



Board of  
Behavioral  
Sciences

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## MEETING NOTICE

### Policy and Advocacy Committee April 7, 2011

Department of Consumer Affairs  
El Dorado Room  
1625 North Market Blvd.  
2<sup>nd</sup> Floor, Room N220  
Sacramento, CA 95834

**9:30 a.m.**

- I. Introductions
- II. Review and Approval of the January 13, 2011 Policy and Advocacy Committee Meeting Minutes
- III. Discussion and Possible Action Regarding Acceptance of Post-Degree Hours of Experience Toward Licensure as a Professional Clinical Counselor
- IV. Discussion and Possible Action Regarding Pending Legislation Including:
  - a. Assembly Bill 40 (Yamada)
  - b. Assembly Bill 154 (Beall)
  - c. Assembly Bill 171 (Beall)
  - d. Assembly Bill 181 (Portantino)
  - e. Assembly Bill 367 (Smyth)
  - f. Assembly Bill 671 (Portantino)
  - g. Assembly Bill 675 (Hagman)
  - h. Assembly Bill 774 (Campos)
  - i. Assembly Bill 956 (Hernandez, R.)
  - j. Assembly Bill 958 (Berryhill, B.)
  - k. Assembly Bill 993 (Wagner)
  - l. Assembly Bill 1205 (Berryhill, B.)
  - m. Senate Bill 146 (Wyland)
  - n. Senate Bill 718 (Vargas)
  - o. Senate Bill 747 (Kehoe)
- V. Discussion and Possible Action Regarding Other Legislation Affecting the Board
- VI. Legislative Update



Governor  
Edmund G. Brown Jr.  
State of California  
State and Consumer  
Services Agency  
Department of  
Consumer Affairs

- VII. Rulemaking Update
- VIII. Public Comment for Items Not on the Agenda
- IX. 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](http://www.bbs.ca.gov).*

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

## Policy and Advocacy Committee Minutes- **DRAFT** January 13, 2011

Alliant International University  
2855 Michelle Drive, Room 319  
Irvine, CA 92606

### Members Present

Renee Lonner, LCSW Member  
Michael Webb, MFT Member

Analyst

### Staff Present

Kim Madsen, Executive Officer  
Tracy Rhine, Asst. Executive Officer  
Rosanne Helms, Legislative Analyst  
Christina Kitamura, Administrative

Michael Santiago, Legal Counsel

### Members Absent

Donna DiGiorgio, Chair, Public Member

### Guest List

On file

## I. Introductions

Renee Lonner served as the Policy and Advocacy Committee (Committee) Chair during Donna DiGiorgio's absence. Ms. Lonner called the meeting to order at approximately 10:05 a.m. Christina Kitamura called roll, and a quorum was established. Staff, Committee members, and attendees introduced themselves.

## II. Review and Approval of the October 12, 2010 Policy and Advocacy Committee Meeting Minutes

Ms. Kitamura noted a correction on page one; Donna DiGiorgio was Chair of the meeting, not Renee Lonner.

Ms. Lonner noted corrections on page seven. On the third paragraph, "different" should be "difference." On the fifth paragraph, "acquire" should be "acquired."

Kim Madsen noted corrections on page 13. On the fourth paragraph, "H" should be "He."

***Renee Lonner moved to approve the Policy and Advocacy Committee meeting minutes of October 12, 2010 as amended. Michael Webb seconded. The Committee voted unanimously (2-0) to approve the meeting minutes as amended.***

### **III. Discussion and Possible Action Regarding HIV/AIDS Continuing Education Course Requirement for Licensed Professional Clinical Counselors**

Rosanne Helms reported that the Board of Behavioral Sciences' (Board) marriage and family therapist (MFT) and clinical social worker (LCSW) licensees are required to take a one-time seven hour continuing education course covering the assessment and treatment of people living with human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS). Ms. Helms explained that proposed regulations do not require the Board's professional clinical counselor (LPCC) licensees to take a continuing education course covering HIV/AIDS. However, LPCCs are as likely as MFTs and LCSWs to treat patients with HIV or AIDS.

Ms. Helms referred to Business and Professions Code (BPC) Section 32, which states that a board regulating certain professions, including MFTs, licensed educational psychologists (LEP), and LCSWs, should consider including training regarding the characteristics and method of assessment and treatment of AIDS in its continuing education (CE) or training requirements. This section of law was established before the creation of the LPCC Act.

Ms. Helms stated that currently, all MFTs, LCSWs, and LPCCs are required to complete 36 hours of continuing education relevant to their field of work during each renewal period. These licensees must also complete a six hour law and ethics course each renewal period. These licensees are also required to have coursework covering a variety of topics. Typically, this coursework is a requirement of licensure; however, depending on when the license was obtained, it may be a renewal requirement if the coursework was not required at the time of licensure. These topics are: Human Sexuality, Child Abuse, Spousal/Partner Abuse, Aging and Long Term Care, and Substance Abuse.

Ms. Helms explained that in addition to the current requirements, MFTs and LCSWs are required to take a one-time, seven hour CE course covering the assessment and treatment of people living with HIV/AIDS. This CE requirement is a condition of the MFT and LCSW renewal. Currently, there is no requirement in law that an LPCC have any coursework covering HIV/AIDS.

Discussion was then opened regarding whether LPCCs should be required to take a one-time, seven hour CE course covering the assessment and treatment of people living with HIV/AIDS.

Dean Porter, California Association for Licensed Professional Clinical Counselors (CALPCC), stated that this was an oversight. Ms. Porter preferred that this requirement be a condition of license renewal as opposed to including it in the degree program because LPCCs applying for grandparenting are required to have 90 hours of CE before they can be licensed.

***Renee Lonner moved to amend Title 16 Section 1887.3(c) to include LPCCs as one of the license types that must take a seven hour continuing education course covering HIV/AIDS. Michael Webb seconded. The Committee voted unanimously (2-0) to pass the motion.***

### **IV. Policy Discussion and Possible Action Regarding Proof of Employment by Registrants for Supervised Work Experience Hours; Stipends**

Ms. Helms reported that when applying for licensure, an MFT Intern and Associate Social Worker (ASW) registrant must provide the Board with verification of his or her

employment for all required supervised work experience hours. By law, this verification can be provided in one of two ways: 1) Provide the Board with a letter from the employer verifying his or her volunteer status, or 2) Provide the Board with copies of his or her W-2 tax forms for each year of experience claimed.

Ms. Helms reported that the Board has received applications from several registrants who are not able to provide the Board with a W-2 or a volunteer status letter, because they were not employees or volunteers. Instead, they received a stipend in exchange for work performed with a specified agency. Typically, the stipend is being credited to the registrant for the repayment of a student loan or educational expenses.

Ms. Helms explained the common types of stipends:

- *County Department of Mental Health Stipend Programs* – These are sometimes done in partnership with various colleges and universities. Graduating MFT students from these schools may be eligible to apply for an educational stipend. In return, they agree to work as an MFT Intern at an agency within the county’s mental health system that is in need of mental health providers for at least 12 months.
- *State Stipend Programs* - The California Department of Mental Health provides stipends to second year social work or marriage and family therapy students who meet certain qualifications. Recipients of the stipends complete an employment payback agreement with a county public mental health agency or a community-based organization under contract to a county public mental health agency. Once they graduate and obtain MFT Intern or ASW registrant status, they are required to complete their employment payback. They are typically paid a salary at this time in addition to their stipend, thus they are considered employees of the agencies.
- *Federal Stipend Programs* - The Indian Health Service and National Health Service Corps are federal programs offering loan reimbursement to MFTs and MFT Interns who work in specified underserved settings.

Ms. Helms explained that most of these government stipend programs also pay the participants a salary for their services while working. Therefore, they are issued a W-2 form and meet the Board’s requirement of being able to provide this form in order to verify the hours of experience claimed. However, the Board occasionally receives applications where experience was gained under other types of non-government stipend programs, such as universities or other service agencies. If a 1099 form instead of a W-2 form is issued, the applicants hours gained may not be counted.

Ms. Helms cited examples where the Board rejected experience hours because a W-2 tax form was not issued. Some of those examples cited involved applicants who received stipends.

Under current tax law, scholarship, fellowship, or tuition reduction for teaching, research and other services are taxable; therefore, a W-2 tax form is issued.

Ms. Helms explained the reasons the Board does not allow interns and associates to be independent contractors. MFT Interns and ASWs contracting themselves out independently would be able to “freelance,” making money indefinitely as an ASW or MFT Intern with no commitment to a particular supervisor or organization. By not having to pay wages to that person as an employee, the organization escapes the tax implications of employing the person, and therefore has no incentive to require that the person work toward licensure.

If the Board accepts 1099 forms, this opens the door to independent contractors being able to freelance indefinitely. However, it seems there are some cases where circumstances beyond the registrant's control required that they receive a 1099, and they received the same experience and supervision as a W-2 employee would. Additionally, because the Board does not accept these forms, it may encourage some applicants who received a 1099 to attempt to pass themselves off as volunteers.

Discussion was opened regarding educational stipends in order to explore if any further action is needed.

Ms. Rhine commented that it is the supervisor's responsibility to know the laws. She also stated that in trying to find a fix to this situation; this could end up more complicated by involving more situations other than the stipends.

Ms. Riemersma stated that when an employer is paying a stipend and providing the employee a 1099 at the end of the year, the employee is considered self-employed, which is in conflict with the law. The employer that is paying the stipend can withhold taxes and give the employee a W-2 at the end of the year. Employers have been pushed to go back and fix this so that the interns can count the hours. CAMFT would like to see people eligible for stipends from outside sources but does not want to see the law changed to allow people to provide services without being employees/volunteers coming under the direct supervision and control of the employer and the supervisor.

Mr. Wong stated that the reason why there are two forms, 1099 and W-2, is for withholding taxes. He explained that the Franchise Tax Board (FTB) and the Employment Development Department (EDD) consider 1099 employees to be independent contractors, not employees. When interns work under supervision, FTB considers the interns as W-2 employees. FTB also assumes that the employer claims the interns as 1099 employees to avoid paying employment taxes. Mr. Wong cautioned the Board on making exceptions to the law especially when other state agencies are involved.

Mr. Wong suggested adding a certification on the Board's forms that indicate the intern understands these circumstances in which their hours of experience will or will not be counted.

Ms. Riemersma stated that the Internal Revenue Service has a form listing criteria of an independent contractor versus an employee. According to the checklist there is no way an intern, training or associate can be permitted to practice independently. Furthermore, it is important to be sure that employers are providing workers compensation insurance.

No action was taken.

#### **V. Discussion and Possible Legislative Action Regarding Licensed Professional Clinical Counselor Supervision of Marriage and Family Therapist Interns**

Ms. Rhine reported that at the November 2010 board meeting, the Board considered changes to allow LPCCs to provide supervision for MFT trainees and interns. Currently, LPCCs are not included as licensees that may supervise MFT interns. Two issues were raised at the November Board meeting regarding the draft language presented. The first issue was that the draft language made changes to allow LPCCs to supervise registrants without also making conforming changes to code sections that outline the relevant licensing law construction with other licensing acts.

Ms. Rhine explained that BPC Section 4980.01 says that nothing in the MFT licensing act can be construed to limit the other licensing acts. A conforming change is required to BPC Section 4980.01 to insert the LPCC act within this section.

Ms. Rhine pointed out the second issue in regards to training and education requirements: Should the Board consider clarifying that an LPCC may not supervise an MFT intern unless the licensee has met the additional training and education requirements to treat couples and families? An amendment to BPC Section 4980.03 is recommended to clarify that an LPCC must meet the additional requirements in order to supervise MFT interns.

Additionally, an amendment to BPC Section 4996.13, which is the LCSW law that correlates to BPC Section 4980.01, is recommended.

The discussion was opened to LPCCs supervising MFT interns, and if so, those supervisors must meet the requirements outlined in BPC Section 4980.01.

Ms. Riemersma stated that clinical social workers, psychologists, and psychiatrists may supervise MFT interns. They may not have had training in marriage and family therapy. Like the LPCCs, they will be signing a supervisory statement that indicates that they are knowledgeable in marriage and family therapy, the licensing law, and supervision. Ms. Riemersma stated that CAMFT is comfortable not imposing additional requirements because it is adequately addressed. CAMFT is interested in opening up supervision.

Olivia Loewy, American Association for Marriage and Family Therapy California Division (AAMFT-CA), stated that the other disciplines do not have the additional training requirement in their licensing law. AAMFT-CA supports legislation for requiring additional training.

Mr. Webb stated that he has mixed feelings over this issue. He expressed that here are a lot of people providing marriage and family therapy who are not well trained and is concerned about the treatment consumers are receiving. He expressed that on the other hand, there is an opportunity to gain from the experienced LPCC population to effectively treat couples and families.

Kathleen Wenger, Pepperdine University, stated that LCSWs can currently supervise all of MFT intern hours; however, MFTs cannot supervise all of clinical social worker hours. She suggests that if LPCCs can supervise MFT interns, that it would be percentage-based, and recommended that interns receive 50% of their hours by a licensed MFT.

Ms. Lonner responded that Ms. Wenger's comment would be a future agenda item, which can be visited after the LPCC program is started.

Ms. Loewy stated that with LPCCs coming to California, there is an opportunity to develop the distinction between the two professions. Ensuring that LPCCs have the training as MFTs and to include it in legislation would serve each profession well in its evolution.

Ms. Rhine added an amendment to the proposed language, BPC Section 4980.03(g)(2), which should read "A professional clinical counselor must meet the requirements of Section 4999.20."

Ms. Porter stated that when AAMFT-CA asked CALPCC to amend the bill to include additional training in order to "hang a shingle," CALPCC felt that was reasonable. The

discussion was not around supervision. A psychologist, social worker or MFT can all supervise an LPCC. Although those professions may not know about any particular area of expertise that the LPCC intern or registrant has developed in their graduate work, the supervisor is overseeing the psychotherapy, which is what the intern/registrant is obtaining licensure to do. This is an ethical concern, and this should not be put into law because it could be a deterrent. CALPCC feels that LPCCs should not be singled out with the additional requirements.

Ms. Riemersma explained that another situation could arise where an LPCC who has experience in supervision, consultation, and continuing education in marriage and family therapy and could be a competent supervisor and be able to sign a supervisory statement. However, they do not have the education. This would limit the LPCC. Furthermore, this is a legal issue because they are signing the supervisory statement under penalty of perjury. Requiring the additional training is overly restrictive.

Ms. Rhine reviewed the requirements: 1) Six semester units or nine core units specifically focused on the theory and application of marriage and family therapy, and 2) a specialization or emphasis in the area on the qualifying degree of marriage and family therapy, and 3) no less than 500 hours of documented supervisory experience working directly with couples, families or children, and 4) six CE hours specific to marriage and family therapy completed at each license renewal.

Mr. Wong cautioned the Board about the language singling out groups and suggested that counsel takes a look at the language.

***Michael Webb moved to direct staff to bring amended language to the Board for consideration for sponsored legislation. Renee Lonner seconded. The Committee voted unanimously (2-0) to pass the motion.***

## **VI. Rulemaking Update**

Ms. Helms provided the rulemaking update. She reported that the rulemaking package relating to the creation of the LPCC program and the continuing education requirements for licensed educational psychologists was submitted to the State and Consumer Services Agency in October 2010. It is still awaiting approval. Once it is approved, it will move forward to the Department of Finance for approval, and then to the Office of Administrative Law.

The text regarding Title 16, CCR Section 1811, Revision of Advertising Regulations, was originally approved by the Board at its November 2009 meeting. Staff will address this rulemaking proposal in 2011 after the current pending regulatory proposal is approved.

Ms. Madsen added that if the Governor does not appoint a Secretary to the Consumer and Services Agency, all Department of Consumer Affairs' rulemaking packages will not move forward.

## **VII. Public Comment for Items Not on the Agenda**

There were no public comments for items not on the agenda.

## **VIII. Suggestions for Future Agenda Items**

There were no suggestions for future agenda items.

The meeting was adjourned at approximately 11:13 a.m.

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**To:** Policy and Advocacy Committee

**Date:** March 23, 2011

**From:** Christina Kitamura  
Administrative Analyst

**Telephone:** (916) 574-7835

**Subject:** Discussion and Possible Action Regarding Acceptance of Post-Degree Hours  
of Experience Toward Licensure as a Professional Clinical Counselor

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Materials for this agenda item will be provided in a supplemental package and will be posted on the website at that time.

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# CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES

## BILL ANALYSIS

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**BILL NUMBER:** AB 40                      **VERSION:** AMENDED MARCH 21, 2011

**AUTHOR:** YAMADA                      **SPONSOR:** YAMADA

**RECOMMENDED POSITION:** NONE

**SUBJECT:** ELDER ABUSE: REPORTING

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### **Existing Law:**

- 1) Specifies that certain individuals, including Marriage Family Therapists, Licensed Clinical Social Workers, and Licensed Educational Psychologists, are “mandated reporters” of suspected instances of elder and dependent adult abuse and must report abuse that occurred in a long-term care facility, except as specified, by calling *either* the local ombudsman or the local law enforcement agency immediately, or as soon as possible (Welfare and Institutions Code [WIC] Section 15630).
- 2) Requires a mandated reporter to submit a written report to the agency within two working days (WIC Section 15630).
- 3) Restricts local ombudsman programs from sharing reports of elder or adult abuse with local law enforcement agencies without the consent of the subject of the reported abuse or his or her legal representative (Section 712 of Chapter 2 of Title VII of the Older Americans Act).
- 4) Requires a mandated reported to report suspected financial abuse of an elder or dependent adult that occurred in a long-term care facility to *either* the local ombudsman or local law enforcement agency (WIC Section 15630.1).
- 5) Allows non-mandated reporters to report suspected instances of abuse of elders or dependent adults that occurred in a long-term care facility to a long-term care ombudsman program or local law enforcement agency (WIC Section 15631).

