety Code).

23 (c) This section shall not apply to accident-only, specified
24 disease, hospital indemnity, Medicare supplement, dental-only, or
25 vision-only insurance policies.

26 SEC. 3. No reimbursement is required by this act pursuant to
27 Section 6 of Article XIII B of the California Constitution because
28 the only costs that may be incurred by a local agency or school
29 district will be incurred because this act creates a new crime or
30 infraction, eliminates a crime or infraction, or changes the penalty
31 for a crime or infraction, within the meaning of Section 17556 of
32 the Government Code, or changes the definition of a crime within
33 the meaning of Section 6 of Article XIII B of the California
34 Constitution.

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CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES

BILL ANALYSIS

BILL NUMBER: AB 509 **VERSION:** INTRODUCED FEBRUARY 20, 2007

AUTHOR: HAYASHI **SPONSOR:** AUTHOR

RECOMMENDED POSITION: SUPPORT

SUBJECT: SUICIDE PREVENTION

Existing Law:

- 1) Permits the Department of Mental Health (DMH), contingent upon funding, to establish and implement a suicide prevention, education, and gatekeeper training program to reduce the severity, duration, and incidence of suicidal behaviors. (WIC § 4098.2(a))
- 2) Requires DMH to build upon the existing network of nonprofit suicide prevention programs in the state in developing and implementing the components of this program, and to use the expertise of existing suicide prevention programs that meet any of the following criteria: (WIC § 4098.2(b))
 - Have been identified by a county as providing suicide prevention services for that county.
 - Are certified by the American Association of Suicidology.
 - Meet criteria for suicide prevention programs that may be established by DMH.
- 3) Requires the suicide prevention program to be consistent with the public health model proposed by the Surgeon General, and the system of care approach. (WIC § 4098.2(c))
- 4) Permits the DMH to contract with an outside agency to establish and implement a targeted public awareness and education campaign on suicide prevention and treatment. Requires target populations to include junior high and high school students, as well as other populations known to be at high risk of suicide. (WIC § 4098.3)
- 5) Permits the DMH to contract with local mental health organizations and professionals with expertise in the assessment and treatment of suicidal behaviors to develop an evidence-based assessment and prevention program for suicide that may be integrated with local mental health departments or replicated by public or private suicide treatment programs, or both. (WIC § 4098.4(a))
- 6) Permits the DMH to establish and implement, or contract with an outside agency for the development of a multicounty, 24-hour, centralized suicide crisis line integrated network. Permits existing crisis lines that meet specifications of the department and the American Association of Suicidology to be included in this network. Requires the crisis line to link persons at risk of committing suicide with local suicide prevention and treatment resources. (WIC § 4098.5)

- 7) Requires the Prevention and Early Intervention component of the Mental Health Services Act (MHSA) to emphasize strategies to reduce suicide, defined as one of seven negative outcomes that may result from untreated mental illness. (WIC § 5840(d))

This Bill:

- 1) Establishes the Office of Suicide Prevention (OSP) under the DMH. (WIC § 4098.6(a))
- 2) Requires the OSP to do all of the following: (WIC § 4098.6(b))
 - Coordinate the creation and implementation of a statewide suicide prevention strategy modeled after the National Strategy for Suicide Prevention.
 - Collect and disseminate information on best practices as determined by an advisory committee made up of prominent minds in the field.
 - Collect and disseminate data compiled from the State Registrar of Vital Statistics and other sources regarding suicide deaths including, but not limited to, manner and means of death, age, race, ethnicity, and city of residence.
 - Compile information from research institutes regarding suicide attempts, treatment, and success of treatment, including whether there were any subsequent attempts.
 - Report to the Legislature and to the public, the extent of the problem and the effectiveness of various prevention measures.

Comment:

- 1) **Author's Intent.** According to the author, 3,323 people commit suicide annually state wide and the numbers that attempt to commit suicide are growing at alarming rates. In California there are many groups of people who are in need of treatment for suicide prevention but they are not receiving the outreach and treatment they require. California does not have a specific state agency that coordinates suicide prevention, performs outreach, or targets at-risk groups. These at-risk groups include teens and young adults ages 15 to 24, where suicide is the third leading cause of death, and for gay, lesbian, bisexual and transgender youth who are up to five times more likely to die from suicide than heterosexual youth.
- 2) **National Strategy for Suicide Prevention.** This bill calls for the statewide prevention strategy to be modeled after the National Strategy for Suicide Prevention (NSSP), which represents the combined work of advocates, clinicians, researchers and survivors around the nation. It lays out a framework for action to prevent suicide and guides development of an array of services and programs. It is designed to be a catalyst for social change with the power to transform attitudes, policies, and services. The NSSP Goals and Objectives for Action was published by the U.S. Department of Health and Human Services in May of 2001, with leadership from the Surgeon General.

In July 2003, the President's New Freedom Commission on Mental Health released a report with goals and recommendations for improving the mental health system in our country. Suicide prevention is one of its top goals. The report acknowledged the link between mental illness and suicide and recommended the implementation of the NSSP, including the creation of state plans.

- 3) **State-Level Efforts.** Senate Resolution 18 and House Resolution 30 were passed in 2003 recognizing the problem of suicide in California. The resolutions state that in the year 2000, 33,000 people who tried to commit suicide unsuccessfully were treated in emergency rooms or admitted to hospitals for treatment. The hospital charges alone for suicide attempt inpatients exceeded \$275,000,000. The resolutions call for state and local public and private

organizations to cooperate to develop and implement a California Strategy for Suicide Prevention and call this a state priority.

4) Support and Opposition.

Not yet known.

5) History

2007

Mar. 12 Referred to Com. on HEALTH.

Feb. 21 From printer. May be heard in committee March 23.

Feb. 20 Read first time. To print.

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ASSEMBLY BILL

No. 509

Introduced by Assembly Member Hayashi

February 20, 2007

An act to add Section 4098.6 to the Welfare and Institutions Code, relating to mental health.

LEGISLATIVE COUNSEL'S DIGEST

AB 509, as introduced, Hayashi. Suicide prevention.

Existing law sets forth the powers and duties of the State Department of Mental Health, including, but not limited to, the administration of the state hospitals for the mentally disordered, the licensing of psychiatric facilities, and oversight responsibilities related to the provision of local mental health services. Existing law, the California Suicide Prevention Act of 2000, authorizes the department to establish and implement a suicide prevention, education, and gatekeeper training program to reduce the severity, duration, and incidence of suicidal behaviors.

This bill would require the department to establish the Office of Suicide Prevention and would set forth its duties relating to the establishment and coordination of statewide suicide prevention strategy.

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

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

- 1 SECTION 1. The Legislature finds and declares all of the
- 2 following:
- 3 (a) More people die by suicide in America than by homicide.

- 1 (b) More people die by suicide in America than by AIDS.
- 2 (c) Approximately 30,000 Americans die by suicide every year;
- 3 the equivalent of 9/11 happening almost every month.
- 4 (d) California has the highest number of suicides in the United
- 5 States.
- 6 (e) Every suicide affects at least six people; family members
- 7 and friends who are left to mourn.
- 8 (f) Every year there are at least 180,000 new people grieving
- 9 the death of a loved one by suicide.
- 10 SEC. 2. Section 4098.6 is added to the Welfare and Institutions
- 11 Code, to read:
- 12 4098.6. (a) The department shall establish an Office of Suicide
- 13 Prevention.
- 14 (b) The Office of Suicide Prevention shall do all of the
- 15 following:
- 16 (1) Coordinate the creation and implementation of a statewide
- 17 suicide prevention strategy modeled after the National Strategy
- 18 for Suicide Prevention.
- 19 (2) Collect and disseminate information on best practices as
- 20 determined by an advisory committee made up of prominent minds
- 21 in the field.
- 22 (3) Collect and disseminate data compiled from the State
- 23 Registrar of Vital Statistics and other sources regarding suicide
- 24 deaths including, but not limited to, manner and means of death,
- 25 age, race, ethnicity, and city of residence.
- 26 (4) Compile information from research institutes regarding
- 27 suicide attempts, treatment, and success of treatment, including
- 28 whether there were any subsequent attempts.
- 29 (5) Report to the Legislature and subsequently to the public, the
- 30 extent of the problem and the effectiveness of various prevention
- 31 measures.

CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES

BILL ANALYSIS

BILL NUMBER: AB 512 **VERSION:** INTRODUCED FEBRUARY 20, 2007

AUTHOR: LIEBER **SPONSOR:** AUTHOR

RECOMMENDED POSITION: NONE

SUBJECT: PERSONAL INFORMATION: SECURITY BREACHES

Existing Law:

- 1) Defines unprofessional conduct for Licensed Clinical Social Workers (LCSW), Licensed Educational Psychologists (LEP), and Marriage and Family Therapists (MFT), in part, as the failure to keep records consistent with sound clinical judgment, the standards of the profession, and the services being rendered. (B&P Code § § 4982(v), 4989.54(i), 4992.3(s))
- 2) Requires a health care provider who uses an electronic recordkeeping system to: (HSC § 123149(g))
 - Develop and implement policies and procedures to safeguard confidentiality and unauthorized access
 - Require authentication by electronic signature keys
 - Perform systems maintenance
- 3) Requires any agency, person or business that owns, licenses or maintains computerized data that includes personal information to disclose any breach of the security of the system to any resident of California whose unencrypted personal information is reasonably believed to have been acquired by an unauthorized person. (Civil Code § § 1798.29(a), 1798.82(a))
- 4) Requires the disclosure to be made in the most expedient time possible and without unreasonable delay unless a law enforcement agency determines that notification will impede its investigation. (Civil Code § § 1798.29(a),(c), 1798.82(a),(c))
- 5) Defines “breach of the security of the system” as unauthorized acquisition of computerized data that compromises the security, confidentiality, or integrity of personal information maintained by the agency. (Civil Code § 1798.29(d), 1798.82(d))
- 6) Defines “personal information” as an individual’s first name or first initial and last name in combination with any one or more of the following data elements, when the data are not encrypted: (Civil Code § § 1798.29(e), 1798.82(e))
 - Social security number.
 - Driver’s license number or California Identification Card number.
 - Account number, credit or debit card number, in combination with any required security code, access code, or password that would permit access to an individual’s financial account.

- 7) Establishes that “personal information” does not include publicly available information that is lawfully made available to the general public from federal, state, or local government records. (Civil Code § § 1798.29(f), 1798.82(f))

This Bill:

- 1) Adds to the definition of “personal information” private medical or health care records. (Civil Code § § 1798.29(e)(4), 1798.82(e)(4))
- 2) Repeals duplicate provisions of law. (Civil Code § § 1798.29, 1798.82)

Comment:

- 1) **Author’s Intent.** According to the author, as the electronic storage of health care records increases, the risk of privacy and security breaches rise. Identity thieves can hack into systems with sensitive health and insurance information. Medical identity theft occurs when someone uses a person’s name and sometimes other parts of their identity, such as insurance information, without the person’s knowledge or consent. This frequently results in erroneous entries in existing medical records and can involve the creation of fictitious medical records in the victim’s name. There could be as many as a quarter to a half million Americans that are victims of medical identity theft. The Government Accountability Office (GAO) in September 2006 revealed that over 40% of the federal contractors and state Medicaid agencies reported that they experienced a recent privacy breach involving personal health information.
- 2) **Data and Security.** The use of computerized recordkeeping systems requires enhanced security measures for practitioners. The federal Health Insurance Portability and Accountability Act (HIPAA) requires high standards for maintaining the security of confidential electronic records. However, independent practitioners are less likely than those working in a clinic or hospital setting to have developed information security policies and procedures. Security challenges can be contained by staff training, offsite backup, a regular independent audit, and implementation of other security procedures.

While there is a risk to having records in an electronic format, there is also a risk when records are kept on paper. Any risk to having records in an electronic system is a trade-off because the ability to compile data sets for studies will help to create evidence-based treatment and best practices. AB 1674, the Center for Quality Medicine Act, requires the center to conduct periodic research regarding medical treatment data to develop evidence based guidelines, recommend benefit design, evaluate cost effectiveness of new technologies and pharmaceuticals, and quality measurements by providers and health plans. The Center will be required to widely disseminate its findings.

- 3) **Suggested Amendment.** This bill does not contain a definition for “private medical or health care records.” The Confidentiality of Medical Information Act, Civil Code Section 56.05(g), provides a definition of “medical information” that may be useful.
- 4) **Support and Opposition.**

Support:
California School Employees Association

Opposition:
None on file

5) History

2007

Mar. 12

Referred to Coms. on JUD. and B. & P.

Feb. 21

From printer. May be heard in committee March 23.

Feb. 20

Read first time. To print.

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ASSEMBLY BILL

No. 512

Introduced by Assembly Member Lieber

February 20, 2007

An act to repeal and amend Sections 1798.29 and 1798.82 of the Civil Code, relating to personal information.

LEGISLATIVE COUNSEL'S DIGEST

AB 512, as introduced, Lieber. Personal information: security breaches.

Existing law requires a state agency, or a person or business that conducts business in California, that owns or licenses computerized data that includes "personal information," as defined, to disclose any breach of the security of that data to any resident of California whose unencrypted personal information was, or is reasonably believed to have been, acquired by an unauthorized person. The intentional disclosure of medical, psychiatric, or psychological information by a state agency in violation of the disclosure provisions of the Information Practice Act of 1977 is punishable as a misdemeanor if the wrongful disclosure results in economic loss or personal injury to the individual to whom the information pertains.

Under the above-described provisions, this bill would add private medical and health care records to the definition of "personal information," thereby requiring a state agency, or a person or business that conducts business in California, as specified, to disclose a breach of the security of a person's unencrypted medical or health care records. The bill would also repeal duplicate provisions of law.

In addition, because the intentional disclosure of medical, psychiatric, or psychological information by a state agency in violation of the

disclosure provisions of the Information Practices Act of 1977 is punishable as a misdemeanor, as specified, and because this bill expands upon those disclosure requirements, this bill would create a new crime, thereby imposing a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

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

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

1 SECTION 1. Section 1798.29 of the Civil Code, as added by
2 Section 2 of Chapter 915 of the Statutes of 2002, is repealed.
3 ~~1798.29. (a) Any agency that owns or licenses computerized~~
4 ~~data that includes personal information shall disclose any breach~~
5 ~~of the security of the system following discovery or notification~~
6 ~~of the breach in the security of the data to any resident of California~~
7 ~~whose unencrypted personal information was, or is reasonably~~
8 ~~believed to have been, acquired by an unauthorized person. The~~
9 ~~disclosure shall be made in the most expedient time possible and~~
10 ~~without unreasonable delay, consistent with the legitimate needs~~
11 ~~of law enforcement, as provided in subdivision (c), or any measures~~
12 ~~necessary to determine the scope of the breach and restore the~~
13 ~~reasonable integrity of the data system.~~
14 ~~(b) Any agency that maintains computerized data that includes~~
15 ~~personal information that the agency does not own shall notify the~~
16 ~~owner or licensee of the information of any breach of the security~~
17 ~~of the data immediately following discovery, if the personal~~
18 ~~information was, or is reasonably believed to have been, acquired~~
19 ~~by an unauthorized person.~~
20 ~~(c) The notification required by this section may be delayed if~~
21 ~~a law enforcement agency determines that the notification will~~
22 ~~impede a criminal investigation. The notification required by this~~
23 ~~section shall be made after the law enforcement agency determines~~
24 ~~that it will not compromise the investigation.~~
25 ~~(d) For purposes of this section, “breach of the security of the~~
26 ~~system” means unauthorized acquisition of computerized data that~~

1 compromises the security, confidentiality, or integrity of personal
2 information maintained by the agency. Good faith acquisition of
3 personal information by an employee or agent of the agency for
4 the purposes of the agency is not a breach of the security of the
5 system, provided that the personal information is not used or
6 subject to further unauthorized disclosure.

7 (e) For purposes of this section, “personal information” means
8 an individual’s first name or first initial and last name in
9 combination with any one or more of the following data elements,
10 when either the name or the data elements are not encrypted:

11 (1) Social security number.

12 (2) Driver’s license number or California Identification Card
13 number.

14 (3) Account number, credit or debit card number, in combination
15 with any required security code, access code, or password that
16 would permit access to an individual’s financial account.

17 (f) For purposes of this section, “personal information” does
18 not include publicly available information that is lawfully made
19 available to the general public from federal, state, or local
20 government records.

21 (g) For purposes of this section, “notice” may be provided by
22 one of the following methods:

23 (1) Written notice.

24 (2) Electronic notice, if the notice provided is consistent with
25 the provisions regarding electronic records and signatures set forth
26 in Section 7001 of Title 15 of the United States Code.

27 (3) Substitute notice, if the agency demonstrates that the cost
28 of providing notice would exceed two hundred fifty thousand
29 dollars (\$250,000), or that the affected class of subject persons to
30 be notified exceeds 500,000, or the agency does not have sufficient
31 contact information. Substitute notice shall consist of all of the
32 following:

33 (A) E-mail notice when the agency has an e-mail address for
34 the subject persons.

35 (B) Conspicuous posting of the notice on the agency’s Web site
36 page, if the agency maintains one.

37 (C) Notification to major statewide media.

38 (h) Notwithstanding subdivision (g), an agency that maintains
39 its own notification procedures as part of an information security
40 policy for the treatment of personal information and is otherwise

1 consistent with the timing requirements of this part shall be deemed
2 to be in compliance with the notification requirements of this
3 section if it notifies subject persons in accordance with its policies
4 in the event of a breach of security of the system.

5 SEC. 2. Section 1798.29 of the Civil Code, as added by Section
6 2 of Chapter 1054 of the Statutes of 2002, is amended to read:

7 1798.29. (a) Any agency that owns or licenses computerized
8 data that includes personal information shall disclose any breach
9 of the security of the system following discovery or notification
10 of the breach in the security of the data to any resident of California
11 whose unencrypted personal information was, or is reasonably
12 believed to have been, acquired by an unauthorized person. The
13 disclosure shall be made in the most expedient time possible and
14 without unreasonable delay, consistent with the legitimate needs
15 of law enforcement, as provided in subdivision (c), or any measures
16 necessary to determine the scope of the breach and restore the
17 reasonable integrity of the data system.

18 (b) Any agency that maintains computerized data that includes
19 personal information that the agency does not own shall notify the
20 owner or licensee of the information of any breach of the security
21 of the data immediately following discovery, if the personal
22 information was, or is reasonably believed to have been, acquired
23 by an unauthorized person.

24 (c) The notification required by this section may be delayed if
25 a law enforcement agency determines that the notification will
26 impede a criminal investigation. The notification required by this
27 section shall be made after the law enforcement agency determines
28 that it will not compromise the investigation.

29 (d) For purposes of this section, “breach of the security of the
30 system” means unauthorized acquisition of computerized data that
31 compromises the security, confidentiality, or integrity of personal
32 information maintained by the agency. Good faith acquisition of
33 personal information by an employee or agent of the agency for
34 the purposes of the agency is not a breach of the security of the
35 system, provided that the personal information is not used or
36 subject to further unauthorized disclosure.

37 (e) For purposes of this section, “personal information” means
38 an individual’s first name or first initial and last name in
39 combination with any one or more of the following data elements,
40 when either the name or the data elements are not encrypted:

1 (1) Social security number.
2 (2) Driver’s license number or California Identification Card
3 number.

4 (3) Account number, credit or debit card number, in combination
5 with any required security code, access code, or password that
6 would permit access to an individual’s financial account.

7 (4) *Private medical or health care records.*

8 (f) For purposes of this section, “personal information” does
9 not include publicly available information that is lawfully made
10 available to the general public from federal, state, or local
11 government records.

12 (g) For purposes of this section, “notice” may be provided by
13 one of the following methods:

14 (1) Written notice.

15 (2) Electronic notice, if the notice provided is consistent with
16 the provisions regarding electronic records and signatures set forth
17 in Section 7001 of Title 15 of the United States Code.

18 (3) Substitute notice, if the agency demonstrates that the cost
19 of providing notice would exceed two hundred fifty thousand
20 dollars (\$250,000), or that the affected class of subject persons to
21 be notified exceeds 500,000, or the agency does not have sufficient
22 contact information. Substitute notice shall consist of all of the
23 following:

24 (A) E-mail notice when the agency has an e-mail address for
25 the subject persons.

26 (B) Conspicuous posting of the notice on the agency’s Web site
27 page, if the agency maintains one.

28 (C) Notification to major statewide media.

29 (h) Notwithstanding subdivision (g), an agency that maintains
30 its own notification procedures as part of an information security
31 policy for the treatment of personal information and is otherwise
32 consistent with the timing requirements of this part shall be deemed
33 to be in compliance with the notification requirements of this
34 section if it notifies subject persons in accordance with its policies
35 in the event of a breach of security of the system.

36 SEC. 3. Section 1798.82 of the Civil Code, as added by Section
37 4 of Chapter 915 of the Statutes of 2002, is repealed.

38 ~~1798.82. (a) Any person or business that conducts business~~
39 ~~in California, and that owns or licenses computerized data that~~
40 ~~includes personal information, shall disclose any breach of the~~

1 security of the system following discovery or notification of the
2 breach in the security of the data to any resident of California
3 whose unencrypted personal information was, or is reasonably
4 believed to have been, acquired by an unauthorized person. The
5 disclosure shall be made in the most expedient time possible and
6 without unreasonable delay, consistent with the legitimate needs
7 of law enforcement, as provided in subdivision (c), or any measures
8 necessary to determine the scope of the breach and restore the
9 reasonable integrity of the data system.

10 (b) Any person or business that maintains computerized data
11 that includes personal information that the person or business does
12 not own shall notify the owner or licensee of the information of
13 any breach of the security of the data immediately following
14 discovery, if the personal information was, or is reasonably
15 believed to have been, acquired by an unauthorized person.

16 (c) The notification required by this section may be delayed if
17 a law enforcement agency determines that the notification will
18 impede a criminal investigation. The notification required by this
19 section shall be made after the law enforcement agency determines
20 that it will not compromise the investigation.

21 (d) For purposes of this section, “breach of the security of the
22 system” means unauthorized acquisition of computerized data that
23 compromises the security, confidentiality, or integrity of personal
24 information maintained by the person or business. Good faith
25 acquisition of personal information by an employee or agent of
26 the person or business for the purposes of the person or business
27 is not a breach of the security of the system, provided that the
28 personal information is not used or subject to further unauthorized
29 disclosure.

30 (e) For purposes of this section, “personal information” means
31 an individual’s first name or first initial and last name in
32 combination with any one or more of the following data elements,
33 when either the name or the data elements are not encrypted:

34 (1) Social security number.

35 (2) Driver’s license number or California Identification Card
36 number.

37 (3) Account number, credit or debit card number, in combination
38 with any required security code, access code, or password that
39 would permit access to an individual’s financial account.

1 ~~(f) For purposes of this section, “personal information” does~~
2 ~~not include publicly available information that is lawfully made~~
3 ~~available to the general public from federal, state, or local~~
4 ~~government records.~~

5 ~~(g) For purposes of this section, “notice” may be provided by~~
6 ~~one of the following methods:~~

7 ~~(1) Written notice.~~

8 ~~(2) Electronic notice, if the notice provided is consistent with~~
9 ~~the provisions regarding electronic records and signatures set forth~~
10 ~~in Section 7001 of Title 15 of the United States Code.~~

11 ~~(3) Substitute notice, if the person or business demonstrates that~~
12 ~~the cost of providing notice would exceed two hundred fifty~~
13 ~~thousand dollars (\$250,000), or that the affected class of subject~~
14 ~~persons to be notified exceeds 500,000, or the person or business~~
15 ~~does not have sufficient contact information. Substitute notice~~
16 ~~shall consist of all of the following:~~

17 ~~(A) E-mail notice when the person or business has an e-mail~~
18 ~~address for the subject persons.~~

19 ~~(B) Conspicuous posting of the notice on the Web site page of~~
20 ~~the person or business, if the person or business maintains one.~~

21 ~~(C) Notification to major statewide media.~~

22 ~~(h) Notwithstanding subdivision (g), a person or business that~~
23 ~~maintains its own notification procedures as part of an information~~
24 ~~security policy for the treatment of personal information and is~~
25 ~~otherwise consistent with the timing requirements of this part, shall~~
26 ~~be deemed to be in compliance with the notification requirements~~
27 ~~of this section if the person or business notifies subject persons in~~
28 ~~accordance with its policies in the event of a breach of security of~~
29 ~~the system.~~

30 ~~SEC. 4. Section 1798.82 of the Civil Code, as added by Section~~
31 ~~4 of Chapter 1054 of the Statutes of 2002, is amended to read:~~

32 ~~1798.82. (a) Any person or business that conducts business~~
33 ~~in California, and that owns or licenses computerized data that~~
34 ~~includes personal information, shall disclose any breach of the~~
35 ~~security of the system following discovery or notification of the~~
36 ~~breach in the security of the data to any resident of California~~
37 ~~whose unencrypted personal information was, or is reasonably~~
38 ~~believed to have been, acquired by an unauthorized person. The~~
39 ~~disclosure shall be made in the most expedient time possible and~~
40 ~~without unreasonable delay, consistent with the legitimate needs~~

1 of law enforcement, as provided in subdivision (c), or any measures
2 necessary to determine the scope of the breach and restore the
3 reasonable integrity of the data system.

4 (b) Any person or business that maintains computerized data
5 that includes personal information that the person or business does
6 not own shall notify the owner or licensee of the information of
7 any breach of the security of the data immediately following
8 discovery, if the personal information was, or is reasonably
9 believed to have been, acquired by an unauthorized person.

10 (c) The notification required by this section may be delayed if
11 a law enforcement agency determines that the notification will
12 impede a criminal investigation. The notification required by this
13 section shall be made after the law enforcement agency determines
14 that it will not compromise the investigation.

15 (d) For purposes of this section, “breach of the security of the
16 system” means unauthorized acquisition of computerized data that
17 compromises the security, confidentiality, or integrity of personal
18 information maintained by the person or business. Good faith
19 acquisition of personal information by an employee or agent of
20 the person or business for the purposes of the person or business
21 is not a breach of the security of the system, provided that the
22 personal information is not used or subject to further unauthorized
23 disclosure.

24 (e) For purposes of this section, “personal information” means
25 an individual’s first name or first initial and last name in
26 combination with any one or more of the following data elements,
27 when either the name or the data elements are not encrypted:

28 (1) Social security number.

29 (2) Driver’s license number or California Identification Card
30 number.

31 (3) Account number, credit or debit card number, in combination
32 with any required security code, access code, or password that
33 would permit access to an individual’s financial account.

34 (4) *Private medical or health care records.*

35 (f) For purposes of this section, “personal information” does
36 not include publicly available information that is lawfully made
37 available to the general public from federal, state, or local
38 government records.

39 (g) For purposes of this section, “notice” may be provided by
40 one of the following methods:

1 (1) Written notice.

2 (2) Electronic notice, if the notice provided is consistent with
3 the provisions regarding electronic records and signatures set forth
4 in Section 7001 of Title 15 of the United States Code.

5 (3) Substitute notice, if the person or business demonstrates that
6 the cost of providing notice would exceed two hundred fifty
7 thousand dollars (\$250,000), or that the affected class of subject
8 persons to be notified exceeds 500,000, or the person or business
9 does not have sufficient contact information. Substitute notice
10 shall consist of all of the following:

11 (A) E-mail notice when the person or business has an e-mail
12 address for the subject persons.

13 (B) Conspicuous posting of the notice on the Web site page of
14 the person or business, if the person or business maintains one.

15 (C) Notification to major statewide media.

16 (h) Notwithstanding subdivision (g), a person or business that
17 maintains its own notification procedures as part of an information
18 security policy for the treatment of personal information and is
19 otherwise consistent with the timing requirements of this part, shall
20 be deemed to be in compliance with the notification requirements
21 of this section if the person or business notifies subject persons in
22 accordance with its policies in the event of a breach of security of
23 the system.

24 SEC. 5. No reimbursement is required by this act pursuant to
25 Section 6 of Article XIII B of the California Constitution because
26 the only costs that may be incurred by a local agency or school
27 district will be incurred because this act creates a new crime or
28 infraction, eliminates a crime or infraction, or changes the penalty
29 for a crime or infraction, within the meaning of Section 17556 of
30 the Government Code, or changes the definition of a crime within
31 the meaning of Section 6 of Article XIII B of the California
32 Constitution.

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CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES

BILL ANALYSIS

BILL NUMBER: AB 612 **VERSION:** AMENDED MARCH 26, 2007

AUTHOR: RUSKIN **SPONSOR:** AUTHOR

RECOMMENDED POSITION: NONE

SUBJECT: CHILD CUSTODY INVESTIGATIONS

Existing Law:

- 1) Permits any party to obtain discovery by means of a physical or mental examination of (1) a party to the action, (2) an agent of any party, or (3) a natural person in the custody or under the legal control of a party, in any action in which the mental or physical condition of that party or other person is in controversy in the action. (CCP § 2032.020(a))
- 2) Requires a mental examination to be performed only by a licensed physician, or by a licensed clinical psychologist who holds a doctoral degree in psychology and has had at least five years of postgraduate experience in the diagnosis of emotional and mental disorders. (CCP § 2032.020(c))
- 3) Requires the court to only grant a motion for a physical or mental examination for good cause shown. (CCP § 2032.320(a))
- 4) Requires an order granting a physical or mental examination to specify the persons who may perform the examination, as well as the time, place, manner, diagnostic tests and procedures, conditions, scope, and nature of the examination. (CCP § 2032.320(d))
- 5) Permits the examiner and examinee to have the right to record a mental examination by audio technology. (CCP § 2032.530(a))
- 6) If a party submits to, or produces another for a required physical or mental examination, that party has the option of making a written demand that the party at whose instance the examination was made deliver both of the following to the demanding party within 30 days of the demand or within 15 days of the trial, whichever is earlier: (CCP § 2032.610(a))
 - A copy of a detailed written report setting out the history, examinations, findings, including the results of all tests made, diagnoses, prognoses, and conclusions.
 - A copy of reports of all earlier examinations of the same condition of the examinee made by that or any other examiner.
- 7) Requires the party who submitted to, or produced another for, a physical or mental examination, who demands and obtains the report or who takes the deposition of the examiner in any action involving the same controversy, to waive any privilege, as well as any protection for work product that the party or other examinee may have as well as the testimony of every other licensed health care practitioner who has examined or may thereafter examine the party or other examinee in respect of the same physical or mental condition. (CCP § 2032.630)

- 8) Permits a person who receives a demand for a report of a party's physical or mental examination to receive a copy of any existing written report of any examination of the same condition by any other health care practitioner. In addition, that party is entitled to receive promptly any later report of any previous or subsequent examination of the same condition. (CCP § 2032.640)

This Bill:

- 1) Defines "Child custody evaluator" as a court-appointed investigator. (FC § 3110(b))
- 2) Requires a court to only grant a motion for a mental or psychological examination of a parent, as part of a child custody evaluation for good cause shown. (FC § 3110.6(a))
- 3) Requires a mental or psychological examination, including standardized psychological testing, to be conducted only by written court order by a licensed physician or psychologist who holds a doctoral degree in psychology and has had at least five years of postgraduate experience in the diagnosis of emotional and mental disorders. (FC § 3110.6(b))
- 4) Requires the order for a mental or psychological examination to include a description of the legally admissible evidence that demonstrates the need for the examination and a request for a diagnosis. (FC § 3110.6(c))
- 5) Requires the child custody evaluator that conducts the mental or psychological examination to do all of the following: (FC § 3110.6(d))
 - Summarize the data-gathering procedures, information sources, and the amount of time spent conducting the examination.
 - Present all relevant information, including information that does not support the conclusions reached.
- 6) Prohibits the use of nonscientific labels and assessments that are not consistent with diagnostic or medical standards generally accepted by the medical, psychiatric and psychological communities for court use. (FC § 3110.6(d))

Comment:

- 1) **Author's Intent.** According to the author, this bill would correct instances where child custody evaluations were conducted improperly by using unscientific and unvalidated methods.
- 2) **Diagnoses.** This bill prohibits the use of nonscientific labels and assessments not consistent with standards generally accepted by the medical, psychiatric and psychological communities. The introduced version of the bill specifically prohibited the use of the terms "parental alienation syndrome," "parental alienation," or "alienated child" as diagnoses and for court use. Parental alienation syndrome (PAS) and similar terms have been used over the past approximately twenty years to describe a child who has been "brainwashed" by one parent against another parent with no justification, and includes "the child's own contributions to the vilification of the target parent." It is described as "a disorder that arises primarily in the context of child custody disputes" and does not include true cases of parental abuse/neglect.¹

¹ *Basic Facts About Parental Alienation Syndrome*, Richard Gardner, May 31, 2001, www.rgardner.com/refs/pas_intro.html

Articles on the topic have appeared in a number of peer-reviewed journals, and has been recognized in several court cases. Despite a growing body of literature, there are controversies regarding PAS, especially by mental health professionals. As stated in the American Journal of Forensic Psychiatry², “Critics of PAS argue that it:

- Oversimplifies the causes of alienation
- Leads to confusion in clinical work with alienated children
- Lacks an adequate scientific foundation to be a syndrome.”

They also believe that PAS is “misused in court and that testimony regarding this diagnosis, its course and its treatment should be inadmissible.”

3) Support and Opposition.

Not yet known.

4) History

2007

Mar. 26 From committee chair, with author's amendments: Amend, and re-refer to Com. on JUD. Read second time and amended.

Mar. 15 Referred to Com. on JUD.

Feb. 22 From printer. May be heard in committee March 24.

Feb. 21 Read first time. To print.

² *Current Controversies Regarding Parental Alienation Syndrome*. American Journal of Forensic Psychology, Vol. 19, No. 3, 2001, P. 29-59. Richard A. Warshak, Ph.D.

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ASSEMBLY BILL

No. 612

Introduced by Assembly Member Ruskin

February 21, 2007

An act to amend Sections 3110.5 and 3111 of, and to add Section 3110.6 to, the Family Code, relating to child custody.

LEGISLATIVE COUNSEL'S DIGEST

AB 612, as introduced, Ruskin. Child custody investigations.

Existing law authorizes the court, in a contested proceeding involving child custody or visitation rights, to appoint a child custody evaluator to conduct a child custody evaluation in cases in which the court determines it is in the best interests of the child. Existing law requires court-connected and private child custody evaluators to complete a described domestic violence and child abuse training program and to comply with other requirements. Existing law requires the Judicial Council to formulate a statewide rule of court by January 1, 2002, that establishes education, experience, and training requirements for all court-appointed child custody evaluators, and requires child custody evaluators to declare under penalty of perjury that they meet all of the education, experience, and training requirements of the rule and, if applicable, possess a license in good standing. For purposes of these provisions, a "child custody evaluator" is a "court-appointed investigator."

This bill would revise these provisions by replacing references to "child custody evaluators" and "evaluations" with conforming references to "child custody investigators" and "investigations." The bill would permit a court, as part of a child custody investigation pursuant to these provisions, to grant a motion for a mental or psychological examination

of a parent only for good cause shown, as specified, under exceptional circumstances when there is strong evidence that a parent’s current mental or psychological status might seriously impair his or her parenting ability.

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

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

1 SECTION 1. Section 3110.5 of the Family Code is amended
 2 to read:

3 3110.5. (a) ~~No~~A person ~~may~~ shall not be a court-connected,
 4 *court-appointed*, or private child custody-~~evaluator~~ *investigator*
 5 under this chapter unless the person has completed the domestic
 6 violence and child abuse training program described in Section
 7 1816 and has complied with Rules 5.220 and 5.230 of the
 8 California Rules of Court.

9 (b) (1) On or before January 1, 2002, the Judicial Council shall
 10 formulate a statewide rule of court that establishes education,
 11 experience, and training requirements for all *court-connected*,
 12 *court-appointed*, and *private child custody-~~evaluators~~ investigators*
 13 appointed pursuant to this chapter, Section 730 of the Evidence
 14 Code, or Chapter 15 (commencing with Section 2032.010) of Title
 15 4 of Part 4 of the Code of Civil Procedure.

16 (A) The rule shall require a child custody-~~evaluator~~ *investigator*
 17 to declare under penalty of perjury that he or she meets all of the
 18 education, experience, and training requirements specified in the
 19 rule and, if applicable, possesses a license in good standing. The
 20 Judicial Council shall establish forms to implement this section.
 21 The rule shall permit court-connected-~~evaluators~~, *court-appointed*,
 22 *and private child custody investigators* to conduct-~~evaluations~~
 23 *investigations* if they meet all of the qualifications established by
 24 the Judicial Council. The education, experience, and training
 25 requirements to be specified for court-connected-~~evaluators~~
 26 *,court-appointed, and private child custody investigators* shall
 27 include, but not be limited to, knowledge of the psychological and
 28 developmental needs of children and parent-child relationships.

29 (B) The rule shall require all-~~evaluators~~ *investigators* to utilize
 30 comparable interview, assessment, and testing procedures for all
 31 parties that are consistent with generally accepted clinical, forensic,

1 scientific, diagnostic, or medical standards. The rule shall also
2 require ~~evaluators~~ *investigators* to inform each adult party of the
3 purpose, nature, and method of the ~~evaluation~~ *investigation*.

4 (C) The rule may allow courts to permit the parties to stipulate
5 to an ~~evaluator~~ *investigator* of their choosing with the approval of
6 the court under the circumstances set forth in subdivision (d). The
7 rule may require courts to provide general information about how
8 parties can contact qualified child custody ~~evaluators~~ *investigators*
9 in their county.

10 (2) On or before January 1, 2004, the Judicial Council shall
11 include in the statewide rule of court created pursuant to this
12 section a requirement that all court-connected, *court-appointed*,
13 and private child custody ~~evaluators~~ *investigators* receive training
14 in the nature of child sexual abuse. The Judicial Council shall
15 develop standards for this training that shall include, but not be
16 limited to, the following:

17 (A) Children’s patterns of hiding and disclosing sexual abuse
18 occurring in a family setting.

19 (B) The effects of sexual abuse on children.

20 (C) The nature and extent of child sexual abuse.

21 (D) The social and family dynamics of child sexual abuse.

22 (E) Techniques for identifying and assisting families affected
23 by child sexual abuse.

24 (F) Legal rights, protections, and remedies available to victims
25 of child sexual abuse.

26 (c) In addition to the education, experience, and training
27 requirements established by the Judicial Council pursuant to
28 subdivision (b), on or after January 1, 2005, ~~no~~ a person ~~may~~ *shall*
29 *not* be a child custody ~~evaluator~~ *investigator* under this chapter,
30 Section 730 of the Evidence Code, or Chapter 15 (commencing
31 with Section 2032.010) of Title 4 of Part 4 of the Code of Civil
32 Procedure unless the person meets *at least* one of the following
33 criteria:

34 (1) He or she is licensed as a physician under Chapter 5
35 (commencing with Section 2000) of Division 2 of the Business
36 and Professions Code and either is a board certified psychiatrist
37 or has completed a residency in psychiatry.

38 (2) He or she is licensed as a psychologist under Chapter 6.6
39 (commencing with Section 2900) of Division 2 of the Business
40 and Professions Code.

1 (3) He or she is licensed as a marriage and family therapist under
2 Chapter 13 (commencing with Section 4980) of Division 2 of the
3 Business and Professions Code.

4 (4) He or she is licensed as a clinical social worker under Article
5 4 (commencing with Section 4996) of Chapter 14 of Division 2
6 of the Business and Professions Code.

7 (5) He or she is a court-connected~~evaluator~~, *court-appointed*,
8 *or private investigator* who has been certified by the court as
9 meeting all of the qualifications for court-connected~~evaluators~~,
10 *court-appointed*, *or private investigators*, as specified by the
11 Judicial Council pursuant to subdivision (b).

12 (d) Subdivision (c) does not apply in ~~any~~ a case ~~where in which~~
13 the court determines that there are no ~~evaluators~~ *investigators* who
14 meet the criteria of subdivision (c) who are willing and available,
15 within a reasonable period of time, to perform child custody
16 ~~evaluations~~ *investigations*. In those cases, the parties may stipulate
17 to an individual who does not meet the criteria of subdivision (c),
18 subject to approval by the court.

19 (e) A child custody~~evaluator~~ *investigator* who is licensed by
20 the Medical Board of California, the Board of Psychology, or the
21 Board of Behavioral Sciences, shall be subject to disciplinary
22 action by that board for unprofessional conduct, as defined in the
23 licensing law applicable to that licensee.

24 (f) On or after January 1, 2005, a court-connected,
25 *court-appointed*, or private child custody~~evaluator~~~~may~~
26 *investigator shall* not evaluate, investigate, or mediate an issue of
27 child custody in a proceeding pursuant to this division unless that
28 person has completed child sexual abuse training as required by
29 this section.

30 SEC. 2. Section 3110.6 is added to the Family Code, to read:

31 3110.6. (a) The court shall grant a motion for a mental or
32 psychological examination of a parent, as part of a child custody
33 investigation pursuant to this chapter, only for good cause shown,
34 pursuant to Section 2032.310 of the Code of Civil Procedure, under
35 exceptional circumstances when there is strong evidence that a
36 parent's current mental or psychological status might seriously
37 impair his or her parenting ability.

38 (b) A mental or psychological examination, including
39 standardized psychological testing, may be conducted only by
40 written court order, by a licensed physician or psychologist who

1 meets the requirements of subdivision (c) of Section 2032.020 of
2 the Code of Civil Procedure.

3 (c) The order for a mental or psychological examination shall
4 include a description of the legally admissible evidence that
5 demonstrates the need for the examination and a request for a
6 diagnosis. Controversial, nonscientific labels, such as parental
7 alienation syndrome, parental alienation, or alienated child, are
8 specifically excluded as allowable diagnoses and for court use.

9 (d) The report to the court resulting from the examination, any
10 underlying “raw” data from psychological testing, and notes from
11 the mental or psychological examination, shall be provided within
12 10 days from the date of the request of the parties and their
13 attorneys.

14 SEC. 3. Section 3111 of the Family Code is amended to read:

15 3111. (a) In ~~any~~ a contested proceeding involving child
16 custody or visitation rights, the court may appoint a child custody
17 ~~evaluator~~ *investigator* to conduct a child custody ~~evaluation~~
18 *investigation* in cases ~~where in which~~ the court determines it is in
19 the best interests of the child. The child custody ~~evaluation~~
20 *investigation* shall be conducted in accordance with the standards
21 adopted by the Judicial Council pursuant to Section 3117, and all
22 other standards adopted by the Judicial Council regarding child
23 custody ~~evaluations~~ *investigations*. If directed by the court, the
24 *court-connected*, court-appointed, or *private* child custody
25 ~~evaluator~~ *investigator* shall file a written confidential report on his
26 or her ~~evaluation~~ *investigation*. At least 10 days before any hearing
27 regarding custody of the child, the report shall be filed with the
28 clerk of the court in which the custody hearing will be conducted
29 and served on the parties or their attorneys, and any other counsel
30 appointed for the child pursuant to Section 3150. The report may
31 be considered by the court.

32 (b) The report shall not be made available other than as provided
33 in subdivision (a), or as described in Section 204 of the Welfare
34 and Institutions Code or Section 1514.5 of the Probate Code. Any
35 information obtained from access to a juvenile court case file, as
36 defined in subdivision (e) of Section 827 of the Welfare and
37 Institutions Code, is confidential and shall only be disseminated
38 as provided by paragraph (4) of subdivision (a) of Section 827 of
39 the Welfare and Institutions Code.

- 1 (c) The report may be received in evidence on stipulation of all
- 2 interested parties and is competent evidence as to all matters
- 3 contained in the report.

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CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES

BILL ANALYSIS

BILL NUMBER: AB 673 **VERSION:** INTRODUCED FEBRUARY 21, 2007

AUTHOR: HAYASHI **SPONSOR:** CAMFT

RECOMMENDED POSITION: NONE

SUBJECT: CHILD ABUSE REPORTING

Existing Law:

- 1) Defines "child abuse or neglect" as: (Penal Code [PC] § § 11165.3, 11165.6)
 - Physical injury inflicted intentionally upon a child
 - Sexual abuse
 - Neglect
 - Intentionally causing or permitting a child to suffer
 - Inflicting unjustifiable physical pain or mental suffering
 - Causing or permitting the child to be placed in a situation where the child or the child's health is endangered
 - Unlawful corporal punishment or injury.
- 2) Defines "severe neglect" as: (PC § 11165.2(a))
 - The negligent failure of a person having the care or custody of a child to protect the child from severe malnutrition or medically diagnosed nonorganic failure to thrive.
 - Situations of neglect where a person having the care or custody of a child willfully causes or permits the child to be endangered, including the intentional failure to provide adequate food, clothing, shelter, or medical care.
- 3) Requires the following practitioners to report suspected child abuse or neglect: (PC § 11165.7)
 - Marriage and Family Therapists (MFT), MFT interns and trainees
 - Social workers, including Licensed Clinical Social Workers (LCSW) and Associate Clinical Social Workers (ACSW)
 - Licensed Educational Psychologists (LEP)
 - Other persons and professionals who come into direct contact with children, elders, and dependent adults
- 4) Requires a mandated reporter to report child abuse immediately or as soon as possible by telephone and in writing within 36 hours when, in his or her professional capacity, he or she reasonably suspects a child has been the victim of child abuse or neglect. (PC § 11166(a))
- 5) Permits "any other person" who has knowledge of or observes a child whom he or she knows or suspects has been a victim or child abuse or neglect to make a report. (PC § 11166(g))
- 6) Permits "any other person" who makes a report of child abuse or neglect to make that report anonymously. (PC § 11167(f))

- 7) Establishes that a mandated reporter who fails to report an incident of known or suspected child abuse or neglect is guilty of a misdemeanor punishable by up to six months in a county jail or by a fine of one thousand dollars or by both that imprisonment and fine. (PC § 11166(c))

This Bill:

- 1) Adds “death inflicted by other than accidental means” to the definition of "child abuse or neglect.” (PC § 11165.6)
- 2) Clarifies that a mandated reporter may report known or suspected child abuse when the mandated reporter acts in his or her private capacity and not in his or her professional capacity. (PC § 11166(g))

Comment:

- 1) **Author’s Intent.** According to the sponsor, the California Association of Marriage and Family Therapists (CAMFT), it is important to make clear in the definition of child abuse that the death of a child, as opposed to a mere injury, is reportable. Additionally, they feel it is important to clarify that mandated reporters who report in their private capacities are permitted to report child abuse. By making this clear, it will allow these persons to report anonymously (as is the case for any other person) when they observe a child who may have been abused, but outside of their professional role or scope of employment.
- 2) **Child Death.** Current law already requires a child’s death to be reported when it is the result of physical abuse or when there is evidence of prior physical abuse or severe neglect. However, this bill would make this requirement more explicit.
- 3) **Mandated Reporters.** Currently, mandated reporters are permitted to make an anonymous report as a private citizen when they observe child abuse in their private capacity, outside the scope of their employment. This bill would make this authorization more explicit.
- 4) **Support and Opposition.**
None known at this time.
- 5) **History**
2007
Mar. 8 Referred to Com. on PUB. S.
Feb. 22 From printer. May be heard in committee March 24.
Feb. 21 Read first time. To print.

ASSEMBLY BILL

No. 673

Introduced by Assembly Member Hayashi

February 21, 2007

An act to amend Sections 11165.6 and 11166 of the Penal Code, relating to child abuse.

LEGISLATIVE COUNSEL'S DIGEST

AB 673, as introduced, Hayashi. Child abuse or neglect: mandated reports.

Existing law, the Child Abuse and Neglect Reporting Act, requires the filing of a report with a police department or county sheriff's office or county welfare department by a mandated reporter, as defined, who, in his or her professional capacity or within the scope of his or her employment, has knowledge of or observes a child whom the mandated reporter knows or reasonably suspects has been the victim of child abuse or neglect. For the purposes of these provisions, the term "child abuse or neglect" is defined as including physical injury inflicted by other than accidental means. Failure to file a mandated report is a misdemeanor.

This bill would amend the term "child abuse or neglect" to include death inflicted by other than accidental means.

Existing law also provides that any other person who has knowledge of or observes a child whom he or she 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.

This bill would specify that these provisions apply to a mandated reporter who acts in his or her private capacity and not in his or her professional capacity or within the scope of his or her employment.

Because this bill would increase the duties of local officials, and increase the scope of a crime, this bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that with regard to certain mandates no reimbursement is required by this act for a specified reason.

With regard to any other mandates, this bill would provide that, if the Commission on State Mandates determines that the bill contains costs so mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

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

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

1 SECTION 1. Section 11165.6 of the Penal Code is amended
2 to read:

3 11165.6. As used in this article, the term “child abuse or
4 neglect” includes physical injury *or death* inflicted by other than
5 accidental means upon a child by another person, sexual abuse as
6 defined in Section 11165.1, neglect as defined in Section 11165.2,
7 the willful harming or injuring of a child or the endangering of the
8 person or health of a child, as defined in Section 11165.3, and
9 unlawful corporal punishment or injury as defined in Section
10 11165.4. “Child abuse or neglect” does not include a mutual affray
11 between minors. “Child abuse or neglect” does not include an
12 injury caused by reasonable and necessary force used by a peace
13 officer acting within the course and scope of his or her employment
14 as a peace officer.

15 SEC. 2. Section 11166 of the Penal Code is amended to read:

16 11166. (a) Except as provided in subdivision (d), and in
17 Section 11166.05, a mandated reporter shall make a report to an
18 agency specified in Section 11165.9 whenever the mandated
19 reporter, in his or her professional capacity or within the scope of
20 his or her employment, has knowledge of or observes a child whom
21 the mandated reporter knows or reasonably suspects has been the
22 victim of child abuse or neglect. The mandated reporter shall make
23 an initial report to the agency immediately or as soon as is

1 practicably possible by telephone and the mandated reporter shall
2 prepare and send, fax, or electronically transmit a written followup
3 report thereof within 36 hours of receiving the information
4 concerning the incident. The mandated reporter may include with
5 the report any nonprivileged documentary evidence the mandated
6 reporter possesses relating to the incident.

7 (1) For the purposes of this article, “reasonable suspicion” means
8 that it is objectively reasonable for a person to entertain a suspicion,
9 based upon facts that could cause a reasonable person in a like
10 position, drawing, when appropriate, on his or her training and
11 experience, to suspect child abuse or neglect. For the purpose of
12 this article, the pregnancy of a minor does not, in and of itself,
13 constitute a basis for a reasonable suspicion of sexual abuse.

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

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

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

31 (1) The one-time automated written report form prescribed by
32 the Department of Justice shall be clearly identifiable so that it is
33 not mistaken for a standard written followup report. In addition,
34 the automated one-time report shall contain a section that allows
35 the mandated reporter to state the reason the initial telephone call
36 was not able to be completed. The reason for the submission of
37 the one-time automated written report in lieu of the procedure
38 prescribed in subdivision (a) shall be captured in the Child Welfare
39 Services/Case Management System (CWS/CMS). The department
40 shall work with stakeholders to modify reporting forms and the

1 CWS/CMS as is necessary to accommodate the changes enacted
2 by these provisions.

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

6 (3) This subdivision shall become inoperative three years after
7 this subdivision becomes operative or on January 1, 2009, which
8 ever occurs first.

9 (4) On the inoperative date of these provisions, a report shall
10 be submitted to the counties and the Legislature by the Department
11 of Social Services that reflects the data collected from automated
12 one-time reports indicating the reasons stated as to why the
13 automated one-time report was filed in lieu of the initial telephone
14 report.

15 (5) Nothing in this section shall supersede the requirement that
16 a mandated reporter first attempt to make a report via telephone,
17 or that agencies specified in Section 11165.9 accept reports from
18 mandated reporters and other persons as required.

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

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

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

6 (3) (A) On or before January 1, 2004, a clergy member or any
7 custodian of records for the clergy member may report to an agency
8 specified in Section 11165.9 that the clergy member or any
9 custodian of records for the clergy member, prior to January 1,
10 1997, in his or her professional capacity or within the scope of his
11 or her employment, other than during a penitential communication,
12 acquired knowledge or had a reasonable suspicion that a child had
13 been the victim of sexual abuse that the clergy member or any
14 custodian of records for the clergy member did not previously
15 report the abuse to an agency specified in Section 11165.9. The
16 provisions of Section 11172 shall apply to all reports made pursuant
17 to this paragraph.

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

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

25 (e) Any commercial film and photographic print processor who
26 has knowledge of or observes, within the scope of his or her
27 professional capacity or employment, any film, photograph,
28 videotape, negative, or slide depicting a child under the age of 16
29 years engaged in an act of sexual conduct, shall report the instance
30 of suspected child abuse to the law enforcement agency having
31 jurisdiction over the case immediately, or as soon as practicably
32 possible, by telephone and shall prepare and send, fax, or
33 electronically transmit a written report of it with a copy of the film,
34 photograph, videotape, negative, or slide attached within 36 hours
35 of receiving the information concerning the incident. As used in
36 this subdivision, "sexual conduct" means any of the following:

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

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

1 (3) Masturbation for the purpose of sexual stimulation of the
2 viewer.

3 (4) Sadoomasochistic abuse for the purpose of sexual stimulation
4 of the viewer.

5 (5) Exhibition of the genitals, pubic, or rectal areas of any person
6 for the purpose of sexual stimulation of the viewer.

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

13 (g) Any other person who has knowledge of or observes a child
14 whom he or she knows or reasonably suspects has been a victim
15 of child abuse or neglect may report the known or suspected
16 instance of child abuse or neglect to an agency specified in Section
17 11165.9. *For purposes of this section, "any other person" includes*
18 *a mandated reporter who acts in his or her private capacity and*
19 *not in his or her professional capacity or within the scope of his*
20 *or her employment.*

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

29 (i) (1) The reporting duties under this section are individual,
30 and no supervisor or administrator may impede or inhibit the
31 reporting duties, and no person making a report shall be subject
32 to any sanction for making the report. However, internal procedures
33 to facilitate reporting and apprise supervisors and administrators
34 of reports may be established provided that they are not inconsistent
35 with this article.

36 (2) The internal procedures shall not require any employee
37 required to make reports pursuant to this article to disclose his or
38 her identity to the employer.

39 (3) Reporting the information regarding a case of possible child
40 abuse or neglect to an employer, supervisor, school principal,

1 school counselor, coworker, or other person shall not be a substitute
2 for making a mandated report to an agency specified in Section
3 11165.9.

4 (j) A county probation or welfare department shall immediately,
5 or as soon as practicably possible, report by telephone, fax, or
6 electronic transmission to the law enforcement agency having
7 jurisdiction over the case, to the agency given the responsibility
8 for investigation of cases under Section 300 of the Welfare and
9 Institutions Code, and to the district attorney's office every known
10 or suspected instance of child abuse or neglect, as defined in
11 Section 11165.6, except acts or omissions coming within
12 subdivision (b) of Section 11165.2, or reports made pursuant to
13 Section 11165.13 based on risk to a child which relates solely to
14 the inability of the parent to provide the child with regular care
15 due to the parent's substance abuse, which shall be reported only
16 to the county welfare or probation department. A county probation
17 or welfare department also shall send, fax, or electronically transmit
18 a written report thereof within 36 hours of receiving the information
19 concerning the incident to any agency to which it makes a
20 telephone report under this subdivision.

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

1 SEC. 3. No reimbursement is required by this act pursuant to
2 Section 6 of Article XIII B of the California Constitution for certain
3 costs that may be incurred by a local agency or school district
4 because, in that regard, this act creates a new crime or infraction,
5 eliminates a crime or infraction, or changes the penalty for a crime
6 or infraction, within the meaning of Section 17556 of the
7 Government Code, or changes the definition of a crime within the
8 meaning of Section 6 of Article XIII B of the California
9 Constitution.

10 However, if the Commission on State Mandates determines that
11 this act contains other costs mandated by the state, reimbursement
12 to local agencies and school districts for those costs shall be made
13 pursuant to Part 7 (commencing with Section 17500) of Division
14 4 of Title 2 of the Government Code.

CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES

BILL ANALYSIS

BILL NUMBER: AB 1025 **VERSION:** INTRODUCED FEBRUARY 22, 2007

AUTHOR: BASS **SPONSOR:** UNKNOWN

RECOMMENDED POSITION: OPPOSE

SUBJECT: DENIAL OF LICENSURE

Existing Law:

- 1) Permits a board to deny a license on the grounds that the applicant has been convicted of a crime or has committed an act substantially related to the qualifications, functions, or duties of the business or profession for which application is made. (B&P Code § 480 (a))
- 2) Requires applicants for licensure to furnish evidence to the Board of Behavioral Sciences (BBS) that he or she has not committed any crimes or acts constituting grounds for denial of licensure, defined as conviction of a crime substantially related to the qualifications, functions, or duties of the business or profession for which application is made. (B&P Code § 4996.2(d), 4989.20(a), 4980.40(h))
- 3) Defines a crime or act as substantially related if, to a substantial degree, it shows present or potential unfitness to perform the functions authorized by the license consistent with the public health, safety or welfare. (Title 16, CCR § 1812)
- 4) Requires the BBS to evaluate the following information when considering the rehabilitation of the applicant and his or her present eligibility for a license: (Title 16, CCR § 1812)
 - The nature and severity of the act(s) or crime(s)
 - The time that has elapsed since commission of the act(s) or crime(s)
 - The extent to which the applicant has complied with any terms of probation, parole, restitution, or any other sanctions
 - Evidence of rehabilitation submitted by the applicant
- 5) Requires the BBS to deny a license to any person who has been convicted of any crime in this or another state or in a territory of the United States that involves sexual abuse of children or who is required to register as a sex offender. (B&P Code § 4996.2(d), 4989.24, 4980.40(h))
- 6) Permits the BBS to refuse to issue a license if the applicant has been guilty of unprofessional conduct. (B&P Code § 4982, 4989.54, 4992.3)
- 7) Defines unprofessional conduct for Licensed Clinical Social Worker (LCSW) and Marriage and Family Therapist (MFT) applicants to include, but not be limited to: (B&P Code § 4982, 4989.54, 4992.3)
 - A crime substantially related to the qualifications functions, or duties of a licensee
 - The conviction of more than one misdemeanor or any felony involving the use of any substances considered unsafe

- Commission of an act punishable as a sexually related crime
- 8) Allows the BBS to inquire into the circumstances surrounding the commission of the crime in order to fix the degree of discipline or to determine if the conviction is substantially related, for LCSW and MFT applicants. (B&P Code § 4982(a), 4989.54(a), 4992.3(a))
 - 9) Permits a defendant (with exceptions for certain types of crimes) to petition the court to set aside the verdict of guilty and provide a certificate of rehabilitation and pardon when they have fulfilled all conditions of probation, have been discharged prior to the termination period of probation, or in any other case in which a court makes such a determination. (PC § 1203.4.(a), (b))
 - 10) Permits, in any subsequent prosecution of the defendant for any other offense, the prior conviction to have the same effect as if probation had not been granted or the accusation or information dismissed. (PC § 1203.4.(a))
 - 11) Requires such an order to state, and the probationer to be informed, that the order does not relieve him or her of the obligation to disclose the conviction in response to any direct question contained in any questionnaire or application for public office, for licensure by any state or local agency. (PC § 1203.4.(a))
 - 12) Permits a defendant convicted of a misdemeanor (with certain crimes excepted) and not granted probation to, at any time after the lapse of one year from the date of the judgment, if he or she has fully complied with the sentence, lived an honest and upright life and has obeyed the laws of the land, be permitted by the court to set aside the verdict of guilty and released the defendant from all penalties and disabilities resulting from the offense of which he or she has been convicted. (PC § 1203.4a.(a))

This Bill:

- 1) Prohibits a person from being denied licensure or from having his or her license suspended or revoked based on a criminal conviction that has been dismissed under Penal Code Section 1203.4 or 1203.4a. (BPC § § 480(a)(1), (b); 490)
- 2) Prohibits denial of licensure for an arrest more than one year old if no disposition is reported. (BPC § 480(d))
- 3) Requires the board to provide an applicant or ex-licensure whose application has been denied or whose license has been suspended or revoked based upon a crime with a copy of the criminal history record information relied upon in making the determination. (BPC § § 485(b)(1); 490)
- 4) Prohibits the criminal history record from being modified from its form or content as provided by the DOJ. (BPC § § 485(b)(1); 490)
- 5) Requires the board to provide the criminal history in a manner that protects the confidentiality and privacy of the individual's record and prohibits the information from being made available to any employer. (BPC § § 485(b)(1); 490)

Comment:

- 1) **Author's Intent.** Staff did not receive a return call from the author's office after repeated attempts, so the author's (or sponsor's) intent is not yet known.
- 2) **Dismissed Convictions.** This proposal is in conflict with BPC Sections 4982(a), 4989.54(a) and 4992.3(a), which state, in part:

"The board may order any license or registration suspended or revoked, or may decline to issue a license or registration when...an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under Section 1203.4 of the Penal Code allowing the person to withdraw a plea of guilty and enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, information or indictment."

The Board's processes and laws pertaining to criminal convictions are currently working well. Applicants with a criminal conviction are not categorically excluded. Licenses are being denied with just cause, and applicants are provided with ample due process. The board needs to be able to consider all past criminal history, including dismissed convictions, rather than a formulaic standard in making a decision regarding a denial or disciplinary action.

Through the 1203.4 process, felony convictions are reduced to misdemeanors and subsequently dismissed. The board needs to retain the right to be able to deny based on those convictions if they are substantially related. Such standards would result in prohibiting denial of a license based on multiple misdemeanors, or any felony which is not considered serious or violent by law, but may be substantially related to the license.

When a conviction is dismissed under Penal Code Section 1203.4, this basically means the individual was convicted, complied with probation terms, stayed out of trouble, and petitioned for dismissal. However, a dismissed conviction under 1203.4 is still a conviction. It is very rare for the board to take disciplinary action or deny an application based on one dismissed conviction. The Board has taken action when there have been a number of dismissed convictions, but the conviction history reveals a pattern of criminal activity (such as petty theft, drug abuse) or where the history demonstrates that the individual has a problem.

- 3) **Arrest Reports.** This bill would prohibit the board from denying licensure for an arrest more than one year old if no disposition is reported. Applicants are only required to disclose convictions, not arrests, when applying to the board for a license or registration. Staff has received fingerprint results that disclose an arrest, with no disposition or warrant issued. The Board hasn't denied in those cases, but have requested information from the applicant. The Board has had several cases in which the arrest occurred more than a year previously and the case is still moving slowly through criminal courts. The major concern would be when this arrest was for a serious violation, such as a felony. Another concern would be when an individual has had one or more past convictions, but these convictions were so far in the past that the board would not deny license. However, the outstanding arrest might become the conviction that justifies a denial.
- 4) **Criminal Record.** This bill would require the Board to provide certain applicants with a copy of his or her criminal history record. This appears to be in conflict with Penal Code Section 11105 which states, in part:

"Any information obtained from the state summary criminal history is confidential and the receiving public utility shall not disclose its contents, other than for the purpose for which it was acquired."

While the Board is investigating a conviction, the licensee or applicant is aware of the conviction history being investigated. The denial or accusation contains the complete history as given by criminal offender record information (CORI) which includes court, docket number, sentence, etc. Additionally, any licensee or applicant can obtain their criminal history by having their prints taken and having the results sent to them. A denial or disciplinary action is never based on CORI. CORI is just the means by which the Board finds out about it. A denial or action is taken based on arrest report, court documents, explanation, proof of rehabilitation, etc.

5) Substantial Relationship Criteria. Reviewing criminal histories to determine whether a crime is substantially related to the qualifications, functions, or duties of the profession is one of the Board's most critical tasks. Title 16, California Code of Regulations Section 1812 provides the criteria for determining when a crime or act is substantially related. It states:

"For purposes of denial, suspension, or revocation of a license or registration...a crime or act shall be considered to be substantially related to the qualifications, functions or duties of a person holding a license...if to a substantial degree it evidences present or potential unfitness of a person holding a license to perform the functions authorized by his or her license in a manner consistent with the public health, safety or welfare."

In order to help make the determination, an applicant may provide evidence of rehabilitation, and the Board is authorized to inquire into the circumstances surrounding the charges. Current law requires the Board to deny a license to persons convicted of a crime involving sexual abuse of children or resulting in registration as a sex offender. The Board is also permitted to deny a license to applicants guilty of unprofessional conduct, which includes but is not limited to, the conviction or more than one misdemeanor, any felony involving the use of any substances considered unsafe, or an act punishable as a sexually related crime.

6) Statistics.

	03/04	04/05	05/06
Applications Received	6,279	6,587	6,974
Criminal Convictions Reported	383	384	455
Conviction-Related Denials	5	1	5

7) BBS Process for Denial of Licensure. When an applicant has a conviction, Board's lead enforcement analyst:

- Reviews the conviction information
- Reviews any rehabilitation information
- May request additional information
- Makes a recommendation to the Executive Officer

The Executive Officer makes the decision whether to deny licensure or continue processing the application. The applicant has 60 days to appeal the decision. If an appeal is received:

- The file is transmitted to the Attorney General's office
- A Statement of Issues is prepared
- A hearing date is set
- The case is heard by an administrative law judge who proposes a decision
- The board members vote on the proposed decision

8) Support and Opposition.

Not known at this time.

9) History

2007

Mar. 12 Referred to Com. on B. & P.

Feb. 23 From printer. May be heard in committee March 25.

Feb. 22 Read first time. To print.

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ASSEMBLY BILL

No. 1025

Introduced by Assembly Member Bass

February 22, 2007

An act to amend Sections 480, 485, 490, and 491 of the Business and Professions Code, relating to professions and vocations.

LEGISLATIVE COUNSEL'S DIGEST

AB 1025, as introduced, Bass. Professions and vocations: denial of licensure.

Existing law provides for the licensure and regulation of various professions and vocations by boards within the Department of Consumer Affairs. Existing law authorizes a board to deny licensure on certain bases, including an applicant's conviction of a crime regardless of whether the conviction has been dismissed on specified grounds, an applicant's performance of any act involving dishonesty, fraud, or deceit with the intent to substantially benefit himself or herself or another or to substantially injure another, or an applicant's performance of any act that would be grounds for suspension or revocation of the license. Existing law requires a board that denies an application for licensure to provide the applicant with notice of the denial, as specified. Existing law authorizes a board to suspend or revoke a license on the basis that a licensee has been convicted of a crime that is substantially related to the qualifications, functions, or duties of the business or profession for which the license was issued, regardless of whether the conviction has been dismissed on specified grounds, and requires the board to provide the ex-licensuree with certain information upon doing so.

This bill would provide that a person may not be denied licensure or have his or her license suspended or revoked based on a criminal

conviction that has been dismissed on specified grounds. The bill would also provide that an arrest more than one year old does not constitute grounds for denial of a license pursuant to the above provisions if no disposition is reported. This bill would require the board to provide an applicant or ex-licensee whose application has been denied or whose license has been suspended or revoked based upon a crime with a copy of the criminal history record information relied upon in making the determination, as specified.

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

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

1 SECTION 1. Section 480 of the Business and Professions Code
2 is amended to read:

3 480. (a) A board may deny a license regulated by this code
4 on the grounds that the applicant has *done* one of the following:

5 (1) Been convicted of a crime. A conviction within the meaning
6 of this section means a plea or verdict of guilty or a conviction
7 following a plea of nolo contendere. Any action which a board is
8 permitted to take following the establishment of a conviction may
9 be taken when the time for appeal has elapsed, or the judgment of
10 conviction has been affirmed on appeal, or when an order granting
11 probation is made suspending the imposition of sentence;
12 ~~irrespective of a subsequent order under the provisions of Section~~
13 ~~4203.4 of the Penal Code.~~

14 (2) Done any act involving dishonesty, fraud or deceit with the
15 intent to substantially benefit himself or another, or substantially
16 injure another; or

17 (3) Done any act which if done by a licentiate of the business
18 or profession in question, would be grounds for suspension or
19 revocation of license.

20 The board may deny a license pursuant to this subdivision only
21 if the crime or act is substantially related to the qualifications,
22 functions or duties of the business or profession for which
23 application is made.

24 (b) Notwithstanding any other provision of this code, no person
25 shall be denied a license solely on the basis that he *or she* has been
26 convicted of a felony if he *or she* has obtained a certificate of
27 rehabilitation under Section 4852.01 and following of the Penal

1 Code or that he *or she* has been convicted of a misdemeanor if he
2 *or she* has met all applicable requirements of the criteria of
3 rehabilitation developed by the board to evaluate the rehabilitation
4 of a person when considering the denial of a license under
5 subdivision (a) of Section 482. *In addition, no person shall be*
6 *denied a license based on any criminal conviction that has been*
7 *dismissed pursuant to Section 1203.4 or 1203.4a of the Penal*
8 *Code.*

9 (c) A board may deny a license regulated by this code on the
10 ground that the applicant knowingly made a false statement of fact
11 required to be revealed in the application for such license.

12 (d) *For purposes of this section, the term “act” does not include*
13 *arrests more than one year old if no disposition is reported.*

14 SEC. 2. Section 485 of the Business and Professions Code is
15 amended to read:

16 485. Upon denial of an application for a license under this
17 chapter or Section 496, the board shall do either of the following:

18 (a) File and serve a statement of issues in accordance with
19 Chapter 5 (commencing with Section 11500) of Part 1 of Division
20 3 of Title 2 of the Government Code.

21 (b) Notify the applicant that the application is denied, stating
22 (1) the reason for the denial, and (2) that the applicant has the
23 right to a hearing under Chapter 5 (commencing with Section
24 11500) of Part 1 of Division 3 of Title 2 of the Government Code
25 if written request for hearing is made within 60 days after service
26 of the notice of denial. Unless written request for hearing is made
27 within the 60-day period, the applicant’s right to a hearing is
28 deemed waived.

29 Service of the notice of denial may be made in the manner
30 authorized for service of summons in civil actions, or by registered
31 mail addressed to the applicant at the latest address filed by the
32 applicant in writing with the board in his or her application or
33 otherwise. Service by mail is complete on the date of mailing.

34 *If the denial of a license is due at least in part to the individual’s*
35 *state or federal criminal history record, the board shall include*
36 *with the notice of denial a copy of the criminal history record*
37 *relied upon in making the denial determination. The state or federal*
38 *criminal history record shall not be modified or altered from its*
39 *form or content as provided by the Department of Justice, and*
40 *shall be sent to the address specified by the individual in his or*

1 *her application. The criminal history record shall be provided in*
 2 *such a manner as to protect the confidentiality and privacy of the*
 3 *individual’s record, and the criminal history information shall not*
 4 *be made available by the board to any employer.*

5 SEC. 3. Section 490 of the Business and Professions Code is
 6 amended to read:

7 490. A board may suspend or revoke a license on the ground
 8 that the licensee has been convicted of a crime, if the crime is
 9 substantially related to the qualifications, functions, or duties of
 10 the business or profession for which the license was issued. A
 11 conviction within the meaning of this section means a plea or
 12 verdict of guilty or a conviction following a plea of nolo
 13 contendere. Any action which a board is permitted to take
 14 following the establishment of a conviction may be taken when
 15 the time for appeal has elapsed, or the judgment of conviction has
 16 been affirmed on appeal, or when an order granting probation is
 17 made suspending the imposition of sentence, ~~irrespective of a~~
 18 ~~subsequent order under the provisions of Section 1203.4 of the~~
 19 ~~Penal Code.~~ *No license shall be suspended or revoked based on*
 20 *any criminal conviction that has been dismissed pursuant to Section*
 21 *1203.4 or 1203.4a of the Penal Code.*

22 SEC. 4. Section 491 of the Business and Professions Code is
 23 amended to read:

24 491. Upon suspension or revocation of a license by a board on
 25 one or more of the grounds specified in Section 490, the board
 26 shall *do all of the following*:

27 (a) Send a copy of the provisions of Section 11522 of the
 28 Government Code to the ex-licensee.

29 (b) Send a copy of the criteria relating to rehabilitation
 30 formulated under Section 482 to the ex-licensee.

31 (c) *Send a copy of the criminal history record relied upon in*
 32 *making the determination to suspend or revoke the license to the*
 33 *ex-licensee. The state or federal criminal history record*
 34 *information shall not be modified or altered from its form or*
 35 *content as provided by the Department of Justice, and shall be*
 36 *provided to the board’s address of record of the ex-licensee. The*
 37 *criminal history record shall be provided in such a manner as to*
 38 *protect the confidentiality and privacy of the individual’s record,*

- 1 *and the criminal history information shall not be made available*
- 2 *by the board to any employer.*

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CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES

BILL ANALYSIS

BILL NUMBER: AB 1178 **VERSION:** INTRODUCED FEBRUARY 23, 2007

AUTHOR: HERNANDEZ **SPONSOR:** CAMFT

RECOMMENDED POSITION: NONE

SUBJECT: MEDICAL INFORMATION: DISCLOSURES

Existing Law:

- 1) Defines "licensed health care professional" to include all Board licensees and registrants, among others. (CvC § 56.05 (e))
- 2) Defines "medical information" as any individually identifiable information in possession of or derived from a provider of health care, health care service plan, pharmaceutical company, or contractor regarding a patient's medical history, mental or physical condition, or treatment. "Individually identifiable" means that the medical information includes or contains any element of personal information sufficient to allow identification of the individual. (CvC § 56.05(g))
- 3) Defines "Provider of health care" to include all Board licensees and registrants, among others. (CvC § 56.05(j))
- 4) Prohibits a provider of health care from disclosing medical information regarding a patient without first obtaining an authorization, except in specified situations. (CvC § 56.10(a))
- 5) Prohibits a provider of health care from releasing medical information to those authorized by law to receive that information, if the requested information specifically relates to the patient's participation in outpatient treatment with a psychotherapist, unless the person or entity requesting that information submits to the patient and to the provider a written request, signed by the person requesting the information or an authorized agent of the entity requesting the information. (CvC § 56.104(a))
- 6) Requires a therapist who determines, according to professional standards that a patient presents a serious danger of violence to another, to use reasonable care to protect the intended victim(s) against such danger. This includes warning the intended victim(s), the police, or taking whatever other steps are reasonably necessary under the circumstances. (Tarasoff, supra, 17 Cal.3d)
- 7) Requires a therapist whose patient has communicated a serious threat of physical violence against a reasonably identifiable victim(s) to communicate the threat to the victim(s) and police. (CvC § 43.92)
- 8) Requires a mental health professional to breach confidentiality when the professional reasonably suspects that the patient may present a threat to another or another's property. (EvC § 1024)

- 9) Requires a psychotherapist to warn a potential victim(s) if information communicated to the psychotherapist leads the therapist to believe or predict that the patient poses a serious risk of grave bodily injury to another. (Ewing v. Goldstein (2004), Cal.App.4th)
- 10) Defines "confidential communication between patient and psychotherapist" as: (EvC § 1012)
 - Information obtained from examining a patient
 - Information transmitted between a patient and psychotherapist in confidence and to no one else except:
 - Information transmitted to those who are present to further the interest of the patient
 - Information transmitted to those necessary to accomplish the goals of treatment
 - The psychotherapist's diagnosis and advice

This Bill:

- 1) Permits a provider of health care to disclose medical information when a psychotherapist has reasonable cause to believe that the patient is in such a mental or emotional condition as to be dangerous to himself or herself or to the person or property of another and that disclosure is necessary to prevent the threatened danger. (CvC § 56.10(a))

Comment:

- 1) **Author's Intent.** The sponsor, the California Association of Marriage and Family Therapists (CAMFT) states that the change proposed by this bill parallels current law on the subject of a dangerous patient. The California Medical Records Confidentiality Act (CMIA) lists exemptions to provider-patient confidentiality, and the dangerous client exemption is not currently included. However, the authority for a therapist to disclose confidential information about a dangerous patient already appears in the Evidence Code as an exemption to the provider-patient privilege, which has already been interpreted by some courts as an exemption to therapist-client confidentiality if the dangerous patient situation occurs.
- 2) **Confidentiality.** This bill clarifies in the CMIA that a psychotherapist may breach confidentiality in the case of a dangerous patient. Evidence Code Section 1024 already permits therapists to take this action, so this bill would make a conforming change.
- 3) **Support and Opposition.**
Not yet known
- 4) **History**
2007
Feb. 26 Read first time.
Feb. 25 From printer. May be heard in committee March 27.
Feb. 23 Introduced. To print.