### **This Bill:**

- 1) Requires mandated reporters to report suspected instances of elder or dependent adult abuse that occurred in a long-term care facility to *both* the local ombudsman and local law enforcement agency (WIC Section 15630).
- 2) Requires mandated reporters to report suspected instances of elder or dependent adult financial abuse that occurred in a long-term care facility to *both* the local ombudsman and local law enforcement agency (WIC Section 15630.1).
- 3) Allows non-mandated reporters to report suspected instances of elder or dependent adult financial abuse that occurred in a long-term care facility to either the local long-term care ombudsman program or the local law enforcement agency or both entities (WIC Section 15631).

**Comments:**

- 1) **Author's Intent.** According to the Author's Office, the local ombudsman's limited ability to share information on reported abuses with local law enforcement may inhibit a thorough investigation, and ultimately, resolution of certain elder and dependent adult abuse reports. Requiring mandated reporters to report suspected abuse that occurred in a long-term care facility with both the local ombudsman and local law enforcement would ensure that law enforcement is aware of all reports of this type of criminal activity.
  
- 2) **Issue of Trust.** Mandated reporters may not report suspected instances of abuse to local law enforcement for fear of losing the trust of the subject/client. However, Welfare and Institutions Code Section 15633.5 ensures the confidentiality of the identity of the reporter, except as disclosed to specified agencies and under specified circumstances, such as by court order. Section 15633.5 also states that a reporter is not required to disclose his or her identity in the report. This statute suggests that the level of trust between a mandated reporter and the subject of the abuse may not be compromised by submitting the report of abuse to the law enforcement agency.

**3) Support and Opposition.**

*Support:* Association of Retarded Citizens

*Opposition:* None on File.

**4) History**

**2011**

Mar. 21 From committee chair, with author's amendments: Amend, and re-refer to Com. on AGING & L.T.C. Read second time and amended.

Jan. 24 Referred to Coms. on AGING & L.T.C. and PUB. S.

**2010**

Dec. 7 From printer. May be heard in committee January 6.

Dec. 6 Read first time. To print.

**5) Attachments**

- A. Older Americans Act, Title VII, Chapter 2, Section 712
- B. Relevant Code Sections (Welfare and Institutions Code Section 9725 and Welfare and Institutions Code Section 15633.5)

AMENDED IN ASSEMBLY MARCH 21, 2011

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

**ASSEMBLY BILL**

**No. 40**

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**Introduced by Assembly Member Yamada**

December 6, 2010

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An act to amend ~~Section 15630~~ *Sections 15630, 15630.1, and 15631* of the Welfare and Institutions Code, relating to elder abuse.

LEGISLATIVE COUNSEL'S DIGEST

AB 40, as amended, Yamada. Elder abuse: reporting.

The Elder Abuse and Dependent Adult Civil Protection Act establishes various procedures for the reporting, investigation, and prosecution of elder and dependent adult abuse. The act requires certain persons, called mandated reporters, to report known or suspected instances of elder or dependent adult abuse. The act requires a mandated reporter, *and authorizes any person who is not a mandated reporter*, to report the abuse to the local ~~ombudsman~~ *ombudsman* or the local law enforcement agency if the abuse occurs in a long-term care facility. Failure to report physical abuse and financial abuse of an elder or dependent adult under the act is a misdemeanor.

This bill would, instead, require the mandated reporter, *and authorize any person who is not a mandated reporter*, to report the abuse to both the local ~~ombudsman~~ *ombudsman* and the local law enforcement agency. ~~This bill would also make various technical, nonsubstantive changes.~~

*Existing law requires a mandated reporter of suspected financial abuse of an elder or dependent adult, as defined, to report a known or suspected instance of financial abuse, as described, to the local ombudsman or the local law enforcement agency if the mandated*

reporter knows that the elder or dependent adult resides in a long-term care facility.

This bill would, instead, require the mandated reporter to report the abuse to both the local ombudsman and the local law enforcement agency. This bill would also make various technical nonsubstantive changes.

By changing the scope of an existing crime, this bill would impose a state-mandated local program. By increasing the duties of local law enforcement agencies, 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 15630 of the Welfare and Institutions
- 2 Code is amended to read:
- 3 15630. (a) Any person who has assumed full or intermittent
- 4 responsibility for the care or custody of an elder or dependent
- 5 adult, whether or not he or she receives compensation, including
- 6 administrators, supervisors, and any licensed staff of a public or
- 7 private facility that provides care or services for elder or dependent
- 8 adults, or any elder or dependent adult care custodian, health
- 9 practitioner, clergy member, or employee of a county adult
- 10 protective services agency or a local law enforcement agency, is
- 11 a mandated reporter.
- 12 (b) (1) Any mandated reporter who, in his or her professional
- 13 capacity, or within the scope of his or her employment, has
- 14 observed or has knowledge of an incident that reasonably appears
- 15 to be physical abuse, as defined in Section 15610.63, abandonment,
- 16 abduction, isolation, financial abuse, or neglect, or is told by an

1 elder or dependent adult that he or she has experienced behavior,  
2 including an act or omission, constituting physical abuse, as defined  
3 in Section 15610.63, abandonment, abduction, isolation, financial  
4 abuse, or neglect, or reasonably suspects that abuse, shall report  
5 the known or suspected instance of abuse by telephone immediately  
6 or as soon as practicably possible, and by written report sent within  
7 two working days, as follows:

8 (A) If the abuse has occurred in a long-term care facility, except  
9 a state mental health hospital or a state developmental center, the  
10 report shall be made to both the local ~~ombuds~~ *ombudsman*  
11 and the local law enforcement agency.

12 The local ~~ombuds~~ *ombudsman* and the local law  
13 enforcement agency shall, as soon as practicable, except in the  
14 case of an emergency or pursuant to a report required to be made  
15 pursuant to clause (v), in which case these actions shall be taken  
16 immediately, do all of the following:

17 (i) Report to the State Department of Public Health any case of  
18 known or suspected abuse occurring in a long-term health care  
19 facility, as defined in subdivision (a) of Section 1418 of the Health  
20 and Safety Code.

21 (ii) Report to the State Department of Social Services any case  
22 of known or suspected abuse occurring in a residential care facility  
23 for the elderly, as defined in Section 1569.2 of the Health and  
24 Safety Code, or in an adult day care facility, as defined in paragraph  
25 (2) of subdivision (a) of Section 1502.

26 (iii) Report to the State Department of Public Health and the  
27 California Department of Aging any case of known or suspected  
28 abuse occurring in an adult day health care center, as defined in  
29 subdivision (b) of Section 1570.7 of the Health and Safety Code.

30 (iv) Report to the Bureau of Medi-Cal Fraud and Elder Abuse  
31 any case of known or suspected criminal activity.

32 (v) Report all cases of known or suspected physical abuse and  
33 financial abuse to the local district attorney's office in the county  
34 where the abuse occurred.

35 (B) If the suspected or alleged abuse occurred in a state mental  
36 hospital or a state developmental center, the report shall be made  
37 to designated investigators of the State Department of Mental  
38 Health or the State Department of Developmental Services, or to  
39 the local law enforcement agency.

1 Except in an emergency, the local law enforcement agency shall,  
2 as soon as practicable, report any case of known or suspected  
3 criminal activity to the Bureau of Medi-Cal Fraud and Elder Abuse.

4 (C) If the abuse has occurred any place other than one described  
5 in subparagraph (A), the report shall be made to the adult protective  
6 services agency or the local law enforcement agency.

7 (2) (A) A mandated reporter who is a clergy member who  
8 acquires knowledge or reasonable suspicion of elder or dependent  
9 adult abuse during a penitential communication is not subject to  
10 paragraph (1). For purposes of this subdivision, “penitential  
11 communication” means a communication that is intended to be in  
12 confidence, including, but not limited to, a sacramental confession  
13 made to a clergy member who, in the course of the discipline or  
14 practice of his or her church, denomination, or organization is  
15 authorized or accustomed to hear those communications and under  
16 the discipline tenets, customs, or practices of his or her church,  
17 denomination, or organization, has a duty to keep those  
18 communications secret.

19 (B) This subdivision shall not be construed to modify or limit  
20 a clergy member’s duty to report known or suspected elder and  
21 dependent adult abuse if he or she is acting in the capacity of a  
22 care custodian, health practitioner, or employee of an adult  
23 protective services agency.

24 (C) Notwithstanding any other provision in this section, a clergy  
25 member who is not regularly employed on either a full-time or  
26 part-time basis in a long-term care facility or does not have care  
27 or custody of an elder or dependent adult shall not be responsible  
28 for reporting abuse or neglect that is not reasonably observable or  
29 discernible to a reasonably prudent person having no specialized  
30 training or experience in elder or dependent care.

31 (3) (A) A mandated reporter who is a physician and surgeon,  
32 a registered nurse, or a psychotherapist, as defined in Section 1010  
33 of the Evidence Code, shall not be required to report, pursuant to  
34 paragraph (1), an incident if all of the following conditions exist:

35 (i) The mandated reporter has been told by an elder or dependent  
36 adult that he or she has experienced behavior constituting physical  
37 abuse, as defined in Section 15610.63, abandonment, abduction,  
38 isolation, financial abuse, or neglect.

1 (ii) The mandated reporter is not aware of any independent  
2 evidence that corroborates the statement that the abuse has  
3 occurred.

4 (iii) The elder or dependent adult has been diagnosed with a  
5 mental illness or dementia, or is the subject of a court-ordered  
6 conservatorship because of a mental illness or dementia.

7 (iv) In the exercise of clinical judgment, the physician and  
8 surgeon, the registered nurse, or the psychotherapist, as defined  
9 in Section 1010 of the Evidence Code, reasonably believes that  
10 the abuse did not occur.

11 (B) This paragraph shall not be construed to impose upon  
12 mandated reporters a duty to investigate a known or suspected  
13 incident of abuse and shall not be construed to lessen or restrict  
14 any existing duty of mandated reporters.

15 (4) (A) In a long-term care facility, a mandated reporter shall  
16 not be required to report as a suspected incident of abuse, as defined  
17 in Section 15610.07, an incident if all of the following conditions  
18 exist:

19 (i) The mandated reporter is aware that there is a proper plan  
20 of care.

21 (ii) The mandated reporter is aware that the plan of care was  
22 properly provided or executed.

23 (iii) A physical, mental, or medical injury occurred as a result  
24 of care provided pursuant to clause (i) or (ii).

25 (iv) The mandated reporter reasonably believes that the injury  
26 was not the result of abuse.

27 (B) This paragraph shall not be construed to require a mandated  
28 reporter to seek, nor to preclude a mandated reporter from seeking,  
29 information regarding a known or suspected incident of abuse prior  
30 to reporting. This paragraph shall apply only to those categories  
31 of mandated reporters that the State Department of Public Health  
32 determines, upon approval by the Bureau of Medi-Cal Fraud and  
33 Elder Abuse and the state long-term care ~~ombudsperson~~  
34 *ombudsman*, have access to plans of care and have the training  
35 and experience necessary to determine whether the conditions  
36 specified in this section have been met.

37 (c) (1) Any mandated reporter who has knowledge, or  
38 reasonably suspects, that types of elder or dependent adult abuse  
39 for which reports are not mandated have been inflicted upon an  
40 elder or dependent adult, or that his or her emotional well-being

1 is endangered in any other way, may report the known or suspected  
2 instance of abuse.

3 (2) If the suspected or alleged abuse occurred in a long-term  
4 care facility other than a state mental health hospital or a state  
5 developmental center, the report may be made to the long-term  
6 care ~~ombudsperson~~ *ombudsman* program. Except in an emergency,  
7 the local ~~ombudsperson~~ *ombudsman* shall report any case of known  
8 or suspected abuse to the State Department of Public Health and  
9 any case of known or suspected criminal activity to the Bureau of  
10 Medi-Cal Fraud and Elder Abuse, as soon as is practicable.

11 (3) If the suspected or alleged abuse occurred in a state mental  
12 health hospital or a state developmental center, the report may be  
13 made to the designated investigator of the State Department of  
14 Mental Health or the State Department of Developmental Services  
15 or to a local law enforcement agency or to the local ~~ombudsperson~~  
16 *ombudsman*. Except in an emergency, the local ~~ombudsperson~~  
17 *ombudsman* and the local law enforcement agency shall report any  
18 case of known or suspected criminal activity to the Bureau of  
19 Medi-Cal Fraud and Elder Abuse, as soon as is practicable.

20 (4) If the suspected or alleged abuse occurred in a place other  
21 than a place described in paragraph (2) or (3), the report may be  
22 made to the county adult protective services agency.

23 (5) If the conduct involves criminal activity not covered in  
24 subdivision (b), it may be immediately reported to the appropriate  
25 law enforcement agency.

26 (d) If two or more mandated reporters are present and jointly  
27 have knowledge or reasonably suspect that types of abuse of an  
28 elder or a dependent adult for which a report is or is not mandated  
29 have occurred, and there is agreement among them, the telephone  
30 report may be made by a member of the team selected by mutual  
31 agreement, and a single report may be made and signed by the  
32 selected member of the reporting team. Any member who has  
33 knowledge that the member designated to report has failed to do  
34 so shall thereafter make the report.

35 (e) A telephone report of a known or suspected instance of elder  
36 or dependent adult abuse shall include, if known, the name of the  
37 person making the report, the name and age of the elder or  
38 dependent adult, the present location of the elder or dependent  
39 adult, the names and addresses of family members or any other  
40 adult responsible for the elder's or dependent adult's care, the

1 nature and extent of the elder's or dependent adult's condition, the  
2 date of the incident, and any other information, including  
3 information that led that person to suspect elder or dependent adult  
4 abuse, as requested by the agency receiving the report.

5 (f) The reporting duties under this section are individual, and  
6 no supervisor or administrator shall impede or inhibit the reporting  
7 duties, and no person making the report shall be subject to any  
8 sanction for making the report. However, internal procedures to  
9 facilitate reporting, ensure confidentiality, and apprise supervisors  
10 and administrators of reports may be established, provided they  
11 are not inconsistent with this chapter.

12 (g) (1) Whenever this section requires a county adult protective  
13 services agency to report to a law enforcement agency, the law  
14 enforcement agency shall, immediately upon request, provide a  
15 copy of its investigative report concerning the reported matter to  
16 that county adult protective services agency.

17 (2) Whenever this section requires a law enforcement agency  
18 to report to a county adult protective services agency, the county  
19 adult protective services agency shall, immediately upon request,  
20 provide to that law enforcement agency a copy of its investigative  
21 report concerning the reported matter.

22 (3) The requirement to disclose investigative reports pursuant  
23 to this subdivision shall not include the disclosure of social services  
24 records or case files that are confidential, nor shall this subdivision  
25 be construed to allow disclosure of any reports or records if the  
26 disclosure would be prohibited by any other provision of state or  
27 federal law.

28 (h) Failure to report, or impeding or inhibiting a report of,  
29 physical abuse, as defined in Section 15610.63, abandonment,  
30 abduction, isolation, financial abuse, or neglect of an elder or  
31 dependent adult, in violation of this section, is a misdemeanor,  
32 punishable by not more than six months in the county jail, by a  
33 fine of not more than one thousand dollars (\$1,000), or by both  
34 that fine and imprisonment. Any mandated reporter who willfully  
35 fails to report, or impedes or inhibits a report of, physical abuse,  
36 as defined in Section 15610.63, abandonment, abduction, isolation,  
37 financial abuse, or neglect of an elder or dependent adult, in  
38 violation of this section, if that abuse results in death or great bodily  
39 injury, shall be punished by not more than one year in a county  
40 jail, by a fine of not more than five thousand dollars (\$5,000), or

1 by both that fine and imprisonment. If a mandated reporter  
2 intentionally conceals his or her failure to report an incident known  
3 by the mandated reporter to be abuse or severe neglect under this  
4 section, the failure to report is a continuing offense until a law  
5 enforcement agency specified in paragraph (1) of subdivision (b)  
6 of Section 15630 discovers the offense.

7 (i) For purposes of this section, “dependent adult” shall have  
8 the same meaning as in Section 15610.23.

9 *SEC. 2. Section 15630.1 of the Welfare and Institutions Code*  
10 *is amended to read:*

11 15630.1. (a) As used in this section, “mandated reporter of  
12 suspected financial abuse of an elder or dependent adult” means  
13 all officers and employees of financial institutions.

14 (b) As used in this section, the term “financial institution” means  
15 any of the following:

16 (1) A depository institution, as defined in Section 3(c) of the  
17 Federal Deposit Insurance Act (12 U.S.C. Sec. 1813(c)).

18 (2) An institution-affiliated party, as defined in Section 3(u) of  
19 the Federal Deposit Insurance Act (12 U.S.C. Sec. 1813(u)).