ASSEMBLY BILL

No. 1178

Introduced by Assembly Member Hernandez

February 23, 2007

An act to amend Section 56.10 of the Civil Code, relating to medical information.

LEGISLATIVE COUNSEL'S DIGEST

AB 1178, as introduced, Hernandez. Medical information: disclosures.

The Confidentiality of Medical Information Act prohibits a provider of health care, health care service plan, or contractor, as defined, from disclosing medical information regarding a patient, enrollee, or subscriber, except as authorized by that patient, enrollee, or subscriber, or as otherwise required or authorized by law.

This bill would further except from that prohibition, the disclosure of medical information under circumstances in which a psychotherapist, as defined, has reasonable cause to believe that a patient is a danger to himself or herself or to the person or property of another and that disclosure is necessary to prevent the threatened danger.

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

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

- 1 SECTION 1. Section 56.10 of the Civil Code is amended to
2 read:
3 56.10. (a) No provider of health care, health care service plan,
4 or contractor shall disclose medical information regarding a patient
5 of the provider of health care or an enrollee or subscriber of a

1 health care service plan without first obtaining an authorization,
2 except as provided in subdivision (b) or (c).

3 (b) A provider of health care, a health care service plan, or a
4 contractor shall disclose medical information if the disclosure is
5 compelled by any of the following:

6 (1) By a court pursuant to an order of that court.

7 (2) By a board, commission, or administrative agency for
8 purposes of adjudication pursuant to its lawful authority.

9 (3) By a party to a proceeding before a court or administrative
10 agency pursuant to a subpoena, subpoena duces tecum, notice to
11 appear served pursuant to Section 1987 of the Code of Civil
12 Procedure, or any provision authorizing discovery in a proceeding
13 before a court or administrative agency.

14 (4) By a board, commission, or administrative agency pursuant
15 to an investigative subpoena issued under Article 2 (commencing
16 with Section 11180) of Chapter 2 of Part 1 of Division 3 of Title
17 2 of the Government Code.

18 (5) By an arbitrator or arbitration panel, when arbitration is
19 lawfully requested by either party, pursuant to a subpoena duces
20 tecum issued under Section 1282.6 of the Code of Civil Procedure,
21 or any other provision authorizing discovery in a proceeding before
22 an arbitrator or arbitration panel.

23 (6) By a search warrant lawfully issued to a governmental law
24 enforcement agency.

25 (7) By the patient or the patient's representative pursuant to
26 Chapter 1 (commencing with Section 123100) of Part 1 of Division
27 106 of the Health and Safety Code.

28 (8) By a coroner, when requested in the course of an
29 investigation by the coroner's office for the purpose of identifying
30 the decedent or locating next of kin, or when investigating deaths
31 that may involve public health concerns, organ or tissue donation,
32 child abuse, elder abuse, suicides, poisonings, accidents, sudden
33 infant deaths, suspicious deaths, unknown deaths, or criminal
34 deaths, or when otherwise authorized by the decedent's
35 representative. Medical information requested by the coroner under
36 this paragraph shall be limited to information regarding the patient
37 who is the decedent and who is the subject of the investigation and
38 shall be disclosed to the coroner without delay upon request.

39 (9) When otherwise specifically required by law.

1 (c) A provider of health care or a health care service plan may
2 disclose medical information as follows:

3 (1) The information may be disclosed to providers of health
4 care, health care service plans, contractors, or other health care
5 professionals or facilities for purposes of diagnosis or treatment
6 of the patient. This includes, in an emergency situation, the
7 communication of patient information by radio transmission or
8 other means between emergency medical personnel at the scene
9 of an emergency, or in an emergency medical transport vehicle,
10 and emergency medical personnel at a health facility licensed
11 pursuant to Chapter 2 (commencing with Section 1250) of Division
12 2 of the Health and Safety Code.

13 (2) The information may be disclosed to an insurer, employer,
14 health care service plan, hospital service plan, employee benefit
15 plan, governmental authority, contractor, or any other person or
16 entity responsible for paying for health care services rendered to
17 the patient, to the extent necessary to allow responsibility for
18 payment to be determined and payment to be made. If (A) the
19 patient is, by reason of a comatose or other disabling medical
20 condition, unable to consent to the disclosure of medical
21 information and (B) no other arrangements have been made to pay
22 for the health care services being rendered to the patient, the
23 information may be disclosed to a governmental authority to the
24 extent necessary to determine the patient's eligibility for, and to
25 obtain, payment under a governmental program for health care
26 services provided to the patient. The information may also be
27 disclosed to another provider of health care or health care service
28 plan as necessary to assist the other provider or health care service
29 plan in obtaining payment for health care services rendered by that
30 provider of health care or health care service plan to the patient.

31 (3) The information may be disclosed to any person or entity
32 that provides billing, claims management, medical data processing,
33 or other administrative services for providers of health care or
34 health care service plans or for any of the persons or entities
35 specified in paragraph (2). However, no information so disclosed
36 shall be further disclosed by the recipient in any way that would
37 be violative of this part.

38 (4) The information may be disclosed to organized committees
39 and agents of professional societies or of medical staffs of licensed
40 hospitals, licensed health care service plans, professional standards

1 review organizations, independent medical review organizations
2 and their selected reviewers, utilization and quality control peer
3 review organizations as established by Congress in Public Law
4 97-248 in 1982, contractors, or persons or organizations insuring,
5 responsible for, or defending professional liability that a provider
6 may incur, if the committees, agents, health care service plans,
7 organizations, reviewers, contractors, or persons are engaged in
8 reviewing the competence or qualifications of health care
9 professionals or in reviewing health care services with respect to
10 medical necessity, level of care, quality of care, or justification of
11 charges.

12 (5) The information in the possession of any provider of health
13 care or health care service plan may be reviewed by any private
14 or public body responsible for licensing or accrediting the provider
15 of health care or health care service plan. However, no
16 patient-identifying medical information may be removed from the
17 premises except as expressly permitted or required elsewhere by
18 law, nor shall that information be further disclosed by the recipient
19 in any way that would violate this part.

20 (6) The information may be disclosed to the county coroner in
21 the course of an investigation by the coroner's office when
22 requested for all purposes not included in paragraph (8) of
23 subdivision (b).

24 (7) The information may be disclosed to public agencies, clinical
25 investigators, including investigators conducting epidemiologic
26 studies, health care research organizations, and accredited public
27 or private nonprofit educational or health care institutions for bona
28 fide research purposes. However, no information so disclosed shall
29 be further disclosed by the recipient in any way that would disclose
30 the identity of any patient or be violative of this part.

31 (8) A provider of health care or health care service plan that has
32 created medical information as a result of employment-related
33 health care services to an employee conducted at the specific prior
34 written request and expense of the employer may disclose to the
35 employee's employer that part of the information that:

36 (A) Is relevant in a lawsuit, arbitration, grievance, or other claim
37 or challenge to which the employer and the employee are parties
38 and in which the patient has placed in issue his or her medical
39 history, mental or physical condition, or treatment, provided that

1 information may only be used or disclosed in connection with that
2 proceeding.

3 (B) Describes functional limitations of the patient that may
4 entitle the patient to leave from work for medical reasons or limit
5 the patient's fitness to perform his or her present employment,
6 provided that no statement of medical cause is included in the
7 information disclosed.

8 (9) Unless the provider of health care or health care service plan
9 is notified in writing of an agreement by the sponsor, insurer, or
10 administrator to the contrary, the information may be disclosed to
11 a sponsor, insurer, or administrator of a group or individual insured
12 or uninsured plan or policy that the patient seeks coverage by or
13 benefits from, if the information was created by the provider of
14 health care or health care service plan as the result of services
15 conducted at the specific prior written request and expense of the
16 sponsor, insurer, or administrator for the purpose of evaluating the
17 application for coverage or benefits.

18 (10) The information may be disclosed to a health care service
19 plan by providers of health care that contract with the health care
20 service plan and may be transferred among providers of health
21 care that contract with the health care service plan, for the purpose
22 of administering the health care service plan. Medical information
23 may not otherwise be disclosed by a health care service plan except
24 in accordance with the provisions of this part.

25 (11) Nothing in this part shall prevent the disclosure by a
26 provider of health care or a health care service plan to an insurance
27 institution, agent, or support organization, subject to Article 6.6
28 (commencing with Section 791) of Part 2 of Division 1 of the
29 Insurance Code, of medical information if the insurance institution,
30 agent, or support organization has complied with all requirements
31 for obtaining the information pursuant to Article 6.6 (commencing
32 with Section 791) of Part 2 of Division 1 of the Insurance Code.

33 (12) The information relevant to the patient's condition and care
34 and treatment provided may be disclosed to a probate court
35 investigator engaged in determining the need for an initial
36 conservatorship or continuation of an existent conservatorship, if
37 the patient is unable to give informed consent, or to a probate court
38 investigator, probation officer, or domestic relations investigator
39 engaged in determining the need for an initial guardianship or
40 continuation of an existent guardianship.

1 (13) The information may be disclosed to an organ procurement
2 organization or a tissue bank processing the tissue of a decedent
3 for transplantation into the body of another person, but only with
4 respect to the donating decedent, for the purpose of aiding the
5 transplant. For the purpose of this paragraph, the terms “tissue
6 bank” and “tissue” have the same meaning as defined in Section
7 1635 of the Health and Safety Code.

8 (14) The information may be disclosed when the disclosure is
9 otherwise specifically authorized by law, such as the voluntary
10 reporting, either directly or indirectly, to the federal Food and Drug
11 Administration of adverse events related to drug products or
12 medical device problems.

13 (15) Basic information, including the patient’s name, city of
14 residence, age, sex, and general condition, may be disclosed to a
15 state or federally recognized disaster relief organization for the
16 purpose of responding to disaster welfare inquiries.

17 (16) The information may be disclosed to a third party for
18 purposes of encoding, encrypting, or otherwise anonymizing data.
19 However, no information so disclosed shall be further disclosed
20 by the recipient in any way that would be violative of this part,
21 including the unauthorized manipulation of coded or encrypted
22 medical information that reveals individually identifiable medical
23 information.

24 (17) For purposes of disease management programs and services
25 as defined in Section 1399.901 of the Health and Safety Code,
26 information may be disclosed as follows: (A) to any entity
27 contracting with a health care service plan or the health care service
28 plan’s contractors to monitor or administer care of enrollees for a
29 covered benefit, provided that the disease management services
30 and care are authorized by a treating physician, or (B) to any
31 disease management organization, as defined in Section 1399.900
32 of the Health and Safety Code, that complies fully with the
33 physician authorization requirements of Section 1399.902 of the
34 Health and Safety Code, provided that the health care service plan
35 or its contractor provides or has provided a description of the
36 disease management services to a treating physician or to the health
37 care service plan’s or contractor’s network of physicians. Nothing
38 in this paragraph shall be construed to require physician
39 authorization for the care or treatment of the adherents of any
40 well-recognized church or religious denomination who depend

1 solely upon prayer or spiritual means for healing in the practice
2 of the religion of that church or denomination.

3 (18) The information may be disclosed, as permitted by state
4 and federal law or regulation, to a local health department for the
5 purpose of preventing or controlling disease, injury, or disability,
6 including, but not limited to, the reporting of disease, injury, vital
7 events such as birth or death, and the conduct of public health
8 surveillance, public health investigations, and public health
9 interventions, as authorized or required by state or federal law or
10 regulation.

11 (19) *The information may be disclosed when a psychotherapist,*
12 *as defined in Section 1010 of the Evidence Code, has reasonable*
13 *cause to believe that the patient is in such a mental or emotional*
14 *condition as to be dangerous to himself or herself or to the person*
15 *or property of another and that disclosure of the information is*
16 *necessary to prevent the threatened danger.*

17 (d) Except to the extent expressly authorized by the patient or
18 enrollee or subscriber or as provided by subdivisions (b) and (c),
19 no provider of health care, health care service plan, contractor, or
20 corporation and its subsidiaries and affiliates shall intentionally
21 share, sell, use for marketing, or otherwise use any medical
22 information for any purpose not necessary to provide health care
23 services to the patient.

24 (e) Except to the extent expressly authorized by the patient or
25 enrollee or subscriber or as provided by subdivisions (b) and (c),
26 no contractor or corporation and its subsidiaries and affiliates shall
27 further disclose medical information regarding a patient of the
28 provider of health care or an enrollee or subscriber of a health care
29 service plan or insurer or self-insured employer received under
30 this section to any person or entity that is not engaged in providing
31 direct health care services to the patient or his or her provider of
32 health care or health care service plan or insurer or self-insured
33 employer.

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- Adults or older adults who require or are at risk of requiring acute psychiatric inpatient care, residential treatment, or outpatient crisis intervention because of a mental disorder with symptoms of psychosis, suicidality, or violence.
- 4) Requires California veterans in need of mental health services and who meet the existing eligibility requirements of this section, to be provided services to the extent resources are available. (PC § 5600.3(b)(5))
 - Encourages counties to advise veterans who may be eligible for mental health services through the United States Department of Veterans Affairs (VA) that such services are available.
 - Prohibits an eligible veteran from being denied county mental health services based solely on his or her status as a veteran.
 - Requires counties to refer a veteran to the county veterans service officer, if any, to determine the veteran's eligibility for, and the availability of, mental health services provided by the VA or other federal health care provider.
 - Requires counties to consider contracting with community-based veterans' services agencies, where possible, to provide high-quality, veteran specific mental health services.
 - 5) Prohibits the use in the prisons, any cruel, corporal or unusual punishment or to inflict any treatment or allow any lack of care whatever which would injure or impair the health of the prisoner, inmate or person confined. (PC § 2652).
 - 6) Permits any mentally ill, mentally deficient, or insane person confined in a state prison to be treated at any one of the state hospitals with the approval of the Board of Prison Terms (BPT). (PC § 2684(a))
 - Requires the director of the appropriate department to evaluate the prisoner to determine if he or she would benefit from care and treatment in a state hospital
 - Permits the superintendent of the hospital to receive the prisoner and keep him or her until in the opinion of the superintendent the person has been treated to the extent that he or she will not benefit from further care and treatment in the state hospital.
 - 7) Requires the superintendent to immediately notify the Director of Corrections the mentally ill, mentally deficient or insane prisoner has been treated to such an extent that he or she will not benefit by further care and treatment in the state hospital. Requires the Director of Corrections to immediately send for, take and receive the prisoner back into prison. (PC § 2685)
 - 8) Declares legislative findings that: (PC § 2960)
 - There are prisoners who have a treatable, severe mental disorder that was one of the causes of, or was an aggravating factor in the commission of the crime for which they were incarcerated.
 - If the severe mental disorders of those prisoners are not in remission or cannot be kept in remission at the time of their parole or upon termination of parole, there is a danger to society, and the state has a compelling interest in protecting the public.
 - In order to protect the public from those persons it is necessary to provide mental health treatment until the severe mental disorder which was one of the causes of or was an aggravating factor in the person's prior criminal behavior is and can be kept in remission.
 - The California Department of Corrections (CDC) should evaluate each prisoner for severe mental disorders during the first year of the prisoner's sentence, and severely mentally disordered prisoners should be provided with an appropriate level of mental health treatment while in prison and when returned to the community.

- 9) Requires, as a condition of parole, a prisoner who meets the following criteria to be treated by the Department of Mental Health (DMH): (PC § 2962)
 - Has a severe mental disorder that is not in remission or cannot be kept in remission without treatment
 - The severe mental disorder was one of the causes of or was an aggravating factor in the commission of a crime for which the prisoner was sentenced to prison.
 - Has been in treatment for the severe mental disorder for 90 days or more within the year prior to the prisoner's parole or release.
- 10) Defines "severe mental disorder" as a condition that substantially impairs the person's thought, perception of reality, emotional process, or judgment; or which grossly impairs behavior; or that demonstrates evidence of an acute brain syndrome for which prompt remission, in the absence of treatment, is unlikely. (PC § 2962(a))
- 11) Defines "remission" as a finding that the overt signs and symptoms of the severe mental disorder are controlled either by psychotropic medication or psychosocial support. (PC § 2962(a))
- 12) Establishes that a person "cannot be kept in remission without treatment" if during the year prior he or she has been in remission and has been physically violent, except in self-defense, or he or she has made a serious threat of substantial physical harm to another who reasonably fears for his or her safety or the safety of his or her immediate family, or he or she has intentionally caused property damage, or he or she has not voluntarily followed the treatment plan. (PC § 2962(a))
 - In determining if a person has voluntarily followed the treatment plan, the standard shall be whether the person has acted as a reasonable person would in following the treatment plan.
- 13) Requires, prior to release on parole, the person in charge of treating the prisoner and a practicing psychiatrist or psychologist from the DMH to evaluate the prisoner and a chief psychiatrist of the CDC has certified to the BPT that the prisoner: (PC § 2962(d)(1))
 - Has a severe mental disorder which is not in remission, or cannot be kept in remission without treatment
 - That the severe mental disorder was one of the causes or was an aggravating factor in the prisoner's criminal behavior
 - That the prisoner has been in treatment for the severe mental disorder for 90 days or more within the year prior to his or her parole release day
 - By reason of his or her severe mental disorder the prisoner represents a substantial danger of physical harm to others.
- 14) If the professionals doing the evaluation do not concur to the following, then the BPT shall order a further examination by two independent professionals: (PC § 2962(d)(2))
 - The prisoner has a severe mental disorder
 - That the disorder is not in remission or cannot be kept in remission without treatment, or
 - That the severe mental disorder was a cause of, or aggravated, the prisoner's criminal behavior.
- 15) Requires the professionals to inform the prisoner that the purpose of their examination is not treatment but to determine if the prisoner meets certain criteria to be involuntarily treated as a mentally disordered offender. It is not required that the prisoner appreciate or understand that information. (PC § 2962(d)(3))

- 16) Requires treatment to be inpatient unless the DMH certifies to the BPT that there is reasonable cause to believe the parolee can be safely and effectively treated on an outpatient basis, in which case the BPT shall permit the DMH to place the parolee in an outpatient treatment program specified by the DMH. (PC § 2964(a))
- 17) Requires any prisoner who is to be required to accept treatment to be informed in writing of his or her right to request a hearing. Requires the DMH, prior to placing a parolee in a local outpatient program, to consult with the program as to the appropriate treatment plan. (PC § 2964(a))
- 18) Permits a parolee ordered to have outpatient treatment to be placed in an outpatient community treatment program, and: (PC § 2964(a))
 - Permits the community program director to place the parolee in a secure mental health facility if needed until the parolee can be safely and effectively treated in the program.
 - Generally requires the DMH to conduct a hearing within 15 days on whether the parolee can be safely and effectively treated in the program.
 - Before deciding to seek revocation of the parole of a parolee receiving mental health treatment, the parole officer shall consult with the director of the parolee's outpatient program.
- 19) Permits the parolee to request a hearing before the BPT if the DMH has not placed a parolee on outpatient treatment within 60 days after receiving custody of the parolee or after parole is continued. (PC § 2964(b))
 - Requires the board to conduct a hearing to determine whether the prisoner shall be treated as an inpatient or an outpatient.
 - At the hearing, the burden shall be on the DMH to establish that the prisoner requires inpatient treatment as described in this subdivision.
 - If the prisoner or any person appearing on his or her behalf at the hearing requests it, the board shall appoint two independent professionals.
- 20) Requires the medical director of the state hospital which is treating the parolee, or the community program director in charge of the parolee's outpatient program, or the Director of Corrections, not later than 180 days prior to the termination of parole, or release from prison, to submit to the district attorney his or her written evaluation on remission if the prisoner's severe mental disorder is not in remission or cannot be kept in remission without treatment. (PC § 2970)
 - Permits the district attorney to file a petition with the superior court for continued involuntary treatment for one year.
 - Requires the petition to be accompanied by affidavits specifying the following:
 - Treatment has been continuously provided while the prisoner was released from prison on parole
 - The prisoner has a severe mental disorder not in remission or that cannot be kept in remission if the person's treatment is not continued.
 - By reason of his or her severe mental disorder, the prisoner represents a substantial danger of physical harm to others.
- 21) Requires the court to conduct a hearing on the petition for continued treatment within 30 days of when the prisoner would have been released. (PC § 2972(a))
- 22) Permits a petition for recommitment to be filed prior to the termination of a commitment to determine whether the patient's severe mental disorder is not in remission or cannot be kept in remission without treatment, and whether by reason of his or her severe mental disorder, the patient represents a substantial danger of physical harm to others. (PC § 2972(e))

- 23) Clarifies that any commitment places an obligation on the treatment facility to provide treatment for the underlying causes of the person's mental disorder. (PC § 2972(f))
- 24) Requires outpatient status for persons committed to a treatment facility to be for a period not to exceed one year. The person on outpatient status may either be discharged, confined or treated on outpatient status. (PC § 2972.1(a))
- 25) Permits the Director of Corrections to, upon probable cause, place the inmate in a state hospital before releasing or terminating supervision of any parolee who is a danger to self or others, or gravely disabled as a result of mental disorder. (PC § 2972.1(f))
- 26) Requires the DMH, in each year in which additional funding is provided by the annual Budget Act, to establish programs that offer counties sufficient funds to comprehensively serve severely mentally ill adults who are homeless, recently released from a county jail or the state prison, or others who are untreated, unstable, and at significant risk of incarceration or homelessness unless treatment is provided to them. (WIC 5814(b))

This Bill:

- 1) Requires a law enforcement official to contact the county mental health director to determine if there is available treatment capacity if all of the following are true: (PC § 851.95(a))
 - The official suspects that a crime has been committed by an individual with a severe mental health or substance abuse condition
 - The official believes that with treatment, criminal behavior would likely not continue
 - The person is willing to participate in treatment.
- 2) Requires the individual to receive services in accordance with the Mental Health Adult System of Care if there is treatment capacity available. If the individual fails to remain in treatment, any pending criminal charges and arrest that had been deferred pending treatment can proceed at that time. (PC § 851.95(b))
- 3) Permits superior courts to develop and implement Mental Health Courts (MHC) consistent with this proposal and Judicial Council guidelines. (PC § 1001.130(a))
- 4) Requires a MHC to have the following objectives: (PC § 1001.130(b))
 - Increased cooperation between the courts, criminal justice, mental health, and substance abuse systems.
 - Modified court processes that lead to placement of as many mentally ill offenders, including those with co-occurring disorders, in community treatment, consistent with public safety.
 - Improved access to necessary services and support.
 - Reduced recidivism.
- 5) Requires a MHC to provide a single point of contact where a defendant with a mental disability or co-occurring disorder may receive court-ordered treatment and support services in connection with a diversion from prosecution, a sentencing alternative, or a term of probation. (PC § 1001.130(c))
- 6) Requires a MHC to meet the following criteria: (PC § 1001.130(d))
 - Defendants may be referred from a variety of sources, including, but not limited to, judges within the court, police, attorneys, family members, probation officers, the district attorney, the public defender, and jail personnel.

- The court shall develop standards for continuing participation in, and graduation from, the MHC program through a collaborative process.
 - The MHC shall use a dedicated calendar, designated staff that include, but are not limited to, a designated judge to preside over the court, prosecutor, public defender, county mental health liaison, and probation officer.
 - The county mental health department and drug and alcohol department shall provide initial and ongoing training for designated staff, as needed, on the nature of mental illness and on the treatment and supportive services available in the community.
 - The MHC shall use community mental health providers and other agencies to offer defendants access to individualized treatment services.
 - The MHC shall establish a treatment plan for each defendant, and other terms and conditions that will optimize the likelihood that the defendant will complete the program.
 - The MHC shall hold frequent reviews of the offender's progress in community treatment and hold the offender accountable to adhere to the treatment plan, remain in treatment, and complete treatment.
- 7) Requires a MHC to contact the county mental health department to ensure that there is coordination and availability of the necessary mental health services, including management and evaluation of the success of those services. (PC § 1001.130(e))
 - 8) Permits defendants suffering from mental illness to be eligible to participate in a MHC if a complaint or citation for an offense is pending in superior court. (PC § 1001.131)
 - 9) Requires each county, with the input of local stakeholders, to establish a method for screening every defendant for mental illness and co-occurring disorders, at the time a complaint or citation is filed for a misdemeanor or felony offense, or at another specified time determined most appropriate by local stakeholders to consider transferring the defendant to a MHC. (PC § 1001.132(a))
 - 10) Requires each county to, with the input of stakeholders, establish case eligibility criteria specifying what factors relating to the amenability of the defendant to treatment and to the facts of the case will make the defendant eligible to participate in a MHC. (PC § 1001.132(b))
 - 11) Requires the local mental health director or his or her designee to determine whether a defendant who has been found to be suffering from mental illness is appropriate for treatment. (PC § 1001.132(c))
 - 12) Requires the district attorney or designee to assess the case of a defendant found to be suffering from mental illness to determine whether it meets the county eligibility criteria. (PC § 1001.132(d))
 - 13) Permits a defendant who is determined to be suffering from mental illness to participate in a MHC designated as treatment appropriate when his or her case meets the county eligibility criteria. (PC § 1001.132(e))
 - 14) Requires a defendant who is determined to be eligible to participate in a MHC and consents to participate to be placed on probation and to participate in the program for a minimum of one year. (PC § 1001.133(a))
 - 15) Requires the terms and conditions of probation to include participation in a Mental Health Treatment Program and, if he or she is on parole, the terms and conditions of his or her parole. (PC § 1001.133(b))

- 16) Requires the court to sentence a defendant who fails to successfully complete the Mental Health Treatment Program for the current misdemeanor or felony offense. (PC § 1001.133(c))
- 17) Requires each MHC to report to the DMH, the Department of Alcohol and Drug Programs, and the California Department of Corrections and Rehabilitation (CDCR) the savings in prison days resulting from implementation of the MHC. (PC § 1001.134)
- 18) Requires the CDCR to provide training for all persons who will be responsible for the management and care of persons with serious mental illness in the custody of the department to ensure that they are trained in recovery oriented rehabilitative services and that those services are provided in prison. (PC § 2686(a))
- 19) Requires the department to ensure that all its correctional officers are trained in dealing with inmates with mental illness. (PC § 2686(b))
- 20) Declares that a system of care for parolees with severe mental illness results in the highest benefit to the client, family, and society while ensuring that the public sector meets its legal responsibility and fiscal liability at the lowest possible cost. (PC § 2687(a))
- 21) States that the underlying philosophy for these systems of care includes the following: (PC § 2687(b))
 - Mental health care is a basic human service.
 - Seriously mentally disordered parolees usually have multiple disorders and disabling conditions.
 - Seriously mentally disordered parolees should be assigned a single person or team to be responsible for all treatment, case management, and support services.
 - The client should be fully informed and volunteer for all treatment provided, unless danger to self or others or grave disability requires temporary involuntary treatment.
 - Clients and families should directly participate in making decisions about services and resource allocations that affect their lives.
 - Mental health services should be responsive to the unique characteristics of people with mental disorders including age, gender, minority, and ethnic background, and the effect of multiple disorders.
 - Treatment, case management, and support services should be designed to prevent inappropriate removal to more restrictive and costly placements.
 - Mental health systems of care shall have measurable goals and be fully accountable by providing measures of client outcomes and cost of services.
 - State and county government agencies each have responsibilities and fiscal liabilities for seriously mentally disordered parolees.
- 22) Requires all parolees with a severe mental illness to receive comprehensive mental health and supportive services comparable to the case management and services available under existing adult systems of care. (PC § 2687.1)
- 23) Requires the CDCR to ensure the mental health needs of all parolees are met in accordance with community standards of mental health care. (PC § 2687.2)
- 24) Declares legislative findings that a mental health system of care for parolees with severe and persistent mental illness is vital for successful management of mental health care in California and should encompass all of the following: (PC § 2687.3(a))

- A comprehensive and coordinated system of care including treatment, early intervention, case management, and system components required for severe and persistent mental illness.
- The recovery of persons with severe mental illness and their financial means are important for all levels of government, business, and the community.
- System of care services that ensure culturally competent care for persons with severe mental illness in the most appropriate, least restrictive level of care are necessary to achieve performance outcomes.
- Mental health service providers need to increase accountability and further develop methods to measure progress toward client outcome goals and cost effectiveness as required by a system of care.

25) Declares legislative intent to accomplish the following using the guidelines and principles developed under the demonstration projects implemented under the elder system of care: (PC § 2687.3(d))

- Encourage each correctional facility to implement a system of care as described in this legislation for the delivery of mental health services to seriously mentally disordered parolees.
- To promote system of care accountability for performance outcomes that enable parolees with severe mental illness to reduce symptoms that impair their ability to live independently, work, maintain community supports, care for their children, stay in good health, not abuse drugs or alcohol, and not commit crimes.
- Provide funds for mental health services and related medications, substance abuse services, supportive housing or other housing assistance, vocational rehabilitation, and other non-medical programs necessary to stabilize mentally ill prisoners and parolees, reduce the risk of being homeless, get them off the street and into treatment and recovery, or to provide access to veterans' services that will also provide for treatment and recovery.

26) Requires the CDCR, in consultation with the DMH, to establish service standards that ensure prisoners with a serious mental disorder are identified, and services are provided to assist them to be able, upon release, to live independently, work, and reach their potential as productive citizens. Requires the department to provide annual oversight of services for compliance with the following standards: (PC § 2687.4)

- A service planning and delivery process that is target population-based and includes the following:
 - Determination of the number of clients to be served and the services that will be provided to meet their needs.
 - Plans for services, including design of mental health services, coordination and access to medications, psychiatric and psychological services, substance abuse services, supportive housing or other housing assistance for parolees, vocational rehabilitation, and veterans' services.
 - Plans shall also contain evaluation strategies that consider cultural, linguistic, gender, age, and special needs of minorities in the target populations.
 - Provision shall be made for staff with the cultural background and linguistic skills necessary to remove barriers to mental health services.
 - Services to meet the needs of target population clients who are physically disabled.
 - Services to meet the special needs of elder adults.
 - Family support and consultation services, parenting support and consultation services, and peer support or self-help group support.
 - Services to be client-directed and that employ psychosocial rehabilitation and recovery principles.

- Psychiatric and psychological services integrated with other services and for psychiatric and psychological collaboration in overall service planning.
- Services specifically directed to seriously mentally ill young adults 25 years of age or younger who are at significant risk of becoming homeless.
- Services reflecting special needs of women from diverse cultural backgrounds, including supportive housing that accepts children, personal services coordinator, therapeutic treatment, and substance treatment programs that address gender specific trauma and abuse in the lives of persons with mental illness, and vocational rehabilitation programs that offer job training programs free of gender bias and sensitive to the needs of women.
- Housing for parolees that is immediate, transitional, or permanent.
- Requires each client to have a mental health personal services coordinator who may be part of a multidisciplinary treatment team responsible for providing or assuring needed services.
 - Responsibilities include complete assessment of the client's needs, development of the client's personal services plan, linkage with all appropriate community services, monitoring of the quality and follow through of services, and necessary advocacy to ensure each client receives those services that are agreed to in the personal services plan.
- Requires each client to participate in the development of his or her personal services plan, and responsible staff shall consult with any designated conservator and, with the consent of the client, consult with the family and other significant persons.
- Requires the individual personal services plan to ensure that members of the target population involved in the system of care receive age, gender, and culturally appropriate services, to the extent feasible, that are designed to enable recipients upon release to:
 - Live in the most independent, least restrictive housing feasible in the local community, and for clients with children, to live in a supportive housing environment that strives for reunification with their children or assists clients in maintaining custody of their children as is appropriate.
 - Engage in the highest level of work or productive activity appropriate to their abilities and experience.
 - Create and maintain a support system consisting of friends, family, and participation in community activities.
 - Access an appropriate level of academic education or vocational training.
 - Obtain an adequate income.
 - Self-manage their illness and exert as much control as possible over both the day-to-day and long-term decisions that affect their lives.
 - Access necessary physical health care and maintain the best possible physical health.
 - Reduce or eliminate serious antisocial or criminal behavior and thereby reduce or eliminate their contact with the criminal justice system.
 - Reduce or eliminate the distress caused by the symptoms of mental illness.
 - Have freedom from dangerous addictive substances.

27) Requires the DMH to continue to work with the CDCR and other interested parties to refine and establish client and cost outcome and interagency collaboration goals including the expected level of attainment with participating counties. (PC § 2687.5)

28) Requires the DMH to provide training, consultation, and technical assistance to the CDCR. This shall include: (PC § 2687.6)

- Efforts to ensure that all of the different programs are operating as well as they can.

- Information on which programs are having particular success in particular areas so that they can be replicated in other counties.
 - Technical assistance to facilities in their first two years of participation to ensure quality and cost-effective service.
- 29) Requires services to be available to parolees who have a serious mental disorder, as defined. (PC § 2687.7)
- 30) Requires funding to be provided at sufficient levels to ensure that each facility and parolee center can provide each parolee served pursuant to this part with the medically necessary mental health services, medications, and supportive services set forth in the applicable treatment plan. (PC § 2687.7(a))
- 31) Requires the funding to only cover the portions of those costs of services that cannot be paid for with other funds including other mental health funds, public and private insurance, and other local, state, and federal funds. (PC § 2687.7(b))
- 32) Requires each correctional facility and parolee center to provide for services in accordance with the system of care for parolees with a serious mental disorder. (PC § 2687.7(c))
- 33) Requires planning for services to be consistent with the following philosophies, principles, and practices: (PC § 2687.7(d))
- To promote concepts key to the recovery for individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.
 - To promote consumer-operated services as a way to support recovery.
 - To reflect the cultural, ethnic, and racial diversity of mental health consumers.
 - To plan for each consumer's individual needs.
- 34) Requires the Director of the CDCR to establish an advisory committee for the purpose of providing advice regarding the development of performance measures for evaluating the effectiveness of programs. (PC § 2687.8(a))
- Requires the committee to review evaluation reports and make findings on evidence-based best practices and recommendations.
 - Requires the advisory committee to provide the director with written comments on program performance.
- 35) Requires the committee to include, but not be limited to: (PC § 2687.8(b))
- Representatives from state, county, and community veterans' services and disabled veterans outreach programs
 - Supportive housing and other housing assistance programs
 - Law enforcement
 - County mental health and private providers of local mental health services and mental health outreach services
 - The Board of Corrections
 - The Department of Alcohol and Drug Programs
 - Local substance abuse services providers
 - The Department of Rehabilitation
 - Providers of local employment services
 - The Department of Social Services
 - The Department of Housing and Community Development
 - A service provider to transition youth

- The United Advocates for Children of California
 - The California Mental Health Advocates for Children and Youth
 - The Mental Health Association of California
 - The California Alliance for the Mentally Ill
 - The California Network of Mental Health Clients
 - The Mental Health Planning Council
 - Other appropriate entities.
- 36) Requires the criteria for the funding for each program to include, but not be limited to, all of the following: (PC § 2687.9(a))
- A description of a comprehensive strategic plan for providing prevention, intervention, and evaluation in a cost-appropriate manner.
 - A description of the population to be served, ability to administer an effective service program, and the degree to which local agencies and advocates will support and collaborate with program efforts for parolees.
 - A description of efforts to maximize the use of other state, federal, and local funds or services that can support and enhance the effectiveness of these programs.
- 37) Requires parolee centers to enter into contracts with sponsors of supportive housing projects to the greatest extent possible in order to reduce the cost of providing supportive housing for clients. Encourages centers to commit a portion of their funds to rental assistance. (PC § 2687.10)
- 38) Requires the department to report to the Legislature on or before May 1 of each year in which additional funding is provided, and to evaluate, at a minimum, the effectiveness of the strategies for parolees in reducing homelessness, recidivism involvement with local law enforcement, and other measures identified by the department. Requires the evaluation to include for each program funded in the current fiscal year as much of the following as available information permits: (PC § 2687.10(a))
- The number of persons served, and of those, the number who receive extensive community mental health services.
 - The number of persons who are able to maintain housing, including the type of housing
 - Amount of funding spent on each type of housing.
 - Other local, state, or federal funds or programs used to house clients.
 - The number of persons with contacts with local law enforcement and the extent to which local and state incarceration has been reduced or avoided.
 - The number of persons participating in employment service programs.
 - The amount of hospitalization that has been reduced or avoided.
 - The extent to which veterans identified through these programs' outreach are receiving federally funded veterans' services.
 - The extent to which programs funded for three or more years are making a measurable and significant difference on the street, in hospitals, and in jails, as compared to other programs and in previous years.
- 39) Subjects each facility to specific terms and conditions of oversight and training that to be developed by the department. (PC § 2687.10(b))
- 40) Defines "receiving extensive mental health services" as having a personal services coordinator and having an individual personal service plan. (PC § 2687.10(c)(1))
- 41) Requires funding to be sufficient to provide the following: (PC § 2687.10(c)(2))
- Mental health services

- Medically necessary medications to treat severe mental illnesses
 - Alcohol and drug services
 - Transportation, supportive housing and other housing assistance
 - Vocational rehabilitation and supported employment services
 - Money management assistance for accessing other health care and obtaining federal income and housing support
 - Accessing veterans' services
 - Stipends, and other incentives to attract and retain sufficient numbers of qualified professionals to provide the necessary levels of services.
- 42) Requires the program to pay for only that portion of the costs of services not otherwise provided by federal funds or other state funds. (PC § 2687.10(c)(2))
- 43) Requires methods to contract for services to promote prompt and flexible use of funds, consistent with the scope of services for which the department has contracted with each provider. (PC § 2687.10(c)(3))
- 44) Permits the department to contract with counties or private providers for the provision of services. (PC § 2687.11)
- 45) At least six months before discharge of a prisoner with a severe mental illness, requires the CDCR to apply for social security and Medi-Cal benefits for those considered disabled, as well as beginning vocational training, independent living assistance, and development of other skills necessary for success during parole and afterward. (PC § 2982(a))
- 46) In the last 90 days before release of a prisoner with a severe mental illness, requires the department to coordinate with a program that will continue the medications and support services provided to the prisoner by the department during parole, after the period of incarceration. (PC § 2982(b))
- 47) Adds individuals successfully completing parole and MHCs to DMH service standards that ensure that members of the target population are identified, and services are provided to assist them to live independently, work, and reach their potential as productive citizens. (WIC § 5806)
- 48) As part of DMH's service standards, adds police, sheriffs and judges to the recipients of outreach services for those who are likely to come into contact with individuals who may be suffering from an untreated severe mental illness who would be likely to become homeless if the illness continued to be untreated for a substantial period of time. (WIC § 5806(a))
- 49) To the extent that funds are made available, requires the following as a third priority for funding: (WIC § 5814(a)(1))
- The establishment of capacity for all counties to be able to serve everyone who meets the criteria who are subject to arrest or hospitalization, discharged from a hospital or jail, or successfully completing parole.