20 (3) A federal credit union or state credit union, as defined in  
21 Section 101 of the Federal Credit Union Act (12 U.S.C. Sec. 1752),  
22 including, but not limited to, an institution-affiliated party of a  
23 credit union, as defined in Section 206(r) of the Federal Credit  
24 Union Act (12 U.S.C. Sec. 1786(r)).

25 (c) As used in this section, “financial abuse” has the same  
26 meaning as in Section 15610.30.

27 (d) (1) Any mandated reporter of suspected financial abuse of  
28 an elder or dependent adult who has direct contact with the elder  
29 or dependent adult or who reviews or approves the elder or  
30 dependent adult’s financial documents, records, or transactions,  
31 in connection with providing financial services with respect to an  
32 elder or dependent adult, and who, within the scope of his or her  
33 employment or professional practice, has observed or has  
34 knowledge of an incident, that is directly related to the transaction  
35 or matter that is within that scope of employment or professional  
36 practice, that reasonably appears to be financial abuse, or who  
37 reasonably suspects that abuse, based solely on the information  
38 before him or her at the time of reviewing or approving the  
39 document, record, or transaction in the case of mandated reporters  
40 who do not have direct contact with the elder or dependent adult,

1 shall report the known or suspected instance of financial abuse by  
2 telephone immediately, or as soon as practicably possible, and by  
3 written report sent within two working days to the local adult  
4 protective services agency or the local law enforcement agency.

5 (2) When two or more mandated reporters jointly have  
6 knowledge or reasonably suspect that financial abuse of an elder  
7 or a dependent adult for which the report is mandated has occurred,  
8 and when there is an agreement among them, the telephone report  
9 may be made by a member of the reporting team who is selected  
10 by mutual agreement. A single report may be made and signed by  
11 the selected member of the reporting team. Any member of the  
12 team who has knowledge that the member designated to report has  
13 failed to do so shall thereafter make that report.

14 (3) If the mandated reporter knows that the elder or dependent  
15 adult resides in a long-term care facility, as defined in Section  
16 15610.47, the report shall be made to the local ombudsman ~~or~~ and  
17 local law enforcement agency.

18 (e) An allegation by the elder or dependent adult, or any other  
19 person, that financial abuse has occurred is not sufficient to trigger  
20 the reporting requirement under this section if both of the following  
21 conditions are met:

22 (1) The mandated reporter of suspected financial abuse of an  
23 elder or dependent adult is aware of no other corroborating or  
24 independent evidence of the alleged financial abuse of an elder or  
25 dependent adult. The mandated reporter of suspected financial  
26 abuse of an elder or dependent adult is not required to investigate  
27 any accusations.

28 (2) In the exercise of his or her professional judgment, the  
29 mandated reporter of suspected financial abuse of an elder or  
30 dependent adult reasonably believes that financial abuse of an  
31 elder or dependent adult did not occur.

32 (f) Failure to report financial abuse under this section shall be  
33 subject to a civil penalty not exceeding one thousand dollars  
34 (\$1,000) or if the failure to report is willful, a civil penalty not  
35 exceeding five thousand dollars (\$5,000), which shall be paid by  
36 the financial institution that is the employer of the mandated  
37 reporter to the party bringing the action. Subdivision (h) of Section  
38 15630 shall not apply to violations of this section.

39 (g) (1) The civil penalty provided for in subdivision (f) shall  
40 be recovered only in a civil action brought against the financial

1 institution by the Attorney General, district attorney, or county  
2 counsel. No action shall be brought under this section by any  
3 person other than the Attorney General, district attorney, or county  
4 counsel. Multiple actions for the civil penalty may not be brought  
5 for the same violation.

6 (2) Nothing in the Financial Elder Abuse Reporting Act of 2005  
7 shall be construed to limit, expand, or otherwise modify any civil  
8 liability or remedy that may exist under this or any other law.

9 (h) As used in this section, “suspected financial abuse of an  
10 elder or dependent adult” occurs when a person who is required  
11 to report under subdivision (a) observes or has knowledge of  
12 behavior or unusual circumstances or transactions, or a pattern of  
13 behavior or unusual circumstances or transactions, that would lead  
14 an individual with like training or experience, based on the same  
15 facts, to form a reasonable belief that an elder or dependent adult  
16 is the victim of financial abuse as defined in Section 15610.30.

17 (i) Reports of suspected financial abuse of an elder or dependent  
18 adult made by an employee or officer of a financial institution  
19 pursuant to this section are covered under subdivision (b) of Section  
20 47 of the Civil Code.

21 (j) This section shall remain in effect only until January 1, 2013,  
22 and as of that date is repealed, unless a later enacted statute, that  
23 is enacted before January 1, 2013, deletes or extends that date.

24 *SEC. 3. Section 15631 of the Welfare and Institutions Code is*  
25 *amended to read:*

26 15631. (a) Any person who is not a mandated reporter under  
27 Section 15630, who knows, or reasonably suspects, that an elder  
28 or a dependent adult has been the victim of abuse may report that  
29 abuse to a long-term care ombudsman program or local law  
30 enforcement agency *or both the long-term care ombudsman*  
31 *program and local law enforcement agency* when the abuse is  
32 alleged to have occurred in a long-term care facility.

33 (b) Any person who is not a mandated reporter under Section  
34 15630, who knows, or reasonably suspects, that an elder or a  
35 dependent adult has been the victim of abuse in any place other  
36 than a long-term care facility may report the abuse to the county  
37 adult protective services agency or local law enforcement agency.

38 ~~SEC. 2.~~

39 *SEC. 4.* No reimbursement is required by this act pursuant to  
40 Section 6 of Article XIII B of the California Constitution for certain

1 costs that may be incurred by a local agency or school district  
2 because, in that regard, this act creates a new crime or infraction,  
3 eliminates a crime or infraction, or changes the penalty for a crime  
4 or infraction, within the meaning of Section 17556 of the  
5 Government Code, or changes the definition of a crime within the  
6 meaning of Section 6 of Article XIII B of the California  
7 Constitution.

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

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# OLDER AMERICANS ACT OF 1965

As Amended In 2006 (Public Law 109-365)

## TITLE VII—ALLOTMENTS FOR VULNERABLE ELDER RIGHTS PROTECTION ACTIVITIES Subtitle A—State Provision

### CHAPTER 2—OMBUDSMAN PROGRAMS

#### Section 712. STATE LONG-TERM CARE OMBUDSMAN PROGRAM.

##### (d) DISCLOSURE.

(1) IN GENERAL.—The State agency shall establish procedures for the disclosure by the Ombudsman or local Ombudsman entities of files maintained by the program, including records described in subsection (b)(1) or (c).

(2) IDENTITY OF COMPLAINANT OR RESIDENT.—The procedures described in paragraph (1) shall—

(A) provide that, subject to subparagraph (B), the files and records described in paragraph (1) may be disclosed only at the discretion of the Ombudsman (or the person designated by the Ombudsman to disclose the files and records); and

(B) prohibit the disclosure of the identity of any complainant or resident with respect to whom the Office maintains such files or records unless—

(i) the complainant or resident, or the legal representative of the complainant or resident, consents to the disclosure and the consent is given in writing;

(ii) (I) the complainant or resident gives consent orally; and

(II) the consent is documented contemporaneously in a writing made by a representative of the Office in accordance with such requirements as the State agency shall establish; or

(iii) the disclosure is required by court order.

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## Relevant Code Sections

### Welfare and Institutions Code Section 9725

#### §9725

All records and files of the office relating to any complaint or investigation made pursuant to this chapter and the identities of complainants, witnesses, patients, or residents shall remain confidential, unless disclosure is authorized by the patient or resident or his or her conservator of the person or legal representative, required by court order, or release of the information is to a law enforcement agency, public protective service agency, licensing or certification agency in a manner consistent with federal laws and regulations.

### Welfare and Institutions Code Section 15633.5

#### §15633.5

(a) Information relevant to the incident of elder or dependent adult abuse may be given to an investigator from an adult protective services agency, a local law enforcement agency, the office of the district attorney, the office of the public guardian, the probate court, the bureau, or an investigator of the Department of Consumer Affairs, Division of Investigation who is investigating a known or suspected case of elder or dependent adult abuse.

(b) The identity of any person who reports under this chapter shall be confidential and disclosed only among the following agencies or persons representing an agency:

- (1) An adult protective services agency.
- (2) A long-term care ombudsperson program.
- (3) A licensing agency.
- (4) A local law enforcement agency.
- (5) The office of the district attorney.
- (6) The office of the public guardian.
- (7) The probate court.
- (8) The bureau.
- (9) The Department of Consumer Affairs, Division of Investigation.
- (10) Counsel representing an adult protective services agency.

(c) The identity of a person who reports under this chapter may also be disclosed under the following circumstances:

- (1) To the district attorney in a criminal prosecution.
- (2) When a person reporting waives confidentiality.
- (3) By court order.
- (d) Notwithstanding subdivisions (a), (b), and (c), any person reporting pursuant to Section 15631 shall not be required to include his or her name in the report.

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# CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES

## BILL ANALYSIS

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**BILL NUMBER:** AB 154                      **VERSION:** JANUARY 18, 2011

**AUTHOR:** BEALL                              **SPONSOR:** AUTHOR

**RECOMMENDED POSITION:** NONE

**SUBJECT:** MENTAL HEALTH AND SUBSTANCE ABUSE PARITY

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### Existing Law:

- 1) Requires health care service plan contracts and disability insurance policies that provide hospital, medical or surgical coverage to provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses, regardless of age, and of serious emotional disturbances of a child. (Health and Safety Code §1374.72(a), Insurance Code 10144.5(a)).
- 2) Defines “severe mental illnesses” as follows (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.
- 3) Defines “serious emotional disturbances of a child” as a child who has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders IV (DSM IV) (other than a primary substance use disorder or development disorder) that results in age-inappropriate behavior (HSC §1374.72(e), IC §10144.5(e)). One or more of the following criteria must also be met (HSC §5600.3(a)(2)):
  - (A) As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:
    - (i) The child is at risk of removal from home or has already been removed from the home.
    - (ii) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.
  - (B) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

(C) The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

- 4) Requires the benefits provided to include outpatient services, inpatient hospital services, partial hospital services, and prescription drugs (if the plan includes prescription drug coverage). (HSC §1374.72(b), IC §10144.5(b)).
- 5) Requires that maximum lifetime benefits, copayments, and individual and family deductibles that apply to these benefits have the same terms and conditions as they do for any other benefits under the plan contract. (HSC §1374.72(c), IC §10144.5(c)).

**This Bill:**

- 1) Permits the Board of Administration of the Public Employees' Retirement System to purchase a health care benefit plan or contract or a health insurance policy that includes mental health coverage as described in Section 1374.74 of the Health and Safety Code or Section 10144.8 of the Insurance Code. (Government Code §22856).
- 2) Requires a health care services plan contract or health insurance policy that provides hospital, medical, or surgical coverage that is issued, amended, or renewed on or after January 1, 2012 to provide coverage for the diagnosis and medically necessary treatment of a mental illness of a person of any age, including a child, under the same terms and conditions applied to other medical conditions. (HSC 1374.74(a), IC §10144.8(a)).
- 3) The benefits provided under this legislation must include the following(HSC §1374.74(a), IC §10144.8(a)):
  - a. Outpatient services;
  - b. Inpatient hospital services;
  - c. Partial hospital services; and
  - d. Prescription drugs, if the plan contract includes coverage for prescription drugs.
- 4) Defines "mental illness" as a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders IV (DSM IV), published by the American Psychiatric Association, and includes substance abuse. However, treatment of the following diagnoses are excluded: (HSC §1374.74(b)(1), IC §10144.8(b)(1)).
  - (A) Noncompliance With Treatment (V15.81).
  - (B) Partner Relational Problem (V61.1).
  - (C) Physical/Sexual Abuse of an Adult (V61.12).
  - (D) Parent-Child Relational Problem (V61.20).
  - (E) Child Neglect (V61.21).
  - (F) Physical/Sexual Abuse of a Child (V61.21).
  - (G) Sibling Relational Problem (V61.8).
  - (H) Relational Problem Related to a Mental Disorder or General Medical Condition (V61.9).
  - (I) Occupational Problem (V62.29).
  - (J) Academic Problem (V62.3).
  - (K) Acculturation Problem (V62.4).
  - (L) Relational Problems (V62.81).

- (M) Bereavement (V62.82).
- (N) Physical/Sexual Abuse of an Adult (V62.83).
- (O) Borderline Intellectual Functioning (V62.89).
- (P) Phase of Life Problem (V62.89).
- (Q) Religious or Spiritual Problem (V62.89).
- (R) Malingering (V65.2).
- (S) Adult Antisocial Behavior (V71.01).
- (T) Child or Adolescent Antisocial Behavior (V71.02).
- (U) There is not a Diagnosis or a Condition on Axis I (V71.09).
- (V) There is not a Diagnosis on Axis II (V71.09).
- (W) Nicotine Dependence (305.10).

- 5) Provides that the definition of “mental illness” must be revised to conform to any revisions to the list of mental disorders defined in the most current version of the DSM IV. (HSC §1374.74(b)(2), IC §10144.8(b)(2)).
- 6) Requires any revision of the definition of “mental illness” to be established by regulation. (HSC §1374.74(b)(3), IC §10144.8(b)(3)).
- 7) 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. The plan or insurer is not required to obtain an additional or specialized license for this purpose. (HSC § 1374.74(c)(1), IC §10144.8(c)(1)).
- 8) Requires a plan or insurer to provide mental health coverage in its entire service area and in emergency situations as required by law and regulation (HSC §1374.74(c)(2), IC §10144.8(c)(2)).
- 9) Does not apply to contracts entered into between the State Department of Health Care Services and a health care service plan for enrolled Medi-Cal beneficiaries. (HSC §1374.74(e)).
- 10) Does not apply to a health care benefit plan or contract entered into with the Board of Administration of the Public Employees’ Retirement System unless the board elects to purchase a health care benefit plan or contract that provides mental health coverage as described in this legislation. (HSC §1374.74(f), IC §10144.8(e)).
- 11) Does not apply to accident-only, specified disease, hospital indemnity, Medicare supplement, dental-only, or vision-only health care service plan contracts. (HSC §1374.74(g)).

**Comments:**

- 1) **Author’s Intent.** The intent of this bill is to end discrimination against patients with mental disorders and substance abuse issues by requiring treatment and coverage of those illnesses at a level equitable to the coverage provided for other medical illnesses. The author notes that many health plans do not provide coverage for mental disorders, and the plans that do impose much stricter limits on mental health care coverage than on other medical care.

Research provided by the author’s office notes that individuals with mental illnesses quickly exhaust their limited coverage and personal savings, becoming dependent on taxpayer

supported benefits. This creates costs to the counties' indigent health care pool, the emergency room, and the corrections system.

- 2) **Parity Laws.** Parity laws require insurance coverage for mental health to be equal to or better than insurance already provided for other medical and surgical benefits, including maximum lifetime benefits, co-payments, and deductibles.
- 3) **Federal Mental Health Parity Act.** The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Act) was enacted in October 2008. The Act amended the Mental Health Parity Act of 1996. The Act banned differences in co-pays, deductibles, coinsurance, out of network coverage, out of pocket expenses and treatment limitations such as caps on visits, limits on days, and limits on duration of treatment for mental health or addiction therapy. This law does not apply to employers with fewer than 50 employees.

The passage of the Act did not mandate mental health or substance use disorder benefit coverage but only stated that if mental health/substance use disorder benefits are offered through a health insurance plan, that those benefits must not be more restrictive or limiting than those offered for medical and surgical coverage under the plan.

Two major limitations were included in the Act. The first, as with the original 1996 parity law, allows a small employer exemption, making the parity requirements contained therein applicable only to group health plans with more than fifty-one employees. Secondly, the Act states that if a group health plan experiences an increase in actual total costs with respect to medical/surgical and mental health/substance use benefits of 1% as a result of the parity requirements (2% in the first plan –year to which this Act is applicable), the plan can be exempted from the law for the following plan year.

- 4) **National Health Care Reform.** The 2010 Patient Protection and Affordable Care Act (PPACA, also known as national health care reform) requires private insurance plans to include certain mental health and substance use disorder treatment beginning in 2014. The mental health and substance use disorders covered are to be determined through rulemaking.

The PPACA would also require health insurance plans sold through the state-based health insurance Exchanges to include mental health and substance use disorder services at parity.

- 5) **State of California Mental Health Parity.** California's current mental health parity law, AB 88, was enacted in 2000. The bill requires health plans to provide coverage for mental health services that are equal to medical services. However, they are required to cover only certain diagnoses that are defined as a severe mental illness or a serious emotional disturbance of a child. This bill would extend parity to mental illnesses not currently defined as a serious mental illness, as well as substance use disorders.
- 6) **Necessity of AB 154 with Passage of National Health Care Reform.** Although the PPACA requires health insurance plans to provide mental health and substance use disorder treatment beginning, the law does not yet define mental health and substance use treatments to be covered. Additionally, the law does not go into effect until 2014, leaving many uncovered until then.
- 7) **Previous Legislation and Board Position.** AB 423 (Beall, 2007), AB 1887 (Beall, 2008) and AB 244 (Beall, 2009) were all very similar to this bill. All three were vetoed by Governor Schwarzenegger. The Board took a position of "support" on these bills, recognizing that

mental health parity is a large and complex issue, and that support was grounded in the general idea that people should have access to mental health care.

The Board did not take a position on last year's version of this bill, AB 1600 (Beall, 2010). AB 1600 was also vetoed by the Governor, with the following veto message:

I am returning Assembly Bill 1600 without my signature. This is the fourth time that I have vetoed this measure. In addition to the concerns that I have consistently cited over the last three vetoes regarding the overall rising cost of healthcare and lack of affordability for employers and individuals struggling to keep their existing coverage, I am now able to add a new concern. The federal health reform provisions that take effect in 2014 will require states to pay the entire cost of mandates that go above and beyond the definition of "essential benefits." This bill certainly requires a higher level of service than contemplated on a federal level and as such, will mandate California to spend new General Fund dollars for these benefits.

I cannot agree to a significant expenditure of new funds when we are struggling to provide basic levels of coverage to our most needy and fragile populations.

**8) Related Legislation.** A similar bill, AB 171 (Beall) seeks to end health care discrimination against those with autism spectrum disorder (ASD). It would require every health care service plan contract or health insurance policy issued, amended, or renewed after January 1, 2012, that provides hospital, medical, or surgical coverage must provide coverage for the screening, diagnosis, and treatment of autism spectrum disorders. Current law lacks detail as to the nature of coverage that must be provided for ASD. This bill would make the law more explicit about what must be covered.

**9) Suggested Amendment.** Insurance Code §10144.8(d) states that "This section shall not apply to accident-only, specified disease, hospital indemnity, or Medicare supplement insurance policies, or specialized health insurance policies, except behavioral health-only policies." Health and Safety Code §1374.74(g) has similar language that exempts certain health care service plan contracts, but does not have an exception for behavioral health-only policies. Staff recommends that language providing an exception for behavioral health-only policies should be added to Health and Safety Code §1374.74(g).

## **10) Support and Opposition.**

### **Support:**

- California Communities United Institute
- Health Access California
- Jericho California
- California School Employees Association
- AFL-CIO
- California Academy of Family Physicians
- California Academy of Physician Assistants
- California Psychiatric Association
- California Association of Alcohol and Drug Pro-gram Executives
- California Psychological Association
- County Alcohol and Drug Program Administrators Association of California
- California State Association of Counties

- Mental Health Association in California
- California Council of Community Mental Health Agencies
- California Coalition for Mental Health

**Oppose:**

- Department of Managed Health Care
- CSAC-Excess Insurance Authority
- Kaiser Permanente
- California Association of Health Underwriters
- Association of California Life & Health Insurance Companies
- Anthem Blue Cross
- California Chamber of Commerce
- Health Net
- California Advocates, Inc.

**11) History**

2011

Feb. 3            Referred to Com. on HEALTH.

Jan. 19           From printer. May be heard in committee February 18.

Jan. 18           Read first time. To print.

**12) Attachments.** Policy Briefs: California Senate Office of Research, February 2011.

**ASSEMBLY BILL**

**No. 154**

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**Introduced by Assembly Member Beall**

January 18, 2011

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An act to add Section 22856 to the Government Code, to add Section 1374.74 to the Health and Safety Code, and to add Section 10144.8 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 154, as introduced, Beall. Health care coverage: mental health services.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, 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 certain health care service plan contracts and health insurance policies issued, amended, or renewed on or after January 1, 2012, to include the diagnosis and treatment of a mental illness of a person of any age and would define mental illness for this purpose as a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders IV, including substance abuse but excluding nicotine dependence and specified diagnoses defined in the manual, subject to regulatory revision,

as specified. The bill would specify that this requirement does not apply to a health care benefit plan, contract, or health insurance policy with the Board of Administration of the Public Employees' Retirement System unless the board elects to purchase a plan, contract, or policy that provides mental health coverage.

Because this bill would expand coverage requirements for health care service plans, the willful violation of which would be 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 22856 is added to the Government Code,  
2 to read:

3 22856. The board may purchase a health care benefit plan or  
4 contract or a health insurance policy that includes mental health  
5 coverage as described in Section 1374.74 of the Health and Safety  
6 Code or Section 10144.8 of the Insurance Code.

7 SEC. 2. Section 1374.74 is added to the Health and Safety  
8 Code, to read:

9 1374.74. (a) A health care service plan contract issued,  
10 amended, or renewed on or after January 1, 2012, that provides  
11 hospital, medical, or surgical coverage shall provide coverage for  
12 the diagnosis and medically necessary treatment of a mental illness  
13 of a person of any age, including a child, under the same terms  
14 and conditions applied to other medical conditions as specified in  
15 subdivision (c) of Section 1374.72. The benefits provided under  
16 this section shall include all those set forth in subdivision (b) of  
17 Section 1374.72.

18 (b) (1) "Mental illness" for the purposes of this section means  
19 a mental disorder defined in the Diagnostic and Statistical Manual  
20 of Mental Disorders IV, published by the American Psychiatric  
21 Association, and includes substance abuse, but excludes treatment  
22 of the following diagnoses, all as defined in the manual:

- 1 (A) Noncompliance With Treatment (V15.81).
- 2 (B) Partner Relational Problem (V61.1).
- 3 (C) Physical/Sexual Abuse of an Adult (V61.12).
- 4 (D) Parent-Child Relational Problem (V61.20).
- 5 (E) Child Neglect (V61.21).
- 6 (F) Physical/Sexual Abuse of a Child (V61.21).
- 7 (G) Sibling Relational Problem (V61.8).
- 8 (H) Relational Problem Related to a Mental Disorder or General
- 9 Medical Condition (V61.9).
- 10 (I) Occupational Problem (V62.29).
- 11 (J) Academic Problem (V62.3).
- 12 (K) Acculturation Problem (V62.4).
- 13 (L) Relational Problems (V62.81).
- 14 (M) Bereavement (V62.82).
- 15 (N) Physical/Sexual Abuse of an Adult (V62.83).
- 16 (O) Borderline Intellectual Functioning (V62.89).
- 17 (P) Phase of Life Problem (V62.89).
- 18 (Q) Religious or Spiritual Problem (V62.89).
- 19 (R) Malingering (V65.2).
- 20 (S) Adult Antisocial Behavior (V71.01).
- 21 (T) Child or Adolescent Antisocial Behavior (V71.02).
- 22 (U) There is not a Diagnosis or a Condition on Axis I (V71.09).
- 23 (V) There is not a Diagnosis on Axis II (V71.09).
- 24 (W) Nicotine Dependence (305.10).

25 (2) Following publication of each subsequent volume of the  
26 manual, the definition of “mental illness” shall be subject to  
27 revision to conform to, in whole or in part, the list of mental  
28 disorders defined in the then-current volume of the manual.

29 (3) Any revision to the definition of “mental illness” pursuant  
30 to paragraph (2) shall be established by regulation promulgated  
31 jointly by the department and the Department of Insurance.

32 (c) (1) For the purpose of compliance with this section, a plan  
33 may provide coverage for all or part of the mental health services  
34 required by this section through a separate specialized health care  
35 service plan or mental health plan and shall not be required to  
36 obtain an additional or specialized license for this purpose.

37 (2) A plan shall provide the mental health coverage required by  
38 this section in its entire service area and in emergency situations  
39 as may be required by applicable laws and regulations. For  
40 purposes of this section, health care service plan contracts that

1 provide benefits to enrollees through preferred provider contracting  
2 arrangements are not precluded from requiring enrollees who reside  
3 or work in geographic areas served by specialized health care  
4 service plans or mental health plans to secure all or part of their  
5 mental health services within those geographic areas served by  
6 specialized health care service plans or mental health plans.

7 (3) In the provision of benefits required by this section, a health  
8 care service plan may utilize case management, network providers,  
9 utilization review techniques, prior authorization, copayments, or  
10 other cost sharing to the extent permitted by law or regulation.

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

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

21 (f) This section shall not apply to a health care benefit plan or  
22 contract entered into with the Board of Administration of the Public  
23 Employees' Retirement System pursuant to the Public Employees'  
24 Medical and Hospital Care Act (Part 5 (commencing with Section  
25 22750) of Division 5 of Title 2 of the Government Code) unless  
26 the board elects, pursuant to Section 22856 of the Government  
27 Code, to purchase a health care benefit plan or contract that  
28 provides mental health coverage as described in this section.

29 (g) This section shall not apply to accident-only, specified  
30 disease, hospital indemnity, Medicare supplement, dental-only, or  
31 vision-only health care service plan contracts.

32 SEC. 3. Section 10144.8 is added to the Insurance Code, to  
33 read:

34 10144.8. (a) A policy of health insurance that covers hospital,  
35 medical, or surgical expenses in this state that is issued, amended,  
36 or renewed on or after January 1, 2012, shall provide coverage for  
37 the diagnosis and medically necessary treatment of a mental illness  
38 of a person of any age, including a child, under the same terms  
39 and conditions applied to other medical conditions as specified in  
40 subdivision (c) of Section 10144.5. The benefits provided under

1 this section shall include all those set forth in subdivision (b) of  
2 Section 10144.5.

3 (b) (1) “Mental illness” for the purposes of this section means  
4 a mental disorder defined in the Diagnostic and Statistical Manual  
5 of Mental Disorders IV, published by the American Psychiatric  
6 Association, and includes substance abuse, but excludes treatment  
7 of the following diagnoses, all as defined in the manual:

8 (A) Noncompliance With Treatment (V15.81).

9 (B) Partner Relational Problem (V61.1).

10 (C) Physical/Sexual Abuse of an Adult (V61.12).

11 (D) Parent-Child Relational Problem (V61.20).

12 (E) Child Neglect (V61.21).

13 (F) Physical/Sexual Abuse of a Child (V61.21).

14 (G) Sibling Relational Problem (V61.8).

15 (H) Relational Problem Related to a Mental Disorder or General  
16 Medical Condition (V61.9).

17 (I) Occupational Problem (V62.29).

18 (J) Academic Problem (V62.3).

19 (K) Acculturation Problem (V62.4).

20 (L) Relational Problems (V62.81).

21 (M) Bereavement (V62.82).

22 (N) Physical/Sexual Abuse of an Adult (V62.83).

23 (O) Borderline Intellectual Functioning (V62.89).

24 (P) Phase of Life Problem (V62.89).

25 (Q) Religious or Spiritual Problem (V62.89).

26 (R) Malingering (V65.2).

27 (S) Adult Antisocial Behavior (V71.01).

28 (T) Child or Adolescent Antisocial Behavior (V71.02).

29 (U) There is not a Diagnosis or a Condition on Axis I (V71.09).

30 (V) There is not a Diagnosis on Axis II (V71.09).

31 (W) Nicotine Dependence (305.10).

32 (2) Following publication of each subsequent volume of the  
33 manual, the definition of “mental illness” shall be subject to  
34 revision to conform to, in whole or in part, the list of mental  
35 disorders defined in the then-current volume of the manual.

36 (3) Any revision to the definition of “mental illness” pursuant  
37 to paragraph (2) shall be established by regulation promulgated  
38 jointly by the department and the Department of Managed Health  
39 Care.

1 (c) (1) For the purpose of compliance with this section, a health  
2 insurer may provide coverage for all or part of the mental health  
3 services required by this section through a separate specialized  
4 health care service plan or mental health plan and shall not be  
5 required to obtain an additional or specialized license for this  
6 purpose.

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

16 (3) In the provision of benefits required by this section, a health  
17 insurer may utilize case management, managed care, or utilization  
18 review to the extent permitted by law or regulation.

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

26 (d) This section shall not apply to accident-only, specified  
27 disease, hospital indemnity, or Medicare supplement insurance  
28 policies, or specialized health insurance policies, except behavioral  
29 health-only policies.

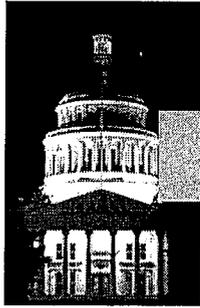
30 (e) This section shall not apply to a policy of health insurance  
31 purchased by the Board of Administration of the Public Employees'  
32 Retirement System pursuant to the Public Employees' Medical  
33 and Hospital Care Act (Part 5 (commencing with Section 22750)  
34 of Division 5 of Title 2 of the Government Code) unless the board  
35 elects, pursuant to Section 22856 of the Government Code, to  
36 purchase a policy of health insurance that covers mental health  
37 services as described in this section.

38 SEC. 4. No reimbursement is required by this act pursuant to  
39 Section 6 of Article XIII B of the California Constitution because  
40 the only costs that may be incurred by a local agency or school

1 district will be incurred because this act creates a new crime or  
2 infraction, eliminates a crime or infraction, or changes the penalty  
3 for a crime or infraction, within the meaning of Section 17556 of  
4 the Government Code, or changes the definition of a crime within  
5 the meaning of Section 6 of Article XIII B of the California  
6 Constitution.

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FEBRUARY  
2011

# policy briefs

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OFFICE OF RESEARCH

## PATH TO CARE

### How Federal Legislation Requiring Mental Health and Substance Use Disorder Treatment Will Impact California

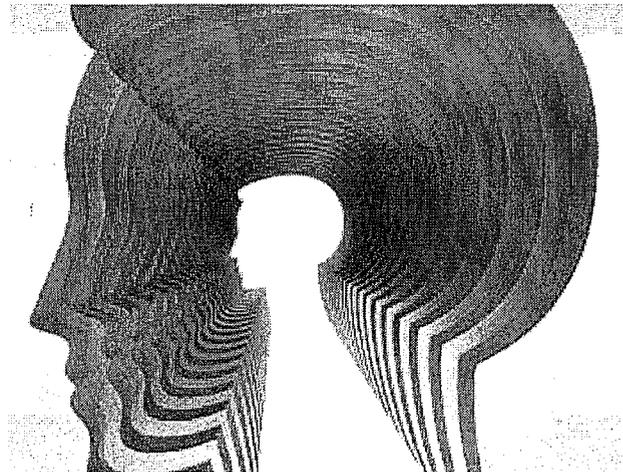
Nearly 1 in 5 California adults suffers from a mental disorder, about 1 in 25 has signs of a serious mental illness, and nearly 1 in 10 abuses or is dependent on illicit drugs or alcohol.

Federal and state lawmakers are trying to address gaps in behavioral health insurance coverage either by mandating coverage or requiring parity. Parity laws require insurance coverage for mental health to be equal to or better than the insurance already provided for other medical and surgical benefits, including maximum lifetime benefits, co-payments, and deductibles.

### California's Current Coverage

**California's mental health parity law** (Assembly Bill 88, Chapter 534, Statutes of 1999) requires health plans and disability insurance policies to diagnose and provide medically necessary treatment for nine severe mental illnesses to people of all ages, as well as serious emotional disturbances in children. This must be done under the same terms that apply to physical illnesses. For example, an insurance policy cannot limit the number of visits for a covered mental health condition if it does not limit the number of visits for treatment of a covered diabetes condition.

California's parity law applies to all private policies and plans and to small businesses; the law does not require substance use treatment services, and plans that provide health care to low-income Californians through the government-funded Medi-Cal program are not included.



### **New Federal Laws Require Equal Coverage for Mental Health and Substance Use Disorders**

National health care reform and a federal parity law require insurance plans to provide mental health and substance use disorders coverage equal to the coverage of other physical ailments. Discussion is under way at the national level to define specific regulations, and as a result, California will have its own policy decisions to make in the near future.

## New Federal Legislation

### **The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008**

(introduced by U.S. Representative Patrick Kennedy) applies to group health plans that already offer mental health or substance use disorder benefits. If these benefits already are being offered, they can no longer be less generous than the plans' existing medical and surgical benefits.

In Medi-Cal plans, this law applies only to those with patients in managed health care (such as Kaiser) or Pre-Paid Inpatient Health Plans. It does not apply to plans insuring employees in small businesses (those with 50 workers or fewer). The federal government will issue regulations governing Medicaid plan requirements.

**The 2010 Patient Protection and Affordable Care Act—also known as national health care reform—**requires private insurance plans to include mental health and substance use disorder treatment beginning in 2014.

For all Medi-Cal health plans, national health care reform expands coverage for mental health and substance use disorders and requires coverage for those services. It also creates a new, no-cost insurance category for poor, childless adults who previously were ineligible for Medi-Cal and are at or below 133 percent of the federal poverty level.

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## Implications for California

- > **Indigent Adults Without Disabilities or Children.** Prior to national health care reform, California did not provide Medi-Cal for poor, childless people who did not have disabilities; now, however, they will qualify for health benefits as of 2014. Those who live with mental illness or a substance use disorder are expected to be

heavily represented in this group. States will be responsible for defining the scope of these benefits within established federal guidelines, which are forthcoming. Benefit options may include inpatient and outpatient care and a broader range of rehabilitation and therapeutic services, among other possibilities.

- > **Definition of Substance Use Disorders.** National health care reform requires substance use disorder treatment to be provided in health plans as of 2014. The federal government will define parameters for coverage. Presently, California has not defined at what point substance use becomes a medical issue that requires treatment or the level of services recommended for various stages of substance abuse.
- > **Mental Health Structure.** In most counties, Medi-Cal patients with serious and persistent mental illness or serious emotional disturbances beyond what a primary care physician can typically treat are now referred to county mental health departments. This shift in responsibility from the state to the counties for treatment and funding is sometimes referred to as a "carve-out," because the responsibility was shifted from (or carved out of) the state's Medi-Cal health plan. The county-based mental health system provides an array of federally authorized inpatient and outpatient care, including case management and rehabilitation.