Comment:

- 1) **Author's Intent.** According to the author, people with mental illness are overrepresented in prisons and jails. Without appropriate care for their mental health these individuals continue to reenter the criminal justice system. Presently, when an officer encounters someone with severe mental health needs who has committed a minor crime, there is seldom capacity available in mental health programs and the only safe housing option is jail. However once a more serious crime has been committed and a person becomes part of the state

corrections system, Prop. 63 explicitly reads, “Funds shall not be used to pay for persons incarcerated in state prison or parolees from state prisons.” The author argues, “If the governor can find \$10.9 billion for his prison reform plan, the state should be able to shift funds or find additional revenue to pay for a mental health overhaul that could deliver long-term savings.”ⁱ

Now that community mental health needs are beginning to be addressed, it is time to revisit what was left undone. Now that population levels behind bars have become a court-intervention crisis, it is time to address offenders’ mental health needs. The opportunity is in routing mentally ill offenders into services as early as possible, thereby treating their needs, stabilizing their illness, increasing their ability to fully incorporate the living situation around them, and reducing the likelihood that they will re-offend. This proposal looks at the continuum of an offender’s experience in the criminal justice system by employing proven methods of care.

MENTAL HEALTH COURTS

2) Mental Health Courts. A mental health court typically has the following characteristics:

- Anyone can request a transfer to the mental health court after arrest, including prosecutors
- Defendants must plead guilty and pass intensive psychiatric evaluations before being admitted.
 - Findings must show persistent mental illness and that the illness contributed to the crime charged.
 - The judge determines whether the psychiatric evidence is sufficient.
- Most only treat defendants accused of misdemeanors.
- At any time before the plea agreement is final, prosecutors can decide to switch the case to a regular criminal court.ⁱⁱ

The following are typically provided by the court for defendants with mental illness:

- Court-supervised treatment and stabilization, including medication monitoring for up to two years
- A court team composed of a judge, court personnel and treatment providers, who define terms of participation
- Continued status assessments with individualized sanctions and incentives
- Resolution of the case upon successful completion of the mandated treatment plan, or dropping the charges to a misdemeanor (may include probation, however).

Mental health courts are emerging around the country. At least 15 currently exist in California, which vary in their source of funding and organization. In 2000, Congress passed America's Law Enforcement and Mental Health Project in order to begin assisting states to enact innovative approaches to diverting offenders into treatment programs and easing the growing burden on criminal justice and corrections systems.

For more information about mental health courts, see the attached article from *The Wall Street Journal* entitled, “In Brooklyn Court, a Route Out of Jail for the Mentally Ill.”

PRISONER / PAROLEE MENTAL HEALTH CARE

3) Prisoners and Parolees. This bill proposes to treat California’s mentally ill prisoners and parolees using the model set forth by the Mental Health Services Act(MHSA). California's Little Hoover Commission reports:ⁱⁱⁱ

“The influx of persons with a mental illness into the criminal justice systems is the result of a web of interrelated causes:

- downsizing of state psychiatric institutions;
- inadequate community-based mental health services;
- economic pressures imposed upon treatment systems by managed care;
- punitive laws that tend to penalize people with serious mental illness;
- a lack of pre-arrest intervention services; and
- a lack of appropriate services designed to reintegrate a person with serious mental illness into the community following release from jail or prison.

These policy failures result in what some refer to as the criminalization of mental illness.”

California’s prisons have been described by U.S. District Judge Lawrence Karlton as “...in effect, mental hospitals.”^{iv}

According to a recent study by the U.S. Department of Justice, “More than half of the nation’s jail and prison inmates suffer from mental health problems.” The study shows “a direct relationship between gaps in community mental health care and the large numbers of mentally ill people winding up in the criminal justice system.” Additionally, there is a shortage of beds for inmates who are considered “so disturbed” that they must be kept segregated from the general population. Suicide is also a problem. In California, the suicide rate in prison is “nearly double the national average.”^v

California’s Little Hoover Commissionⁱⁱⁱ reports the following regarding parolees with serious mental illness:

- People with serious mental illness are at greater risk for recidivism.
- Parole officers are burdened with huge caseloads, making it impossible for them to handle mental health needs.
- Upon release, inmates with serious mental illness face a real risk of homelessness.
- Unstable housing increases the likelihood that persons with a mental illness will become involved in the criminal justice system.

4) Prisons. A federal court took over the California prison system's 33-facility mental health program 11 years ago as a result of a class-action lawsuit. The system's chronic overcrowding led another federal judge to take control of the prison system's other medical programs in 2004. The Governor was expected to propose more than \$600 million in new mental health facilities for the state's 31,000 inmates with mental illness after a federal judge approved the administration's plan to add 695 beds for mentally ill inmates.^{vi}

Another federal judge has ordered the state to hire more than 550 new mental health care staff to improve inadequate treatment for inmates. The Governor agreed to hire more than 200 mental health care workers earlier this year and to build new facilities at a cost of more than \$600 million. An additional mandate was handed down to increase the pay of prison mental health care workers.^{vii}

5) Support and Opposition.

Not yet known

6) History

2007

Mar. 20 Set, first hearing. Hearing canceled at the request of author.

Mar. 13 Set for hearing March 28.

Mar. 8 To Coms. on HEALTH and PUB. S.

Feb. 26 Read first time.

Feb. 24 From print. May be acted upon on or after March 26.

Feb. 23 Introduced. To Com. on RLS. for assignment. To print.

ATTACHMENT: "In Brooklyn Court, a Route Out of Jail for the Mentally Ill," *The Wall Street Journal*.

ⁱ "An Rx to Thin California Prison Population," *Los Angeles Times*, Steve Lopez, February 22, 2007.

ⁱⁱ "In Brooklyn Court, a Route Out of Jail for the Mentally Ill," *The Wall Street Journal*, Gary Fields, August 21, 2006

ⁱⁱⁱ "Criminal Justice Primer for State Mental Health Agencies," Little Hoover Commission, September 2002.

^{iv} "Mental Ills Common in Prison, Jail," *Los Angeles Times*, Jennifer Warren, September 7, 2006.

^v "Trapped by Rules, the Mentally Ill Languish in Prison," *The Wall Street Journal*, Gary Fields, May 3, 2006.

^{vi} "Calif. Ordered to Upgrade, Expand Prison Mental Health Services," *Psychiatric News*, Volume 41, Number 11, page 2, American Psychiatric Association, Rich Daly, June 2, 2006.

^{vii} "U.S. Judge Tells State to Hire Prison Mental Health Staff," *San Francisco Chronicle*, James Sterngold, August 1, 2006.

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August 21, 2006

PAGE ONE*Trial Run*

In Brooklyn Court, A Route Out of Jail For the Mentally Ill

Judge D'Emic, With Humor,
Guides Felons' Treatment;
Model for Others in U.S.

'Never Heard of Jimi Hendrix?'

By **GARY FIELDS**

August 21, 2006; Page A1

BROOKLYN, N.Y. -- Judge Matthew Jude D'Emic of the Brooklyn Mental Health Court summoned Calvin Berry to the bench to find out why he had been arguing with his court-appointed therapists.

In a series of staccato gripes, Mr. Berry said he'd been mistreated. Before he could finish, Judge D'Emic, a towering man with ruddy cheeks, cut him off: "Your bull -- arguing will get you thrown out of the program and into prison. Do you understand?"



Matthew D'Emic

Mr. Berry, 23 years old, was shocked into silence. The court's mental-health program, an increasingly popular way of dealing with mentally ill criminals, is the only thing standing between him and two years in jail. Mr. Berry suffers from severe depression caused by a childhood brain injury. Last April, he pleaded guilty to threatening to blow up a bus, among other charges. Instead of being locked up, however, he was put under the supervision of Judge D'Emic's court.

Brooklyn's mental-health program has become a model for localities trying to deal with a seemingly intractable problem: the increasing number of mentally ill people filling the nation's prisons. The problem stems largely from the shuttering of state-run mental-health facilities a generation ago. Once behind bars, the mentally ill are rarely paroled. If released, they usually end up back in prison because of a lack of outside treatment options. The Justice Department estimates that about 330,000 of the nation's 2.2 million inmates are mentally ill.

Mental-health courts, which work in tandem with prosecutors' offices, are slowly emerging as a promising alternative. They came on the scene in the late 1990s and are designed to allow the mentally ill to avoid prison time, provided they adhere to extensive treatment plans set up and monitored by the new courts. Defendants must plead guilty and pass intensive psychiatric evaluations before being admitted. Once under the court's authority, they undergo regular therapy sessions and often their medication is monitored. Prosecutors and judges typically have complete discretion as to whether a defendant can seek this alternative path.

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What makes the idea appealing to many is that it represents a middle ground between locking up the mentally ill and letting them roam free.

"The easiest thing we do is put people in jail, [but] you cannot prison-build your way into reducing crime," says Charles Hynes, the longtime Brooklyn district attorney, who helped create the Brooklyn Mental Health Court.

The Brooklyn court routinely hosts visiting judges and court officers interested in the concept. In the past four years, eight mental-health courts have been created in New York state, and three other local jurisdictions are preparing to open such courts of their own. When all are up and running, New York will account for about 10% of the 120 mental-health courts in the U.S.

Most mental-health courts treat only defendants accused of misdemeanors. That's because many lawmakers and prosecutors worry that criminals will game the system and that the mentally ill will relapse and commit new crimes. Brooklyn is one of the few that accept serious felons. Judge D'Emic is keenly aware of the risk that involves.



Judge Matthew D'Emic in his Brooklyn, N.Y., court earlier this month.

"If something went really wrong that could be not only the end of your mental-health court, but of mental-health courts in general," he says in an interview.

Close Calls

There have been some close calls. One participant -- a pharmacist who had been self-medicating and who had pleaded guilty to driving under the influence -- crashed into a line of parked cars while driving drunk. The judge kicked him out of the program and sent him to prison, where he may be held up to four years.

Another defendant, diverted into the program after stealing a car in Brooklyn, went to Florida last October, stole a Mercedes and led police on a high-speed chase. He has also been imprisoned.

This danger is one reason mental-health courts have been slow to take off. Legislators in Oklahoma, where more than a third of the state's 24,000 inmates have identifiable mental illnesses, have struggled to set up such a court. And mental-health experts question the court's reliance on medication.

The Brooklyn Mental Health Court was started in 2002 in the aftermath of two notorious New York crimes. Andrew Goldstein, then a 30-year-old schizophrenic with a history of violence, had requested treatment from a number of hospitals but had received only short-term care before he pushed Kendra Webdale in front of a New York subway train, killing her. A few months later, Edgar Rivera lost both legs when another former mental patient shoved him under a train.

"I got tired of reading about the poor soul who pushes another poor soul off the subway platform onto the tracks," says Mr. Hynes, who was first elected in 1989.

Anyone can request a transfer to the mental-health court at any point after an arrest, and sometimes prosecutors themselves suggest it. Potential participants undergo extensive assessments by the court's psychologists. The findings must show persistent mental illness and that the illness contributed to the crime charged. A judge then decides whether the psychiatric evidence is sufficient.

If prosecutors agree, they'll craft a plea offer while the court's clinical team develops a treatment plan. Defendants plead guilty on being accepted into the program and undergo treatment for up to two years, longer in rare circumstances. At any time before the plea agreement is made final, prosecutors can decide to push the case through regular criminal courts based on factors such as the clinical evidence or the severity of the crime.

Of the 244 felons who have appeared before Judge D'Emic in this court in the past four years, only 19 have violated the terms of the program to such a degree that the judge sent them to jail. There are no data showing what happens to felons after they've completed the court's program.

Most of the participants have setbacks, like failed drug tests as well as missed therapy sessions and court appearances, says Judge D'Emic. But unlike some probation and parole officers who send defendants back to prison for minor infractions, Judge D'Emic doesn't do so quickly or easily. Instead, he urges them, with a mix of humor and schoolmaster sternness, to stick with the program. He has jailed people briefly to get their attention.

After snapping at Mr. Berry, for instance, the judge softened. The court, he told the defendant, is an opportunity to build a strong foundation for combating mental-health problems, but only if Mr. Berry stuck to his treatment plan. Even Jimi Hendrix understood the importance of a foundation, he said to Mr. Berry, before quoting from the late singer: "Castles made of sand fall in the sea, eventually."

Mr. Berry looked blank. "Who is Jimi Hendrix?" he asked.

"You've never heard of Jimi Hendrix? What are they teaching you in school?" Judge D'Emic replied. "Have you heard of the Beatles?"

At the end of conversation, Mr. Berry apologized and promised to be more cooperative.

Appointed to the bench in 1996 by Gov. George Pataki, Judge D'Emic, 53, has deep Brooklyn roots. He lives in the borough's Bay Ridge section, one street over from where he grew up as one of 10 children. Eight of his nine siblings live within a mile of him, including three who are firefighters.

Judge D'Emic had no special medical training before he joined the court. For about a year, he and his law clerk invited their consulting psychiatrist to tutor them every Tuesday. The weekly 90-minute sessions included lectures on depression, schizophrenia and therapy strategies, as well as medications and their side effects. The two still attend conferences and lectures on mental health.

One early success was a college student who had a breakdown. He was suffering from paranoia and schizophrenia, and voices told him to rob students. The prosecutor was initially reluctant to turn him over to the mental-health court because "it was such an easy case to win," the judge recalls. The student eventually pleaded guilty to robbery, underwent treatment for 18 months, finished the program and is now completing college.

"It's not an impossible task to keep this population compliant and out of jail," he says. "If they don't comply, I have the big hammer, the jail sentence."

Judge D'Emic's courtroom, on the 15th floor of the courthouse on Jay Street, is informal. "The very first day he took the bench, his court clerk did the 'all rise routine' and Judge D'Emic asked him not to bother with that again," says Karen Kleinberg, his clerk.

Moments after he entered the courtroom on a recent day, ushering people back to their seats, those

in attendance gasped when a cellphone rang loudly. The owner scrambled to silence it, apologizing profusely and looking fearfully at the bench. "It's OK; don't worry about it," said Judge D'Emic. "Is it for me?"

One man, a Russian immigrant, was there because he tried to rob a bank while brandishing a television remote control as a weapon. He spoke little English and was accompanied by an interpreter. Subdued at first, he became animated when Judge D'Emic talked to him -- in Russian.

Another defendant, Lynval Samuel, his salt-and-pepper beard in two braids, came to the bench dressed in a white robe and wearing white gloves. He carried two red roses and asked to address the court. "First I'd like to bring greetings to you from the orders of the Eastern Star," he said, his voice deep and majestic. He read briefly from the Bible and then asked the judge if he had the Bibles Mr. Samuel had presented to him. The judge said he did.

Mr. Samuel -- 53, and bipolar -- was in court for threatening and stalking a U.S. congressman, Major Owens, a New York Democrat. He was doing well enough in therapy and counseling to move from Phase II to Phase III, which meant he was one level from graduating. He was given a certificate from the Mental Health Court to mark the promotion.

"From my left hand to your left hand," said Judge D'Emic as he passed the certificate to Mr. Samuel, taking care to make the hand-off exactly as he described. The judge's computer summary noted that one of Mr. Samuel's idiosyncrasies is that he accepts and passes items only with his left hand.

The defendants came steadily, an average of one every three minutes, all suffering from some form of mental illness. There was the burglar who walked into a neighbor's home and started eating a chicken dinner that had been left on the dining-room table. Another robbed ATM patrons by putting a knife to his own throat and threatened to slash himself unless they gave him money. One woman, of Irish descent, tried to snatch babies out of their mothers' arms, convinced that she was rescuing Irish children kidnapped by Jewish women.



Mary Brown

Mary Brown, 43 and a mother of three, was a newcomer to the program. She quit school in the 11th grade after becoming pregnant and is only now learning to read. For the past seven years, she has been married to Eddie McQueen. The pair -- who both hail from South Carolina -- met at the Tar-Heel Lounge, a Brooklyn nightspot, where Ms. Brown had come to hear rhythm and blues. Mr. McQueen was performing on the piano.

Mr. McQueen, when asked for his age, would say only that he was in his late 50s. He says he often woke at night to find his wife wandering around their apartment building, knocking on neighbors' doors asking, "Where's Eddie?" On occasion, Ms. Brown would vanish outright. "I stayed up half the night hoping she'd call," he says. Sometimes she'd wander into oncoming traffic.

Last October, Ms. Brown stopped taking medication for schizophrenia. Early one morning, she walked into a neighbor's unlocked apartment and entered the bedroom where her neighbor was asleep. As Ms. Brown passed back through the living room, she took a cup filled with \$23 in change, according to court records. By the time she walked out of the apartment, the neighbor was awake. Ms. Brown was arrested and pleaded guilty to second-degree burglary.

Despite the relatively benign nature of the crime, the charge of second-degree burglary lumped Ms. Brown into the category of defendants who were armed and injured their victims. Mr.

McQueen learned of the mental-health court and asked if his wife might be eligible. The prosecutor ultimately agreed.

Out of Prison

Mr. McQueen says he was looking for anything to keep her out of prison. These days, he gets up before 6 a.m. to fix her breakfast. "I like his cooking," Ms. Brown explains. "I don't want anybody else's cooking."

Joyce Kendrick, Ms. Brown's attorney, who works for Brooklyn Defender Services, a legal-aid organization, says that without the mental-health court, her client was facing mandatory prison time. "I don't know if she understands how serious the charges are against her."

At Judge D'Emic's courtroom, Ms. Brown approached the bench reluctantly and stood there with her head down, like a child waiting to be chastised.

"You're doing great," Judge D'Emic told her. "You're making all your meetings and all your counseling sessions. You're doing perfect. Keep it up." The judge then called her husband to the bench. Shaking Mr. McQueen's hand, the judge thanked him for attending every one of his wife's court appearances and therapy sessions.

As Ms. Brown left, she walked past Harry Rivera, who was wiping a tear from his cheek. He had just learned that his appearance in court would be his last. "What? Nobody told you? Well, you're graduating," said Judge D'Emic, smiling as Mr. Rivera was presented with a gift bag of chocolate.

On graduating, the charge is dropped to a misdemeanor, although the probation part of the sentence remains active.

Mr. Rivera, 27, was a longstanding member of the program. In 2002, he was arrested for armed robbery after he and a co-defendant robbed a victim at gunpoint. Instead of five years behind bars, Mr. Rivera, who suffers from anxiety, depression and a stress-related disorder, pleaded guilty and joined the newly formed mental-health court.

When Mr. Rivera was 5 years old, he scampered into the street and was hit by a car as his pregnant mother, arms laden with groceries, watched helplessly. He stayed in a coma for five days. Learning disabilities and hyperactiveness followed, along with depression and anxiety attacks.

His court-mandated treatment plan included a year at Aurora Concept Inc., a mental-health facility in the New York City borough of Queens, a year in the psychiatric and chemical dependency program of St. Vincent's Services, in the Canarsie section of Brooklyn, as well as weekly meetings with a therapist and monthly meetings with a psychiatrist. He also had to appear almost weekly before Judge D'Emic. While participating in the program, Mr. Rivera received his GED and is training at Interborough College to become a medical technician.

His voice filled with emotion, he thanked the court for giving him a second chance. Judge D'Emic called him to the bench and whispered: "I saw your progress little by little. Now look at you. You're making something of your life."

Six weeks later, Mr. Rivera was back at Rikers Island on a probation violation. His return to jail saddens court officials who don't know whether he will be funneled back to the mental-health court, where he will start at the beginning, or into prison.

"It happens," says Lucille Jackson, clinical director of the Mental Health Court. "It shows the difficulty of this program. If someone has cognitive disorders and their judgment and thinking is impaired, the court doesn't make all that go away."

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Introduced by Senators Steinberg and RomeroFebruary 23, 2007

An act to add Sections 851.95, 2686, and 2982 to, to add Article 3.5 (commencing with Section 2687) to Chapter 4 of Title 1 of Part 3 of, Chapter 2.73 (commencing with Section 1001.130) to Title 6 of Part 2 of, the Penal Code, and to amend Sections 5806 and 5814 of the Welfare and Institutions Code, relating to mentally ill offenders.

LEGISLATIVE COUNSEL'S DIGEST

SB 851, as introduced, Steinberg. Mentally ill offenders.

Existing law provides for the diversion of specified criminal offenders in alternate sentencing and treatment programs.

This bill would provide that if a law enforcement official suspects that a crime has been committed by an individual with a severe mental health or substance abuse condition, he or she shall contact the county mental health director to ascertain if there is available treatment capacity to provide that person with services, as specified. This bill would provide that if the individual fails to remain in treatment, any pending criminal charges and arrest that had been deferred pending treatment can proceed at that time.

This bill would authorize superior courts to develop and implement mental Health Courts, as specified, for offenders suffering from mental illness against whom a complaint or citation for a misdemeanor or felony offense is pending. This bill would require each county, with the input of local stakeholders, to establish a method for screening every defendant for mental illness and co-occurring disorders at the time a complaint or citation is filed for a misdemeanor or felony offense and establish case eligibility criteria specifying what factors relating to the amenability of the defendant to treatment and to the facts of the case

will make the defendant eligible to participate in a mental health court. This bill would provide that if a defendant is determined to be eligible to participate in a mental health court and consents to participate, the defendant will be placed on probation and will be required to participate in the program for a minimum of one year.

This bill would also require each mental health court to report to the State Department of Mental Health, the State Department of Alcohol and Drug Programs, and the Department of Corrections and Rehabilitation. Because this bill would change the punishment for commission of various crimes and would require local officials to provide a higher level of service, this bill would impose a state-mandated local program.

Existing law provides for the allocation of state funds to counties for mental health programs.

This bill would make various statements of legislative findings and intent regarding the need to provide mental health and related services to parolees. This bill would require all parolees with a severe mental illness to receive comprehensive mental health and supportive services, as specified. This bill would provide that the department may contract with counties or private providers for these services.

This bill would state the intent of the Legislature to encourage each correctional facility to implement a system of care, as described, for the delivery of mental health services to parolees who have a serious mental disorder.

This bill would require the Department of Corrections and Rehabilitation in consultation with the State Department of Mental Health to establish service standards that ensure that parolees who have a serious mental disorder are identified, and services provided to assist them to be able upon release to live independently, work, and reach their potential as productive citizens, as specified. This bill would require the State Department of Mental Health to provide training, consultation, and technical assistance for facilities and programs, as specified.

This bill would provide that funding, based on specified criteria, at sufficient levels to ensure that each facility and parolee center can provide each parolee served pursuant to these provisions with the medically necessary mental health services shall be provided, but that the portion of those costs of services that can be paid for with other funds including other mental health funds, public and private insurance, and other local, state, and federal funds shall not be covered.

This bill would require the Director of the Department of Corrections and Rehabilitation to establish an advisory committee for the purpose of providing advice regarding the development of the identification of specific performance measures for evaluating the effectiveness of programs. This bill would require the department, in consultation with the advisory committee, to provide in a report to the Legislature, submitted on or before May 1 of each year in which additional funding is provided, an evaluation of the effectiveness of the strategies for parolees in reducing homelessness, recidivism involvement with local law enforcement, and other measures identified by the department.

This bill would provide that in order to reduce the cost of providing supportive housing for clients, parolee centers shall enter into contracts with sponsors of supportive housing projects to the greatest extent possible.

Existing law provides that there is within the Department of Corrections and Rehabilitation the Council on Mentally Ill Offenders, the goal of which is to investigate and promote cost-effective approaches to meeting the long-term needs of adults and juveniles with mental disorders who are likely to become offenders, or who have a history of offending, by considering strategies that improve service coordination among state and local mental health, criminal justice, and juvenile justice programs, as specified. Existing law also provides a procedure whereby, if, in the opinion of the Director of the department of Corrections and Rehabilitation, the rehabilitation of any mentally ill, mentally deficient, or insane person confined in a state prison may be expedited by treatment at any one of the state hospitals, he or she may have that person evaluated to determine if he or she would benefit from care and treatment in a state hospital.

This bill would require the department to provide training for all persons who will be responsible for the management and care of persons with serious mental illness in its custody to ensure that they are trained in recovery oriented rehabilitative services and that those services are provided in prison. This bill would also require the department to ensure that all its correctional officers are trained in dealing with inmates with mental illness.

Existing law requires, as a condition of parole, that a prisoner who has a treatable, severe mental disorder that was one of the causes of, or was an aggravating factor in, the commission of the crime for which he or she was incarcerated, be treated by the State Department of Mental Health, as specified.

This bill would require the Department of Corrections and Rehabilitation to apply for social security and Medi-Cal benefits for a prisoner with a severe mental illness who is considered disabled, and to begin vocational training, independent living assistance, and development of other skills necessary for success at least 6 months before his or her discharge. This bill would also require the department to coordinate with a program that will continue the medications and support services provided to the prisoner by the department after the period of incarceration, in the last 90 days before release of a prisoner with a severe mental illness.

This bill would make other conforming changes.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that with regard to certain mandates no reimbursement is required by this act for a specified reason.

With regard to any other mandates, this bill would provide that, if the Commission on State Mandates determines that the bill contains costs so mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

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

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

1 SECTION 1. Section 851.95 is added to the Penal Code, to
2 read:
3 851.95. (a) If a law enforcement official suspects that a crime
4 has been committed by an individual with a severe mental health
5 or substance abuse condition, and believes that with mental health
6 or substance abuse treatment, criminal behavior would not, in all
7 likelihood, continue and the person is willing to participate in a
8 treatment program, the law enforcement official shall contact the
9 county mental health director to ascertain if there is available
10 treatment capacity.
11 (b) If there is treatment capacity available, the individual shall
12 receive services in accordance with the Mental Health Adult
13 System of Care set forth in Section 5806 of the Welfare and
14 Institutions Code. If the individual fails to remain in treatment,

1 any pending criminal charges and arrest that had been deferred
2 pending treatment can proceed at that time.

3 SEC. 2. Chapter 2.73 (commencing with Section 1001.130) is
4 added to Title 6 of Part 2 of the Penal Code, to read:

5

6 CHAPTER 2.73. DIVERSION OF MENTALLY ILL OFFENDERS

7

8 1001.130. (a) Superior courts are hereby authorized to develop
9 and implement mental health courts consistent with this section
10 and any existing Judicial Council guidelines.

11 (b) For purposes of this section, a mental health court shall have
12 the following objectives:

13 (1) Increased cooperation between the courts, criminal justice,
14 mental health, and substance abuse systems.

15 (2) Modified court processes that lead to placement of as many
16 mentally ill offenders, including those with cooccurring disorders,
17 in community treatment, consistent with public safety.

18 (3) Improved access to necessary services and support.

19 (4) Reduced recidivism.

20 (c) A Mental Health Court shall provide a single point of contact
21 where a defendant with a mental disability or cooccurring disorder
22 may receive court-ordered treatment and support services in
23 connection with a diversion from prosecution, a sentencing
24 alternative, or a term of probation.

25 (d) A Mental Health Court shall meet the following criteria:

26 (1) Defendants may be referred to the Mental Health Court from
27 a variety of sources, including, but not limited to, judges within
28 the court, police, attorneys, family members, probation officers,
29 the district attorney, the public defender, and jail personnel.

30 (2) The court shall develop standards for continuing participation
31 in, and graduation from, the Mental Health Court program through
32 a collaborative process.

33 (3) The Mental Health Court shall use a dedicated calendar,
34 designated staff that include, but is not limited to, a designated
35 judge to preside over the court, prosecutor, public defender, county
36 mental health liaison, and probation officer.

37 (4) The county mental health department and drug and alcohol
38 department shall provide initial and ongoing training for designated
39 staff, as needed, on the nature of mental illness and on the treatment
40 and supportive services available in the community.

1 (5) The Mental Health Court shall use community mental health
2 providers and other agencies to offer defendants access to
3 individualized treatment services.

4 (6) The Mental Health Court shall establish a treatment plan for
5 each defendant, and other terms and conditions that will optimize
6 the likelihood that the defendant will complete the program.

7 (7) The Mental Health Court shall hold frequent reviews of the
8 offender's progress in community treatment and hold the offender
9 accountable to adhere to the treatment plan, remain in treatment,
10 and complete treatment.

11 (e) A Mental Health Court shall contact the county mental health
12 department to ensure that there is coordination and availability of
13 the necessary mental health services, including management and
14 evaluation of the success of those services.

15 1001.131. Defendants suffering from mental illness shall be
16 eligible to participate in a Mental Health Court pursuant to this
17 chapter if a complaint or citation for an offense is pending in
18 superior court.

19 1001.132. (a) Each county, with the input of local stakeholders,
20 shall establish a method for screening every defendant for mental
21 illness and cooccurring disorders, at the time a complaint or citation
22 is filed for a misdemeanor or felony offense, or at another specified
23 time determined most appropriate by local stakeholders to consider
24 transferring the defendant to a Mental Health Court.

25 (b) Each county shall, with the input of stakeholders, establish
26 case eligibility criteria specifying what factors relating to the
27 amenability of the defendant to treatment and to the facts of the
28 case will make the defendant eligible to participate in a Mental
29 Health Court.

30 (c) If the defendant is found to be suffering from mental illness,
31 subsequent evaluation by the local mental health director or his or
32 her designee shall determine whether a defendant who is suffering
33 from mental illness is appropriate for treatment under the county
34 eligibility criteria established pursuant to subdivision (b).

35 (d) If the defendant is found to be suffering from mental illness,
36 the district attorney or other designee shall assess his or her case
37 to determine whether it meets the county eligibility criteria
38 established pursuant to subdivision (b).

39 (e) If a defendant is determined to be suffering from mental
40 illness, designated as treatment appropriate, and his or her case

1 meets the county eligibility criteria, he or she may participate in
2 a Mental Health Court.

3 1001.133. (a) If a defendant is determined to be eligible to
4 participate in a Mental Health Court and consents to participate,
5 the defendant will be placed on probation and will be required to
6 participate in the program for a minimum of one year.

7 (b) The terms and conditions of probation shall include
8 participation in a Mental Health Treatment Program and, if he or
9 she is on parole, the terms and conditions of his or her parole.

10 (c) If the defendant fails to successfully complete the Mental
11 Health Treatment Program, the court shall sentence the defendant
12 for the current misdemeanor or felony offense.

13 1001.134. Each Mental Health Court shall report to the State
14 Department of Mental Health, the State Department of Alcohol
15 and Drug Programs, and the Department of Corrections and
16 Rehabilitation the savings in prison days resulting from
17 implementation of the Mental Health Court in a manner consistent
18 with the present reporting system for the Comprehensive Drug
19 Court Implementation Act of 1999 (Article 2 (commencing with
20 Section 11970.1) of Chapter 2 of Part 3 of Division 10.5 of the
21 Health and Safety Code).

22 SEC. 3. Section 2686 is added to the Penal Code, to read:

23 2686. (a) The Department of Corrections and Rehabilitation
24 shall provide training for all persons who will be responsible for
25 the management and care of persons with serious mental illness
26 in the custody of the department to ensure that they are trained in
27 recovery oriented rehabilitative services and that those services
28 are provided in prison.

29 (b) The department shall ensure that all its correctional officers
30 are trained in dealing with inmates with mental illness.

31 SEC. 4. Article 3.5 (commencing with Section 2687) is added
32 to Chapter 4 of Title 1 of Part 3 of the Penal Code, to read:

33

34 Article 3.5. Parolee Mental Health

35

36 2687. (a) A system of care for parolees with severe mental
37 illness results in the highest benefit to the client, family, and society
38 while ensuring that the public sector meets its legal responsibility
39 and fiscal liability at the lowest possible cost.

1 (b) The underlying philosophy for these systems of care includes
2 the following:

3 (1) Mental health care is a basic human service.

4 (2) Seriously mentally disordered parolees usually have multiple
5 disorders and disabling conditions.

6 (3) Seriously mentally disordered parolees should be assigned
7 a single person or team to be responsible for all treatment, case
8 management, and support services.

9 (4) The client should be fully informed and volunteer for all
10 treatment provided, unless danger to self or others or grave
11 disability requires temporary involuntary treatment.

12 (5) Clients and families should directly participate in making
13 decisions about services and resource allocations that affect their
14 lives.

15 (6) Mental health services should be responsive to the unique
16 characteristics of people with mental disorders including age,
17 gender, minority, and ethnic background, and the effect of multiple
18 disorders.

19 (7) Treatment, case management, and support services should
20 be designed to prevent inappropriate removal to more restrictive
21 and costly placements.

22 (8) Mental health systems of care shall have measurable goals
23 and be fully accountable by providing measures of client outcomes
24 and cost of services.

25 (9) State and county government agencies each have
26 responsibilities and fiscal liabilities for seriously mentally
27 disordered parolees.

28 2687.1. All parolees with a severe mental illness shall receive
29 comprehensive mental health and supportive services comparable
30 to the case management and services available under Section 5806
31 of the Welfare and Institutions Code as set forth in this article.

32 2687.2. The Department of Corrections and Rehabilitation
33 shall ensure the mental health needs of all parolees are met in
34 accordance with community standards of mental health care. For
35 those with a serious mental disorder, as defined in paragraph (2)
36 of subdivision (b) of Section 5600.3 of the Welfare and Institutions
37 Code, all services shall be in accordance with this article.

38 2687.3. (a) The Legislature finds that a mental health system
39 of care for parolees with severe and persistent mental illness is

1 vital for successful management of mental health care in California
2 and should encompass all of the following:

3 (1) A comprehensive and coordinated system of care including
4 treatment, early intervention strategies, case management, and
5 system components required by parolees with severe and persistent
6 mental illness.

7 (2) The recovery of persons with severe mental illness and their
8 financial means are important for all levels of government,
9 business, and the community.

10 (3) System of care services that ensure culturally competent
11 care for persons with severe mental illness in the most appropriate,
12 least restrictive level of care are necessary to achieve the desired
13 performance outcomes.

14 (4) Mental health service providers need to increase
15 accountability and further develop methods to measure progress
16 toward client outcome goals and cost effectiveness as required by
17 a system of care.

18 (b) The Legislature further finds that the adult system of care
19 model, begun in the 1989–90 fiscal year through the
20 implementation of Chapter 982 of the Statutes of 1988, provides
21 models for parolees with severe mental illness that can meet the
22 performance outcomes required by the Legislature.

23 (c) The Legislature also finds that the system components
24 established in adult systems of care are of value in providing
25 greater benefit to parolees with severe and persistent mental illness
26 at a lower cost in California.

27 (d) Therefore, using the guidelines and principles developed
28 under the demonstration projects implemented under the elder
29 system of care legislation in 1989, it is the intent of the Legislature
30 to accomplish the following:

31 (1) Encourage each correctional facility to implement a system
32 of care as described in this legislation for the delivery of mental
33 health services to seriously mentally disordered parolees.

34 (2) To promote system of care accountability for performance
35 outcomes that enable parolees with severe mental illness to reduce
36 symptoms that impair their ability to live independently, work,
37 maintain community supports, care for their children, stay in good
38 health, not abuse drugs or alcohol, and not commit crimes.

39 (3) Provide funds for mental health services and related
40 medications, substance abuse services, supportive housing or other

1 housing assistance, vocational rehabilitation, and other nonmedical
2 programs necessary to stabilize mentally ill prisoners and parolees,
3 reduce the risk of being homeless, get them off the street and into
4 treatment and recovery, or to provide access to veterans' services
5 that will also provide for treatment and recovery.

6 2687.4. The Department of Corrections and Rehabilitation in
7 consultation with the State Department of Mental Health shall
8 establish service standards that ensure that prisoners with a serious
9 mental disorder, as defined in paragraph (2) of subdivision (b) of
10 Section 5600.3 of the Welfare and Institutions Code, are identified,
11 and services are provided to assist them to be able, upon release,
12 to live independently, work, and reach their potential as productive
13 citizens. The department shall provide annual oversight of services
14 pursuant to this part for compliance with these standards.

15 These standards shall include, but are not limited to, all of the
16 following:

17 (a) A service planning and delivery process that is target
18 population-based and includes the following:

19 (1) Determination of the number of clients to be served and the
20 programs and services that will be provided to meet their needs.

21 (2) Plans for services, including design of mental health services,
22 coordination and access to medications, psychiatric and
23 psychological services, substance abuse services, supportive
24 housing or other housing assistance for parolees, vocational
25 rehabilitation, and veterans' services. Plans shall also contain
26 evaluation strategies that shall consider cultural, linguistic, gender,
27 age, and special needs of minorities in the target populations.
28 Provision shall be made for staff with the cultural background and
29 linguistic skills necessary to remove barriers to mental health
30 services due to limited-English-speaking ability and cultural
31 differences.

32 (3) Provisions for services to meet the needs of target population
33 clients who are physically disabled.

34 (4) Provision for services to meet the special needs of elder
35 adults.

36 (5) Provision for family support and consultation services,
37 parenting support and consultation services, and peer support or
38 self-help group support, if appropriate for the individual.

39 (6) Provision for services to be client-directed and that employ
40 psychosocial rehabilitation and recovery principles.

1 (7) Provision for psychiatric and psychological services that are
2 integrated with other services and for psychiatric and psychological
3 collaboration in overall service planning.

4 (8) Provision for services specifically directed to seriously
5 mentally ill young adults 25 years of age or younger who are at
6 significant risk of becoming homeless.