California and the federal government already are working to integrate the Medi-Cal mental health and primary health care systems. The national health-care reform act encourages integration of behavioral and physical health systems in a variety of settings. How this path to care ultimately will be achieved will be played out over the next several years.

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Written by Mareva Brown. The California Senate Office of Research is a nonpartisan office charged with serving the research needs of the California State Senate and assisting Senate members and committees with the development of effective public policy. It was established by the Senate Rules Committee in 1969. For more information and copies of this report, please visit [www.sen.ca.gov/sor](http://www.sen.ca.gov/sor) or call (916) 651-1500.

Sources: Center for Health Policy Research at the University of California, Los Angeles, and the U.S. Substance Abuse and Mental Health Services Administration.

# CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES

## BILL ANALYSIS

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**BILL NUMBER:** AB 171

**VERSION:** JANUARY 20, 2011

**AUTHOR:** BEALL

**SPONSOR:** Alliance of California Autism Organizations

**RECOMMENDED POSITION:** NONE

**SUBJECT:** AUTISM SPECTRUM DISORDER

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### Existing Law:

1) Requires health care service plan contracts and disability insurance policies that provide hospital, medical or surgical coverage to provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses, regardless of age, and of serious emotional disturbances of a child. (Health and Safety Code §1374.72(a), Insurance Code 10144.5(a)).

2) Defines “severe mental illnesses” as follows (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.

3) Defines “serious emotional disturbances of a child” as a child who has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM IV) (other than a primary substance use disorder or development disorder) that results in age-inappropriate behavior (HSC §1374.72(3), IC §10144.5(e))). One or more of the following criteria must also be met (HSC §5600.3(a)(2)):

(A) As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:

- (i) The child is at risk of removal from home or has already been removed from the home.
- (ii) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.

(B) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

(C) The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

- 4) Requires the benefits provided to include outpatient services, inpatient hospital services, partial hospital services, and prescription drugs (if the plan includes prescription drug coverage). (HSC §1374.72(b), IC §10144.5(b)).
- 5) Requires that maximum lifetime benefits, copayments, and individual and family deductibles that apply to these benefits have the same terms and conditions as they do for any other benefits under the plan contract. (HSC §1374.72(c), IC §10144.5(c)).

**This Bill:**

- 1) Would require every health care service plan contract or health insurance policy issued, amended, or renewed after January 1, 2012, that provides hospital, medical, or surgical coverage must provide coverage for the screening, diagnosis, and treatment of autism spectrum disorders. (HSC §1374.73(a), IC §10144.51(a))
- 2) Defines “autism spectrum disorder” as a neurobiological condition that includes autistic disorder, Asperger’s disorder, Rett’s disorder, childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified. (HSC §1374.73 (h)(1), IC §10144.51(h)(1))
- 3) Defines “diagnosis of autism spectrum disorders” as medically necessary assessment, evaluations, or tests to diagnose whether one has an autism spectrum disorder (HSC §1374.73(h)(4), IC §10144.51(h)(4))
- 4) Defines “treatment for autism spectrum disorders” to mean the following care, and necessary equipment, that is ordered for an individual with autism spectrum disorder by an appropriately licensed or certified provider who deems it medically necessary (HSC §1374.73(h)(10), IC§10144.51(h)(10)):
  - Behavioral health treatment
  - Pharmacy care
  - Psychiatric care
  - Psychological care
  - Therapeutic care
  - Any other care for individuals with autism spectrum disorders that is demonstrated, based on best practices or evidence based research, to be medically necessary.
- 5) Prohibits a health care service plan from terminating coverage or refusing to deliver, execute, issue, amend, adjust, or renew coverage to an enrollee solely because that person is diagnosed with or has received treatment for an autism spectrum disorder. (HSC §1374.73(a), IC§10144.51(a))
- 6) Requires coverage to include all medically necessary services and prohibits any limitations based on age, number of visits, or dollar amounts. (HSC §1374.73(b), IC §10144.51(b))

- 7) Provisions for lifetime maximums, deductibles, copayments, coinsurance or other terms and conditions for coverage of autism spectrum disorders must not be less favorable than the provisions that apply to general physical illnesses covered by the plan. (HSC §1374.73(b), IC §10144.51(b))
- 8) Prohibits coverage for autism spectrum disorder from being denied on the basis that treatment is habilitative, nonrestorative, educational, academic, or custodial in nature. (HSC §1374.73(c), IC §10144.51(c))
- 9) Requires a health care service plan and health insurer to establish and maintain an adequate network of qualified autism service providers, with appropriate training and experience in autism spectrum disorders so that patients have a choice of providers, timely access, continuity of care, and ready referral to the services required to be provided by this bill. (HSC §1374.73(e), IC §10144.51(e))
- 10) Provides that no benefits are required to be provided by a health benefit plan offered through the California Health Benefit Exchange that are in excess of federally required essential health benefits as defined by Federal Law. (HSC §1374.73(g), IC §10144.51(g)).

### **Comments:**

- 1) **Author's Intent.** Due to loopholes in current law, those with autism spectrum disorders (ASD) are frequently denied coverage for their disorder. When they are denied coverage, those with ASD must either go without treatment, pay for treatment privately, or spend time appealing health plan and insurer denials. Many with health insurance who are denied coverage for ASD seek treatment through Regional Centers, school districts, or counties, shifting the cost burden to the taxpayers. The goal of this bill is to end health care discrimination against those with ASD by specifically requiring health plans and insurers to cover screening, diagnosis, and all medically necessary treatment related to the disorder.
- 2) **Expansion of Current Law.** Current law requires coverage for the diagnosis and medically necessary treatment of pervasive developmental disorder or autism. However, lack of detail as to the nature of this coverage provides loopholes for insurers to frequently deny coverage for treatments. For example, they may say the treatment is not medically necessary, non-medical, experimental, or educational only. This bill would make the law more explicit about what must be covered.
- 3) **Previous Legislation.** In 2010 SB 1282 (Steinberg) was introduced. At the time the Board took a position on this bill, it established the California Behavioral Certification Organization (CBCO), a nonprofit organization that provides for the certification and registration of applied behavioral analysis practitioners if they submit a written application, pay fees as required by CBCO, meet specified educational and professional requirements, and submit fingerprints. At its May meeting the Board voted to take an "oppose" position on this bill.

This bill was later amended and the above language was removed. The bill was amended to state that it is the intent of the Legislature to enact legislation clarifying the duties of health care service plans and insurers to inform consumers about the coverage provided to them for the diagnosis and treatment of autism and pervasive developmental disorders under the existing mental health parity law. SB 1282 failed passage.

- 4) **Current Legislation.** Senator Steinberg has introduced SB 166, entitled "Health Care Coverage: Autism Spectrum Disorders." It proposes adding the same sections to the Health and Safety Code and Insurance Code, although the content of the added sections is not

specified at this time. This bill states that “it is the intent of the Legislature to enact legislation that would develop standards for the diagnosis and treatment by health care service plans of individuals with autism spectrum disorders”. Senator Steinberg’s office is awaiting analysis of the California Health Benefit Review Board (CHBRP) before incorporating any further amendments. Established in 2002, the CHBRP responds to requests from the State Legislature to provide independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit mandates and repeals.

**5) Suggested Amendment.** This bill would require insurers to provide coverage for the screening, diagnosis, and treatment of autism spectrum disorders. The bill specifically defines “diagnosis of autism spectrum disorders” and “treatment of autism spectrum disorders,” citing specific care that these entail. However, there is no definition of “screening of autism spectrum disorders.” As the purpose of this bill is to close loopholes allowing denial of medically necessary coverage, it is suggested that “screening of autism spectrum disorders” also be specifically defined.

**6) Support and Opposition.**

*Support: Alliance of California Autism Organizations (Sponsor)*

*Oppose: None on file.*

**7) History**

2011

Feb. 3 Referred to Com. on HEALTH.

Jan. 21 From printer. May be heard in committee February 20.

Jan. 20 Read first time. To print.

**ASSEMBLY BILL**

**No. 171**

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**Introduced by Assembly Member Beall**

January 20, 2011

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

LEGISLATIVE COUNSEL'S DIGEST

AB 171, as introduced, Beall. Autism spectrum disorder.

(1) Existing law provides for licensing and regulation of health care service plans by the Department of Managed Health Care. A willful violation of these provisions is a crime. Existing law provides for licensing and regulation of health insurers by the Insurance Commissioner. Existing law requires health care service plan contracts and health insurance policies to provide benefits for specified conditions, including certain mental health conditions.

This bill would require health care service plan contracts and health insurance policies to provide coverage for the screening, diagnosis, and treatment of autism spectrum disorders. The bill would, however, provide that no benefits are required to be provided by a health benefit plan offered through the California Health Benefit Exchange that exceed the essential health benefits required under federal law. The bill would prohibit coverage from being denied for specified reasons. Because the bill would change the definition of a crime with respect to health care service plans, it would thereby impose a state-mandated local program.

(2) 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) Every health care service plan contract issued,  
4 amended, or renewed on or after January 1, 2012, that provides  
5 hospital, medical, or surgical coverage shall provide coverage for  
6 the screening, diagnosis, and treatment of autism spectrum  
7 disorders. A health care service plan shall not terminate coverage,  
8 or refuse to deliver, execute, issue, amend, adjust, or renew  
9 coverage, to an enrollee solely because the individual is diagnosed  
10 with, or has received treatment for, an autism spectrum disorder.  
11 (b) Coverage required to be provided under this section shall  
12 extend to all medically necessary services and shall not be subject  
13 to any limits regarding age, number of visits, or dollar amounts.  
14 Coverage required to be provided under this section shall not be  
15 subject to provisions relating to lifetime maximums, deductibles,  
16 copayments, or coinsurance or other terms and conditions that are  
17 less favorable to an enrollee than lifetime maximums, deductibles,  
18 copayments, or coinsurance or other terms and conditions that  
19 apply to physical illness generally under the plan contract.  
20 (c) Coverage required to be provided under this section is a  
21 health care service and a covered health care benefit for purposes  
22 of this chapter. Coverage shall not be denied on the basis that the  
23 treatment is habilitative, nonrestorative, educational, academic, or  
24 custodial in nature.  
25 (d) A health care service plan may request, no more than once  
26 annually, a review of treatment provided to an enrollee for autism  
27 spectrum disorders. The cost of obtaining the review shall be borne  
28 by the plan. This subdivision does not apply to inpatient services.  
29 (e) A health care service plan shall establish and maintain an  
30 adequate network of qualified autism service providers with  
31 appropriate training and experience in autism spectrum disorders  
32 to ensure that enrollees have a choice of providers, and have timely  
33 access, continuity of care, and ready referral to all services required

1 to be provided by this section consistent with Sections 1367 and  
2 1367.03 and the regulations adopted pursuant thereto.

3 (f) (1) This section shall not be construed as reducing any  
4 obligation to provide services to an enrollee under an individualized  
5 family service plan, an individualized program plan, a prevention  
6 program plan, an individualized education program, or an  
7 individualized service plan.

8 (2) This section shall not be construed as limiting benefits that  
9 are otherwise available to an enrollee under a health care service  
10 plan.

11 (3) This section shall not be construed as affecting litigation  
12 that is pending on January 1, 2012.

13 (g) On and after January 1, 2014, to the extent that this section  
14 requires health benefits to be provided that exceed the essential  
15 health benefits required to be provided under Section 1302(b) of  
16 the federal Patient Protection and Affordable Care Act (Public  
17 Law 111-148), as amended by the federal Health Care and  
18 Education Reconciliation Act of 2010 (Public Law 111-152) by  
19 qualified health plans offering those benefits in the California  
20 Health Benefit Exchange pursuant to Title 22 (commencing with  
21 Section 100500) of the Government Code, the specific benefits  
22 that exceed the federally required essential health benefits are not  
23 required to be provided when offered by a health care service plan  
24 contract through the Exchange. However, those specific benefits  
25 are required to be provided if offered by a health care service plan  
26 contract outside of the Exchange.

27 (h) As used in this section, the following terms shall have the  
28 following meanings:

29 (1) “Autism spectrum disorder” means a neurobiological  
30 condition that includes autistic disorder, Asperger’s disorder, Rett’s  
31 disorder, childhood disintegrative disorder, and pervasive  
32 developmental disorder not otherwise specified.

33 (2) “Behavioral health treatment” means professional services  
34 and treatment programs, including behavioral intervention therapy,  
35 applied behavioral analysis, and other intensive behavioral  
36 programs, that have demonstrated efficacy to develop, maintain,  
37 or restore, to the maximum extent practicable, the functioning or  
38 quality of life of an individual and that have been demonstrated  
39 to treat the core symptoms associated with autism spectrum  
40 disorder.

1 (3) “Behavioral intervention therapy” means the design,  
2 implementation, and evaluation of environmental modifications,  
3 using behavioral stimuli and consequences, to produce socially  
4 significant improvement in behaviors, including the use of direct  
5 observation, measurement, and functional analyses of the  
6 relationship between environment and behavior.

7 (4) “Diagnosis of autism spectrum disorders” means medically  
8 necessary assessment, evaluations, or tests to diagnose whether  
9 an individual has one of the autism spectrum disorders.

10 (5) “Evidence-based research” means research that applies  
11 rigorous, systematic, and objective procedures to obtain valid  
12 knowledge relevant to autism spectrum disorders.

13 (6) “Pharmacy care” means medications prescribed by a licensed  
14 physician and surgeon or other appropriately licensed or certified  
15 provider and any health-related services deemed medically  
16 necessary to determine the need or effectiveness of the medications.

17 (7) “Psychiatric care” means direct or consultative psychiatric  
18 services provided by a psychiatrist or any other appropriately  
19 licensed or certified provider.

20 (8) “Psychological care” means direct or consultative  
21 psychological services provided by a psychologist or any other  
22 appropriately licensed or certified provider.

23 (9) “Therapeutic care” means services provided by licensed or  
24 certified speech therapists, occupational therapists, or physical  
25 therapists or any other appropriately licensed or certified provider.

26 (10) “Treatment for autism spectrum disorders” means all of  
27 the following care, including necessary equipment, prescribed or  
28 ordered for an individual diagnosed with one of the autism  
29 spectrum disorders by a licensed physician and surgeon or a  
30 licensed psychologist or any other appropriately licensed or  
31 certified provider who determines the care to be medically  
32 necessary:

33 (A) Behavioral health treatment.

34 (B) Pharmacy care.

35 (C) Psychiatric care.

36 (D) Psychological care.

37 (E) Therapeutic care.

38 (F) Any care for individuals with autism spectrum disorders  
39 that is demonstrated, based upon best practices or evidence-based  
40 research, to be medically necessary.

1 SEC. 2. Section 10144.51 is added to the Insurance Code, to  
2 read:

3 10144.51. (a) Every health insurance policy issued, amended,  
4 or renewed on or after January 1, 2012, that provides hospital,  
5 medical, or surgical coverage shall provide coverage for the  
6 screening, diagnosis, and treatment of autism spectrum disorders.  
7 A health insurer shall not terminate coverage, or refuse to deliver,  
8 execute, issue, amend, adjust, or renew coverage, to an insured  
9 solely because the individual is diagnosed with, or has received  
10 treatment for, an autism spectrum disorder.

11 (b) Coverage required to be provided under this section shall  
12 extend to all medically necessary services and shall not be subject  
13 to any limits regarding age, number of visits, or dollar amounts.  
14 Coverage required to be provided under this section shall not be  
15 subject to provisions relating to lifetime maximums, deductibles,  
16 copayments, or coinsurance or other terms and conditions that are  
17 less favorable to an insured than lifetime maximums, deductibles,  
18 copayments, or coinsurance or other terms and conditions that  
19 apply to physical illness generally under the policy.

20 (c) Coverage required to be provided under this section is a  
21 health care service and a covered health care benefit for purposes  
22 of this part. Coverage shall not be denied on the basis that the  
23 treatment is habilitative, nonrestorative, educational, academic, or  
24 custodial in nature.

25 (d) A health insurer may request, no more than once annually,  
26 a review of treatment provided to an insured for autism spectrum  
27 disorders. The cost of obtaining the review shall be borne by the  
28 insurer. This subdivision does not apply to inpatient services.

29 (e) A health insurer shall establish and maintain an adequate  
30 network of qualified autism service providers with appropriate  
31 training and experience in autism spectrum disorders to ensure  
32 that insureds have a choice of providers, and have timely access,  
33 continuity of care, and ready referral to all services required to be  
34 provided by this section consistent with Sections 10133.5 and  
35 10133.55 and the regulations adopted pursuant thereto.

36 (f) (1) This section shall not be construed as reducing any  
37 obligation to provide services to an insured under an individualized  
38 family service plan, an individualized program plan, a prevention  
39 program plan, an individualized education program, or an  
40 individualized service plan.

1 (2) This section shall not be construed as limiting benefits that  
2 are otherwise available to an enrollee under a health insurance  
3 policy.

4 (3) This section shall not be construed as affecting litigation  
5 that is pending on January 1, 2012.

6 (g) On and after January 1, 2014, to the extent that this section  
7 requires health benefits to be provided that exceed the essential  
8 health benefits required to be provided under Section 1302(b) of  
9 the federal Patient Protection and Affordable Care Act (Public  
10 Law 111-148), as amended by the federal Health Care and  
11 Education Reconciliation Act of 2010 (Public Law 111-152) by  
12 qualified health plans offering those benefits in the California  
13 Health Benefit Exchange pursuant to Title 22 (commencing with  
14 Section 100500) of the Government Code, the specific benefits  
15 that exceed the federally required essential health benefits are not  
16 required to be provided when offered by a health insurance policy  
17 through the Exchange. However, those specific benefits are  
18 required to be provided if offered by a health insurance policy  
19 outside of the Exchange.

20 (h) As used in this section, the following terms shall have the  
21 following meanings:

22 (1) “Autism spectrum disorder” means a neurobiological  
23 condition that includes autistic disorder, Asperger’s disorder, Rett’s  
24 disorder, childhood disintegrative disorder, and pervasive  
25 developmental disorder not otherwise specified.

26 (2) “Behavioral health treatment” means professional services  
27 and treatment programs, including behavioral intervention therapy,  
28 applied behavioral analysis, and other intensive behavioral  
29 programs, that have demonstrated efficacy to develop, maintain,  
30 or restore, to the maximum extent practicable, the functioning or  
31 quality of life of an individual and that have been demonstrated  
32 to treat the core symptoms associated with autism spectrum  
33 disorder.

34 (3) “Behavioral intervention therapy” means the design,  
35 implementation, and evaluation of environmental modifications,  
36 using behavioral stimuli and consequences, to produce socially  
37 significant improvement in behaviors, including the use of direct  
38 observation, measurement, and functional analyses of the  
39 relationship between environment and behavior.

1 (4) “Diagnosis of autism spectrum disorders” means medically  
2 necessary assessment, evaluations, or tests to diagnose whether  
3 an individual has one of the autism spectrum disorders.

4 (5) “Evidence-based research” means research that applies  
5 rigorous, systematic, and objective procedures to obtain valid  
6 knowledge relevant to autism spectrum disorders.

7 (6) “Pharmacy care” means medications prescribed by a licensed  
8 physician and surgeon or other appropriately licensed or certified  
9 provider and any health-related services deemed medically  
10 necessary to determine the need or effectiveness of the medications.

11 (7) “Psychiatric care” means direct or consultative psychiatric  
12 services provided by a psychiatrist or any other appropriately  
13 licensed or certified provider.

14 (8) “Psychological care” means direct or consultative  
15 psychological services provided by a psychologist or any other  
16 appropriately licensed or certified provider.

17 (9) “Therapeutic care” means services provided by licensed or  
18 certified speech therapists, occupational therapists, or physical  
19 therapists or any other appropriately licensed or certified provider.

20 (10) “Treatment for autism spectrum disorders” means all of  
21 the following care, including necessary equipment, prescribed or  
22 ordered for an individual diagnosed with one of the autism  
23 spectrum disorders by a licensed physician and surgeon or a  
24 licensed psychologist or any other appropriately licensed or  
25 certified provider who determines the care to be medically  
26 necessary:

27 (A) Behavioral health treatment.

28 (B) Pharmacy care.

29 (C) Psychiatric care.

30 (D) Psychological care.

31 (E) Therapeutic care.

32 (F) Any care for individuals with autism spectrum disorders  
33 that is demonstrated, based upon best practices or evidence-based  
34 research, to be medically necessary.

35 SEC. 3. No reimbursement is required by this act pursuant to  
36 Section 6 of Article XIII B of the California Constitution because  
37 the only costs that may be incurred by a local agency or school  
38 district will be incurred because this act creates a new crime or  
39 infraction, eliminates a crime or infraction, or changes the penalty  
40 for a crime or infraction, within the meaning of Section 17556 of

- 1 the Government Code, or changes the definition of a crime within
- 2 the meaning of Section 6 of Article XIII B of the California
- 3 Constitution.

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# CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES

## BILL ANALYSIS

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**BILL NUMBER:** AB 181                      **VERSION:** AMENDED MARCH 21, 2011  
**AUTHOR:** PORTANTINO AND BEALL    **SPONSOR:** CALIFORNIA YOUTH CONNECTION  
**RECOMMENDED POSITION:** NONE  
**SUBJECT:** FOSTER YOUTH: MENTAL HEALTH BILL OF RIGHTS

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### **Existing Law:**

1. Requires that when a child is removed from his or her family and placed into foster care, that placement must provide the child as nearly as possible the same custody, care, and discipline that should have been provided by the parents. (Welfare and Institutions Code (WIC) §16000(a))
2. Establishes a list of rights for children in foster care, which includes the right “to receive medical, dental, vision, and mental health services.” (WIC §16001.9(a)(4))
3. Establishes the Office of the State Foster Care Ombudsperson for the purposes of providing foster children with a way to resolve issues related to their care, placement, or services. (WIC §16161)
4. Requires the Office of the State Foster Care Ombudsperson to disseminate information on the rights of foster children. (WIC §16164(a)(1))

### **This Bill:**

1. Creates a list of rights for children in foster care and transition-age foster youth relating to mental health services, as follows: (WIC §16001.10(a))
  - a. To receive needed mental health services.
  - b. To interview a therapist prior to commencing treatment.
  - c. To discontinue psychotropic medication, as deemed appropriate by a physician, if the youth experiences potentially dangerous side effects.
  - d. To be presented with mental health options, including, but not limited to, holistic or natural approaches, mentoring, peer counseling, therapy, and medication.
  - e. To continue services with their therapist or counselor for at least one year when their residential placement changes or as long as it is in the best interest of the youth, as determined by a court.
  - f. To be evaluated by a medical professional.

- g. To have mental health services provided outside of the place of residence, if the child wishes.
  - h. To be provided with information on how to seek mental health services in their county of residence, or to have this information provided to the child's caregiver, depending on the age of the child.
  - i. To gain access to personal mental health records.
  - j. Consistent with other state laws, to be guaranteed the protection of confidentiality when interacting with mental health professionals, unless the youth is deemed at risk of harming himself or herself or others, and when reporting suspected child abuse to the child protection agency.
  - k. To be given age-appropriate information on drug interactions if prescribed more than one medication.
  - l. To receive timely mental health services in the county of residence and not to be denied services based on the child's county of origin.
  - m. To refuse mental health treatment at any time unless deemed medically necessary by the court.
2. Requires the Office of the State Foster Care Ombudsperson to develop standardized information explaining the above rights in an age-appropriate manner by July 1, 2012. (WIC §16001.10(b))
  3. Requires the Office of the State Foster Care Ombudsperson to disseminate the information pursuant to the provisions of this bill. (WIC §16164(a)(1))

**Comment:**

- 1) **Author's Intent.** According to the author's office, although mental health treatment is listed as one of the foster youth's rights, barriers often prevent foster children from receiving the mental health care that they need. The goal of this bill is to provide additional rights to foster youth related to mental health services.
- 2) **Lack of Treatment.** According to research provided by the author's office, children entering the foster care system are at risk for mental health issues for several reasons. They cite research that shows that 50-60% of children in foster care have moderate to severe mental health problems. However, only 28% of these children receive mental health services during the year after their contact with the child welfare system.
- 3) **Provision of Mental Health Services.** Although this bill outlines the rights of foster youth, it fails to require that mental health services be provided to those who may qualify.
- 4) **Support and Opposition.**  
*Support:* California Youth Connection (Sponsor)  
*Opposition:* None on file.

**5) History**

**2011**

Mar. 21 From committee chair, with author's amendments: Amend, and re-refer

to Com. on HUM. S. Read second time and amended.  
Mar. 16 Re-referred to Com. on HUM. S.  
Mar. 15 From committee chair, with author's amendments: Amend, and re-refer  
to Com. on HUM. S. Read second time and amended.  
Feb. 3 Referred to Com. on HUM. S.  
Jan. 25 From printer. May be heard in committee February 24.  
Jan. 24 Read first time. To print.

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AMENDED IN ASSEMBLY MARCH 21, 2011

AMENDED IN ASSEMBLY MARCH 15, 2011

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

**ASSEMBLY BILL**

**No. 181**

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**Introduced by Assembly Members ~~Beall~~ and Portantino and Beall**

(Principal coauthor: Senator Steinberg)

**(Coauthors: Assembly Members Ammiano, Blumenfield, Brownley, Carter, Chesbro, Dickinson, Fong, Galgiani, Gordon, Huffman, Ma, Skinner, and Swanson)**

(Coauthors: Senators Correa, Evans, Price, and Vargas)

January 24, 2011

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An act to amend Section 16164 of, and to add Section 16001.10 to, the Welfare and Institutions Code, relating to foster youth.

LEGISLATIVE COUNSEL'S DIGEST

AB 181, as amended, ~~Beall~~ *Portantino*. Foster youth: mental health bill of rights.

Existing law provides that, when a child is removed from his or her family by the juvenile court, placement of the child in foster care should secure, as nearly as possible, the custody, care, and discipline equivalent to that which should have been given the child by his or her parents. Existing law provides enumerated rights for children who are placed in foster care. Existing law establishes the Office of the State Foster Care Ombudsperson to disseminate specified information, including the stated rights of foster youth, and to investigate and attempt to resolve complaints made by or on behalf of children placed in foster care, related to their care, placement, or services.

This bill would enumerate rights for foster youth relating to mental health services. The bill would require the office, in consultation with various entities, to develop, no later than July 1, 2012, standardized information explaining the rights specified and to distribute this information to foster youth.

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 16001.10 is added to the Welfare and
- 2 Institutions Code, to read:
- 3 16001.10. (a) It is the policy of the state that all children in
- 4 foster care and transition-age foster youth shall have the following
- 5 rights relating to mental health services:
- 6 (1) To receive needed mental health services.
- 7 (2) To interview a therapist prior to commencing treatment.
- 8 (3) To discontinue psychotropic medication, as deemed
- 9 appropriate by a physician, if the youth experiences potentially
- 10 dangerous side effects.
- 11 (4) To be presented with mental health options, including, but
- 12 not limited to, holistic or natural approaches, mentoring, peer
- 13 counseling, therapy, and medication.
- 14 (5) To continue services with their therapist or counselor for at
- 15 least one year when their residential placement changes or as long
- 16 as it is in the best interest of the youth, as determined by a court.
- 17 (6) To be evaluated by a medical professional.
- 18 (7) To have mental health services provided outside of the place
- 19 of residence, if the child wishes.
- 20 (8) To be provided with information on how to seek mental
- 21 health services in their county of residence, or to have this
- 22 information provided to the child’s caregiver, depending on the
- 23 age of the child.
- 24 (9) To gain access to personal mental health records.
- 25 (10) Consistent with other state laws, to be guaranteed the
- 26 protection of confidentiality when interacting with mental health
- 27 professionals, unless the youth is deemed at risk of harming himself
- 28 or herself or others, and when reporting suspected child abuse to
- 29 the child protection agency.

1 (11) To be given age-appropriate information on drug  
2 interactions if prescribed more than one medication.

3 (12) To receive timely mental health services in the county of  
4 residence and not to be denied services based on the child's county  
5 of origin.

6 (13) To refuse mental health treatment at any time unless  
7 deemed medically necessary by the court.

8 (b) The Office of the State Foster Care Ombudsperson, in  
9 consultation with the State Department of Mental Health, the State  
10 Department of Social Services, the State Department of Health  
11 Care Services, foster youth advocacy and support groups,  
12 representatives of county child welfare agencies, and groups  
13 representing children, families, foster parents, and children's  
14 facilities, and other interested parties, shall develop, no later than  
15 July 1, 2012, standardized information explaining the rights  
16 specified in this section. The information shall be presented in an  
17 age-appropriate manner and shall reflect any relevant licensing  
18 requirements and medical information laws.

19 SEC. 2. Section 16164 of the Welfare and Institutions Code is  
20 amended to read:

21 16164. (a) The Office of the State Foster Care Ombudsperson  
22 shall do all of the following:

23 (1) Disseminate information on the rights of children and youth  
24 in foster care and the services provided by the office. The rights  
25 of children and youths in foster care are listed in Sections 16001.9  
26 and 16001.10. The information shall include notification that  
27 conversations with the office may not be confidential.

28 (2) Investigate and attempt to resolve complaints made by or  
29 on behalf of children placed in foster care, related to their care,  
30 placement, or services.

31 (3) Decide, in its discretion, whether to investigate a complaint,  
32 or refer complaints to another agency for investigation.

33 (4) Upon rendering a decision to investigate a complaint from  
34 a complainant, notify the complainant of the intention to  
35 investigate. If the office declines to investigate a complaint or  
36 continue an investigation, the office shall notify the complainant  
37 of the reason for the action of the office.

38 (5) Update the complainant on the progress of the investigation  
39 and notify the complainant of the final outcome.

1 (6) Document the number, source, origin, location, and nature  
2 of complaints.

3 (7) (A) Compile and make available to the Legislature all data  
4 collected over the course of the year, including, but not limited to,  
5 the number of contacts to the toll-free telephone number, the  
6 number of complaints made, including the type and source of those  
7 complaints, the number of investigations performed by the office,  
8 the trends and issues that arose in the course of investigating  
9 complaints, the number of referrals made, and the number of  
10 pending complaints.

11 (B) Present this compiled data, on an annual basis, at appropriate  
12 child welfare conferences, forums, and other events, as determined  
13 by the department, that may include presentations to, but are not  
14 limited to, representatives of the Legislature, the County Welfare  
15 Directors Association, child welfare organizations, children’s  
16 advocacy groups, consumer and service provider organizations,  
17 and other interested parties.

18 (C) It is the intent of the Legislature that representatives of the  
19 organizations described in subparagraph (B) consider this data in  
20 the development of any recommendations offered toward  
21 improving the child welfare system.

22 (D) The compiled data shall be posted so that it is available to  
23 the public on the existing Internet Web site of the State Foster Care  
24 Ombudsperson.

25 (8) Have access to any record of a state or local agency that is  
26 necessary to carry out his or her responsibilities. Representatives  
27 of the office may meet or communicate with any foster child in  
28 his or her placement or elsewhere.

29 (b) The office may establish, in consultation with a committee  
30 of interested individuals, regional or local foster care ombudsperson  
31 offices for the purposes of expediting investigations and resolving  
32 complaints, subject to appropriations in the annual Budget Act.

33 (c) (1) The office, in consultation with the California Welfare  
34 Directors Association, Chief Probation Officers of California,  
35 foster youth advocate and support groups, groups representing  
36 children, families, foster parents, children’s facilities, and other  
37 interested parties, shall develop, no later than July 1, 2002,  
38 standardized information explaining the rights specified in Section  
39 16001.9. The information shall be developed in an age-appropriate  
40 manner, and shall reflect any relevant licensing requirements with

1 respect to foster care providers' responsibilities to adequately  
2 supervise children in care.  
3 (2) The office, counties, foster care providers, and others may  
4 use the information developed in paragraph (1) in carrying out  
5 their responsibilities to inform foster children and youth of their  
6 rights pursuant to Section 1530.91 of the Health and Safety Code,  
7 Sections 27 and 16501.1, and this section.

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# CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES

## BILL ANALYSIS

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**BILL NUMBER:** AB 367                      **VERSION:** INTRODUCED FEBRUARY 14, 2011

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

**RECOMMENDED POSITION:** NONE

**SUBJECT:** ELDER ABUSE: REPORTING

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### **Existing Law:**

1. Defines “mandated reporter” for purposes of reporting child abuse and neglect. (Penal Code § 11165.7).
2. States that a report of child abuse and neglect must be accepted by specified agencies even if the agency to which the report is being made lacks the subject matter or geographical jurisdiction to investigate the reported case. (Penal Code § 11165.9)
3. Defines “mandated reporter” for purposes of reporting elder or dependent adult abuse and neglect. (Welfare and Institutions Code § 15630(a),(b))
4. Specifies the agencies a mandated reporter is required to report elder and dependent adult abuse and neglect, depending on where the abuse has occurred. (Welfare and Institutions Code §§ 15630, 15630.1, 16531)

### **This Bill:**

1. Requires a county adult protective services agency or a local law enforcement agency to accept a report by a mandated reporter, or any other person, of suspected elder or dependent adult abuse even if the agency lacks jurisdiction to investigate the report, unless the call can be immediately transferred to an agency with proper jurisdiction. (Business and Professions (B&P) Code § 15631.5)
2. Requires a county adult protective services agency or local law enforcement agency that lacks jurisdiction to immediately refer the report of suspected abuse by telephone, facsimile, or electronic transmission to a county adult protective services agency or a local law enforcement agency with proper jurisdiction. (B&P Code § 15631.5)

### **Comment:**

- 1) **Author’s Intent.** Under current law, when a case of child abuse and neglect is reported to an agency, that agency must take the abuse report whether or not it has jurisdiction. The agency must then refer the matter to an agency with proper jurisdiction. However, similar provisions do not exist for the reporting of a case of elder and dependent adult abuse. As a

result, mandated reporters trying to make a report of elder and dependent adult abuse may be sent from agency to agency, navigating local and county bureaucracies, until they find the proper department to take the report.

Examples of when this may happen are when the alleged perpetrator lives out of the area, or if the investigation will be conducted out of the area. The mandated reporter then must spend time tracking down the appropriate authority. The intent of this legislation is to eliminate the burden on the mandated reporter to find the authority that actually has jurisdiction of the case.

## **2) Support and Opposition.**

### *Support:*

California Association of Marriage and Family Therapists (Sponsor)  
American Association of Retired Persons  
California Senior Legislature

### *Opposition:*

None on file.