7 (9) Services reflecting special needs of women from diverse
8 cultural backgrounds, including supportive housing that accepts
9 children, personal services coordinator, therapeutic treatment, and
10 substance treatment programs that address gender specific trauma
11 and abuse in the lives of persons with mental illness, and vocational
12 rehabilitation programs that offer job training programs free of
13 gender bias and sensitive to the needs of women.

14 (10) Provision for housing for parolees that is immediate,
15 transitional, or permanent.

16 (b) Each client shall have a clearly designated mental health
17 personal services coordinator who may be part of a
18 multidisciplinary treatment team who is responsible for providing
19 or assuring needed services. Responsibilities include complete
20 assessment of the client's needs, development of the client's
21 personal services plan, linkage with all appropriate community
22 services, monitoring of the quality and follow through of services,
23 and necessary advocacy to ensure each client receives those
24 services that are agreed to in the personal services plan. Each client
25 shall participate in the development of his or her personal services
26 plan, and responsible staff shall consult with the designated
27 conservator, if one has been appointed, and, with the consent of
28 the client, consult with the family and other significant persons as
29 appropriate.

30 (c) The individual personal services plan shall ensure that
31 members of the target population involved in the system of care
32 receive age, gender, and culturally appropriate services, to the
33 extent feasible, that are designed to enable recipients upon release
34 to:

35 (1) Live in the most independent, least restrictive housing
36 feasible in the local community, and for clients with children, to
37 live in a supportive housing environment that strives for
38 reunification with their children or assists clients in maintaining
39 custody of their children as is appropriate.

- 1 (2) Engage in the highest level of work or productive activity
- 2 appropriate to their abilities and experience.
- 3 (3) Create and maintain a support system consisting of friends,
- 4 family, and participation in community activities.
- 5 (4) Access an appropriate level of academic education or
- 6 vocational training.
- 7 (5) Obtain an adequate income.
- 8 (6) Self-manage their illness and exert as much control as
- 9 possible over both the day-to-day and long-term decisions that
- 10 affect their lives.
- 11 (7) Access necessary physical health care and maintain the best
- 12 possible physical health.
- 13 (8) Reduce or eliminate serious antisocial or criminal behavior
- 14 and thereby reduce or eliminate their contact with the criminal
- 15 justice system.
- 16 (9) Reduce or eliminate the distress caused by the symptoms of
- 17 mental illness.
- 18 (10) Have freedom from dangerous addictive substances.
- 19 (d) The individual personal services plan shall describe the
- 20 service array that meets the requirements of subdivision (c), and
- 21 to the extent applicable to the individual, the requirements of
- 22 subdivision (a).
- 23 2687.5. The State Department of Mental Health shall continue
- 24 to work with the Department of Corrections and Rehabilitation
- 25 and other interested parties to refine and establish client and cost
- 26 outcome and interagency collaboration goals including the expected
- 27 level of attainment with participating counties. These outcome
- 28 measures should include specific objectives addressing the
- 29 following goals:
- 30 (a) Client benefit outcomes.
- 31 (b) Client and family member satisfaction.
- 32 (c) System of care access.
- 33 (d) Cost savings, cost avoidance, and cost-effectiveness
- 34 outcomes that measure short-term or long-term cost savings and
- 35 cost avoidance achieved in public sector expenditures to the target
- 36 population.
- 37 2687.6. The State Department of Mental Health shall provide
- 38 training consultation, and technical assistance to the Department
- 39 of Corrections and Rehabilitation. This training, consultation, and
- 40 technical assistance shall include:

1 (a) Efforts to ensure that all of the different programs are
2 operating as well as they can.

3 (b) Information on which programs are having particular success
4 in particular areas so that they can be replicated in other counties.

5 (c) Technical assistance to facilities in their first two years of
6 participation to ensure quality and cost-effective service.

7 2687.7. Services shall be available to parolees who have a
8 serious mental disorder who meet the eligibility criteria in
9 subdivisions (b) and (c) of Section 5600.3 of the Welfare and
10 Institutions Code.

11 (a) Funding shall be provided at sufficient levels to ensure that
12 each facility and parolee center can provide each parolee served
13 pursuant to this part with the medically necessary mental health
14 services, medications, and supportive services set forth in the
15 applicable treatment plan.

16 (b) The funding shall only cover the portions of those costs of
17 services that cannot be paid for with other funds including other
18 mental health funds, public and private insurance, and other local,
19 state, and federal funds.

20 (c) Each correctional facility and parolee center shall provide
21 for services in accordance with the system of care for parolees
22 who meet the eligibility criteria in subdivisions (b) and (c) of
23 Section 5600.3 of the Welfare and Institutions Code.

24 (d) Planning for services shall be consistent with the following
25 philosophies, principles, and practices:

26 (1) To promote concepts key to the recovery for individuals
27 who have mental illness: hope, personal empowerment, respect,
28 social connections, self-responsibility, and self-determination.

29 (2) To promote consumer-operated services as a way to support
30 recovery.

31 (3) To reflect the cultural, ethnic, and racial diversity of mental
32 health consumers.

33 (4) To plan for each consumer's individual needs.

34 2687.8. (a) The Director of the Department of Corrections and
35 Rehabilitation shall establish an advisory committee for the purpose
36 of providing advice regarding the development of the identification
37 of specific performance measures for evaluating the effectiveness
38 of programs. The committee shall review evaluation reports and
39 make findings on evidence-based best practices and
40 recommendations. At not less than one meeting annually, the

1 advisory committee shall provide to the director written comments
2 on the performance of each of the programs.

3 (b) The committee shall include, but not be limited to,
4 representatives from state, county, and community veterans'
5 services and disabled veterans outreach programs, supportive
6 housing and other housing assistance programs, law enforcement,
7 county mental health and private providers of local mental health
8 services and mental health outreach services, the Board of
9 Corrections, the State Department of Alcohol and Drug Programs,
10 local substance abuse services providers, the Department of
11 Rehabilitation, providers of local employment services, the State
12 Department of Social Services, the Department of Housing and
13 Community Development, a service provider to transition youth,
14 the United Advocates for Children of California, the California
15 Mental Health Advocates for Children and Youth, the Mental
16 Health Association of California, the California Alliance for the
17 Mentally Ill, the California Network of Mental Health Clients, the
18 Mental Health Planning Council, and other appropriate entities.

19 2687.9. The criteria for the funding for each program shall
20 include, but not be limited to, all of the following:

21 (a) A description of a comprehensive strategic plan for providing
22 prevention, intervention, and evaluation in a cost-appropriate
23 manner.

24 (b) A description of the population to be served, ability to
25 administer an effective service program, and the degree to which
26 local agencies and advocates will support and collaborate with
27 program efforts for parolees.

28 (c) A description of efforts to maximize the use of other state,
29 federal, and local funds or services that can support and enhance
30 the effectiveness of these programs.

31 2687.10. In order to reduce the cost of providing supportive
32 housing for clients, parolee centers shall enter into contracts with
33 sponsors of supportive housing projects to the greatest extent
34 possible. Centers are encouraged to commit a portion of their funds
35 to rental assistance.

36 (a) In consultation with the advisory committee established
37 pursuant to subdivision (a) of Section 2687.8, the department shall
38 report to the Legislature on or before May 1 of each year in which
39 additional funding is provided, and shall evaluate, at a minimum,
40 the effectiveness of the strategies for parolees in reducing

1 homelessness, recidivism involvement with local law enforcement,
2 and other measures identified by the department. The evaluation
3 shall include for each program funded in the current fiscal year as
4 much of the following as available information permits:

5 (1) The number of persons served, and of those, the number
6 who receive extensive community mental health services.

7 (2) The number of persons who are able to maintain housing,
8 including the type of housing and whether it is emergency,
9 transitional, or permanent housing, as defined by the department.

10 (3) (A) The amount of funding spent on each type of housing.

11 (B) Other local, state, or federal funds or programs used to house
12 clients.

13 (4) The number of persons with contacts with local law
14 enforcement and the extent to which local and state incarceration
15 has been reduced or avoided.

16 (5) The number of persons participating in employment service
17 programs including competitive employment.

18 (6) The amount of hospitalization that has been reduced or
19 avoided.

20 (7) The extent to which veterans identified through these
21 programs' outreach are receiving federally funded veterans'
22 services for which they are eligible.

23 (8) The extent to which programs funded for three or more years
24 are making a measurable and significant difference on the street,
25 in hospitals, and in jails, as compared to other programs and in
26 previous years.

27 (b) Each facility shall be subject to specific terms and conditions
28 of oversight and training that shall be developed by the department,
29 in consultation with the advisory committee.

30 (c) (1) As used in this part, "receiving extensive mental health
31 services" means having a personal services coordinator, as
32 described in subdivision (b) of Section 5806, and having an
33 individual personal service plan, as described in subdivision (c)
34 of Section 5806.

35 (2) The funding provided pursuant to this article shall be
36 sufficient to provide mental health services, medically necessary
37 medications to treat severe mental illnesses, alcohol and drug
38 services, transportation, supportive housing and other housing
39 assistance, vocational rehabilitation and supported employment
40 services, money management assistance for accessing other health

1 care and obtaining federal income and housing support, accessing
 2 veterans’ services, stipends, and other incentives to attract and
 3 retain sufficient numbers of qualified professionals as necessary
 4 to provide the necessary levels of these services. This program
 5 shall, however, pay for only that portion of the costs of those
 6 services not otherwise provided by federal funds or other state
 7 funds.

8 (3) Methods to contract for services pursuant to paragraph (2)
 9 shall promote prompt and flexible use of funds, consistent with
 10 the scope of services for which the department has contracted with
 11 each provider.

12 2687.11. The department may contract with counties or private
 13 providers for the provision of any of the services described in this
 14 article.

15 SEC. 5. Section 2982 is added to the Penal Code, to read:

16 2982. (a) At least six months before discharge of a prisoner
 17 with a severe mental illness, the Department of Corrections and
 18 Rehabilitation shall apply for social security and Medi-Cal benefits
 19 for those considered disabled, as well as beginning vocational
 20 training, independent living assistance, and development of other
 21 skills necessary for success during parole and afterward.

22 (b) In the last 90 days before release of a prisoner with a severe
 23 mental illness, the department shall coordinate with a program that
 24 will continue the medications and support services provided to the
 25 prisoner by the department during parole, after the period of
 26 incarceration.

27 SEC. 6. Section 5806 of the Welfare and Institutions Code is
 28 amended to read:

29 5806. The State Department of Mental Health shall establish
 30 service standards that ensure that members of the target population
 31 are identified, and services provided to assist them to live
 32 independently, work, and reach their potential as productive
 33 citizens. The department shall provide annual oversight of grants
 34 issued pursuant to this part for compliance with these standards.
 35 These standards shall include, but are not limited to, all of the
 36 following:

37 (a) A service planning and delivery process that is target
 38 population based and includes the following:

39 (1) Determination of the numbers of clients to be served and
 40 the programs and services that will be provided to meet their needs.

1 The local director of mental health shall consult with the sheriff,
2 the police chief, the probation officer, the mental health board,
3 contract agencies, and family, client, ethnic and citizen
4 constituency groups as determined by the director.

5 (2) Plans for services, including outreach to *individuals*
6 *successfully completing parole, mental health courts, and families*
7 whose severely mentally ill adult is living with them, design of
8 mental health services, coordination and access to medications,
9 psychiatric and psychological services, substance abuse services,
10 supportive housing or other housing assistance, vocational
11 rehabilitation, and veterans' services. Plans shall also contain
12 evaluation strategies, that shall consider cultural, linguistic, gender,
13 age, and special needs of minorities in the target populations.
14 Provision shall be made for staff with the cultural background and
15 linguistic skills necessary to remove barriers to mental health
16 services due to limited-English-speaking ability and cultural
17 differences. Recipients of outreach services may include families,
18 the public, primary care physicians, *police, sheriffs, judges,* and
19 others who are likely to come into contact with individuals who
20 may be suffering from an untreated severe mental illness who
21 would be likely to become homeless if the illness continued to be
22 untreated for a substantial period of time. Outreach to adults may
23 include adults voluntarily or involuntarily hospitalized as a result
24 of a severe mental illness.

25 (3) Provisions for services to meet the needs of target population
26 clients who are physically disabled.

27 (4) Provision for services to meet the special needs of older
28 adults.

29 (5) Provision for family support and consultation services,
30 parenting support and consultation services, and peer support or
31 self-help group support, where appropriate for the individual.

32 (6) Provision for services to be client-directed and that employ
33 psychosocial rehabilitation and recovery principles.

34 (7) Provision for psychiatric and psychological services that are
35 integrated with other services and for psychiatric and psychological
36 collaboration in overall service planning.

37 (8) Provision for services specifically directed to seriously
38 mentally ill young adults 25 years of age or younger who are
39 homeless or at significant risk of becoming homeless. These
40 provisions may include continuation of services that would still

1 be received through other funds had eligibility not been terminated
2 due to age.

3 (9) Services reflecting special needs of women from diverse
4 cultural backgrounds, including supportive housing that accepts
5 children, personal services coordinator therapeutic treatment, and
6 substance treatment programs that address gender specific trauma
7 and abuse in the lives of persons with mental illness, and vocational
8 rehabilitation programs that offer job training programs free of
9 gender bias and sensitive to the needs of women.

10 (10) Provision for housing for clients that is immediate,
11 transitional, permanent, or all of these.

12 (11) Provision for clients who have been suffering from an
13 untreated severe mental illness for less than one year, and who do
14 not require the full range of services but are at risk of becoming
15 homeless unless a comprehensive individual and family support
16 services plan is implemented. These clients shall be served in a
17 manner that is designed to meet their needs.

18 (b) Each client shall have a clearly designated mental health
19 personal services coordinator who may be part of a
20 multidisciplinary treatment team who is responsible for providing
21 or assuring needed services. Responsibilities include complete
22 assessment of the client's needs, development of the client's
23 personal services plan, linkage with all appropriate community
24 services, monitoring of the quality and follow through of services,
25 and necessary advocacy to ensure each client receives those
26 services which are agreed to in the personal services plan. Each
27 client shall participate in the development of his or her personal
28 services plan, and responsible staff shall consult with the designated
29 conservator, if one has been appointed, and, with the consent of
30 the client, consult with the family and other significant persons as
31 appropriate.

32 (c) The individual personal services plan shall ensure that
33 members of the target population involved in the system of care
34 receive age, gender, and culturally appropriate services, to the
35 extent feasible, that are designed to enable recipients to:

36 (1) Live in the most independent, least restrictive housing
37 feasible in the local community, and for clients with children, to
38 live in a supportive housing environment that strives for
39 reunification with their children or assists clients in maintaining
40 custody of their children as is appropriate.

1 (2) Engage in the highest level of work or productive activity
2 appropriate to their abilities and experience.

3 (3) Create and maintain a support system consisting of friends,
4 family, and participation in community activities.

5 (4) Access an appropriate level of academic education or
6 vocational training.

7 (5) Obtain an adequate income.

8 (6) Self-manage their illness and exert as much control as
9 possible over both the day-to-day and long-term decisions which
10 affect their lives.

11 (7) Access necessary physical health care and maintain the best
12 possible physical health.

13 (8) Reduce or eliminate serious antisocial or criminal behavior
14 and thereby reduce or eliminate their contact with the criminal
15 justice system.

16 (9) Reduce or eliminate the distress caused by the symptoms of
17 mental illness.

18 (10) Have freedom from dangerous addictive substances.

19 (d) The individual personal services plan shall describe the
20 service array that meets the requirements of subdivision (c), and
21 to the extent applicable to the individual, the requirements of
22 subdivision (a).

23 SEC. 7. Section 5814 of the Welfare and Institutions Code is
24 amended to read:

25 5814. (a) (1) This part shall be implemented only to the extent
26 that funds are appropriated for purposes of this part. To the extent
27 that funds are made available, the first priority shall go to maintain
28 funding for the existing programs that meet adult system of care
29 contract goals. The next priority for funding shall be given to
30 counties with a high incidence of persons who are severely
31 mentally ill and homeless or at risk of homelessness, and meet the
32 criteria developed pursuant to paragraphs (3) and (4). *The next*
33 *priority for funding, including the funding pursuant to Section*
34 *5892, shall be for the establishment of capacity for all counties to*
35 *be able to serve everyone who meets the criteria for this part who*
36 *are subject to arrest or hospitalization, discharged from a hospital*
37 *or jail, or successfully completing parole.*

38 (2) The director shall establish a methodology for awarding
39 grants under this part consistent with the legislative intent

1 expressed in Section 5802, and in consultation with the advisory
2 committee established in this subdivision.

3 (3) (A) The director shall establish an advisory committee for
4 the purpose of providing advice regarding the development of
5 criteria for the award of grants, and the identification of specific
6 performance measures for evaluating the effectiveness of grants.
7 The committee shall review evaluation reports and make findings
8 on evidence-based best practices and recommendations for grant
9 conditions. At not less than one meeting annually, the advisory
10 committee shall provide to the director written comments on the
11 performance of each of the county programs. Upon request by the
12 department, each participating county that is the subject of a
13 comment shall provide a written response to the comment. The
14 department shall comment on each of these responses at a
15 subsequent meeting.

16 (B) The committee shall include, but not be limited to,
17 representatives from state, county, and community veterans'
18 services and disabled veterans outreach programs, supportive
19 housing and other housing assistance programs, law enforcement,
20 county mental health and private providers of local mental health
21 services and mental health outreach services, the Board of
22 Corrections, the State Department of Alcohol and Drug Programs,
23 local substance abuse services providers, the Department of
24 Rehabilitation, providers of local employment services, the State
25 Department of Social Services, the Department of Housing and
26 Community Development, a service provider to transition youth,
27 the United Advocates for Children of California, the California
28 Mental Health Advocates for Children and Youth, the Mental
29 Health Association of California, the California Alliance for the
30 Mentally Ill, the California Network of Mental Health Clients, the
31 Mental Health Planning Council, and other appropriate entities.

32 (4) The criteria for the award of grants shall include, but not be
33 limited to, all of the following:

34 (A) A description of a comprehensive strategic plan for
35 providing outreach, prevention, intervention, and evaluation in a
36 cost appropriate manner corresponding to the criteria specified in
37 subdivision (c).

38 (B) A description of the local population to be served, ability
39 to administer an effective service program, and the degree to which

1 local agencies and advocates will support and collaborate with
2 program efforts.

3 (C) A description of efforts to maximize the use of other state,
4 federal, and local funds or services that can support and enhance
5 the effectiveness of these programs.

6 (5) In order to reduce the cost of providing supportive housing
7 for clients, counties that receive a grant pursuant to this part after
8 January 1, 2004, shall enter into contracts with sponsors of
9 supportive housing projects to the greatest extent possible.
10 Participating counties are encouraged to commit a portion of their
11 grants to rental assistance for a specified number of housing units
12 in exchange for the counties' clients having the right of first refusal
13 to rent the assisted units.

14 (b) In each year in which additional funding is provided by the
15 annual Budget Act the department shall establish programs that
16 offer individual counties sufficient funds to comprehensively serve
17 severely mentally ill adults who are homeless, recently released
18 from a county jail or the state prison, or others who are untreated,
19 unstable, and at significant risk of incarceration or homelessness
20 unless treatment is provided to them and who are severely mentally
21 ill adults. For purposes of this subdivision, "severely mentally ill
22 adults" are those individuals described in subdivision (b) of Section
23 5600.3. In consultation with the advisory committee established
24 pursuant to paragraph (3) of subdivision (a), the department shall
25 report to the Legislature on or before May 1 of each year in which
26 additional funding is provided, and shall evaluate, at a minimum,
27 the effectiveness of the strategies in providing successful outreach
28 and reducing homelessness, involvement with local law
29 enforcement, and other measures identified by the department.
30 The evaluation shall include for each program funded in the current
31 fiscal year as much of the following as available information
32 permits:

33 (1) The number of persons served, and of those, the number
34 who receive extensive community mental health services.

35 (2) The number of persons who are able to maintain housing,
36 including the type of housing and whether it is emergency,
37 transitional, or permanent housing, as defined by the department.

38 (3) (A) The amount of grant funding spent on each type of
39 housing.

- 1 (B) Other local, state, or federal funds or programs used to house
2 clients.
- 3 (4) The number of persons with contacts with local law
4 enforcement and the extent to which local and state incarceration
5 has been reduced or avoided.
- 6 (5) The number of persons participating in employment service
7 programs including competitive employment.
- 8 (6) The number of persons contacted in outreach efforts who
9 appear to be severely mentally ill, as described in Section 5600.3,
10 who have refused treatment after completion of all applicable
11 outreach measures.
- 12 (7) The amount of hospitalization that has been reduced or
13 avoided.
- 14 (8) The extent to which veterans identified through these
15 programs' outreach are receiving federally funded veterans'
16 services for which they are eligible.
- 17 (9) The extent to which programs funded for three or more years
18 are making a measurable and significant difference on the street,
19 in hospitals, and in jails, as compared to other counties or as
20 compared to those counties in previous years.
- 21 (10) For those who have been enrolled in this program for at
22 least two years and who were enrolled in Medi-Cal prior to, and
23 at the time they were enrolled in, this program, a comparison of
24 their Medi-Cal hospitalizations and other Medi-Cal costs for the
25 two years prior to enrollment and the two years after enrollment
26 in this program.
- 27 (11) The number of persons served who were and were not
28 receiving Medi-Cal benefits in the 12-month period prior to
29 enrollment and, to the extent possible, the number of emergency
30 room visits and other medical costs for those not enrolled in
31 Medi-Cal in the prior 12-month period.
- 32 (c) To the extent that state savings associated with providing
33 integrated services for the mentally ill are quantified, it is the intent
34 of the Legislature to capture those savings in order to provide
35 integrated services to additional adults.
- 36 (d) Each project shall include outreach and service grants in
37 accordance with a contract between the state and approved counties
38 that reflects the number of anticipated contacts with people who
39 are homeless or at risk of homelessness, and the number of those

1 who are severely mentally ill and who are likely to be successfully
2 referred for treatment and will remain in treatment as necessary.

3 (e) All counties that receive funding shall be subject to specific
4 terms and conditions of oversight and training which shall be
5 developed by the department, in consultation with the advisory
6 committee.

7 (f) (1) As used in this part, “receiving extensive mental health
8 services” means having a personal services coordinator, as
9 described in subdivision (b) of Section 5806, and having an
10 individual personal service plan, as described in subdivision (c)
11 of Section 5806.

12 (2) The funding provided pursuant to this part shall be sufficient
13 to provide mental health services, medically necessary medications
14 to treat severe mental illnesses, alcohol and drug services,
15 transportation, supportive housing and other housing assistance,
16 vocational rehabilitation and supported employment services,
17 money management assistance for accessing other health care and
18 obtaining federal income and housing support, accessing veterans’
19 services, stipends, and other incentives to attract and retain
20 sufficient numbers of qualified professionals as necessary to
21 provide the necessary levels of these services. These grants shall,
22 however, pay for only that portion of the costs of those services
23 not otherwise provided by federal funds or other state funds.

24 (3) Methods used by counties to contract for services pursuant
25 to paragraph (2) shall promote prompt and flexible use of funds,
26 consistent with the scope of services for which the county has
27 contracted with each provider.

28 (g) Contracts awarded pursuant to this part shall be exempt from
29 the Public Contract Code and the state administrative manual and
30 shall not be subject to the approval of the Department of General
31 Services.

32 (h) Notwithstanding any other provision of law, funds awarded
33 to counties pursuant to this part and Part 4 (commencing with
34 Section 5850) shall not require a local match in funds.

35 SEC. 8. No reimbursement is required by this act pursuant to
36 Section 6 of Article XIII B of the California Constitution for certain
37 costs that may be incurred by a local agency or school district
38 because, in that regard, this act creates a new crime or infraction,
39 eliminates a crime or infraction, or changes the penalty for a crime
40 or infraction, within the meaning of Section 17556 of the

1 Government Code, or changes the definition of a crime within the
2 meaning of Section 6 of Article XIII B of the California
3 Constitution.

4 However, if the Commission on State Mandates determines that
5 this act contains other costs mandated by the state, reimbursement
6 to local agencies and school districts for those costs shall be made
7 pursuant to Part 7 (commencing with Section 17500) of Division
8 4 of Title 2 of the Government Code.

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CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES

BILL ANALYSIS

BILL NUMBER: SB 993 **VERSION:** INTRODUCED FEBRUARY 23, 2007

AUTHOR: CALDERON **SPONSOR:** UNKNOWN

RECOMMENDED POSITION: NONE

SUBJECT: PSYCHOLOGISTS: SCOPE OF PRACTICE

Existing Law:

- 1) Prohibits psychologists from prescribing drugs, performing surgery or administering electroconvulsive therapy. (BPC § 2904)
- 2) Requires the Board of Psychology (BOP) to encourage licensed psychologists to take continuing education courses in psychopharmacology and biological basis of behavior as part of their continuing education. (BPC § 2914.2)
- 3) Requires the BOP to encourage institutions that offer a doctorate degree program in psychology to include in their biobehavioral curriculum, education and training in psychopharmacology and related topics including pharmacology and clinical pharmacology. (BPC § 2914.3(a))
- 4) Requires the BOP to develop guidelines for the basic education and training of psychologists whose practices include patients with medical conditions or mental and emotional disorders, who may require psychopharmacological treatment and whose management may require collaboration with physicians and other licensed prescribers. (BPC § 2914.3(a))

This Bill:

- 1) Deletes the statute that prohibits the prescribing of drugs when practicing psychology. (BPC § 2904)
- 2) Defines "Collaborative relationship" as a cooperative working relationship between a psychologist holding a conditional prescription certificate and a physician who are providing patient care, including diagnosis and management and delivery of physical and mental health care. (BPC § 2919.10(b))
- 3) Defines "Narcotics" as natural and synthetic opioid analgesics, and their derivatives used to relieve pain. (BPC § 2919.10(c))
- 4) Defines "Nonpsychotropic treating formulary" as any medication that is labeled to treat adverse conditions caused by a psychotropic medication. (BPC § 2919.10(d))

- 5) Defines "Prescribing mental health professional" as a medically trained and licensed physician, psychiatrist, advance practice nurse, or nurse practitioner specializing in mental health care. (BPC § 2919.10(e))
- 6) Defines "Psychotropic medication" as only those agents related to the diagnosis and treatment of mental and emotional disorders, including controlled substances, except narcotics. (BPC § 2919.10(f))
- 7) Permits a psychologist to apply to the board for a conditional prescription certificate. Requires the application to be accompanied by evidence that the applicant complies with all of the following: (BPC § 2919.15(a))
 - Holds a current license in good standing to practice psychology in the state.
 - Has successfully completed psychopharmacological training from a school approved by the Board of Psychology (BOP), or from a continuing education program consistent with professional psychology's postdoctoral training in psychopharmacology or has been recommended by the National Alliance of Professional Psychology Providers.
 - Declares that any applicant who has received a postdoctoral Master of Science degree in psychopharmacology from an accredited or approved school, or received a certificate of completion from an approved provider of continuing education, meets the requirements of this section.
 - Requires the training to include didactic classroom instruction in at least the following core areas of instruction:
 - Anatomy and physiology.
 - Biochemistry.
 - Neurosciences.
 - Pharmacology.
 - Psychopharmacology.
 - Pathophysiology.
 - Health assessment, including relevant physical and laboratory assessment.
 - Clinical pharmacotherapeutics.
 - Has passed a national proficiency examination, approved by the board, that tests the applicant's knowledge of pharmacology in the diagnosis, care, and treatment of mental disorders.
 - Applies for a federal Drug Enforcement License for limited use as restricted by state law.
- 8) Permits a psychologist holding a conditional prescription certificate to administer and prescribe psychotropic medication within the scope of practice, including the ordering and review of laboratory tests in conjunction with prescribing medication. (BPC § 2919.20(a))
- 9) Requires a psychologist holding a conditional prescription certificate, when prescribing psychotropic medication for a patient, to maintain an ongoing collaborative relationship with the medical practitioner who oversees the patient's general medical care to ensure that necessary medical examinations are conducted, and to be aware of any significant changes in the patient's physical condition. (BPC § 2919.20(b))
- 10) Requires a prescription written by a psychologist with a conditional prescription certificate to do all of the following: (BPC § 2919.20(c))
 - Comply with applicable state and federal laws.
 - Be identified as issued by a "Medical Psychologist."
 - Include the psychologist's board number or the identification number assigned by the department.

- 11) Prohibits a psychologist holding a conditional prescription certificate from delegating prescriptive authority to any other person. (BPC § 2919.20(d))
- 12) Requires records of all prescriptions to be maintained in the prescribing psychologists' patient records. (BPC § 2919.20(d))
- 13) Requires a psychologist holding a conditional prescription certificate to file with the BOP in a timely manner all individual federal Drug Enforcement Agency registrations and numbers. (BPC § 2919.20(e))
- 14) Permits a psychologist to apply to the BOP for a prescription certificate. Requires the application to be accompanied by evidence that the applicant complies with all of the following: (BPC § 2191.25(a))
 - Has been issued a conditional prescription certificate and has successfully completed one year of prescribing psychotropic medication.
 - Holds a current license to practice psychology in California.
- 15) Requires the board to issue a conditional prescription certificate or prescription certificate if it finds that the applicant has met the requirements. (BPC § § BPC 2919.15(b), 2191.25(a))
- 16) Permits a psychologist with a prescription certificate to prescribe psychotropic medication if the psychologist complies with all of the following: (BPC § 2191.30)
 - Holds a current license to practice psychology in California.
 - Meets the requirements for issuance of a conditional prescription certificate
 - Annually satisfies the continuing education requirements for psychologists, if any are set by the BOP.
- 17) Requires the BOP, by July 1, 2008, to adopt rules pursuant to the procedures required to obtain a conditional prescription certificate, a prescription certificate, and renewals of a conditional prescription certificate and prescription certificate. (BPC § 2191.35(a))
- 18) Requires the BOP to adopt rules pursuant to establishing the grounds for denial, suspension, or revocation of a conditional prescription certificate and prescription certificate including a provision for suspension or revocation of a license to practice psychology upon suspension or revocation of a conditional prescription certificate or prescription certificate. (BPC § 2191.35(b))
 - Requires actions of denial, suspension, or revocation of a conditional prescription certificate or a prescription certificate to be in accordance with the psychology licensing laws.
- 19) Requires the BOP to maintain current records on every prescribing psychologist, including federal registrations and numbers. (BPC § 2191.35(c))
- 20) Requires the BOP to provide the Board of Pharmacy with an annual list of psychologists holding a conditional prescription certificate which contains the information agreed upon between the BOP and the Board of Pharmacy. Requires the board to promptly notify the Board of Pharmacy of psychologists who are added or deleted from the list. (BPC § 2191.35(d))
- 21) Requires the BOP to be the sole and exclusive administrative body to implement and oversee this article. (BPC § 2191.35(e))

22) Does not permit a medical psychologist to administer or prescribe a narcotic. (BPC § 2191.40(a))

23) Does not apply to any of the following: (BPC § 2191.40(b))

- Any person teaching, lecturing, consulting, or engaging in research in psychology as long as the activities are performed as part of or are dependent upon employment in a college or university, provided that the person does not engage in the practice of psychology outside the responsibilities of the person's employment.
- Any person who performs any, or any combination, of the professional services defined as the practice of psychology under the direction of a licensed psychologist, provided that the person may use the term "psychological assistant," but shall not identify the person's self as a psychologist or imply that the person is licensed to practice psychology.
- Any person employed by a local, state, or federal government agency in a school psychologist or psychological examiner position, or a position that does not involve diagnostic or treatment services, but only at those times when that person is carrying out the functions of that government employment.
- Any person who is a student of psychology, a psychological intern, or a resident in psychology preparing for the profession of psychology under supervision in a training institution or facility and who is designated by a title as "psychology trainee," "psychology student," "psychology intern," or "psychology resident," that indicates the person's training status; provided that the person shall not identify the person's self as a psychologist or imply that the person is licensed to practice psychology.
- Any person who is a member of another profession licensed under the laws of this jurisdiction to render or advertise services, including psychotherapy, within the scope of practice as defined in the statutes or rules regulating the person's professional practice, provided that the person does not represent the person's self to be a psychologist or does not represent that the person is licensed to practice psychology.
- Any person who is a member of a mental health profession not requiring licensure, provided that the person functions only within the person's professional capacities, and provided further that the person does not represent the person to be a psychologist, or the person's services as psychological.
- Any person who is a duly recognized member of the clergy; provided that the person functions only within the person's capacities as a member of the clergy; and provided further that the person does not represent the person to be a psychologist, or the person's services as psychological.

Comment:

1) **Author's Intent.** Staff did not receive a return call from the author's office after repeated attempts, so the author's (or sponsor's) intent is not yet known. However, the following are selected portions of the legislative findings and declarations declared in the bill, which provide an idea of the intent:

- The delivery of comprehensive and accessible medical care may be enhanced by providing licensed medical psychologists, with limited prescriptive authority to provide integrated mental health care services.
- For many years, psychologists in California have been allowed to discuss and recommend psychotropic medications to both patients and physicians.
- Physicians are not readily available in many areas and for minority populations, which requires patients to consult with and pay for another provider to obtain a prescription. For patients who require treatment in county and state mental health facilities, including the Department of Corrections and Rehabilitation, medical psychologists could eliminate the problem of access to care and psychiatrist shortages.

- Independent evaluations of the Department of Defense Psychopharmacological Demonstration Project by the United States General Accounting Office and the American College of Neuropsychopharmacology have found that appropriately trained medical psychologists prescribe safely and effectively.

2) **BOP.** The Board of Psychology has issued a “Statement on Medication” which states,

“...many psychologists have extensive training and experience in the applications of medications. Psychologists may discuss medications with a patient. A psychologist may suggest to a physician a particular medication to be prescribed by a physician. However, the ultimate decision as to whether a patient should receive medication lies solely with the physician. A psychologist may engage in a collegial discussion with a patient's physician regarding the appropriateness of a medication for the condition being treated. A psychologist has primary responsibility to monitor the patient's progress in psychotherapy which includes assisting in monitoring the changes which may be attributable to the medication in the patient. Psychologists should maintain a close consultative relationship with physician care givers in order to assure appropriate overall treatment of the patient.”

“The best interests of the patient demand that psychologists work closely with primary care physicians and psychiatrists who are prescribing medications to the patient of the psychologist. While a psychologist's responsibility can include involvement in limited aspects of a patient's medications, the patient's physician is the only person who may lawfully prescribe the medication for the patient.”

In accordance with BPC Section 2914.3(a), the BOP developed “guidelines for the basic education and training of psychologists whose practices include patients with medical conditions and patients with mental and emotional disorders who may require psychopharmacological treatment and whose management may require collaboration with physicians and other licensed prescribers.” Those guidelines are as follows:

“A program of didactic courses to prepare psychologists mentioned in section 2914.3(a) of the Business and Professions Code should be an organized program of instruction. The program should have appropriate faculty and facilities for the didactic training and should be from a regionally accredited institution of higher learning. Finally, the program should include, at a minimum, one course from each of the following core content areas:

- I. Neurosciences
- II. Pharmacology and Psychopharmacology
- III. Physiology and Pathophysiology
- IV. Physical and Laboratory Assessment
- V. Clinical Pharmacotherapeutics

While suggesting coursework to meet basic educational academic requirements, we recognize that: training in collaborative consultation with physicians, including indicators for referral; educational consultation with patients and families, including information on drugs that are commonly abused and potential therapeutic uses;

risks, benefits and treatment alternatives to medication, and indications for physician referral are an implicit part of the practice of psychology.”

3) Medical Psychologists. Since 1990, psychologists have been allowed to prescribe medications to personnel and their families in military facilities. New Mexico and Louisiana, and the territory of Guam allow trained psychologists to prescribe psychotropic medications.

4) Suggested Amendment. The following is a suggested technical change to proposed BPC Section 2919.20(c):

(c) Include the psychologist's ~~board~~ license number or the identification number assigned by the Department of ~~commerce and~~ Consumer Affairs.

5) Support and Opposition.

Not yet known

6) History

2007

Mar. 15 To Com. on B., P. & E.D.

Feb. 26 Read first time.

Feb. 24 From print. May be acted upon on or after March 26.

Feb. 23 Introduced. To Com. on RLS. for assignment. To print.

Introduced by Senator Calderon

February 23, 2007

An act to amend Section 2904 of, and to add Article 1.5 (commencing with Section 2919.10) to Chapter 6.6 of Division 2 of, the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 993, as introduced, Calderon. Psychologists: scope of practice: prescribing drugs.

Existing law, the Psychology Licensing Law, provides for the licensure and regulation of the practice of psychology by the Board of Psychology in the Department of Consumer Affairs. Existing law excludes prescribing drugs from the scope of practice of a licensed psychologist.

This bill would, with certain exceptions, authorize the board to grant a prescription certificate or a conditional prescription certificate to a licensed psychologist authorizing, within the scope of practice of a psychologist, the prescription of certain drugs if certain conditions are met.

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

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

- 1 SECTION 1. The Legislature finds and declares all of the
- 2 following:
- 3 (a) The delivery of comprehensive, accessible, and affordable
- 4 medical care may be enhanced by providing trained medical
- 5 psychologists, licensed in California, with limited prescriptive

1 authority for the specific purpose of providing integrated mental
2 health care services. The Legislature has previously authorized
3 prescription privileges to advanced nurse practitioners,
4 optometrists, dentists, podiatrists, osteopaths, physician assistants,
5 and naturopaths.

6 (b) Psychologists with appropriate credentials have been allowed
7 to prescribe medications to active duty personnel and their families
8 in military facilities for many years. Louisiana and New Mexico
9 are two states that have adopted legislation authorizing prescriptive
10 authority for psychologists.

11 (c) For many years, psychologists in California have been
12 allowed to discuss and recommend psychotropic medications to
13 both patients and physicians. California psychologists routinely
14 collaborate with primary care physicians to provide combined
15 therapy and psychopharmacological care for their patients.
16 California psychologists have independent hospital privileges.