## **3) History**

### **2011**

Mar. 3 Referred to Coms. on PUB. S. and AGING & L.T.C.  
Feb. 15 From printer. May be heard in committee March 17.  
Feb. 14 Read first time. To print.

**ASSEMBLY BILL**

**No. 367**

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**Introduced by Assembly Member Smyth**

February 14, 2011

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An act to add Section 15631.5 to the Welfare and Institutions Code, relating to elder abuse.

LEGISLATIVE COUNSEL'S DIGEST

AB 367, as introduced, Smyth. Elder abuse: reporting.

The Elder Abuse and Dependent Adult Civil Protection Act establishes various procedures for the reporting, investigation, and prosecution of elder and dependent adult abuse. The act requires certain persons, called mandated reporters, to report known or suspected instances of elder or dependent adult abuse, and the failure of a mandated reporter to report physical abuse and financial abuse of an elder or dependent adult under the act is a misdemeanor. The act requires the mandated reporter to report the abuse to the adult protective services agency or the local law enforcement agency if the abuse occurs anywhere other than a long-term facility.

The act permits a person who is not a mandated reporter who knows, or reasonably suspects, that an elder or dependent adult has been the victim of abuse in a place other than a long-term care facility to report that abuse to the county adult protective services agency or the local law enforcement agency.

This bill would require a county adult protective services agency or a local law enforcement agency to accept a report by a mandated reporter, or any other person, of suspected elder or dependent adult abuse even if the agency lacks jurisdiction to investigate the report, unless the call can be immediately transferred to an agency with proper

jurisdiction. This bill would also require a county adult protective services agency or a local law enforcement agency that lacks jurisdiction to immediately refer the report of suspected abuse by telephone, facsimile, or electronic transmission to an agency with proper jurisdiction. By requiring county adult protective services agencies and local law enforcement agencies to provide a higher level of service, 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, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

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 15631.5 is added to the Welfare and  
2 Institutions Code, to read:  
3 15631.5. Reports of suspected elder or dependent adult abuse  
4 pursuant to either subparagraph (C) of paragraph (1) of subdivision  
5 (b) of Section 15630 or subdivision (b) of Section 15631 may be  
6 made to any county adult protective services agency or local law  
7 enforcement agency. Any county adult protective services agency  
8 or local law enforcement agency shall accept the report of  
9 suspected elder or dependent adult abuse even if the agency to  
10 whom the report is being made lacks subject matter or geographical  
11 jurisdiction to investigate the reported case, unless the county adult  
12 protective services agency or the local law enforcement agency  
13 can immediately transfer the call reporting suspected elder or  
14 dependent adult abuse to a county adult protective services agency  
15 or a local law enforcement agency with proper jurisdiction. If a  
16 county adult protective services agency or a local law enforcement  
17 agency accepts a report about a case of suspected elder or  
18 dependent adult abuse in which that agency lacks jurisdiction, the  
19 agency shall immediately refer the case by telephone, facsimile,  
20 or electronic transmission to a county adult protective services  
21 agency or a local law enforcement agency with proper jurisdiction.

1     SEC. 2. If the Commission on State Mandates determines that  
2 this act contains costs mandated by the state, reimbursement to  
3 local agencies and school districts for those costs shall be made  
4 pursuant to Part 7 (commencing with Section 17500) of Division  
5 4 of Title 2 of the Government Code.

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# CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES

## BILL ANALYSIS

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**BILL NUMBER:** AB 671                      **VERSION:** INTRODUCED FEBRUARY 17, 2011

**AUTHOR:** PORTANTINO                      **SPONSOR:** NATIONAL ASSOCIATION OF SOCIAL WORKERS – CALIFORNIA CHAPTER

**RECOMMENDED POSITION:** NONE

**SUBJECT:** CHILD WELFARE SERVICES: EDUCATION AND TRAINING REQUIREMENTS

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### Existing Law:

1. States that it is the intent of the legislature that all children are entitled to be safe and free from abuse and neglect. (Welfare and Institutions Code §16500).
2. Provides for a statewide system of child welfare services that must be available in each county of the state. (W&I Code §16500).
3. Requires all counties to establish and maintain specialized entities within their county welfare department which are responsible for the child welfare services program. (W&I Code §16500).
4. Defines “child welfare services” as public social services which seek to accomplish the following: (W&I Code §16501(a))
  - Protecting and promoting the welfare of all children;
  - Preventing or remedying, or assisting in the solution of problems which may result in the neglect, abuse, exploitation, or delinquency of children;
  - Preventing the unnecessary separation of children from their families;
  - Restoring to their families children who have been removed;
  - Identifying children to be placed in suitable adoptive homes; and
  - Ensuring adequate care of children away from their homes.

The law also defines “child welfare services” to mean the continuum of services provided on the behalf of children alleged to be the victims of child abuse, neglect, or exploitation.

### This Bill:

1. Requires a child welfare services social work supervisor to have one of the following types of education:
  - a. A master’s degree in social work from a program accredited by the Council on Social Work Education, OR

- b. Both a master's degree in behavioral science from an accredited academic institution, and a certificate from an organization, accredited academic institution, or university-related entity that certifies supervisors in child welfare services. The certification must contain all of the following:
    - i. Twenty contact hours of population-specific education;
    - ii. One year and 1,500 hours of documented, paid, supervised, equivalent master's post-graduate degree social work experience with children, youth, and families;
    - iii. An evaluation from a supervisor;
    - iv. A reference from an MSW or master's degree in behavioral sciences colleague; and
    - v. An agreement to adhere to a professional code of ethics.
2. Declares a child welfare services social work supervisor that is employed before January 1, 2012 to be exempt from the above educational requirements.

**Comment:**

- 1) **Author's Intent.** The author notes that "currently, there are no educational requirements for supervisors in child welfare services. While counties provide supervisor training, it is no substitute for a master's level education in social work or in a behavioral science." The goal of this bill is to enhance consumer protection with respect to child welfare services by ensuring that supervisors have appropriate training, experience and education. The expected result is that outcomes in child welfare cases will improve and there will be fewer cases of children left in abusive situations.
- 2) **Definitions Needed.** Current law does not provide a definition of a "child welfare services social work supervisor." This creates a situation in which it is unclear if this is a supervisor for a particular agency, department, or county. Staff recommends an amendment be made to specify the department or agency under which such a person is employed. Clarification of who is being supervised would also be helpful.
- 3) **Clarification of Degrees and Certificates.** This bill proposes allowing, in lieu of a master's degree in social work, both a master's degree in behavioral science from an accredited academic institution, and a certificate from an organization, accredited academic institution, or university-related entity that certifies supervisors in child welfare services.

Behavioral science is a broad field and there could be a wide range of degrees encompassed under this title, which may or may not prepare someone to be a child welfare services social work supervisor. Staff recommends narrowing the degree type to degrees that would be accepted by the Board of Behavioral Sciences (Board). The Board could specify acceptable degrees in regulation.

Additionally, the "certificate from an organization" that certifies supervisors in child welfare services is vague and does not set any standards by which that organization must comply. Staff recommends defining acceptable organizations which may issue certificates, and setting a threshold that must be met to certify these supervisors.

**4) Conditions of Certification.** Some of the conditions of certification need additional detail in order to be meaningful:

- §16501.4(b)(2)(B)(iv) A reference from an MSW or master's degree in behavioral services colleague. *Staff recommends requiring a letter of recommendation from a supervisor of the certificate-holder instead.*
- §16501.4(b)(2)(B)(iv) An agreement to adhere to a professional code of ethics. *Staff recommends it be specified that this agreement is to be in writing and signed by the certificate-holder.*

**5) Exemption from Educational Requirements.** This bill declares that "A child welfare services social work supervisor employed before January 1, 2012, is exempt from the requirements of this section".

To avoid ambiguity, the legislation should define the specific agency that the child welfare social work supervisor must be employed at before January 1, 2012, in order for the supervisor is be exempt from the requirements of this section.

Allowing an exemption will delay the effectiveness of this program and potentially create a situation in the workplace in which two people in identical positions are held to different standards.

**6) Placement Inappropriate.** This bill proposes to add Section 16501.4 to the Welfare and Institutions Code. The language appears out of context in this placement. Section 16501.3 discusses the Department of Social Services establishing a program of public health nursing within the child welfare services program. Section 16501.5 directs the department to implement a statewide Child Welfare Services Case Management System. This may be confusing without appropriate context as to the exact settings in which a child welfare services social work supervisor is employed.

**7) Support and Opposition.**

*Support:* None on file.

*Opposition:* None on file.

**8) History**

**2011**

Mar. 7 Referred to Com. on HUM. S.

Feb. 18 From printer. May be heard in committee March 20.

Feb. 17 Read first time. To print.

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**ASSEMBLY BILL**

**No. 671**

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**Introduced by Assembly Member Portantino**

February 17, 2011

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An act to add Section 16501.4 to the Welfare and Institutions Code, relating to child welfare services.

LEGISLATIVE COUNSEL'S DIGEST

AB 671, as introduced, Portantino. Child welfare services: education and training requirements.

Existing law requires the establishment and support of a public system of statewide child welfare services, for the protection of children who are alleged to be abused or neglected. Existing law provides for a statewide multipurpose child welfare training program to develop and implement statewide coordinated training programs designed specifically to meet the needs of county child protective services social workers assigned emergency response, family maintenance, family reunification, permanent placement, and adoption responsibilities.

This bill would require a child welfare services social work supervisor to have a master's degree in social work, or a master's degree in behavioral science and a certification from an entity that certifies supervisors in child welfare services, as specified, in addition to any other education, training, or certification required by law. This bill would exempt a social worker employed before January 1, 2012 from these requirements.

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. It is the intent of the Legislature in enacting this  
2 act to improve outcomes and increase consumer protection in child  
3 welfare services by improving the educational standards of  
4 supervisors in child welfare services to ensure that each supervisor  
5 has the appropriate training, experience, and education.

6 SEC. 2. Section 16501.4 is added to the Welfare and  
7 Institutions Code, to read:

8 16501.4. (a) Unless exempt pursuant to subdivision (c), a child  
9 welfare services social work supervisor shall satisfy the education  
10 and training requirements provided for in this section, in addition  
11 to any education, training, or certification otherwise required by  
12 law.

13 (b) A child welfare services social work supervisor shall have  
14 either of the following:

15 (1) A master’s degree in social work (MSW) from a program  
16 accredited by the Council on Social Work Education (CSWE).

17 (2) Both of the following:

18 (A) A master’s degree in behavioral science from an accredited  
19 academic institution.

20 (B) A certificate from an organization, accredited academic  
21 institution, or university-related entity that certifies supervisors in  
22 child welfare services. Certification pursuant to this paragraph  
23 shall include all of the following:

24 (i) Twenty contact hours of population-specific education.

25 (ii) One year and 1,500 hours of documented, paid, supervised,  
26 equivalent master’s post-graduate degree social work experience  
27 with children, youth, and families.

28 (iii) An evaluation from a supervisor.

29 (iv) A reference from an MSW or master’s degree in behavioral  
30 sciences colleague.

31 (v) An agreement to adhere to a professional code of ethics.

32 (c) A child welfare services social work supervisor employed  
33 before January 1, 2012, is exempt from the requirements of this  
34 section.

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# CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES

## BILL ANALYSIS

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**BILL NUMBER:** AB 675                      **VERSION:** INTRODUCED FEBRUARY 17, 2011

**AUTHOR:** HAGMAN                      **SPONSOR:** AUTHOR

**RECOMMENDED POSITION:** NONE

**SUBJECT:** CONTINUING EDUCATION; PROHIBITION OF SPECIFIED COURSES

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### Existing Law:

1. Requires the director of the Department of Consumer Affairs to establish guidelines, by regulation, to prescribe components for mandatory continuing education (CE) programs administered by and board within the department. (Business & Professions Code (BPC) §166)
2. States that the purpose of the guidelines are to ensure that mandatory CE is used to create a more competent licensing population, thereby enhancing public protection. (BPC §166(a)).
3. Requires mandatory CE programs to address the following (BPC §166(a)):
  - Course validity
  - Occupational relevancy
  - Effective presentation
  - Actual attendance
  - Material assimilation
  - Potential for application.
4. States that the Board may not renew the license of a Marriage and Family Therapist (MFT), licensed clinical social worker (LCSW), or a licensed professional clinical counselor (LPCC), unless the applicant certifies, on a form prescribed by the board, that he or she has completed not less than 36 hours of approved CE in or relevant to the field of marriage and family therapy, social work, or professional clinical counseling, in the preceding two years, as determined by the Board. (BPC §§4980.54(c), 4996.22(a)(1), 4999.76(a)(1))
5. Requires the CE to be obtained from one of the following sources: (BPC §§4980.54(f), 4996.22(d), 4999.76(d))
  - An accredited school or state-approved school; or
  - Another CE provider, including, but not limited to, a professional marriage and family therapist association, a professional social work association, a professional clinical counseling association, a licensed health facility, a government entity, a continuing education unit of an accredited four year institution of higher learning, or a mental health professional association, approved by the board.

6. Requires the board to establish, by regulation, a procedure for approving providers of CE courses. (BPC §§4980.54(g), 4996.22(e), 4999.76(e))
7. Allows the board to revoke or deny the right of a provider to offer CE coursework for failure to comply with the requirements of the law or any adopted regulation (BPC §§4980.54(g), 4996.22(e), 4999.76(e))
8. Requires that training, education, and coursework by approved providers must incorporate one or more of the following (BPC §§4980.54(h), 4996.22(f), 4999.76(f)):
  - a. Aspects of the discipline that are fundamental to the understanding or practice of marriage and family therapy, social work, or professional clinical counseling.
  - b. Aspects of the discipline of marriage and family therapy, social work, or professional clinical counseling in which significant recent developments have occurred.
  - c. Aspects of other disciplines that enhance the understanding or the practice of marriage and family therapy, social work, or professional clinical counseling.
9. Requires the CE requirements to comply fully with the guidelines for mandatory continuing education established by the Department of Consumer Affairs pursuant to BPC §166. (BPC §§4980.54(k), 4996.22(h), 4999.76(i))
10. Defines a CE “course” as a form of systematic learning at least one hour in length including, but not limited to, academic studies, extension studies, lectures, conferences, seminars, workshops, viewing of videotapes or film instruction, viewing or participating in other audiovisual activities including interactive video instruction and activities electronically transmitted from another location verified and approved by the CE provider, and self study courses. (Title 16, §1887(a) of the California Code of Regulations (CCR))
11. Defines a CE “provider” as an accredited or approved school, or an association, health facility, governmental entity, educational institution, individual, or other organization that offers CE courses and meets the requirements of the law. (16 CCR §1887(c))
12. Requires a provider to ensure the content of a course is relevant to the practice of marriage and family therapy or clinical social work and meets the requirements of the law. The content of a course must also be related to direct or indirect patient/client care: (16 CCR §1887.4(a))
  - Direct patient/client care courses cover specialty areas of therapy, such as theoretical frameworks for clinical practice or intervention techniques with individuals, couples, or groups.
  - Indirect patient/client care courses cover pragmatic aspects of clinical practice, such as legal or ethical issues, consultation, recordkeeping, office management, insurance risks and benefits, managed care issues, research obligations, or supervision training.

13. Requires a CE provider to meet the board's course content and instructor qualifications criteria to become a board-approved provider. (16 CCR §1887.7(a))
14. Allows the board to revoke its approval of a provider or deny a provider application for good cause. The provider may appeal the revocation or denial in writing. (16 CCR §1887.8)

**This Bill:**

1. Requires a board requiring CE to only allow CE credit for courses with content relevant to the particular practice regulated by that board pursuant to its laws and regulations. (BPC §110.6(a))
2. Prohibits the following courses from being considered as having content relevant to the practice regulated by the board, and prohibits them being accepted for meeting CE requirements: (BPC §110.6(a))
  - a. Courses that advance or promote labor organizing on behalf of a union;
  - b. Courses that advance or promote statutory or regulatory changes, political candidates, political advocacy, or political strategy.
3. Defines "courses" as including institutes, seminars, lectures, conferences, workshops, and any other public events. (BPC §110.6(a))
4. Prohibits an approved provider who offers a course that is described above as prohibited from being accepted as CE courses must not represent that the course is acceptable for meeting the CE requirements. (BPC §110.6(b)(1))
5. Requires that if a provider violates this requirement, then the board shall withdraw its approval of the provider. (BPC §110.6(b)(1))
6. States that if, after the board provides the provider notice and an opportunity to be heard, the board finds the provider in violation of this law, then the board must withdraw approval of the provider for at least five years. (BPC §110.6(b)(2))

**Comment:**

- 1) **Author's Intent.** The author sponsored this bill after it came to his attention that the California Nurses Association (CNA) was offering CE credits to registered nurses (RNs) as an incentive to attend political events. The CNA also offers CE credits to RNs attending classes focused on lobbying and political organizing. The law does not specifically prohibit this. This bill seeks to revise existing law for professions requiring CE credit, stating that courses with this type of content are not acceptable for meeting CE requirements.
- 2) **Previous Legislation.** Last year, upon learning of this issue, the author introduced AB 378. This bill, which eventually died, contained the same prohibitions for CE course content but was applied only to the practice of registered nursing. The Board of Registered Nursing (BRN) is within the Department of Consumer Affairs.

The CNA opposed this legislation, saying that it unfairly singled out RNs, undermined their duty to advocate for patients, and would keep RNs in the dark about important legislative and regulatory developments in the health care field which affect their profession.