17 (d) California licensed psychologists complete an average of
18 seven years of postbaccalaureate study and three thousand hours
19 of postgraduate supervised practice in the diagnosis and treatment
20 of mental illness. Medical psychologists have earned additional
21 Master of Science degrees in clinical psychopharmacology, or its
22 equivalent, and passed a national examination in
23 psychopharmacology. Because the current scope of medical
24 psychologists' practice in California does not include prescribing
25 medications, patients must consult with and pay for another
26 provider to obtain the requisite prescription. However, physicians
27 are not readily available in many areas and for minority
28 populations.

29 (e) This is a particular hardship for patients residing in health
30 care treatment shortage areas and in rural areas. For patients who
31 require treatment in county and state mental health facilities,
32 including the Department of Corrections and Rehabilitation,
33 medical psychologists could eliminate the problem of access to
34 care and psychiatrist shortages while significantly enhancing
35 mental health treatment. Timely, efficient, and cost-effective
36 treatment of mental illnesses could avoid the significantly greater
37 social, economic, and medical costs of nontreatment for these
38 needy populations.

39 (f) Research data soundly demonstrates that there is not enough
40 mental health care available to serve the needs of all people in the

1 California due to the severe shortages of psychiatrists. Further, the
2 economically disadvantaged and medically underserved would
3 receive little or no mental health services if not for the services
4 provided by clinical psychologists.

5 (g) The State of California has long recognized the
6 extraordinarily deficient mental health care of its citizens.
7 California has some of the highest rates of untreated psychological
8 concerns in the United States. Recent concerns include the
9 receivership of the prison system due to the state's inability to
10 provide adequate mental and physical health care to inmates. There
11 are several outstanding lawsuits against the State of California
12 alleging that inmates and patients at state mental hospitals are not
13 receiving constitutionally adequate mental health care due to the
14 severe shortage of competent psychiatrists.

15 (h) Further exacerbating the dire need for mental health
16 treatment in underserved areas is the fact that patients from diverse
17 cultural backgrounds are reluctant to seek treatment due to the
18 stigma of mental health problems. Timely access to accurate
19 diagnosis and effective treatment of emotional and behavioral
20 disorders also may contribute substantially to the state's
21 responsibilities to children and needy adults in underserved rural
22 areas.

23 (i) Professional psychology has developed a model curriculum
24 for the education and training of prescribing psychologists.
25 Independent evaluations of the Department of Defense
26 Psychopharmacological Demonstration Project by the United States
27 General Accounting Office and the American College of
28 Neuropsychopharmacology have found that appropriately trained
29 medical psychologists prescribe safely and effectively. Two states,
30 New Mexico and Louisiana, and the territory of Guam, now allow
31 appropriately trained psychologists to prescribe psychotropic
32 medications. Psychologists in the military have been providing
33 medication services to personnel and their families since 1990.
34 Hundreds of thousands to over 1,000,000 prescriptions written by
35 psychologists with not one patient injured. This record far exceeds
36 the safety records of any prescribing class of professionals.

37 SEC. 2. Section 2904 of the Business and Professions Code is
38 amended to read:

39 2904. The practice of psychology shall not include ~~prescribing~~
40 ~~drugs~~; performing surgery or administering electroconvulsive

1 therapy. *The practice of psychology shall not include prescribing*
2 *drugs, except as authorized pursuant to Article 1.5 (commencing*
3 *with Section 2919.10).*

4 SEC. 3. Article 1.5 (commencing with Section 2919.10) is
5 added to Chapter 6.6 of Division 2 of the Business and Professions
6 Code, to read:

7
8 Article 1.5. Prescription Certificate and Conditional Prescription
9 Certificate.

10
11 2919.10. As used in this article the following terms have the
12 following meanings, unless the context otherwise requires:

- 13 (a) “Board” means the Board of Psychology.
- 14 (b) “Collaborative relationship” means a cooperative working
15 relationship between a psychologist holding a conditional
16 prescription certificate and a doctor of medicine in the provision
17 of patient care, including diagnosis and cooperation in the
18 management and delivery of physical and mental health care.
- 19 (c) “Narcotics” mean natural and synthetic opioid analgesics,
20 and their derivatives used to relieve pain.
- 21 (d) “Nonpsychotropic treating formulary” means any medication
22 that is labeled to treat adverse conditions caused by a psychotropic
23 medication.
- 24 (e) “Prescribing mental health professional” means a medically
25 trained and licensed physician, psychiatrist, advance practice nurse,
26 or nurse practitioner specializing in mental health care.
- 27 (f) “Psychotropic medication” means only those agents related
28 to the diagnosis and treatment of mental and emotional disorders,
29 including controlled substances, except narcotics.

30 2919.15. (a) A psychologist may apply to the board for a
31 conditional prescription certificate. The application shall be made
32 on a form approved by the board, and be accompanied by evidence
33 satisfactory to the board, that the applicant complies with all of
34 the following:

- 35 (1) Holds a current license in good standing to practice
36 psychology in the state.
- 37 (2) Has successfully completed a planned sequence of
38 psychopharmacological training from an institution of higher
39 learning approved by the board, or from a continuing education
40 program consistent with professional psychology’s postdoctoral

1 training in psychopharmacology or has been recommended by the
2 National Alliance of Professional Psychology Providers. Any
3 applicant who has received a postdoctoral Master of Science degree
4 in psychopharmacology from a regionally accredited institution
5 of higher learning, or an educational institution approved by the
6 state to provide this education, or received a certificate of
7 completion from an approved provider of continuing education
8 designated by the board to provide this training to California
9 licensed psychologists, shall be deemed as meeting the
10 requirements of this section. This training shall include didactic
11 classroom instruction in at least the following core areas of
12 instruction:

- 13 (A) Anatomy and physiology.
 - 14 (B) Biochemistry.
 - 15 (C) Neurosciences.
 - 16 (D) Pharmacology.
 - 17 (E) Psychopharmacology.
 - 18 (F) Pathophysiology.
 - 19 (G) Health assessment, including relevant physical and
20 laboratory assessment.
 - 21 (H) Clinical pharmacotherapeutics.
- 22 (3) Has passed a national proficiency examination, approved
23 by the board, that tests the applicant's knowledge of pharmacology
24 in the diagnosis, care, and treatment of mental disorders. The board
25 shall establish what constitutes a passing score and the number of
26 times an applicant may retake the exam within a specific time
27 period.
- 28 (4) Applies for a federal Drug Enforcement License for limited
29 use as restricted by state law.
- 30 (5) Meets all other requirements, as determined by rules adopted
31 by the board pursuant to obtaining a conditional prescription
32 certificate.

33 (b) The board shall issue a conditional prescription certificate
34 if it finds that the applicant has met the requirements of this section.

35 2191.20. (a) A psychologist holding a conditional prescription
36 certificate may administer and prescribe psychotropic medication
37 within the recognized scope of the profession, including the
38 ordering and review of laboratory tests in conjunction with
39 prescribing medication for the treatment of mental disorders.

1 (b) When prescribing psychotropic medication for a patient, a
2 psychologist holding a conditional prescription certificate shall
3 maintain an ongoing collaborative relationship with the medical
4 practitioner who oversees the patient’s general medical care to
5 ensure that necessary medical examinations are conducted, and to
6 be aware of any significant changes in the patient’s physical
7 condition.

8 (c) A prescription written by a psychologist with a conditional
9 prescription certificate shall do all of the following:

10 (1) Comply with applicable state and federal laws.

11 (2) Be identified as issued by the psychologist as a “Medical
12 Psychologist.”

13 (3) Include the psychologist’s board number or the identification
14 number assigned by the department of commerce and consumer
15 affairs.

16 (d) A psychologist holding a conditional prescription certificate
17 shall not delegate prescriptive authority to any other person.
18 Records of all prescriptions shall be maintained in the prescribing
19 psychologists’ patient records.

20 (e) When authorized to prescribe controlled substances, a
21 psychologist holding a conditional prescription certificate shall
22 file with the board in a timely manner all individual federal Drug
23 Enforcement Agency registrations and numbers.

24 2191.25. (a) A psychologist may apply to the board for a
25 prescription certificate. The application shall be made on a form
26 approved by the board and be accompanied by evidence satisfactory
27 to the board that the applicant complies with all of the following:

28 (1) Has been issued a conditional prescription certificate and
29 has successfully completed one year of prescribing psychotropic
30 medication.

31 (2) Holds a current license to practice psychology in California.

32 (3) Meets all other requirements, as determined by rule of the
33 board, for obtaining a prescription certificate.

34 (b) The board shall issue a prescription certificate if it finds that
35 the applicant has met the requirements of subdivision (a).

36 2191.30. A psychologist with a prescription certificate may
37 prescribe psychotropic medication if the psychologist complies
38 with all of the following:

39 (a) Continues to hold a current license to practice psychology
40 in California.

1 (b) Complies with the requirements set forth in paragraph (2)
2 of subdivision (a) of Section 2919.15.

3 (c) Annually satisfies the continuing education requirements
4 for psychologists, if any are set by the board.

5 2191.35. (a) By July 1, 2008, the board shall adopt rules
6 pursuant to establishing the procedures to be followed to obtain a
7 conditional prescription certificate, a prescription certificate, and
8 renewals of a conditional prescription certificate and prescription
9 certificate. The board may set reasonable application and renewal
10 fees.

11 (b) The board shall adopt rules pursuant to establishing the
12 grounds for denial, suspension, or revocation of a conditional
13 prescription certificate and prescription certificate including a
14 provision for suspension or revocation of a license to practice
15 psychology upon suspension or revocation of a conditional
16 prescription certificate or prescription certificate. Actions of denial,
17 suspension, or revocation of a conditional prescription certificate
18 or a prescription certificate shall be in accordance with this chapter.

19 (c) The board shall maintain current records on every prescribing
20 psychologist, including federal registrations and numbers.

21 (d) The board shall provide to the California State Board of
22 Pharmacy an annual list of psychologists holding a conditional
23 prescription certificate that contains the information agreed upon
24 between the board and the board of pharmacy. The board shall
25 promptly notify the board of pharmacy of psychologists who are
26 added or deleted from the list.

27 (e) The board shall be the sole and exclusive administrative
28 body to implement and oversee this article.

29 2191.40. (a) This article shall not be construed to permit a
30 medical psychologist to administer or prescribe a narcotic.

31 (b) This article shall not apply to any of the following:

32 (1) Any person teaching, lecturing, consulting, or engaging in
33 research in psychology insofar as the activities are performed as
34 part of or are dependent upon employment in a college or
35 university, provided that the person shall not engage in the practice
36 of psychology outside the responsibilities of the person's
37 employment.

38 (2) Any person who performs any, or any combination, of the
39 professional services defined as the practice of psychology under
40 the direction of a licensed psychologist in accordance with rules

1 adopted by the board, provided that the person may use the term
2 “psychological assistant,” but shall not identify the person’s self
3 as a psychologist or imply that the person is licensed to practice
4 psychology.

5 (3) Any person employed by a local, state, or federal government
6 agency in a school psychologist or psychological examiner
7 position, or a position that does not involve diagnostic or treatment
8 services, but only at those times when that person is carrying out
9 the functions of that government employment.

10 (4) Any person who is a student of psychology, a psychological
11 intern, or a resident in psychology preparing for the profession of
12 psychology under supervision in a training institution or facility
13 and who is designated by a title as “psychology trainee,”
14 “psychology student,” “psychology intern,” or “psychology
15 resident,” that indicates the person’s training status; provided that
16 the person shall not identify the person’s self as a psychologist or
17 imply that the person is licensed to practice psychology.

18 (5) Any person who is a member of another profession licensed
19 under the laws of this jurisdiction to render or advertise services,
20 including psychotherapy, within the scope of practice as defined
21 in the statutes or rules regulating the person’s professional practice,
22 provided that the person does not represent the person’s self to be
23 a psychologist or does not represent that the person is licensed to
24 practice psychology.

25 (6) Any person who is a member of a mental health profession
26 not requiring licensure, provided that the person functions only
27 within the person’s professional capacities, and provided further
28 that the person does not represent the person to be a psychologist,
29 or the person’s services as psychological.

30 (7) Any person who is a duly recognized member of the clergy;
31 provided that the person functions only within the person’s
32 capacities as a member of the clergy; and provided further that the
33 person does not represent the person to be a psychologist, or the
34 person’s services as psychological.

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**BOARD OF BEHAVIORAL SCIENCES
PROPOSED LANGUAGE
Business and Professions Code (BPC) Sections 4982 and 4992.3**

Amend BPC Sections 4982 and 4992.3 to add the following:

MFT - §4982

Unprofessional conduct shall include, but not be limited to:

An act or omission by a licensee when acting as a custody evaluator under Chapter 6, Part 2 of Division 8 of the Family Code which is in violation of that chapter, or which constitutes unprofessional conduct as defined in this section.

LCSW §4992.3

Unprofessional conduct shall include, but not be limited to:

An act or omission made by a licensee when acting as a custody evaluator under Chapter 6, Part 2 of Division 8 of the Family Code which is in violation of that chapter, or which constitutes unprofessional conduct as defined in this section.

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FAMILY.CODE

SECTION 3110-3118

3110. As used in this chapter, "court-appointed investigator" means a probation officer, domestic relations investigator, or court-appointed evaluator directed by the court to conduct an investigation pursuant to this chapter.

3110.5. (a) No person may be a court-connected or private child custody evaluator under this chapter unless the person has completed the domestic violence and child abuse training program described in Section 1816 and has complied with Rules 5.220 and 5.230 of the California Rules of Court.

(b) (1) On or before January 1, 2002, the Judicial Council shall formulate a statewide rule of court that establishes education, experience, and training requirements for all child custody evaluators appointed pursuant to this chapter, Section 730 of the Evidence Code, or Chapter 15 (commencing with Section 2032.010) of Title 4 of Part 4 of the Code of Civil Procedure.

(A) The rule shall require a child custody evaluator to declare under penalty of perjury that he or she meets all of the education, experience, and training requirements specified in the rule and, if applicable, possesses a license in good standing. The Judicial Council shall establish forms to implement this section. The rule shall permit court-connected evaluators to conduct evaluations if they meet all of the qualifications established by the Judicial Council. The education, experience, and training requirements to be specified for court-connected evaluators shall include, but not be limited to, knowledge of the psychological and developmental needs of children and parent-child relationships.

(B) The rule shall require all evaluators to utilize comparable interview, assessment, and testing procedures for all parties that are consistent with generally accepted clinical, forensic, scientific, diagnostic, or medical standards. The rule shall also require evaluators to inform each adult party of the purpose, nature, and method of the evaluation.

(C) The rule may allow courts to permit the parties to stipulate to an evaluator of their choosing with the approval of the court under the circumstances set forth in subdivision (d). The rule may require courts to provide general information about how parties can contact qualified child custody evaluators in their county.

(2) On or before January 1, 2004, the Judicial Council shall include in the statewide rule of court created pursuant to this section a requirement that all court-connected and private child custody evaluators receive training in the nature of child sexual abuse. The Judicial Council shall develop standards for this training that shall include, but not be limited to, the following:

(A) Children's patterns of hiding and disclosing sexual abuse occurring in a family setting.

(B) The effects of sexual abuse on children.

(C) The nature and extent of child sexual abuse.

(D) The social and family dynamics of child sexual abuse.

(E) Techniques for identifying and assisting families affected by child sexual abuse.

(F) Legal rights, protections, and remedies available to victims of child sexual abuse.

(c) In addition to the education, experience, and training requirements established by the Judicial Council pursuant to subdivision (b), on or after January 1, 2005, no person may be a child custody evaluator under this chapter, Section 730 of the Evidence Code, or Chapter 15 (commencing with Section 2032.010) of Title 4 of Part 4 of the Code of Civil Procedure unless the person meets one of the following criteria:

(1) He or she is licensed as a physician under Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code and either is a board certified psychiatrist or has completed a residency in psychiatry.

(2) He or she is licensed as a psychologist under Chapter 6.6 (commencing with Section 2900) of Division 2 of the Business and Professions Code.

(3) He or she is licensed as a marriage and family therapist under Chapter 13 (commencing with Section 4980) of Division 2 of the Business and Professions Code.

(4) He or she is licensed as a clinical social worker under Article 4 (commencing with Section 4996) of Chapter 14 of Division 2 of the Business and Professions Code.

(5) He or she is a court-connected evaluator who has been certified by the court as meeting all of the qualifications for court-connected evaluators as specified by the Judicial Council pursuant to subdivision (b).

(d) Subdivision (c) does not apply in any case where the court determines that there are no evaluators who meet the criteria of subdivision (c) who are willing and available, within a reasonable period of time, to perform child custody evaluations. In those cases, the parties may stipulate to an individual who does not meet the criteria of subdivision (c), subject to approval by the court.

(e) A child custody evaluator who is licensed by the Medical Board of California, the Board of Psychology, or the Board of Behavioral Sciences shall be subject to disciplinary action by that board for unprofessional conduct, as defined in the licensing law applicable to that licensee.

(f) On or after January 1, 2005, a court-connected or private child custody evaluator may not evaluate, investigate, or mediate an issue of child custody in a proceeding pursuant to this division unless that person has completed child sexual abuse training as required by this section.

3111. (a) In any contested proceeding involving child custody or visitation rights, the court may appoint a child custody evaluator to conduct a child custody evaluation in cases where the court determines it is in the best interests of the child. The child custody evaluation shall be conducted in accordance with the standards adopted by the Judicial Council pursuant to Section 3117, and all other standards adopted by the Judicial Council regarding child custody evaluations. If directed by the court, the court-appointed child custody evaluator shall file a written

confidential report on his or her evaluation. At least 10 days before any hearing regarding custody of the child, the report shall be filed with the clerk of the court in which the custody hearing will be conducted and served on the parties or their attorneys, and any other counsel appointed for the child pursuant to Section 3150. The report may be considered by the court.

(b) The report shall not be made available other than as provided in subdivision (a), or as described in Section 204 of the Welfare and Institutions Code or Section 1514.5 of the Probate Code. Any information obtained from access to a juvenile court case file, as defined in subdivision (e) of Section 827 of the Welfare and Institutions Code, is confidential and shall only be disseminated as provided by paragraph (4) of subdivision (a) of Section 827 of the Welfare and Institutions Code.

(c) The report may be received in evidence on stipulation of all interested parties and is competent evidence as to all matters contained in the report.

3112. (a) Where a court-appointed investigator is directed by the court to conduct a custody investigation or evaluation pursuant to this chapter or to undertake visitation work, including necessary evaluation, supervision, and reporting, the court shall inquire into the financial condition of the parent, guardian, or other person charged with the support of the minor. If the court finds the parent, guardian, or other person able to pay all or part of the expense of the investigation, report, and recommendation, the court may make an order requiring the parent, guardian, or other person to repay the court the amount the court determines proper.

(b) The repayment shall be made to the court. The court shall keep suitable accounts of the expenses and repayments and shall deposit the collections as directed by the Judicial Council.

3113. Where there has been a history of domestic violence between the parties, or where a protective order as defined in Section 6218 is in effect, at the request of the party alleging domestic violence in a written declaration under penalty of perjury or at the request of a party who is protected by the order, the parties shall meet with the court-appointed investigator separately and at separate times.

3114. Nothing in this chapter prohibits a court-appointed investigator from recommending to the court that counsel be appointed pursuant to Chapter 10 (commencing with Section 3150) to represent the minor child. In making that recommendation, the court-appointed investigator shall inform the court of the reasons why it would be in the best interest of the child to have counsel appointed.

3115. No statement, whether written or oral, or conduct shall be held to constitute a waiver by a party of the right to cross-examine the court-appointed investigator, unless the statement is made, or the conduct occurs, after the report has been received by a party or his or her attorney.

3116. Nothing in this chapter limits the duty of a court-appointed investigator to assist the appointing court in the transaction of the business of the court.

3117. The Judicial Council shall, by January 1, 1999, do both of the following:

(a) Adopt standards for full and partial court-connected evaluations, investigations, and assessments related to child custody.

(b) Adopt procedural guidelines for the expeditious and cost-effective cross-examination of court-appointed investigators, including, but not limited to, the use of electronic technology whereby the court-appointed investigator may not need to be present in the courtroom. These guidelines shall in no way limit the requirement that the court-appointed investigator be available for the purposes of cross-examination. These guidelines shall also provide for written notification to the parties of the right to cross-examine these investigators after the parties have had a reasonable time to review the investigator's report.

3118. (a) In any contested proceeding involving child custody or visitation rights, where the court has appointed a child custody evaluator or has referred a case for a full or partial court-connected evaluation, investigation, or assessment, and the court determines that there is a serious allegation of child sexual abuse, the court shall require an evaluation, investigation, or assessment pursuant to this section. When the court has determined that there is a serious allegation of child sexual abuse, any child custody evaluation, investigation, or assessment conducted subsequent to that determination shall be considered by the court only if the evaluation, investigation, or assessment is conducted in accordance with the minimum requirements set forth in this section in determining custody or visitation rights, except as specified in paragraph (1). For purposes of this section, a serious allegation of child sexual abuse means an allegation of child sexual abuse, as defined in Section 11165.1 of the Penal Code, that is based in whole or in part on statements made by the child to law enforcement, a child welfare services agency investigator, any person required by statute to report suspected child abuse, or any other court-appointed personnel, or that is supported by substantial independent corroboration as provided for in subdivision (b) of Section 3011. When an allegation of child abuse arises in any other circumstances in any proceeding involving child custody or visitation rights, the court may require an evaluator or investigator to conduct an evaluation, investigation, or assessment pursuant to this section. The order appointing a child custody evaluator or investigator pursuant to this section shall provide that the evaluator or investigator have access to all juvenile court records pertaining to the child who is the subject of the evaluation, investigation, or assessment. The order shall also provide that any juvenile court records or information gained from those records remain confidential and shall only be released as specified in Section 3111.

(1) This section does not apply to any emergency court-ordered partial investigation that is conducted for the purpose of assisting the court in determining what immediate temporary orders may be necessary to protect and meet the immediate needs of a child. This section does apply when the emergency is resolved and the court is considering permanent child custody or visitation orders.

(2) This section does not prohibit a court from considering evidence relevant to determining the safety and protection needs of the child.

(3) Any evaluation, investigation, or assessment conducted pursuant to this section shall be conducted by an evaluator or investigator who meets the qualifications set forth in Section 3110.5.

(b) The evaluator or investigator shall, at a minimum, do all of the following:

(1) Consult with the agency providing child welfare services and law enforcement regarding the allegations of child sexual abuse, and obtain recommendations from these professionals regarding the child's safety and the child's need for protection.

(2) Review and summarize the child welfare services agency file. No document contained in the child welfare services agency file may be photocopied, but a summary of the information in the file, including statements made by the children and the parents, and the recommendations made or anticipated to be made by the child welfare services agency to the juvenile court, may be recorded by the evaluator or investigator, except for the identity of the reporting party. The evaluator's or investigator's notes summarizing the child welfare services agency information shall be stored in a file separate from the evaluator's or investigator's file and may only be released to either party under order of the court.

(3) Obtain from a law enforcement investigator all available information obtained from criminal background checks of the parents and any suspected perpetrator that is not a parent, including information regarding child abuse, domestic violence, or substance abuse.

(4) Review the results of a multidisciplinary child interview team (hereafter MDIT) interview if available, or if not, or if the evaluator or investigator believes the MDIT interview is inadequate for purposes of the evaluation, investigation, or assessment, interview the child or request an MDIT interview, and shall wherever possible avoid repeated interviews of the child.

(5) Request a forensic medical examination of the child from the appropriate agency, or include in the report required by paragraph

(6) a written statement explaining why the examination is not needed.

(6) File a confidential written report with the clerk of the court in which the custody hearing will be conducted and which shall be served on the parties or their attorneys at least 10 days prior to the hearing. This report may not be made available other than as provided in this subdivision. This report shall include, but is not limited to, the following:

(A) Documentation of material interviews, including any MDIT interview of the child or the evaluator or investigator, written documentation of interviews with both parents by the evaluator or investigator, and interviews with other witnesses who provided

relevant information.

(B) A summary of any law enforcement investigator's investigation, including information obtained from the criminal background check of the parents and any suspected perpetrator that is not a parent, including information regarding child abuse, domestic violence, or substance abuse.

(C) Relevant background material, including, but not limited to, a summary of a written report from any therapist treating the child for suspected child sexual abuse, excluding any communication subject to Section 1014 of the Evidence Code, reports from other professionals, and the results of any forensic medical examination and any other medical examination or treatment that could help establish or disprove whether the child has been the victim of sexual abuse.

(D) The written recommendations of the evaluator or investigator regarding the therapeutic needs of the child and how to ensure the safety of the child.

(E) A summary of the following information: whether the child and his or her parents are or have been the subject of a child abuse investigation and the disposition of that investigation; the name, location, and telephone number of the children's services worker; the status of the investigation and the recommendations made or anticipated to be made regarding the child's safety; and any dependency court orders or findings that might have a bearing on the custody dispute.

(F) Any information regarding the presence of domestic violence or substance abuse in the family that has been obtained from a child protective agency in accordance with paragraphs (1) and (2), a law enforcement agency, medical personnel or records, prior or currently treating therapists, excluding any communication subject to Section 1014 of the Evidence Code, or from interviews conducted or reviewed for this evaluation, investigation, or assessment.

(G) Which, if any, family members are known to have been deemed eligible for assistance from the Victims of Crime Program due to child abuse or domestic violence.

(H) Any other information the evaluator or investigator believes would be helpful to the court in determining what is in the best interests of the child.

(c) If the evaluator or investigator obtains information as part of a family court mediation, that information shall be maintained in the family court file, which is not subject to subpoena by either party. If, however, the members of the family are the subject of an ongoing child welfare services investigation, or the evaluator or investigator has made a child welfare services referral, the evaluator or investigator shall so inform the family law judicial officer in writing and this information shall become part of the family law file. This subdivision may not be construed to authorize or require a mediator to disclose any information not otherwise authorized or required by law to be disclosed.

(d) In accordance with subdivision (d) of Section 11167 of the Penal Code, the evaluator or investigator may not disclose any information regarding the identity of any person making a report of suspected child abuse. Nothing in this section is intended to limit any disclosure of information by any agency that is otherwise required by law or court order.

(e) The evaluation, investigation, or assessment standards set forth in this section represent minimum requirements of evaluation and the court shall order further evaluation beyond these minimum requirements when necessary to determine the safety needs of the child.

(f) If the court orders an evaluation, investigation, or assessment pursuant to this section, the court shall consider whether the best interests of the child require that a temporary order be issued that limits visitation with the parent against whom the allegations have been made to situations in which a third person specified by the court is present or whether visitation will be suspended or denied in accordance with Section 3011.

(g) An evaluation, investigation, or assessment pursuant to this section shall be suspended if a petition is filed to declare the child a dependent child of the juvenile court pursuant to Section 300 of the Welfare and Institutions Code, and all information gathered by the evaluator or investigator shall be made available to the juvenile court.

(h) This section may not be construed to authorize a court to issue any orders in a proceeding pursuant to this division regarding custody or visitation with respect to a minor child who is the subject of a dependency hearing in juvenile court or to otherwise supersede Section 302 of the Welfare and Institutions Code.

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§4982. UNPROFESSIONAL CONDUCT (MFTs)

The board may refuse to issue any registration or license, or may suspend or revoke the license or registration of any registrant or licensee if the applicant, licensee, or registrant has been guilty of unprofessional conduct. Unprofessional conduct shall include, but not be limited to:

(a) The conviction of a crime substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter. The record of conviction shall be conclusive evidence only of the fact that the conviction occurred. The board may inquire into the circumstances surrounding the commission of the crime in order to fix the degree of discipline or to determine if the conviction is substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter. A plea or verdict of guilty or a conviction following a plea of nolo contendere made to a charge substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter shall be deemed to be a conviction within the meaning of this section. The board may order any license or registration suspended or revoked, or may decline to issue a license or registration when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal, or, when an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under Section 1203.4 of the Penal Code allowing the person to withdraw a plea of guilty and enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, information, or indictment.

(b) Securing a license or registration by fraud, deceit, or misrepresentation on any application for licensure or registration submitted to the board, whether engaged in by an applicant for a license or registration, or by a licensee in support of any application for licensure or registration.

(c) Administering to himself or herself any controlled substance or using of any of the dangerous drugs specified in Section 4022, or of any alcoholic beverage to the extent, or in a manner, as to be dangerous or injurious to the person applying for a registration or license or holding a registration or license under this chapter, or to any other person, or to the public, or, to the extent that the use impairs the ability of the person applying for or holding a registration or license to conduct with safety to the public the practice authorized by the registration or license, or the conviction of more than one misdemeanor or any felony involving the use, consumption, or self-administration of any of the substances referred to in this subdivision, or any combination thereof. The board shall deny an application for a registration or license or revoke the license or registration of any person, other than one who is licensed as a physician and surgeon, who uses or offers to use drugs in the course of performing marriage and family therapy services.

(d) Gross negligence or incompetence in the performance of marriage and family therapy.

(e) Violating, attempting to violate, or conspiring to violate any of the provisions of this chapter or any regulation adopted by the board.

(f) Misrepresentation as to the type or status of a license or registration held by the person, or otherwise misrepresenting or permitting misrepresentation of his or her education, professional qualifications, or professional affiliations to any person or entity.

(g) Impersonation of another by any licensee, registrant, or applicant for a license or registration, or, in the case of a licensee, allowing any other person to use his or her license or registration.

(h) Aiding or abetting, or employing, directly or indirectly, any unlicensed or unregistered person to engage in conduct for which a license or registration is required under this chapter.

(i) Intentionally or recklessly causing physical or emotional harm to any client.

(j) The commission of any dishonest, corrupt, or fraudulent act substantially related to the qualifications, functions, or duties of a licensee or registrant.

(k) Engaging in sexual relations with a client, or a former client within two years following termination of therapy, soliciting sexual relations with a client, or committing an act of sexual abuse, or sexual misconduct with a client, or committing an act punishable as a sexually related crime, if that act or solicitation is substantially related to the qualifications, functions, or duties of a marriage and family therapist.

(l) Performing, or holding oneself out as being able to perform, or offering to perform, or permitting any trainee or registered intern under supervision to perform, any professional services beyond the scope of the license authorized by this chapter.

(m) Failure to maintain confidentiality, except as otherwise required or permitted by law, of all information that has been received from a client in confidence during the course of treatment and all information about the client which is obtained from tests or other means.

(n) Prior to the commencement of treatment, failing to disclose to the client or prospective client the fee to be charged for the professional services, or the basis upon which that fee will be computed.

(o) Paying, accepting, or soliciting any consideration, compensation, or remuneration, whether monetary or otherwise, for the referral of professional clients. All consideration, compensation, or remuneration shall be in relation to professional counseling services actually provided by the licensee. Nothing in this subdivision shall prevent collaboration among two or more licensees in a case or cases. However, no fee shall be charged for that collaboration, except when disclosure of the fee has been made in compliance with subdivision (n).

(p) Advertising in a manner that is false, misleading, or deceptive.

(q) Reproduction or description in public, or in any publication subject to general public distribution, of any psychological test or other assessment device, the value of which depends in whole or in part on the naivete of the subject, in ways that might invalidate the test or device.

(r) Any conduct in the supervision of any registered intern or trainee by any licensee that violates this chapter or any rules or regulations adopted by the board.

(s) Performing or holding oneself out as being able to perform professional services beyond the scope of one's competence, as established by one's education, training, or experience. This subdivision shall not be construed to expand the scope of the license authorized by this chapter.

(t) Permitting a trainee or registered intern under one's supervision or control to perform, or permitting the trainee or registered intern to hold himself or herself out as competent to perform, professional services beyond the trainee's or registered intern's level of education, training, or experience.

(u) The violation of any statute or regulation governing the gaining and supervision of experience required by this chapter.

(v) Failure to keep records consistent with sound clinical judgment, the standards of the profession, and the nature of the services being rendered.

§4992.3. UNPROFESSIONAL CONDUCT; EFFECT ON LICENSEE OR REGISTRANT (LCSW)

The board may refuse to issue a registration or a license, or may suspend or revoke the license or registration of any registrant or licensee if the applicant, licensee, or registrant has been guilty of unprofessional conduct. Unprofessional conduct includes, but is not limited to:

(a) The conviction of a crime substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter. The record of conviction shall be conclusive evidence only of the fact that the conviction occurred. The board may inquire into the circumstances surrounding the commission of the crime in order to fix the degree of discipline or to determine if the conviction is substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter. A plea or verdict of guilty or a conviction following a plea of nolo contendere made to a charge substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter is a conviction within the meaning of this section. The board may order any license or registration suspended or revoked, or may decline to issue a license or registration when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal, or, when an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under Section 1203.4 of the Penal Code allowing the person to withdraw a plea of guilty and enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, information, or indictment.

(b) Securing a license or registration by fraud, deceit, or misrepresentation on any application for licensure or registration submitted to the board, whether engaged in by an applicant for a license or registration, or by a licensee in support of any application for licensure or registration.

(c) Administering to himself or herself any controlled substance or using any of the dangerous drugs specified in Section 4022 or any alcoholic beverage to the extent, or in a manner, as to be dangerous or injurious to the person applying for a registration or license or holding a registration or license under this chapter, or to any other person, or to the public, or, to the extent that the use impairs the ability of the person applying for or holding a registration or license to conduct with safety to the public the practice authorized by the registration or license, or the conviction of more than one misdemeanor or any felony involving the use, consumption, or self-administration of any of the substances referred to in this subdivision, or any combination thereof. The board shall deny an application for a registration or license or revoke the license or registration of any person who uses or offers to use drugs in the course of performing clinical social work. This provision does not apply to any person also licensed as a physician and surgeon under Chapter 5 (commencing with Section 2000) or the Osteopathic Act who lawfully prescribes drugs to a patient under his or her care.

(d) Gross negligence or incompetence in the performance of clinical social work.

(e) Violating, attempting to violate, or conspiring to violate this chapter or any regulation adopted by the board.

(f) Misrepresentation as to the type or status of a license or registration held by the person, or otherwise misrepresenting or permitting misrepresentation of his or her education, professional qualifications, or professional affiliations to any person or entity. For purposes of this subdivision, this misrepresentation includes, but is not limited to, misrepresentation of the person's qualifications as an adoption service provider pursuant to Section 8502 of the Family Code.

(g) Impersonation of another by any licensee, registrant, or applicant for a license or registration, or, in the case of a licensee, allowing any other person to use his or her license or registration.

(h) Aiding or abetting any unlicensed or unregistered person to engage in conduct for which a license or registration is required under this chapter.

(i) Intentionally or recklessly causing physical or emotional harm to any client.

(j) The commission of any dishonest, corrupt, or fraudulent act substantially related to the qualifications, functions, or duties of a licensee or registrant.

(k) Engaging in sexual relations with a client or with a former client within two years from the termination date of therapy with the client, soliciting sexual relations with a client, or committing an act of sexual abuse, or sexual misconduct with a client, or committing an act punishable as a sexually related crime, if that act or solicitation is substantially related to the qualifications, functions, or duties of a clinical social worker.

(l) Performing, or holding one's self out as being able to perform, or offering to perform or permitting, any registered associate clinical social worker or intern under supervision to perform any professional services beyond the scope of the license authorized by this chapter.

(m) Failure to maintain confidentiality, except as otherwise required or permitted by law, of all information that has been received from a client in confidence during the course of treatment and all information about the client which is obtained from tests or other means.

(n) Prior to the commencement of treatment, failing to disclose to the client or prospective client the fee to be charged for the professional services, or the basis upon which that fee will be computed.

(o) Paying, accepting, or soliciting any consideration, compensation, or remuneration, whether monetary or otherwise, for the referral of professional clients. All consideration, compensation, or remuneration shall be in relation to professional counseling services actually provided by the licensee. Nothing in this subdivision shall prevent collaboration among two or more licensees in a case or cases. However, no fee shall be charged for that collaboration, except when disclosure of the fee has been made in compliance with subdivision (n).

(p) Advertising in a manner which is false, misleading, or deceptive.

(q) Reproduction or description in public, or in any publication subject to general public distribution, of any psychological test or other assessment device, the value of which depends in whole or in part on the naivete of the subject, in ways that might invalidate the test or device.

(r) Any conduct in the supervision of any registered associate clinical social worker or intern by any licensee that violates this chapter or any rules or regulations adopted by the board.

(s) Failure to keep records consistent with sound clinical judgment, the standards of the profession, and the nature of the services being rendered.

Demographic Survey Results

March 2007

Total Responses Received: 25,910

PERCENTAGES ARE COMPUTED BY TAKING THE NUMBER OF RESPONSES TO A CATEGORY AND DIVIDING BY 25,910

EXCEPTION: FOR "AGE OF RESPONDENTS" AND "RESPONDENTS YEARS IN PRACTICE," FIGURES ARE BASED ON ONLY THOSE WHO INDICATED A RESPONSE IN THESE CATEGORIES

Race and Ethnicity	
Non-Hispanic White	74.40%
Hispanic Latino	8.38%
Multi Race/Other	6.36%
Asian	4.70%
African American	3.59%
American Indian/Alaska Native	0.78%
Pacific Islander	0.40%
No Response	1.41%
25,548 Responses	

Composition of Respondents	
MFT	49.71%
LCSW	29.16%
IMF	10.08%
ASW	8.43%
LEP	2.27%
No Response	0.35%
25,822 Responses	

Age of Respondents (in years)	
Mean =	51.44
Median =	53
25,216 Responses	

Gender	
Female	78.53%
Male	20.95%
No Response	0.53%
25,775 Responses	

Language Fluency (Excluding English)	
Spanish	11.83%
Chinese	1.21%
Korean	0.42%
Tagalog	0.36%
Vietnamese	0.34%

Primary Practice Setting	
Private Practice	39.49%
Non Profit/Charitable	19.24%
County/Municipal Agency	13.02%
Licensed Health Care Facility	9.36%
Schools	5.19%
State/Federal Agency	3.66%
College or University	2%
No Response	1.95%
Other	6.12%
25,409 Responses	

Respondents' Years in Practice	
Mean =	15.53
Median =	14
23,815 Responses	

Past/Current SMEs	
Yes	2.23%

Marriage and Family Therapist (MFT) Demographic Survey

March 2007

Total MFT Intern Responses Received: 12,881

Race and Ethnicity	MFT	Plus/Minus	All Respondents
Non-Hispanic White	81.98%	7.58%	74.40%
Hispanic Latino	4.64%	-3.74%	8.38%
Multi Race/Other	6.37%	0.01%	6.36%
Asian	2.52%	-2.18%	4.70%
African American	1.71%	-1.88%	3.59%
American Indian/Alaska Native	0.71%	-0.07%	0.78%
Pacific Islander	0.19%	-0.21%	0.40%
No Response	1.87%	0.46%	1.41%
12,640 MFT Responses			

Age of Respondents (in years)	MFT	Plus/Minus	All Respondents
Mean =	54.86	3.42	51.44
Median =	56	3	53
12,591 MFT Responses			

Gender	MFT	Plus/Minus	All Respondents
Female	76.00%	-2.53%	78.53%
Male	23.40%	2.45%	20.95%
No Response	0.61%	0.08%	0.53%
12,803 MFT Responses			

Respondents' Years in Practice	MFT	Plus/Minus	All Respondents
Mean =	16.24	0.71	15.53
Median =	15	1	14
11,979 MFT Responses			

Language Fluency (Excluding English)	MFT	Plus/Minus	All Respondents
Spanish	8.08%	-3.75%	11.83%
Chinese	0.64%	-0.57%	1.21%
Korean	0.26%	-0.16%	0.42%
Tagalog	0.16%	-0.20%	0.36%
Vietnamese	0.16%	-0.18%	0.34%

Primary Practice Setting	MFT	Plus/Minus	All Respondents
Private Practice	59.19%	19.70%	39.49%
Non Profit/Charitable	13.71%	-5.53%	19.24%
County/Municipal Agency	8.78%	-4.24%	13.02%
Licensed Health Care Facility	4.05%	-5.31%	9.36%
Schools	3.56%	-1.63%	5.19%
State/Federal Agency	1.72%	-1.94%	3.66%
College or University	1.88%	-0.12%	2.00%
No Response	1.88%	-0.07%	1.95%
Other	5.22%	-0.90%	6.12%
12,639 MFT Responses			

Past/Current SMEs	MFT	Plus/Minus	All Respondents
Yes	2.27%	0.04%	2.23%

PERCENTAGES ARE COMPUTED BY TAKING THE NUMBER OF RESPONSES TO A CATEGORY AND DIVIDING BY 12,881

EXCEPTION: FOR "AGE OF RESPONDENTS" AND "RESPONDENTS YEARS IN PRACTICE," FIGURES ARE BASED ON ONLY THOSE WHO INDICATED A RESPONSE IN THESE CATEGORIES

Licensed Clinical Social Worker (LCS) Demographic Survey

March 2007

Total LCS Responses Received: 7,556

Race and Ethnicity	LCS	Plus/Minus	All Respondents
Non-Hispanic White	72.49%	-1.91%	74.40%
Hispanic Latino	8.96%	0.58%	8.38%
Multi Race/Other	5.74%	-0.62%	6.36%
Asian	5.78%	1.08%	4.70%
African American	4.65%	1.06%	3.59%
American Indian/Alaska Native	0.79%	0.01%	0.78%
Pacific Islander	0.45%	0.05%	0.40%
No Response	1.14%	-0.27%	1.41%
7,470 LCS Responses			

Age of Respondents (in years)	LCS	Plus/Minus	All Respondents
Mean =	52.71	1.27	51.44
Median =	54	1	53
7,384 LCS Responses			

Gender	LCS	Plus/Minus	All Respondents
Female	80.07%	1.54%	78.53%
Male	19.51%	-1.44%	20.95%
No Response	0.42%	-0.11%	0.53%
7,524 LCS Responses			

Respondents' Years in Practice	LCS	Plus/Minus	All Respondents
Mean =	20	4.47	15.53
Median =	20	6	14
7,138 LCS Responses			

Language Fluency (Excluding English)	LCS	Plus/Minus	All Respondents
Spanish	13.22%	1.39%	11.83%
Chinese	1.62%	0.41%	1.21%
Korean	0.33%	-0.09%	0.42%
Tagalog	0.38%	0.02%	0.36%
Vietnamese	0.38%	0.04%	0.34%

Primary Practice Setting	LCS	Plus/Minus	All Respondents
Private Practice	27.77%	-11.72%	39.49%
Non Profit/Charitable	15.03%	-4.21%	19.24%
County/Municipal Agency	16.86%	3.84%	13.02%
Licensed Health Care Facility	17.85%	8.49%	9.36%
Schools	3.30%	-1.89%	5.19%
State/Federal Agency	6.41%	2.75%	3.66%
College or University	2.20%	0.20%	2.00%
No Response	2.02%	0.07%	1.95%
Other	8.56%	2.44%	6.12%
7,403 LCS Responses			

Past/Current SMEs	LCS	Plus/Minus	All Respondents
Yes	2.91%	0.68%	2.23%

PERCENTAGES ARE COMPUTED BY TAKING THE NUMBER OF RESPONSES TO A CATEGORY AND DIVIDING BY 7,556

EXCEPTION: FOR "AGE OF RESPONDENTS" AND "RESPONDENTS YEARS IN PRACTICE," FIGURES ARE BASED ON ONLY THOSE WHO INDICATED A RESPONSE IN THESE CATEGORIES

Licensed Educational Psychologist (LEP) Demographic Survey

March 2007

Total LEP Responses Received: 589

Race and Ethnicity	LEP	Plus/Minus	All Respondents
Non-Hispanic White	81.49%	7.09%	74.40%
Hispanic Latino	4.58%	-3.80%	8.38%
Multi Race/Other	4.58%	-1.78%	6.36%
Asian	4.41%	-0.29%	4.70%
African American	2.89%	-0.70%	3.59%
American Indian/Alaska Native	0.51%	-0.27%	0.78%
Pacific Islander	0.17%	-0.23%	0.40%
No Response	1.36%	-0.05%	1.41%
581 LEP Responses			

Age of Respondents (in years)	LEP	Plus/Minus	All Respondents
Mean =	54.32	2.88	51.44
Median =	56	3	53
574 LEP Responses			

Gender	LEP	Plus/Minus	All Respondents
Female	70.46%	-8.07%	78.53%
Male	28.35%	7.40%	20.95%
No Response	1.19%	0.66%	0.53%
582 LEP Responses			

Respondents' Years in Practice	LEP	Plus/Minus	All Respondents
Mean =	18.9	3.37	15.53
Median =	20	6	14
555 LEP Responses			

Language Fluency (Excluding English)	LEP	Plus/Minus	All Respondents
Spanish	9.51%	-2.32%	11.83%
Chinese	1.36%	0.15%	1.21%
Korean	0.00%	-0.42%	0.42%
Tagalog	0.00%	-0.36%	0.36%
Vietnamese	0.17%	-0.17%	0.34%

Primary Practice Setting	LEP	Plus/Minus	All Respondents
Private Practice	24.96%	-14.53%	39.49%
Non Profit/Charitable	2.04%	-17.20%	19.24%
County/Municipal Agency	1.70%	-11.32%	13.02%
Licensed Health Care Facility	1.02%	-8.34%	9.36%
Schools	65.03%	59.84%	5.19%
State/Federal Agency	1.20%	-2.46%	3.66%
College or University	3.74%	1.74%	2.00%
No Response	2.55%	0.60%	1.95%
Other	6.28%	0.16%	6.12%
574 LEP Responses			

Past/Current SMEs	LEP	Plus/Minus	All Respondents
Yes	10.02%	7.79%	2.23%

PERCENTAGES ARE COMPUTED BY TAKING THE NUMBER OF RESPONSES TO A CATEGORY AND DIVIDING BY 589

EXCEPTION: FOR "AGE OF RESPONDENTS" AND "RESPONDENTS YEARS IN PRACTICE," FIGURES ARE BASED ON ONLY THOSE WHO INDICATED A RESPONSE IN THESE CATEGORIES

MFT Intern (IMF) Demographic Survey**March 2007***Total IMF Responses Received: 2,611*

Race and Ethnicity	IMF	Plus/Minus	All Respondents
Non-Hispanic White	61.51%	-12.89%	74.40%
Hispanic Latino	14.78%	6.40%	8.38%
Multi Race/Other	8.50%	2.14%	6.36%
Asian	6.93%	2.23%	4.70%
African American	6.32%	2.73%	3.59%
American Indian/Alaska Native	0.77%	-0.01%	0.78%
Pacific Islander	0.73%	0.33%	0.40%
No Response	0.46%	-0.95%	1.41%
<i>2,599 IMF Responses</i>			

Age of Respondents (in years)	IMF	Plus/Minus	All Respondents
Mean =	41.51	-9.93	51.44
Median =	40	-13	53
<i>2,539 IMF Responses</i>			

Gender	IMF	Plus/Minus	All Respondents
Female	82.73%	4.20%	78.53%
Male	17.04%	-3.91%	20.95%
No Response	0.23%	-0.30%	0.53%
<i>2,605 IMF Responses</i>			

Respondents' Years in Practice	IMF	Plus/Minus	All Respondents
Mean =	4.32	-11.21	15.53
Median =	3	-11	14
<i>2,133 IMF Responses</i>			

Language Fluency (Excluding English)	IMF	Plus/Minus	All Respondents
Spanish	16.43%	4.60%	11.83%
Chinese	1.38%	0.17%	1.21%
Korean	0.65%	0.23%	0.42%
Tagalog	1.00%	0.64%	0.36%
Vietnamese	0.46%	0.12%	0.34%

Primary Practice Setting	IMF	Plus/Minus	All Respondents
Private Practice	11.18%	-28.31%	39.49%
Non Profit/Charitable	51.28%	32.04%	19.24%
County/Municipal Agency	14.59%	1.57%	13.02%
Licensed Health Care Facility	6.32%	-3.04%	9.36%
Schools	6.17%	0.98%	5.19%
State/Federal Agency	2.45%	-1.21%	3.66%
College or University	2.26%	0.26%	2.00%
No Response	1.84%	-0.11%	1.95%
Other	3.91%	-2.21%	6.12%
<i>2,566 IMF Responses</i>			

Past/Current SMEs	IMF	Plus/Minus	All Respondents
Yes		-2.23%	2.23%

PERCENTAGES ARE COMPUTED BY TAKING THE NUMBER OF RESPONSES TO A CATEGORY AND DIVIDING BY 2,611

EXCEPTION: FOR "AGE OF RESPONDENTS" AND "RESPONDENTS YEARS IN PRACTICE, FIGURES ARE BASED ON ONLY THOSE WHO INDICATED A RESPONSE IN THESE CATEGORIES

Associate Clinical Social Worker (ASW) Demographic Survey

March 2007

Total ASW Responses Received: 2,185

Race and Ethnicity	ASW	Plus/Minus	All Respondents
Non-Hispanic White	49.89%	-24.51%	74.40%
Hispanic Latino	22.01%	13.63%	8.38%
Multi Race/Other	6.32%	-0.04%	6.36%
Asian	11.21%	6.51%	4.70%
African American	7.92%	4.33%	3.59%
American Indian/Alaska Native	1.14%	0.36%	0.78%
Pacific Islander	1.05%	0.65%	0.40%
No Response	0.46%	-0.95%	1.41%
2,175 ASW Responses			

Age of Respondents (in years)	ASW	Plus/Minus	All Respondents
Mean =	37.84	-13.6	51.44
Median =	34	-19	53
2,128 ASW Responses			

Gender	ASW	Plus/Minus	All Respondents
Female	85.77%	7.24%	78.53%
Male	14.00%	-6.95%	20.95%
No Response	0.23%	-0.30%	0.53%
2,180 ASW Responses			

Respondents' Years in Practice	ASW	Plus/Minus	All Respondents
Mean =	5.9	-9.63	15.53
Median =	4	-10	14
1,941 ASW Responses			

Language Fluency (Excluding English)	ASW	Plus/Minus	All Respondents
Spanish	24.30%	12.47%	11.83%
Chinese	2.88%	1.67%	1.21%
Korean	1.56%	1.14%	0.42%
Tagalog	0.78%	0.42%	0.36%
Vietnamese	1.10%	0.76%	0.34%

Primary Practice Setting	ASW	Plus/Minus	All Respondents
Private Practice	2.01%	-37.48%	39.49%
Non Profit/Charitable	32.86%	13.62%	19.24%
County/Municipal Agency	26.13%	13.11%	13.02%
Licensed Health Care Facility	16.98%	7.62%	9.36%
Schools	6.36%	1.17%	5.19%
State/Federal Agency	7.73%	4.07%	3.66%
College or University	1.28%	-0.72%	2.00%
No Response	1.19%	-0.76%	1.95%
Other	5.45%	-0.67%	6.12%
2,159 ASW Responses			

Past/Current SMEs	ASW	Plus/Minus	All Respondents
Yes		-2.23%	2.23%

PERCENTAGES ARE COMPUTED BY TAKING THE NUMBER OF RESPONSES TO A CATEGORY AND DIVIDING BY 2,185

EXCEPTION: FOR "AGE OF RESPONDENTS" AND "RESPONDENTS YEARS IN PRACTICE," FIGURES ARE BASED ON ONLY THOSE WHO INDICATED A RESPONSE IN THESE CATEGORIES

State of California

Memorandum

To: Policy and Advocacy Committee

Date: March 21, 2007

From: Paul Riches
Executive Officer

Telephone: (916) 574-7847

Subject: IX. Recognition of Social Work PhD

Background

In the course of developing a proposal to increase portability of licenses for clinical social workers in 2006, the board received a request from an individual to consider recognizing PhDs in social work in the licensing process. Copies of the letter sent in 2006 and a more recent letter from the individual are attached for your reference.

The committee did not choose to treat a PhD in social work differently than a Master's degree in social work. This decision was primarily based on an assessment that the skills acquired in PhD programs focused on research and development of new knowledge and did not necessarily reflect greater clinical skills. A review of the three PhD programs offered in California confirmed this assessment (see attached materials for program information).

Staff Recommendation

Based on a review of the three PhD programs offered in California, staff recommends that no special recognition be granted to PhD candidates in the licensing process.

It is certainly possible that PhD candidates who pursue research in areas relevant to clinical practice might build an expanded clinical capability, but the focus of professional development in a PhD is to expand skills as a researcher, teacher and scholar. Furthermore, there are a large number of areas of study within social work that have little or no application to the qualifications for a clinical license.

Attachments

March 14, 2006 Letter

March 18, 2007 Letter

Program Information for PhD Programs at UC Berkeley, UC Los Angeles and University of Southern California

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Dear Mr. Riches, Ms. Maggio, Mr. Manoleas, Ms. DiGiorgio, Mr. Gerst, Ms. Johnson, Mr. Law, Ms. Pines, Dr. Russ, Mr. Stein, Ms. Walmsley

March 16, 2006

My name is Marcy Cole and I moved to Marina del Rey, California in the Fall of 2004 from Chicago. I graduated from Northwestern University in 1984, received a Masters in Clinical Social Work from Loyola University in Chicago in 1991, and a Ph.D from The Institute of Clinical Social Work (a fully accredited doctoral program in Chicago) in 1999. I have worked in an in-patient hospital setting, a community mental health clinic working with the chronically mentally ill for 5 years, followed by a private practice working with Adults, Couples and Families for the past decade.

As you are aware, out of State medical professionals must simply send in the required paper work for their credentials, professional identity, and financial livelihood to transfer. Similarly, those who have a Ph.D in Psychology, licensed in another state, must merely take a test on California "Law and Ethics", which I certainly deem appropriate. Yet, due to the lack of reciprocity in this State, **I am writing to you all to share what is it is like to be in the shoes of a degreed and experienced professional in my field to move to the State of California.**

It seems fair and reasonable to require the necessary paper work and references that verify the legitimacy of one's education and breadth of professional experience, taking any necessary classes about what is specific to California Law, and paying the usual and customary licensing fees. However, the additional and overwhelming hoops that we must leap through, required by the current legislation on this matter, as well as the Board of Behavioral Science's Rules and Regulations, truly makes it feel as though professionals from out state are not welcome and, in fact, discouraged from joining forces in this State to provide consistent and reliable care in Mental Health. Despite my advanced degrees and years of professional experience, under present California law, I have felt treated like a new graduate. There are certainly other states that do not grant full reciprocity to licensed health professionals, but to treat highly qualified therapists like novices is not only demeaning, but patently unjust.

In the field of Social Work, the enormous hurdles clinicians must face who have an L.C.S.W. (Licensed Clinical Social Work) and/or a Ph.D, are more akin to moving to another country rather than another State. The process is fraught with months of bureaucratic paperwork, arduous waiting periods, and attendant fees. Last year I had to be supervised for 5 months before I could take 4 classes, in order to be eligible to sit for, not one, but two separate exams. As you know, the first was the "Clinical Written Exam" - a 4-hour test with 200 questions. Currently, The Board of Behavioral Sciences does not offer any study materials to aid persons to prepare for these exams. One is forced to spend hundreds of dollars with individuals or companies who claim to know what materials will adequately prepare you. My experience was that they do not in fact know what these exams are really like.

I passed the first exam and considered myself fortunate, since so many questions were pointedly obtuse. I took the second exam, "The Clinical Vignette Exam" in December of 2005, feeling well prepared given the study materials I'd purchased and the months of study. Nevertheless, I did not pass. I had never failed an exam in my entire academic career, and this one is supposed to be designed for novice clinicians! I would feel better and more hopeful about the future if I had not been prepared. But I was.....just not adequately trained for the confusing nature of this type of exam. I understand that it replaced the oral exam a couple of years ago. I can't help but also share my wondering as to why anything had to serve as a replacement in the first place? It seems a waste of time and moneys for everyone involved. Why isn't one comprehensive exam enough? What does the field of Social Work in this State need to prove? Why are hoops required blatantly higher than others?

Furthermore, what I can report to you, which is borne out by the over 50% of aspirants who consistently fail these exams, is that they are worded in ambiguous ways that trick the versus test for true knowledge. This issue, combined with a system that does not provide the examinees proper and relevant study materials, creates an atmosphere designed to set people up for failure rather than to create tools which define and discern for legitimate competence. In addition, when statistics show that over half are failing these tests, the Board of Behavioral Science's policy of a 6 month waiting period before you can re-take the exam only prolongs the process and agony for everyone, which has major implications for the livelihood of many experienced mental health professionals.

The policy regarding transfer of supervisory hours is also unbelievably disruptive. If professionals who move here got their supervisory training over 6 years before applying for California licenser, then they must repeat part or full time 3200 hours of supervisory time. So in essence, seasoned clinicians from out of State are stripped of their professional credentials and identity and reduced to the position of an intern right out of graduate school! I have done what is expected to garner an ASW license to at least continue practicing in this State. But I must be a W2 employee of an institution or licensed professional, get weekly supervision from that individual, not accept any fees directly from clients (they must write all checks to my "supervisor"), and I can no longer accept insurance from clients. In addition, I of course have resumed responsibility for paying my employer's taxes as well as my own. Thus, my practice and income is half of what it was in Illinois, with no end in sight....given the last 62% failing rate statistic for 2nd time Vignette test takers.

To add insult to injury, this State and the Board of Behavioral Sciences does not even recognize my doctorate!! In the State of California, there is currently no protocol, special attention and recognition for those professionals in the field of Clinical Social Work who have completed 6 more years of academic work and training to achieve a Ph.D in this field. According to the current requirements, we must qualify under the same "rules and regulations" as Social Workers with a Masters Degree from another State. Why are our licensing requirements not identical to the those levied on an experienced therapist with a PhD in Psychology? There are not many in my predicamenta PhD in the field of Clinical Social Work can only be achieved from a handful of accredited schools in the country. I am merely asking to be heard and for the legitimacy of this complaint to compel those of you in positions of licensing authority to take notice of, and action on behalf of my case and this issue at hand.

I've spoken to so many people in the community about the impressions and sentiments expressed in this letter. They all shake their heads and say "Yes, everyone seems to feel that way but that's just the way it is". After months of frustration with current protocol, I have chosen not to remain silent. Beneficial change only occurs when reasonable and dedicated persons are willing and persistent enough to challenge the current system and implement better, more just, and more efficient and effective policies.

Thank you very much for your time, consideration, and support on this matter. I look forward to hearing from you.

Sincerely,

Marcy Cole, Ph.D

Marcy Cole
<marcycole@gmail.com>

03/18/2007 09:35 PM

To Paul_Riches@dca.ca.gov

cc BBSWebMaster@bbs.ca.gov

bcc

Subject UPDATED LETTER FOR APRIL 4TH BOARD MEETING

Dear Mr. Riches, Ms. Maggio, Ms. DiGiorgio, Ms. Johnson, Mr. Law, Ms. Leach, Dr. Russ, Mr. Stein, Ms. Roye, Ms. Lonner, Ms. Walmsley

March 18, 2007

My name is Marcy Cole and I moved to Marina del Rey, California in the Fall of 2004 from Chicago. Having graduated from Northwestern University in 1984, I received a Masters in Clinical Social Work from Loyola University in Chicago in 1991, and a Ph.D from The Institute of Clinical Social Work (a fully accredited doctoral program in Chicago) in 1999. I have worked in an in-patient hospital setting, a community mental health clinic working with the chronically mentally ill, followed by a private practice working with Adults, Couples and Families for the past decade.

In March of 2006, I wrote the board about a number of concerns. In this letter I bring to your attention, once again, the injustice over the fact that, in the State of California, there is still currently no protocol or recognition for those out of State Clinical Social Work professionals, who have completed 6 more years of academic work and training to achieve a very well deserved Ph.D in this field. According to the current requirements, we must qualify under the same "rules and regulations" as Social Workers with a Masters Degree from another State.

The Department of Consumer Affairs was asked by Governor Schwarzenegger's office to respond to this concern.

In their letter to me, dated February 20, 2007, under the section called "Recognition of Ph.D. in Social Work", Director of DCA, Carlene Zettel stated: **"A doctoral degree in social work does provide additional qualifications as a researcher, but does not necessarily provide any greater clinical expertise than a master's degree."** This statement highlighted the discrepancy between fact and assumption that has influence and dictated current legislation. I had to read this line repeatedly to fully realize the magnitude of this distortion. Perhaps it is because a doctorate in Clinical Social Work is still relatively new in it's existence. Nonetheless, the transcripts from my doctoral program, that were sent along with my initial application, clearly legitimize the fact that this Institute places its primary academic and supervisory focus on developing clinical refinement and expertise in its graduates. During the first 4 years of this doctoral program, I completed 34 additional classes on Human Development, Clinical Theory and Clinical Practice. There were several clinical cases each year that required additional supervision hours and case conference presentations. Only 5 classes out of 40 focused on research and it was only during my 5th year that Dissertation Consultation was the sole focus. The Institute is sending a letter to the Board as well, offering further clarification and validation that legitimizes my experience and the clinical dominance of this program.

Thus, there are clearly generalized and incorrect assumptions being made about the degree of advanced clinical experience and training that many out of State Doctoral level Social Workers bring to the State of California. Yet these assumptions still hold the power to enforce and maintain current policy regarding this issue. Rather than continuing to dismiss its value, my hope is that the data I am presenting to the Board be recognized and used as an incentive to require a much more extensive review of the additional professional training that out of state clinicians bring to this State.

I am asking again to be heard, and for the legitimacy of this complaint to compel those of you in positions of licensing authority to take notice of, and action on behalf of this valid and relevant issue. Professionals in other states besides California, invested years of work and clinical training in order to achieve this academic and professional accomplishment, worthy of special consideration and acknowledgment. I hope that, upon further reflection and discussion, the Board is in agreement.

Thank you for your time in continuing to discuss issue.

Sincerely,

Marcy Cole, Ph.D

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Academic Programs > PhD > Program Description

Mission of the Doctoral Program

The main objective of doctoral education at Berkeley is to inspire independence and originality of thought in pursuit of knowledge. The School's Ph.D. program aims to develop scholars who will make significant contributions to the field of social welfare through excellent teaching, research, policy development and analysis, administration and direct practice. Doctoral students become proficient in research methodology and ultimately demonstrate this research competence in their dissertations. Most graduates of the Ph.D. Program become faculty members in schools of social work and social welfare or hold positions in policy-making agencies or research institutions.

Program of Study

The Ph.D. program allows students to pursue individualized courses of study tailored to their intellectual interests. Each student's academic work is designed to focus on knowledge in three fields of study: (1) a social problem field (e.g., children, the family, mental health, status and roles of women); (2) a social science theory field (e.g., theories of human development, psychopathology, theories of planning, economics of social welfare), and (3) a field of social welfare intervention (e.g., policy analysis, social welfare planning, social casework, family therapy, administration).

Doctoral course work includes seminars in the School of Social Welfare and other departments of the university; individual tutorials with members of the faculty; and required courses in research methods and techniques, library research, and the history and philosophy of social welfare.



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Progress to the Ph.D.

First-Year Courses

First-year required courses are:

Public Health 142A (Introduction to Probability and Statistics in Biology and Public Health-Fall) and Public Health 145 (Statistical Analysis of Continuous-Outcome Data-Spring)
 SW 287, Introduction to Library Resources and Faculty Research (fall)
 SW 289A, Doctoral Research Methods and Techniques in Social Welfare (spring)
 SW 279, History and Philosophy of Social Welfare (fall)

First-Year Review:

A progress review designed to assess students' capacity to think about problems and issues conceptually, analytically, and critically is held in the spring of the first year.

Second- and Third-Year Courses

Required courses taken in the second or third year are:

Public Health 241, Statistical Analysis of Categorical Data, offered in the Spring
 An approved elective course in research methodology.
 SW 295, Dissertation/Integrative Seminar, designed to give students feedback as they proceed with their dissertations and to address any relevant areas of research methodology not covered in previous course work.



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Qualifying Examination

The qualifying examination is based upon written materials that students submit for their examination committee's approval, including three substantial research papers, three extensive bibliographies, and a dissertation prospectus. (Please note that a Human Subjects proposal may also be required.)

Advancement to Candidacy

After completing required course work and passing the qualifying examination, students apply for advancement to candidacy for the Ph.D. degree by submitting to the dean of the Graduate Division a dissertation title and the names of three faculty members who have agreed to guide the research and serve on the dissertation committee. Students meet with this committee before beginning work on the dissertation. If dissertation research involves working with human subjects, a CITI course must be completed before advancement to candidacy.

Dissertation

The materials presented as the basis of the qualifying examination include an explicit research design that is carried out in the dissertation. In general, then, both course work and the qualifying examination help to focus attention and clarify plans for a dissertation that will contribute to the knowledge base of social welfare and the social services. After the three dissertation committee members have given it their final approval, the completed dissertation is filed with the Graduate Division. No oral defense of the dissertation is required.

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Fields of Study for the Qualifying Examination

Examples of fields in which members of the School of Social Welfare faculty are prepared to give instruction, examinations, and supervision of dissertation research follow. Students may petition for approval of a field other than those listed, provided it has a large body of literature, is a subject of academic teaching and research, and is related to social welfare.

Social Problem Fields

Children & adolescents	Housing/homelessness
Death and dying	Mental health
Deviant behavior	Migration and immigration
Disability	Poverty
Elderly	Racial and ethnic issues
Employment issues	Status and roles of women
The family, family functioning	Substance abuse
Health	Underdeveloped countries
History of social welfare problems and institutions	Urban development

Fields of Social Science Theory and Research

Behavioral/social learning theory	Theories of deviance
Community theory	Theories of the family
Economics of social welfare	Theories of human development
Ego psychology and psychoanalytic theory	Theories of inter-ethnic relations
Organization theory	Theories of medical sociology
Personality theory	Theories of planning
Philosophy of social science	Theories of psychopathology
Small group theory	Theories of social change
Social psychology (incl. social exchange theory)	Theories of stress and coping
Social work treatment theory	Theories of the welfare state
Theories of acculturation of ethnic minorities (cultural orientation)	

Fields of Social Welfare Intervention (Professional Activity)

Adult psychotherapy	Multicultural practice
Aging services	Occupational social work
Behavioral approaches	Policy analysis
Child & adolescent psychotherapy	Preventive social work
Child welfare services	Research methods
Cognitive approaches	Social casework/case management
Collaborative intervention	Social development
Community development	Social planning
Community mental health services	Social services in public welfare
Community organization	Social welfare administration
Family therapy	Social work in education
Group work	Social work in health care
Institutional care	Training and professional development, social work profession
Long-term care	



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Ph.D Program

Mission Statement

The mission of the doctoral program in social welfare is to train research oriented scholars to advance the field of social welfare and social work practice through research and knowledge development. The purpose of the program is to provide students with the necessary expertise, both substantive and methodological, that will enable them to assume leadership roles in academic, social welfare policy and social work practice settings.

To achieve that mission, all doctoral students are required to develop advanced knowledge and expertise in three interrelated areas: a) a substantive area of social welfare; b) social and behavioral science knowledge applicable to the substantive area; and c) research methods. Expertise in a substantive area of social welfare provides the foundation for advanced research in that area; social and behavioral science knowledge provides the theory and the empirical findings needed to understand the causes, dynamics and outcomes of the subjects and processes addressed by social welfare; and research competence is necessary to conduct the empirical research needed to advance knowledge.

Curriculum

The program has several significant features. Research training, both formal and experiential, is at the core of the program. Flexibility is provided to help students attain in-depth competence in a substantive area of social welfare. Students progress from a common foundation in both policy and practice toward a high degree of individualized specialization. This common foundation emphasizes the acquisition of analytic tools needed to understand, appraise and advance knowledge in social welfare. With these analytical tools, the students select a specific area of specialization and develop expertise in that area. Considerable emphasis is placed on the individualized instructional relationship between students and faculty mentors. The learning process involves more than classroom instruction. Students are expected to work closely

with faculty in their roles as scholars and researchers. The program is interdisciplinary and students are encouraged to use the rich learning resources of the entire University. Doctoral students come with diverse academic backgrounds and levels of preparation and may want to enroll in selected MSW courses that can fill in gaps in knowledge needed to pursue advanced work. Students demonstrate their acquired expertise by producing scholarly work (e.g. the publishable scholarly paper) rather than through merely completing a set of courses. While the program requires completion of a limited set of courses, the emphasis is on acquisition of knowledge, and students who demonstrate possession of such knowledge on the basis of prior work and proficiency examinations may be exempted from specific course requirements.

Full-time students usually will be expected to enroll in twelve units of study each quarter. Although diversity of backgrounds makes it difficult to predict, students are expected to complete the program in about four years. There are approximately two years of coursework and then the dissertation. Those in the combined MSW/Ph.D. program usually require an additional year.

Courses	Expected Progress by End of Each Year
<p>Year 1 Courses</p> <p>Survey of Research Methods (286A)(optional) Policy Formulation and Analysis (225A) Policy Implementation and Evaluation (225B) Epistemology of Practice (245A) Models of Practice Research (245B) 2 Statistics Courses</p>	<p>Pass Written Comprehensive Exam File Doctoral Study Plan Approved Plan for Research Internship</p>
<p>Year 2 Courses</p> <p>3 Social and Behavioral Science Courses 3 quarters of Research Internship (286C) 3 Advanced Research Methods Courses</p>	<p>Approved Outline for Publishable Scholarly Paper</p>

Year 3 Courses Additional courses & Independent Study Dissertation Seminar (258) 2 quarters	Approved Scholarly Paper Dissertation Committee Appointed Dissertation Proposal Developed Pass Oral Defense of Dissertation Proposal
Year 4 Courses Independent Research (599)	Dissertation Completed

Combined MSW/Ph.D

The Department of Social Welfare offers a program whereby those without a master's degree in social work can begin a program of study that leads to both the MSW and the Ph.D. degrees.

The purpose of the combined MSW-Ph.D. program is to provide an integrated educational program for exceptionally talented students who do not already have an MSW degree, but who know they want to prepare for careers as researchers and scholars in the field of social welfare. The combined program provides for a slightly abbreviate course of study by eliminating some redundancy between the MSW and Ph.D. programs. The advantages of the combined program for students is that it allows them to embark on their doctoral course work before completing the MSW program. In addition, the combined program provides a structured educational opportunity for students who have master's degrees in fields other than social work, but who may want to earn an MSW while pursuing the Ph.D. degree. Having an MSW degree is essential to teach practice courses at accredited schools of social work.

There are different ways of completing the combined MSW-Ph.D. program and different routes should be tailored to the individual student's experiences and objectives. In part, the structure of the second and third years of the combined program will depend on when students opt to complete the second year of the MSW field practicum. The second MSW field placement may be a summer block or academic-year concurrent placement and may be taken during the second or third year. Students with significant social work practice experience may apply to have their second field placement include a research and evaluation emphasis, and thereby fulfill the requirement for a Research Internship in the

Doctoral Program. If the student has no prior social work practice experience, the second placement should be a more practice-oriented one.

Financial Aid

The Doctoral Program of the Department of Social Welfare provides various sources of financial aid, including fellowships, tuition waivers, research and teaching assistantships, and training grants. In addition, each year the Program awards the Ruby and Toby Gold Fellowship to a student studying gerontology and the Jim and Judy Bergman Fellowship to a student interested in research on social work practice. In the Department of Social Welfare, allocation of financial aid is based on both academic performance and promise and financial need. Priority for financial aid is given to first and second year students. Financial aid to cover resident tuition fees is considered a higher priority than non-resident tuition fees. Some financial aid is handled by the Director of the Doctoral Program, on behalf of the Doctoral Committee.

Doctoral students who are interested in acquiring experience in teaching as preparation for an academic teaching role are provided with the opportunity to assist faculty members in the instruction of selected undergraduate and graduate courses. Such an experience includes preparation of material for classroom presentation, actual presentation of the material, and opportunities to interact with the students. Requests for a teaching experience should be made to the Director of the Doctoral Program well in advance of the quarter during which students want to teach.

The UCLA Financial Aid Office administers grants-in-aid and loans to students. Students should pick up an application in November for the following academic year. Specific instructions will be available to students each year prior to the deadline date.

The Fellowship and Assistantship Office of Graduate Division administers University fellowships and is also a source of information and application forms for many fellowships offered by private foundations and agencies. An information booklet is published by this office each year. One copy is posted in the Department of Social Welfare; individual copies should be in your campus mailbox by December. The deadline for application for University fellowships is mid-January a half year before the fellowship year. Deadlines for privately funded fellowships vary, but are

usually one year in advance of the actual fellowship award. Interested students should check with the Fellowship and Assistantship Office regularly to keep informed of opportunities as they become available. Much of this information will be distributed by the Director of the Doctoral Program through e-mail.

University emergency loans may be applied for at the Student Loan Service, A227 Murphy Hall. An emergency loan is generally for an amount up to \$100.

Regulations and procedures regarding fellowships and financial aid are quite varied and are subject to change. Therefore, further information should be requested from the specific administrative office involved.

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Academic

DOCTOR OF PHILOSOPHY OF SOCIAL WORK

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Skills Development



Our goal is to prepare students for successful academic careers that include teaching, research and presentation competencies

Teaching

All doctoral students must teach for two semesters before they graduate. Requirements may be fulfilled by co-teaching, teaching as an assistant or solo teaching. Before beginning these experiences, students must take a teaching course approved by the doctoral committee. International students must meet the English proficiency standards set forth by the [American Language Institute](#) and participate, if necessary, in specialized training offered through the [Center for Excellence in Teaching](#)

Research

Faculty provide a rich set of research opportunities tailored to students' specific interests including:

- 10 hours per week of research collaborations with faculty in each of the first two years in the program
- core and advanced research methodology and statistic courses
- engagement in faculty directed research projects
- collaboration with faculty in preparation of publishable articles
- assistance in developing grants for students' dissertations and research
- opportunities for Research Assistant (RA) positions

Presentations

The school provides resources toward travel and lodging expenses for conferences and other scholarly trips.

SAMPLE DOCTORAL STUDENT PLAN AT USC SCHOOL OF SOCIAL WORK

Substantive Core Courses must take 4 of 5 from the following:

- SOWK 702 Theories of Human Behavior in the Context of Social Environments (3)
- SOWK 703 Explanatory Theories for Larger Social Systems (3)
- SOWK 733 Policy Analysis and Advocacy in a Comparative Social Policy Context (3)
- SOWK 743 Theories for Practice with Small Systems (3)
- SOWK 744 Theories for Practice With Large Systems (3)

Minimum Total Required Units 12

Please note: Macro students **must** take at least one course of SOWK 702 or SOWK 743. Micro students must take at least one course SOWK 703, SOWK 733 or SOWK 744 to give them exposure to perspectives, research and theories outside their core interests.

Required Core Research/Statistics Courses:

- SOWK 760L Introduction to Social Work Statistics (3)
- SOWK 761L Multiple Regression in Social Work Research (3)
- SOWK 762 Social Work Research Methods I (3)
- SOWK 763 Social Work Research Methods II: Issues in Research for Social Work Practice (3)
- SOWK 764 Advanced Multivariate Statistics (3)

An additional course in statistics or research inside or outside the School Social Work (note: units for this course come from external course units, elective units, or tutorial units).

Minimum Total Required Units 18

Additional Required Outside Courses and Tutorials

- Course #1 in Other Department (3)
- Course #2 in Other Department (3)
- Course #3 in Other Department (3)
- 790 Faculty Tutorial 1 (2)
- 790 Faculty Tutorial 2 (2)
- 790 Faculty Tutorial 3 (2)

Minimum Total Required Units 15

Minimum Grand Total Required Units 45

TYPICAL FIRST YEAR COURSES

(Minimum of 12 units must be completed per semester excluding Summer)

Fall (First Semester):

- SOWK 760L Introduction to Social Work Statistics (3)
- SOWK 762 Social Work Research Methods I (3)
- SOWK 702 Theories of Human Behavior in the Context of Social Environments (3)
- SOWK 703 Explanatory Theories for Larger Social Systems (3)

12 units Completed First Semester

Spring (Second Semester):

- SOWK 761L Multiple Regression in Social Work Research (3)
- SOWK 763 Social Work Research Methods II: Issues in Research for Social Work Practice (3)
- SOWK 733 Policy Analysis and Advocacy in a Comparative Social Policy Context (3)
- SOWK 743 Theories for Practice with Small Systems (3)

12 units Completed Second Semester

Summer:

- SOWK 790 Faculty Tutorial 1 (2)

2 units Completed

TYPICAL SECOND YEAR COURSES

(Minimum of 10 units must be completed third semester only)

Fall (Third Semester):

SOWK 790 Faculty Tutorial 2 (2)
SOWK 790 Faculty Tutorial 3 (2)
SOWK 764 Advanced Multivariate Statistics (3)
Course #1 Other Department (3)
10 units Completed Third Semester

Spring (Fourth Semester):

Course #2 Other Department (3)
Course #3 Other Department (3)
Elective Internal Statistic Course (3)
9 units Completed Fourth Semester

TYPICAL THIRD YEAR COURSES

Students who have completed all major course requirements in the program AND are not otherwise enrolled during the semester in which the Qualifying Examination is to be taken must enroll in GRSC 800: STUDIES FOR QUALIFYING EXAMINATION.

Fall (Fifth Semester):

GRSC 800 Studies for Qualifying Examination (1)
1 unit Completed Fifth Semester

Spring (Sixth Semester):

GRSC 800 Studies for Qualifying Examination (1)
1 unit Completed Sixth Semester

SAMPLE OF QUALIFYING EXAMINATION TITLES

"Worker Perceptions of Service Quality and their Job Satisfaction: Theoretical and Managerial Implications for Human Service Organizations."

"Home Based Palliative Care Study: Satisfaction and Costs of Medical Care for Patients with CHF, COPD, and Cancer."

"Quality of Life for Family Caregivers of Patients with Chronic Physical Illness: Focus on Family Stress Theory."

"The Relationship Between Organizational Characteristics and Client Outcomes: A Case Study in Child Welfare."

"Community HIV prevention: The Long Beach AIDS Community Demonstration Project."

TYPICAL FOURTH YEAR AND BEYOND COURSES

Students who have passed the Qualifying Examination must enroll in doctoral dissertation SW 794 course (summers excluded). The Graduate School requires that students must be registered for 2 units of SW 794 (a,b,c,z) in every semester during which dissertation is underway until completion (except for summers). A minimum of two semesters of dissertation credit is required (794a & 794b).

Fall (Seventh Semester):

794a Doctoral Dissertation (2)
2 units Completed Seventh Semester

Spring (Eighth Semester):

794b Doctoral Dissertation (2)
2 units Completed Eighth Semester

SAMPLE OF DISSERTATION TITLES

"Functional Outcome in Schizophrenia: A Biosocial Predictive Model Over Time."

"Mental Health Service Use and Placement Change in Foster Care."

"Spiritual Well-Being in Health-Related Quality of Life for Older Chronically Ill Adults."

"Examining Characteristics of School Social Work Macro Practice: The Academic Preparation of MSW Students."

"Prospective and Retrospective Examinations of Factors Related to Intention to Leave and Turnover Among Public Child Welfare Workers."

Memorandum

To: Policy and Advocacy Committee

Date: March 22, 2007

From: Paul Riches
Executive Officer

Telephone: (916) 574-7840

Subject: X. Strategic Plan Update

Background

The board formally adopted the strategic plan at its November 2005 meeting. As part of the implementation of the strategic plan, each committee receives a progress update on the strategic objectives under its jurisdiction. The Budget and Efficiency Committee was merged in to the Policy and Advocacy Committee in September 2006 and the ongoing reporting of progress on Goals 2, 5 and 6 will be incorporated into the Policy and Advocacy Committee work on an ongoing basis.

This regular exchange of information provided will provide mutual accountability between staff and board members in accomplishing our shared objectives.

Update on Objectives

Goal 2: Build an excellent organization through effective leadership and professional staff.

Objective 2.1 -- Meet 80% of training goals identified in IDPs by June 30, 2006.

Methodology

Staff reviewed Individual Development Plans completed in the 2005/2006 fiscal year and found that the plans indicated 23 separate training courses be completed.

Target

Staff would need to complete 18 courses to satisfy the objective.

Current Performance

The backlog of Individual Development Plans (IDPs) has been eliminated, and the board is now current. Of those IDPs given in the current fiscal year, 8 staff members identified 23 classes they desired to attend. To date 21 classes have been completed. This is an 88% completion rate.

This objective has been satisfied for the current quarter. Staff will return with recommendations regarding either the revision or elimination of this objective at a future committee meeting.

Objective 2.2 -- Reduce average application processing time by 33% by December 30, 2006.

Applicants place a priority on the timely resolution of their application, and this objective was established to improve the board's responsiveness to its applicants.

Methodology

Application processing time is defined as follows:

Number of days from receipt of application - Number of days elapsed awaiting resolution of deficiencies

Results for Baseline Period

Baseline processing time was established in the period from April – June 2005 as 23.4 days.

In the January – March 2006 quarter, the average processing time across all programs was 13.4 days (45 days with Deficiencies).

In the April – June 2006 quarter, the average processing time across all programs was 8.2 days (34.8 days with Deficiencies).

In the July – September quarter, the average processing time across all programs was 8.9 days (26.8 days with Deficiencies).

In the October – December quarter, the average processing time across all programs was 14.4 days (34.2 days with Deficiencies).

For the 2006 calendar year the average processing time across all programs was 11.2 days (35.3 days with Deficiencies).

Target Processing Times

An average processing time of 15.7 days would satisfy this strategic objective. The processing time for the October – November 2006 quarter was 14.4 days still satisfies the objective, but is a 62% increase in processing time over the prior quarter.

The overall average processing time for 2006 well exceeds the objective (a 52% reduction).

Future Focus

While the most recent quarter's performance still satisfies the objective, it does represent a significant setback from prior performance levels. The October – December quarter was a perfect storm of licensing challenges. The board was short two cashiers and two license evaluators for much of the quarter. That quarter also has significantly higher leave losses due to holiday vacations and the start of cold and flu season. This performance level has persisted into the early months of 2007 and the first quarter statistics are likely to be consistent with the last quarter of 2006. We now have a full complement of cashiers and evaluators and we anticipate a return to the same level of performance seen in prior quarters.

Objective 2.3 -- Increase staff training hours by 15% by June 30, 2010.

Methodology

Staff reviewed training records for the prior two fiscal years to establish an average number of training hours to utilize as a baseline.

In the fiscal year 2003/2004, staff completed 150 hours of formal training. In the fiscal year 2004/2005, staff completed 813 hours of formal training. This data yields an average of 481 hours of staff training over the two-year period. Given the significant divergence between those two numbers, staff will use the 2004/2005 fiscal year as the baseline for this objective.

Target

Staff would need to complete 934 hours per year to satisfy the objective.

Current Performance

In the fiscal year 2004/2005, 813 hours were devoted to staff training. In 2005/06 961.5 hours staff training was completed (an 18% increase over the previous year).

In the current fiscal year, staff has completed 439 hours of training.

Objective 2.4 -- Joint participation by executive staff and board members in 20 external events (non-board meeting) by June 30, 2010.

This objective was included to develop closer working relationships between board members and board staff outside the context of formal board and committee meetings. The following list includes both past and currently scheduled events.

1. *October 2005* MSW educators meeting at USC [Peter Manoleas, Paul Riches]
2. *January 2006* MSW student meeting at UC Berkeley [Peter Manoleas, Paul Riches, Janene Mayberry]
3. *March 2006* National Association of School Psychologists meeting in Anaheim [Judy Johnson, Paul Riches]
4. *April 2006* MFT Student outreach meeting at Pepperdine University [Karen Pines, Sean O'Connor]
5. *May 2006* CAMFT annual meeting in Palm Springs [Joan Walmsley, Mona Maggio, Paul Riches]
6. *June 2006* MFT students and educators meeting at Phillips Graduate Institute [Ian Russ, Victor Law, Paul Riches, Kari Frank, Mona Maggio]
7. *July 2006* Orange County Community Counseling Consortium meeting at Pepperdine University, Orange County [Paul Riches, Joan Walmsley]
8. *October 2006* [Ian Russ, Paul Riches, Mona Maggio, Rosanna Webb-Flores, Pearl Yu, Mary Hanifen, Julie McAuliffe] Workgroup on Custody Evaluators with the Administrative Office of the Courts.
9. *November 2006* Presentation at Human Options agency [Sean O'Connor and Joan Walmsley]
10. January 23, 2007 - USC LCSW School Presentation [Sean O'Connor and Victor Law]
11. February 6, 2007 - Azusa Pacific MFT School Presentation [Sean O'Connor and Victor Law]
12. February 13, 2007 - USC Orange County LCSW School Presentation [Sean O'Connor and Joan Walmsley]

Goal 4: Advocate for increased access to mental health services.

Objective 4.1 -- Participate in 15 public policy forums throughout the State addressing access to mental health services by June 30, 2010.

The board has been actively participating with the MHSA Education and Training initiative. This initiative is developing the strategic plan for spending MHSA revenues dedicated to building the mental health workforce. This initiative has an advisory group (where the board is represented by Peter Manoleas), which has formed nine workgroups to write elements of the plan. The board is actively participating in the following workgroups:

1. Needs Assessment [Mona Maggio]
 6. Distance Learning [Christy Berger]
 8. Post Secondary Education and Training [Judy Johnson]
 9. Licensing and Certification [Paul Riches]
- On June 12, 2006 Ms. Maggio attended the initiative's Needs Assessment workgroup.
 - On June 28, 2006 Ms. Berger will attend the Distance Learning workgroup.
 - On July 6, 2006, Ms. Johnson will attend the Post-Secondary Education/Training workgroup.
 - On July 12, 2006, Mr. Riches will attend the Licensing and Certification workgroup.
 - On July 19, 2006, Mr. Manoleas attended the Advisory Committee meeting.
 - On August 10, 2006 Ms. Maggio attended the Needs Assessment workgroup meeting.
 - On September 6, 2006 Mr. Riches attended the Licensing and Certification workgroup.
 - On October 18, 2006 Ms. Maggio and Peter Manoleas attended the Advisory Committee Meeting.
 - On March 7, 2007 Mr. Riches attended the Advisory Committee meeting.

Mr. Riches has been invited to participate with two workgroups established by the California Social Work Education Center (CalSWEC) regarding implementation of the MHSA and Workforce development.

- On September 28, 2006 Mr. Riches made a presentation on board activities to the California Social Work Education Center (CalSWEC) Mental Health Initiative workgroup.
- On September 28, 2006 Mr. Riches attended the CalSWEC Workforce Initiative workgroup and was invited to join the group on an ongoing basis.

Objective 4.2 -- Develop 4 proposals related to behavioral science licensing law that address delivery of services to consumers in light of demographic changes in both the general and licensee populations by December 31, 2007.

A board-sponsored conference on diversity issues in professional licensing will be held on Friday, April 28 in Sacramento. The conference will feature state and national experts in demography and cultural competence in mental health care as well as working sessions designed to provide feedback and suggestions for the

board's consideration. A report on the conference was provided at the May 18-19, 2006 board meeting. Staff is working through suggestions from that conference to begin developing proposals for board committees to consider. The Policy and Advocacy Committee reviewed the suggestions and took public input regarding prioritizing board efforts at its September 27, 2006 meeting.

A demographic survey of board licensees and registrants has been completed. Staff is continuing work on data entry. Results from the survey will provide the board with demographic information that will be important in its deliberations on this subject.

Objective 4.3 -- Advocate for 5 laws that expand access to mental health services by June 30, 2010.

No action to report.

Goal 5: Utilize technology to improve and expand services.

Objective 5.1 -- Provide the ability to accept electronic payments by June 30, 2008.

Objective 5.2 -- Process 70% of all renewal applications on-line by June 30, 2009.

Objective 5.3 -- Process 33% of all new applications on-line by June 30, 2010

Objective 5.4 -- Provide the ability to check the status of all applications online by June 30, 2010.

These four goals are linked to the implementation of the iLicensing system being developed by the Department of Consumer Affairs. The Legislature included \$10.7 million in the 2006-07 budget bill (SB 1129) for the Department to implement the system. All of the boards and bureaus within the Department will share the expense of the system. It is expected that the system will provide a platform to meet these goals. The BBS budget was increased by \$50,000 in the 2006-07 fiscal year to reflect its share of the first year expense. Additional expenditures in future budget years are expected as the project is implemented. The budget action included total department-wide budget reductions of \$500,000 per year ongoing beginning in the 2009-10 fiscal year to reflect efficiencies from the system.

This project is underway and is in the early planning stages. Board staff is participating in the development of business requirements for the system. Current schedules anticipate deployment for the board in 2009.

Goal 6: Maximize the efficiency and effectiveness of the Board's resources.

The productivity targets in each of these objectives were established by projecting future workload based on an evaluation of the trends established in the past five years. These productivity increases are required if the new workload is to be absorbed without either an increase in staffing or reduction in service levels.

Objective 6.1 -- Increase licensing staff productivity 13% by June 30, 2010

With the close of the January – March 2006 quarter, we now have one full year of data available as a baseline measure of productivity. It is important to measure licensing productivity on an annual basis because of the substantial seasonality to the workload.

Methodology

Productivity is defined as the total number of completed applications divided by the total time. The licensing unit has 4.5 personnel years allocated to evaluate applications for registration and licensure. There are 246 working days in a personnel year (52 weeks x 5 days – 14 paid state holidays). Based on 8 hour workdays that allows 1107 total working days (8856 hours) for our license evaluators. This figure does not account for vacancies, training time, sick leave, or vacation so the resulting number is expected to understate the actual productivity, but including these confounding variables would make valid year to year comparisons unworkable.

Results for Baseline Period

In the period of April 1, 2005 to March 31, 2006 the license evaluators completed 6377 applications. Based on that performance the license evaluators completed 0.7 applications per work hour.

Results for April 1 2006 – Feb 28, 2007 are 6264 applications completed in 5903 staff hours. This yields a productivity of 0.77 applications per hour a 7% increase in productivity over the baseline period.

Productivity Target

To meet the 13% productivity increase target the license evaluators will have to complete .81 applications per work hour. The 2006 – 2007 results easily exceed this target.

Objective 6.2 -- Increase enforcement staff productivity in processing consumer complaints 29% by June 30, 2010.

Methodology

Measuring productivity in enforcement poses a significantly greater challenge than in other board programs. This objective specifically references consumer complaints and therefore actions taken based on internal investigations or criminal conviction information were not considered. Both of these categories do include a significant portion of the enforcement unit workload, but the objective sought to focus on consumer complaints as the most important element of that workload.

First, it was not immediately apparent what the “product” is. After considerable reflection and discussion, we arrived at “resolution” as basic element in enforcement. Actions that resolved (or completed) a consumer complaint were deemed to be products. Consumer complaints are generally “resolved” in one of four categories:

1. Disciplinary Action
2. Citation and Fine
3. Cease/Desist Letter
4. Complaint Closure (No Action).

Second, it is very difficult to assign a numeric value to that “product.” There is little discernible difference in value in the principal products in the licensing and examination units. However, staff believes that there is a significant difference in the value assigned to different enforcement actions. To arrive at values for the four

possible resolutions, staff assigned a score of 1-10 (1 = minimum 10 = maximum) based on the perceived impact or significance of the resolution by enforcement staff, complainants and the licensees. These values are highly subjective but are based on the experience of enforcement unit staff with all parties for a long period of time. Below are the values arrived at (maximum score = 30):

Discipline -- 30
Citation and Fine – 22
Cease/Desist – 12
Closure (No Action) – 9.5

Great care and consideration was given to arriving at these values. Specifically, staff focused on the perceived impact of the resolution, not the amount of resources required to reach it. For instance, while discipline was rated as the maximum impact, reaching a disciplinary outcome has roughly triple the “value” of a closure, but represents far more than triple the resources required to close a complaint. This is methodologically important because measuring productivity requires measuring outputs or products, not the inputs they require. It is also important for policy reasons, because we do not want to create incentives to take one action or another based on anything except for the objective assessment of whether we can prove a violation by clear and convincing evidence. We believe that the value scale presented accomplishes that balance. Individuals can fairly challenge the staff’s subjective assessments but I believe that it meets the test of not establishing an incentive system and if applied over time will consistently evaluate the enforcement staff’s productivity.

Results for Baseline Period

In the 2004-05 Fiscal Year the Enforcement Unit had three analysts handling consumer complaints. Total staff hours for the year (3 positions x 246 working days x 8 hours) were 5904. In that fiscal year consumer complaints had the following resolutions:

Discipline – 11
Citation and Fine – 18
Cease/Desist – 31
Closure (No Action) – 501

Based on the assigned values this yields a score of 5857.5 for the fiscal year.

Productivity for the fiscal year was 1.0 units per hour.

Productivity Target

The objective calls for a 29% increase in productivity in processing consumer complaints. This would require a productivity of 1.3 to satisfy the objective.

Fiscal Year 2005-06 Results

In the 2005-06 Fiscal Year the Enforcement Unit had two analysts handling consumer complaints. Total staff hours for the year (2 positions x 246 working days x 8 hours) were 3936. In that fiscal year consumer complaints had the following resolutions:

Discipline – 15
Citation and Fine – 11

Cease/Desist – 25
Closure (No Action) – 451

Based on the assigned values this yields a score of 5276.5 for the fiscal year.

Productivity (value score / staff hours) for the fiscal year was 1.3 units per hour. This result satisfied the objective.

Fiscal Year 2006-07 Results

In the 2006-07 Fiscal Year the Enforcement Unit had two analysts handling consumer complaints for the first six months and a third analyst working an 80% schedule contributing since January 2007. Total staff hours for the year through February 28, 2007 are 2886. Through the end of February consumer complaints had the following resolutions:

Discipline – 16
Citation and Fine – 16
Cease/Desist – 22
Closure (No Action) – 339

Based on the assigned values this yields a value score of 4316.

Productivity (value score / staff hours) through February 28, 2007 is 1.5 units per hour. This is a 15% increase in productivity for the current fiscal year.

Objective 6.3 -- Increase examination staff productivity 15% by June 30, 2010.

Methodology

Productivity is defined as the total number of examinations administered divided by the total time. The exam unit has 2.8 personnel years allocated to develop and administer examinations for registration and licensure. There are 246 working days in a personnel year (52 weeks x 5 days – 14 paid state holidays). Based on 8-hour workdays that allow 5510 total working hours in the exam unit. This figure does not account for vacancies, training time, sick leave, or vacation so the resulting number is expected to understate the actual productivity. However, including these confounding variables would make valid year-to-year comparisons unworkable.

Baseline Period

The 2004-2005 fiscal year will serve as the baseline period. In that year, 6626 exams were administered which yields a productivity of 1.2 examinations per staff hour.

Productivity Target

To meet the 15% productivity increase target the examination unit will have to reach 1.4 examinations per staff hour.

Results for 2005-06 Fiscal Year

In the 2005-06 Fiscal Year, the board administered 7257 examinations, which yields a productivity of 1.3 examinations per staff hour.

Memorandum

To: Budget and Efficiency Committee

Date: March 22, 2007

From: Paul Riches
Executive Officer

Telephone: (916) 574-7840

Subject: XI. Budget Update

2006-07 Budget

The board's total spending authority for 2006-07 is \$5 million. This is an increase of approximately \$260,000 (5%) over the 2005-06 fiscal year budget. This increase includes a \$35,000 augmentation to fund the board's share of the iLicensing system for 2006/07.

Current projections indicate a year end balance of approximately \$60,000 (1.1% of budget authority). This is a significant reduction (8.1%) from prior years. This change is attributed to a number of factors:

1. Increased contracts for consulting and professional services. The board has several significant contracts including the communications audit and program development by BPCubed, supplemental psychometric services by Comira Inc., and strategic planning services by Hatton Management Consultants. The communications audit and program development is a one-time contract expense that will be mostly completed in the current fiscal year. The contracts for psychometric services and strategic planning span multiple fiscal years.
2. Increase interagency contracts for examination services. The board signed an agreement with the Office of Examination Resources to conduct an occupational analysis for marriage and family therapist examinations. This is a one-time expense (repeated every five years) that will mostly completed in the current fiscal year.
3. Increase costs from the Attorney General and Office of Administrative Hearings. This expense is largely caseload driven and the board has approximately doubled its caseload for disciplinary proceedings.

Please see the attached expenditure report and fund condition for more detailed information.

2007-08 Budget

Staff has submitted a budget change proposal (BCP) requesting two additional enforcement analysts with an estimated cost of \$163,000 ongoing. This proposal was submitted in response to increasing consumer complaint workload in the enforcement unit. The BCP proposes to redirect funding from existing line items for Attorney General and Office of Administrative Hearings expenses. Both of these items have had significant unexpended balances in recent years and those resources are needed elsewhere in the board's enforcement program. The BCP was approved and will be included in the annual budget act.

2008-09 Budget

Staff is in the early planning stages for the 2008-09 budget. A number of BCPs are being developed for submission this year. These include proposals related to enforcement, improving customer service, and funding occupational analyses.

BOARD OF BEHAVIORAL SCIENCES
EXPENDITURE REPORT FY 2006/2007

OBJECT DESCRIPTION	FY 2005/2006	FY 2006/2007			
	ACTUAL EXPENDITURES	BUDGET ALLOTMENT	CURRENT AS OF 2/28/07	YEAR END PROJECTIONS	BALANCE
PERSONAL SERVICES					
Salary & Wages (Civ Svc Perm)	1,045,321	1,289,337	780,676	1,200,000	89,337
Salary & Wages (Stat Exempt)	85,132	85,488	58,402	87,231	(1,743)
Temp Help (907)(Seasonals)	29,210	14,105	36,366	55,000	(40,895)
Temp Help (915)(Proctors)	0	19,444	0	0	19,444
Board Memb (Per Diem)	9,500	12,900	5,800	9,000	3,900
Overtime	6,203	7,533	3,340	6,000	1,533
Totals Staff Benefits	471,626	541,898	336,479	500,000	41,898
Salary Savings		(57,708)			(57,708)
TOTALS, PERSONAL SERVICES	1,645,992	1,912,997	1,221,063	1,857,231	55,766
OPERATING EXP & EQUIP					
Fingerprint Reports	4,394	36,954	2,522	4,000	32,954
General Expense	80,090	24,643	29,665	50,000	(25,357)
Printing	79,402	90,184	81,783	100,000	(9,816)
Communication	17,051	25,837	4,395	15,000	10,837
Postage	103,109	103,459	103,680	120,000	(16,541)
Travel, In State	63,898	57,955	53,680	85,000	(27,045)
Travel, Out-of-State	0	2,700	1,176	2,700	0
Training	21,767	16,149	9,830	13,000	3,149
Facilities Operations	178,368	187,951	107,966	187,951	0
C&P Services - Interdept.	0	27,287	0	0	27,287
C&P Services-External Contracts	8,405	9,632	19,055	115,000	(105,368)
DEPARTMENTAL PRORATA					
DP Billing	252,057	299,774	199,849	299,774	0
Indirect Distribution Costs	279,793	282,919	188,613	282,919	0
Communication/Educ. Division	16,539	10,701	7,134	10,701	0
D of I Prorata	7,880	8,327	5,551	8,327	0
Consumer Relations Division		11,218	7,479	11,218	0
Interagency Services (OER IACs)	196,680	0	81,547	270,568	(270,568)
Consolidated Data Services	15,000	21,390	1,599	15,000	6,390
Data Processing (Maint,Supplies,Contract)	12,839	4,630	4,535	8,000	(3,370)
Central Admin. Svcs - Pro Rata	146,345	141,971	106,479	141,971	0
EXAM EXPENSES					
Exam Site Rental	65,403	202,894	48,682	74,000	128,894
Exam Contract (Thomson) (404.00)	375,496	293,382	187,590	375,000	(81,618)
Expert Examiners (404.01)	255,957	473,460	256,974	260,000	213,460
ENFORCEMENT					
Attorney General	341,213	560,542	297,649	450,000	110,542
Office of Admin. Hearing	36,859	157,834	0	115,000	42,834
Court Reporters	2,623	0	0	17,000	(17,000)
Evidence/Witness Fees	42,462	62,583	0	30,000	32,583
Division of Investigation	43,063	82,632	0	82,632	0
Minor Equipment (226)	26,397	0	5,122	30,000	(30,000)
Replacement/Additional Equipment	448	0	14,069	15,000	(15,000)
TOTAL, OE&E	2,673,538	3,197,008	1,826,621	3,189,761	7,247
TOTAL EXPENDITURES	\$4,319,530	\$5,110,005	\$3,047,684	\$5,046,992	\$63,013
Fingerprints	4,494	(24,000)	1,536	(4,000)	(20,000)
Other Reimbursement	14,545	(26,000)	14,330	(23,000)	(3,000)
Unscheduled Reimbursements	17,903	0	16,585	(20,000)	20,000
Total Reimbursements	36,942	(50,000)	32,451	(47,000)	(3,000)
NET APPROPRIATION	\$4,356,472	\$5,060,005	\$3,080,135	\$4,999,992	\$60,013

BOARD OF BEHAVIORAL SCIENCES

Analysis of Fund Condition

(Dollars in Thousands)

NOTE: \$6.0 Million General Fund Repayment Outstanding

	ACTUAL				
	2005-06	2006-07	2007-08	2008-09	2009-10
BEGINNING BALANCE	\$ 4,090	\$ 5,368	\$ 5,800	\$ 5,708	\$ 5,451
Prior Year Adjustment	\$ 47	\$ -	\$ -	\$ -	\$ -
Adjusted Beginning Balance	\$ 4,137	\$ 5,368	\$ 5,800	\$ 5,708	\$ 5,451
 REVENUES AND TRANSFERS					
Revenues:					
Fees	\$ 5,281	\$ 5,373	\$ 5,404	\$ 5,404	\$ 5,404
Income from surplus money investments	\$ 205	\$ 117	\$ 128	\$ 107	\$ 100
Escheat of unclaimed checks and warrants	\$ 3	\$ 3	\$ 3	\$ 3	\$ 3
Miscellaneous revenues	\$ 2	\$ 2	\$ 2	\$ 2	\$ 2
Totals, Revenues	\$ 5,491	\$ 5,495	\$ 5,537	\$ 5,516	\$ 5,509
Transfers from Other Funds	\$ -	\$ -	\$ -	\$ -	\$ -
Transfers to Other Funds	\$ -	\$ -	\$ -	\$ -	\$ -
Totals, Revenues and Transfers	\$ 5,491	\$ 5,495	\$ 5,537	\$ 5,516	\$ 5,509
Totals, Resources	\$ 9,628	\$ 10,863	\$ 11,337	\$ 11,224	\$ 10,960
 EXPENDITURES					
Disbursements:					
0840 State Controller (State Operations)	\$ -	\$ 3	\$ 4	\$ -	\$ -
<u>Budget Act of 2006</u>					
1110 Program Expenditures (State Operations) - Galley 2	\$ 4,260	\$ 5,060	\$ 5,625	\$ 5,773	\$ 5,856
<u>2007-08 BCPs: Board</u>					
Enforcement (funding redirection)			\$ -	\$ -	\$ -
Total Disbursements	\$ 4,260	\$ 5,063	\$ 5,629	\$ 5,773	\$ 5,856
 FUND BALANCE					
Reserve for economic uncertainties	\$ 5,368	\$ 5,800	\$ 5,708	\$ 5,451	\$ 5,104
 Months in Reserve	12.7	12.4	11.9	11.2	10.3

NOTES:

- A. ASSUMES WORKLOAD AND REVENUE PROJECTIONS ARE REALIZED
- B. EXPENDITURE GROWTH PROJECTED AT 2% BEGINNING FY 2008-09

Memorandum

To: Policy and Advocacy Committee
From: Christy Berger
Legislation Analyst
Date: March 26, 2007
Telephone: (916) 574-7847
Subject: XII. Update on Board Sponsored Legislation

Board-Proposals for 2007

The Board of Behavioral Sciences has proposed the following statutory changes for the 2007 legislative season:

Bureau for Private, Postsecondary and Vocational Education (BPPVE)

This proposal would allow the Board to accept degrees granted within the time frame of the most recent approval/renewal granted to the degree program. It would also allow the Board to recognize degrees granted by universities accredited by other regional accrediting bodies.

Unprofessional Conduct

The Board proposes several changes to its unprofessional conduct statutes, including:

- Add a willful violation of the Health and Safety Code pertaining to release of records.
- Add a violation of the telemedicine statute.
- List all instances of potential unprofessional conduct in one place and make minor editorial changes.

Eliminate Extensions for Associate Clinical Social Worker Registrations

This proposal would require an Associate Clinical Social Worker (ASW) to obtain new registration, if needed, rather than one-year extensions, once his or her registration is no longer renewable. This new registration can be retained for another six years.

Out-of-State MFT Education

This proposal would clarify that persons seeking license as a Marriage and Family Therapist (MFT), who live in California while attending a school located outside of California, must meet California's education standards.

Reduce License Delinquency Period to Three Years

This proposal would decrease the amount of time a license can remain delinquent from five years to three years.

Fictitious Business Names

This proposal addresses the use of fictitious business names for Licensed Clinical Social Workers (LCSWs) in private practice, in line with current MFT statute.

Fee Statutes

This proposal would make a number of technical and structural changes related to the Board's fee and renewal statutes for consistency and clarity.

Continuing Education

This proposal would award Board licensees with 6 hours of continuing education credit for attending one full day board meeting per renewal cycle.

Exempt Practice Settings

This proposal would align exempt settings specified in LCSW statute with those specified in MFT statute.

Portability of MFT Licensure

This proposal would modify California's licensing requirements for MFTs licensed at an equivalent level in another state by making reasonable allowances for equivalent coursework, and for supervised experience gained more than six years ago.

Qualifications for MFT Intern Registration

This proposal would eliminate an outdated provision which permits applicants for MFT Intern registration to qualify under an alternative method.

Memorandum

To: Policy and Advocacy Committee
From: Justin Sotelo
Regulations Analyst
Date: March 23, 2007
Telephone: (916) 574-7836
Subject: XIII. Rulemaking Update

Following is the status of regulatory changes proposed by the Board:

Title 16, CCR Section 1803, Delegation of Authority to the Executive Officer

This proposal would allow the Board's executive officer to sign orders to compel a physical or mental evaluation of a Board licensee or registrant as part of an investigation of a complaint. A regulatory hearing was held on October 4, 2006; no public comments were received at the hearing. The Board gave final approval to this regulation at its meeting on November 16, 2006. Staff is awaiting final departmental approval and will then submit the completed regulatory packet to the Office of Administrative Law (OAL) for approval.

Title 16, CCR Sections 1833.1 and 1870, Supervisor Qualifications

Supervisors of registrants are currently required to have practiced psychotherapy for two out of the five years preceding any supervision. This proposal would allow supervisors to count time spent directly supervising persons who perform psychotherapy toward this requirement and delete the requirement that supervisors of MFT Interns and Trainees average 5 hours of client contact per week for two out of the five years prior to supervising. At its April 19, 2006 meeting, the Board's Policy and Advocacy Committee voted to recommend this language to the Board. The Board reviewed the proposal at its May 18, 2006 meeting and sent it back to the Committee for further work. At its June 28, 2006 meeting, the Committee recommended to the Board that the original language of the proposal be retained and additionally recommended to delete the requirement that supervisors of MFT Interns average 5 hours of client contact per week for two out of the five years prior to supervising. The Board approved this proposal at its meeting on July 27, 2006. Staff completed the required regulatory documents, and the notice was published by OAL on September 29, 2006. The required regulatory documents were also mailed to the Board's interested party list and posted on the Board's web site; the Board received written comments regarding the proposal. The regulatory hearing was held on November 16, 2006; no public comments were received. Staff distributed a 15-day notice on December 22, 2006 in order to incorporate minor modifications into the language; no public comments were received. The final language was given final approval by the Board at its February 15, 2007 meeting. The completed regulatory packet will be submitted to the Legal Office in March for final departmental approval.

Title 16, CCR, Technical Cleanup - Licensed Educational Psychologists and Board Administration

This proposal would make technical and editorial changes to the Board's regulations in line with statutory changes proposed under SB 1475 to update the Licensed Educational Psychologist and Board administration statutes. At its June 28, 2006 meeting, the Board's Policy and Advocacy Committee recommended that the Board adopt these proposed regulations. The Board approved this proposal at its meeting on July 27, 2006. Staff completed the required regulatory documents and the notice was published by OAL on September 29, 2006. The required regulatory documents were also mailed to the Board's interested party list and posted on the Board's web site; the Board

received written comments regarding the proposal. The regulatory hearing was held on November 16, 2006; no public comments were received. Staff distributed a 15-day notice on December 22, 2006 in order to incorporate minor modifications into the language; no public comments were received. The final language was given final approval by the Board at its February 15, 2007 meeting. The completed regulatory packet will be submitted to the Legal Office in March for final departmental approval.

Title 16, CCR Sections 1805, 1806, and 1833.3, Abandonment of Application Files.

Section 1806 currently requires candidates to take an examination within one year of notification of eligibility to take the examination. Section 1833.3 currently requires applicants who fail an examination to retake that examination within one year from the date of the failure. However, candidates who fail are provided with a notice of eligibility 180 days from the date of failure, so both sections apply and reflect two different time frames. This regulatory proposal would resolve the conflict between these two regulations, providing all candidates with a one-year period in which to take an examination to avoid abandonment of their application. At its June 28, 2006 meeting, the Board's Policy and Advocacy Committee recommended that the Board adopt these proposed regulations. The Board approved this proposal at its meeting on July 27, 2006. Staff completed the required regulatory documents and the notice was published by OAL on September 29, 2006. The required regulatory documents were also mailed to the Board's interested party list and posted on the Board's web site; the Board received written comments regarding the proposal. The regulatory hearing was held on November 16, 2006; no public comments were received. Staff distributed a 15-day notice on December 22, 2006 in order to incorporate minor modifications into the language; no public comments were received. The final language was given final approval by the Board at its February 15, 2007 meeting. The completed regulatory packet will be submitted to the Legal Office in March for final departmental approval.

Title 16, CCR, Sections 1816.7, 1887.7, 1887.75, and 1887.77, Delinquency Fees for Continuing Education Providers

This proposal would allow a registered provider of continuing education (PCE) a period of two years from the registration's expiration date in order to renew an expired PCE registration with a \$100 delinquency fee. Currently, when a PCE does not renew the registration prior to its expiration date, the registration is cancelled and a new registration must be obtained. At its June 21, 2006 meeting, the Board's Budget and Efficiency Committee recommended that the Board adopt these proposed regulations. The Board approved this proposal at its meeting on July 27, 2006. Staff completed the required regulatory documents and the notice was published by OAL on September 29, 2006. The required regulatory documents were also mailed to the Board's interested party list and posted on the Board's web site; the Board received written comments regarding the proposal. The regulatory hearing was held on November 16, 2006; no public comments were received. Staff distributed a 15-day notice on December 22, 2006 in order to incorporate minor modifications into the language; no public comments were received. The final language was given final approval by the Board at its February 15, 2007 meeting. The completed regulatory packet will be submitted to the Legal Office in March for final departmental approval.

Title 16, CCR, Fees

This proposal would make technical changes to the Board's regulations regarding fees. These changes would conform the Board's regulations to the non-substantive statutory changes the Budget and Efficiency Committee is recommending to the Board regarding fees, renewals, and inactive licenses. At its June 28, 2006 meeting, the Board's Policy and Advocacy Committee recommended that the Board adopt these proposed regulations. The Board approved this proposal at its meeting on July 27, 2006. Staff completed the required regulatory documents and the notice was published by OAL on September 29, 2006. The required regulatory documents were also mailed to the Board's interested party list and posted on the Board's web site; the Board received written comments regarding the proposal. The regulatory hearing was held on November 16, 2006; no public comments were received. Staff distributed a 15-day notice on December 22,

2006 in order to incorporate minor modifications into the language; no public comments were received. The final language was given final approval by the Board at its February 15, 2007 meeting. The completed regulatory packet will be submitted to the Legal Office in March for final departmental approval.

Title 16, CCR, Sections 1887.2(a) and 1887.3(a) Continuing Education

Licensees are currently permitted to take an unlimited amount of continuing education (CE) by conventional or online means. However, hours earned through “self-study” courses are limited to one-third of the total required CE hours. The original intent of this proposal was to delete the definition of a “self-study course” and delete the limitations regarding self-study hours. The Consumer Protection Committee approved this proposal at its September 20, 2006 meeting. The proposal went before the Board for preliminary approval at its November 16, 2006 meeting; however, the Board recommended modifications to the proposed language – to retain the definition of a “self-study course” and to increase the self-study course limitations to one-half of the total required CE hours. Staff completed the required regulatory documents and the notice was published by OAL on December 29, 2006, which initiated the 45-day public comment period. The required regulatory documents were also mailed to the Board’s interested party list and posted on the Board’s web site; the Board received one written comment regarding the proposal. A regulatory hearing was held at the Board’s February 15, 2007 meeting; no public comments were received. The proposal will go before the Board for final approval at its meeting on May 31, 2007.

Title 16, CCR Section 1887.2, Exceptions to Continuing Education Requirements

This regulation sets forth CE exception criteria for MFT and LCSW license renewals. This proposal would amend the language in order to clarify and/or better facilitate the request for exception from the CE requirement process. On January 10, 2007, the Consumer Protection Committee reviewed and approved the proposal. On February 15, 2007, the proposal went before the Board for preliminary approval. However, a modification to the language, which addresses minimum timeframes for circumstances that exempt licensees from the CE requirement, was recommended by the Board. Staff will present this recommendation to the Committee on April 11, 2007 before pursuing the regulatory change process.

Title 16, CCR, Section 1886, Citation and Fine of Continuing Education Providers

This proposal would provide the Board with the authority to issue a citation and fine to a continuing education provider. This proposal is currently on hold due to staff workload considerations.

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**State of California
Board of Behavioral Sciences**

Memorandum

To: Policy and Advocacy Committee

Date: March 26, 2007

From: Paul Riches
Executive Officer

Telephone: (916) 574-7840

Subject: XIV. Future Meeting Dates

Due to the rescheduling of the spring Board meeting, the Policy and Advocacy Committee meeting date was changed. The Committee is requested to confirm the next meeting scheduled on Friday, July 13, 2007 in southern California.

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