The United Nurses Association of California/Union of Health Care Professionals also opposed the bill, saying education on regulatory and statutory changes is an important tool in professional development.

The Board of Behavioral Sciences did not take a position on AB 378.

- 3) Intent of the Law.** This bill appears to be consistent with the intent of the law to ensure that mandatory CE is used to create a more competent licensing population, thereby enhancing public protection, and not to promote labor organizing or political movements. In addition, classes promoting labor organizing or promote political agendas do not appear to meet Board regulations specifying that the content of a course must be related to direct or indirect patient/client care. Therefore, this bill would simply specify a component of law that is already implied in the Board's statute.
- 4) Concerns About Prohibiting Courses That Discuss Statutory and Regulatory Changes.** It is very important for the board's licensees to know the law regarding their profession and be informed of recent statutory and regulatory changes that affect their profession. It is unclear whether CE courses that discuss the legislative process and any changes to statutes and regulations affecting the profession would constitute "courses that advance or promote statutory or regulatory changes." To avoid any confusion, staff recommends that language be added to clarify that courses containing discussion of recent statutory and regulatory changes to the profession for which the CE is being offered is permitted.
- 5) Misplacement in the Code.** This bill proposes to add Section 110.6 to the Business and Professions Code. This does not appear to be an appropriate placement within the law. The preceding code section, §110, discusses Department of Consumer Affairs (DCA) possession and control of records and property. The next code section, §111, discusses DCA board's appointment of commissioners on examination.

A more appropriate location for adding this section appears to be after §166, which discusses DCA development of guidelines for CE.

**6) Support and Opposition.**

*Support:* None on file.

*Opposition:* None on file.

**7) History**

**2011**

Mar. 14 Re-referred to Com. on B., P. & C.P. pursuant to Assembly Rule 96.

Mar. 3 Referred to Coms. on HIGHER ED. and B., P. & C.P.

Feb. 18 From printer. May be heard in committee March 20.

Feb. 17 Read first time. To print.

**ASSEMBLY BILL**

**No. 675**

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**Introduced by Assembly Member Hagman**  
(Coauthor: Senator Huff)

February 17, 2011

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An act to add Section 110.6 to the Business and Professions Code, relating to professions and vocations.

LEGISLATIVE COUNSEL'S DIGEST

AB 675, as introduced, Hagman. Continuing education.

Existing law provides for the licensure and regulation of professions and vocations by boards within the Department of Consumer Affairs and these boards may require licensees to satisfy continuing education course requirements.

This bill would provide, if applicable, that continuing education courses, as specified, that advance or promote labor organizing on behalf of a union, or that advance or promote statutory or regulatory changes, political candidates, political advocacy, or political strategy shall not be considered content relevant to the practice regulated by the board and shall not be acceptable for meeting requirements for licensure renewal. The bill would also prohibit, to the extent applicable, an approved provider from representing that such a continuing education course is acceptable for meeting requirements for licensure renewal and would require a board, subject to specified procedural requirements, to withdraw its approval of a provider that violates that requirement for no less than 5 years, 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 110.6 is added to the Business and  
2 Professions Code, to read:

3 110.6. Notwithstanding any other provision of law, if a board  
4 described in Section 101 requires its licensees to satisfy continuing  
5 education requirements by pursuing a course of continuing  
6 education, the following shall apply:

7 (a) Continuing education courses shall contain only content  
8 relevant to the particular practice regulated by the board pursuant  
9 to its laws and regulations. Continuing education courses that  
10 advance or promote labor organizing on behalf of a union, or that  
11 advance or promote statutory or regulatory changes, political  
12 candidates, political advocacy, or political strategy shall not be  
13 considered content relevant to the practice regulated by the board  
14 and shall not be acceptable for meeting continuing education  
15 requirements. For the purposes of this section, “courses” includes  
16 institutes, seminars, lectures, conferences, workshops, and any  
17 other public events.

18 (b) (1) To the extent applicable, if an approved provider offers  
19 a course described in subdivision (a), the provider shall not  
20 represent that the course is acceptable for meeting the continuing  
21 education requirements. If a provider violates this requirement,  
22 the board shall withdraw its approval of the provider, subject to  
23 paragraph (2).

24 (2) If, after the board provides the provider notice and an  
25 opportunity to be heard, the board finds that the provider violated  
26 the requirement in paragraph (1), the board shall withdraw approval  
27 of the provider for no less than five years.

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**To:** Policy and Advocacy Committee

**Date:** March 23, 2011

**From:** Christina Kitamura  
Administrative Analyst

**Telephone:** (916) 574-7835

**Subject:** **Assembly Bill 774**

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Materials for agenda item IV.h. (AB 774) will be provided in a supplemental package and will be posted on the website at that time.

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# CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES

## BILL ANALYSIS

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**BILL NUMBER:** AB 956                      **VERSION:** INTRODUCED FEBRUARY 18, 2011

**AUTHOR:** HERNANDEZ, R.                      **SPONSOR:** CALIFORNIA ASSOCIATION OF  
MARRIAGE AND FAMILY THERAPISTS  
(CAMFT)

**RECOMMENDED POSITION:** NONE

**SUBJECT:** MARRIAGE AND FAMILY THERAPY: INTERNS AND TRAINEES: ADVERTISEMENTS

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### Existing Law:

1. Allows the Board of Behavioral Sciences (Board) to adopt regulations that define services to be advertised by professions under its jurisdiction for the purpose of determining whether advertisements are false or misleading. Business and Professions Code (BPC §651).
2. Requires an unlicensed marriage and family therapist intern to inform each client or patient, prior to performing any professional services, that he or she is unlicensed and under the supervision of one of the following (Business and Professions Code (BPC §4980.44):
  - a. A licensed marriage and family therapist;
  - b. A licensed clinical social worker;
  - c. A licensed psychologist; or
  - d. A licensed physician and surgeon certified in psychiatry by the American Board of Psychiatry and Neurology.
3. Requires a marriage and family therapy trainee to inform each client or patient, prior to performing any professional services, that he or she is unlicensed and under the supervision of one of the following (BPC §4980.48(a)):
  - a. A licensed marriage and family therapist;
  - b. A licensed clinical social worker;
  - c. A licensed psychologist; or
  - d. A licensed physician certified in psychiatry by the American Board of Psychiatry and Neurology.
4. Requires an advertisement of services performed by a trainee to include all of the following information (BPC §4980.48(b)):
  - a. The trainee's name;
  - b. The supervisor's license designation or abbreviation; and
  - c. The supervisor's license number.

5. Requires all persons or referral services regulated by the Board who advertise their services to include their license or registration number in the advertisement unless the advertisement contains the following (Section 1811 of Title 16 of the California Code of Regulations (CCR)):
  - a. The full name of the licensee or registered referral service as filed with the Board; and
  - b. A designation of the type of license or registration held as follows:
    - i. Licensed Marriage and Family Therapist
    - ii. Licensed Educational Psychologist
    - iii. Licensed Clinical Social Worker
    - iv. Registered MFT Referral Service
6. An unlicensed Marriage and Family Therapist Registered Intern may advertise if the advertisement complies with law stating that the patient is informed, prior to performance of any professional services, that he or she is unlicensed and under the supervision of a licensed marriage and family therapist, licensed clinical social worker, licensed psychologist, or a licensed physician and surgeon certified in psychiatry by the American Board of Psychiatry and Neurology (16 CCR Section 1811) (*NOTE: This section currently contains an errant reference. The law stated here reflects what is stated in the Board's most recent regulation package, which is currently pending approval*).

**This Bill:**

1. Requires an unlicensed marriage and family therapist intern to inform each client or patient, prior to performing any professional services, of the following (BPC §4980.44(c)):
  - a. That he or she is an unlicensed marriage and family therapist registered intern (current law);
  - b. The name of his or her employer (new provision); and
  - c. Indicate whether he or she is under the supervision of a licensed marriage and family therapist, licensed clinical social worker, licensed psychologist, or a licensed physician and surgeon certified in psychiatry by the American Board of Psychiatry and Neurology (current law).
2. Requires any advertisement by or on behalf of a marriage and family therapist registered intern must include, at a minimum, all of the following (BPC §4980.44(d)):
  - a. That he or she is an unlicensed marriage and family therapist registered intern;
  - b. The name of his or her employer; and
  - c. That he or she is supervised by a licensed person.
3. Prohibits the use of the abbreviation "MFTI" in an advertisement unless the title "marriage and family therapist registered intern" appears in the advertisement. (BPC §4980.44(d)(2)).

4. Requires a trainee to inform each client or patient, prior to performing any professional services, of the following (BPC §4980.48(a)):
  - a. That he or she is an unlicensed marriage and family therapist trainee (current law);
  - b. The name of his or her employer (new provision);
  - c. Indicate whether he or she is under the supervision of a licensed marriage and family therapist, licensed clinical social worker, licensed psychologist, or a licensed physician certified in psychiatry by the American Board of Psychiatry and Neurology (current law).
5. Requires any advertisement of services performed by a trainee must include, at a minimum, all of the following (BPC §4980.48(c)):
  - a. That he or she is a marriage and family therapist trainee;
  - b. The name of his or her employer; and
  - c. That he or she is supervised by a licensed person.

**Comment:**

- 1) **Author's Intent.** The intent of this bill is to clear up inconsistencies in current law about advertising requirements for MFT interns and trainees. This bill would require marriage and family therapist interns and trainees to be clear in their advertising that they are not yet licensed, and are under supervision. It would prohibit the acronym "MFTI" unless "marriage and family therapy intern" is spelled out in the advertisement.
- 2) **History.** The Board has been attempting to address the inconsistencies regarding advertising law for the past several years. At its meeting on November 18, 2008, the Board approved proposed language to CCR §1811 related to advertising, and directed staff to initiate a rulemaking package. However, the proposed rulemaking has been delayed by the LPCC rulemaking package that is currently in the approval process. This is because the LPCC rulemaking package also modifies Section 1811, and the board is unable to propose two rulemaking packages modifying the same section at the same time.

The proposed advertising regulations include the following provisions that are not addressed in this bill:

- Requires that an advertisement include the individual's license or registration number;
- Requires that an advertisement for a registrant's services include the name, complete title or acceptable abbreviation of the supervisor's license, and the supervisor's license number.
- Allows inclusion of academic credentials in an advertisement, as long as the degree is earned and statements regarding the degree are true and not misleading.

This bill would not affect the proposed regulations, and therefore changes to the Section 1811 would still need to be made. Staff is planning to initiate the regulations process once the LPCC regulations are approved.

- 3) Disclosure of Registration Number:** The Board approved the advertising regulations at its November 2008 meeting. As drafted, those approved regulations require that advertisements include a license or registration number. The Board may wish to discuss whether this bill should contain the same requirement.

Additionally, the Board may want to discuss requiring an MFT intern to provide each patient, prior to performance of any professional services, his or her registration number. As an MFT intern is practicing without a license while under supervision, a requirement to provide a registration number may provide increased public protection.

- 4) Employer Name Required.** This bill would require an MFT intern or trainee to provide the name of his or her employer prior to performing any professional services, and also to include this information in an advertisement. However, it is the supervisor, not the employer, who is responsible for the services performed by the intern or trainee.
- 5) Inclusion of LPCCs as those who may Supervise.** An unlicensed marriage and family therapist intern or trainee is currently required by law to inform each client or patient, prior to performing any professional services, that he or she is unlicensed and under the supervision of one of a specified list of licensees. Currently, a Licensed Professional Clinical Counselor (LPCC) is not included in that list because they are not yet authorized to supervise MFT interns. The Board is currently seeking Legislation (SB 363, Emmerson) that would specify requirements an LPCC would need to complete in order to supervise MFT interns.

- 6) Support and Opposition.**  
*Support:* CAMFT (sponsor)  
*Opposition:* None on file.

## 2011

Feb. 20 From printer. May be heard in committee March 22.  
Feb. 18 Read first time. To print.

- 7) Attachment:** *Board of Behavioral Sciences Proposed Regulatory Changes – Advertising (As approved by the Board on November 18, 2008).*

**ASSEMBLY BILL**

**No. 956**

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**Introduced by Assembly Member Roger Hernández**

February 18, 2011

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An act to amend Sections 4980.44 and 4980.48 of the Business and Professions Code, relating to marriage and family therapy.

LEGISLATIVE COUNSEL'S DIGEST

AB 956, as introduced, Roger Hernández. Marriage and family therapy: interns and trainees: advertisements.

Existing law, the Marriage and Family Therapist Act, provides for the licensure or registration and regulation of marriage and family therapists and interns by the Board of Behavioral Sciences and makes a violation of its provisions a crime. Existing law requires marriage and family therapist interns, trainees, and applicants for licensure or registration to at all times be under supervision. Existing law requires interns and trainees to inform each client or patient prior to performing any professional services that he or she is unlicensed and under the supervision of a licensed marriage and family therapist, licensed clinical social worker, licensed psychologist, or a licensed physician and surgeon certified in psychiatry. Existing law requires any person that advertises services performed by a trainee to include the trainee's name, the supervisor's license designation or abbreviation, and the supervisor's license number.

This bill would require an intern or trainee, prior to performing professional services, to provide each client or patient with the name of his or her employer and indicate whether he or she is under the supervision of a licensed marriage and family therapist, licensed clinical social worker, licensed psychologist, or a licensed physician and surgeon

certified in psychiatry. The bill would require any advertisement by or on behalf of an intern or trainee to include specified information, including the name of the employer of the intern or trainee and that the intern or trainee is supervised by a licensed person. The bill would also require an advertisement for interns to include the title “marriage and family therapist registered intern” if the abbreviation MFTI is used in the advertisement.

Because a violation of the bill’s provisions would be 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 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 4980.44 of the Business and Professions
- 2 Code is amended to read:
- 3 4980.44. An unlicensed marriage and family therapist intern
- 4 employed under this chapter shall comply with the following
- 5 requirements:
- 6 (a) Possess, at a minimum, a master’s degree as specified in
- 7 Section 4980.36 or 4980.37, as applicable.
- 8 (b) Register with the board prior to performing any duties,
- 9 except as otherwise provided in subdivision (g) of Section 4980.43.
- 10 (c) ~~Inform each client or patient prior~~ *Prior* to performing any
- 11 professional services, *inform each client or patient* that he or she
- 12 is *an unlicensed marriage and family therapist registered intern,*
- 13 *provide the name of his or her employer, and indicate whether he*
- 14 *or she is* under the supervision of a licensed marriage and family
- 15 therapist, licensed clinical social worker, licensed psychologist,
- 16 or a licensed physician and surgeon certified in psychiatry by the
- 17 American Board of Psychiatry and Neurology.
- 18 (d) (1) *Any advertisement by or on behalf of a marriage and*
- 19 *family therapist registered intern shall include, at a minimum, all*
- 20 *of the following information:*

1 (A) *That he or she is a marriage and family therapist registered*  
2 *intern.*

3 (B) *The name of his or her employer.*

4 (C) *That he or she is supervised by a licensed person.*

5 (2) *The abbreviation “MFTI” shall not be used in an*  
6 *advertisement unless the title “marriage and family therapist*  
7 *registered intern” appears in the advertisement.*

8 SEC. 2. Section 4980.48 of the Business and Professions Code  
9 is amended to read:

10 4980.48. (a) A trainee shall, *prior to performing any*  
11 *professional services*, inform each client or patient, ~~prior to~~  
12 ~~performing any professional services~~, that he or she is an  
13 *unlicensed marriage and family therapist trainee, provide the name*  
14 *of his or her employer*, and *indicate whether he or she is* under the  
15 supervision of a licensed marriage and family therapist, a licensed  
16 clinical social worker, a licensed psychologist, or a licensed  
17 physician certified in psychiatry by the American Board of  
18 Psychiatry and Neurology.

19 (b) Any person that advertises services performed by a trainee  
20 shall include the trainee’s name, the supervisor’s license  
21 designation or abbreviation, and the supervisor’s license number.

22 (c) *Any advertisement by or on behalf of a marriage and family*  
23 *therapist trainee shall include, at a minimum, all of the following*  
24 *information:*

25 (1) *That he or she is a marriage and family therapist trainee.*

26 (2) *The name of his or her employer.*

27 (3) *That he or she is supervised by a licensed person.*

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

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**BOARD OF BEHAVIORAL SCIENCES  
PROPOSED REGULATORY CHANGES  
ADVERTISING**

**MFT, LEP, LCSW**

**16CCR§1811. USE OF LICENSE NUMBER IN DIRECTORIES AND ADVERTISEMENTS ADVERTISING**

(a) All persons or referral services regulated by the board who advertise their services shall include their license or registration number in the advertisement unless such advertisement contains the following specific information: all of the following information in any advertisement:

(a) (1) The full name of the licensee, registrant, or registered referral service as filed with the board; and

(b) (2) A designation of the ~~The~~ type of complete title of the license or registration held or an acceptable abbreviation, as follows:

(1) (A) Licensed Marriage and Family Therapist, MFT or LMFT.

(2) (B) Licensed Educational Psychologist or LEP.

(3) (C) Licensed Clinical Social Worker or LCSW.

(D) Registered Marriage and Family Therapist Intern or Registered MFT Intern.

(E) Registered Associate Clinical Social Worker or Registered Associate CSW.

(4) (F) Registered MFT Referral Service.

(3) The license or registration number.

(e) (b) An unlicensed ~~A~~ registered Marriage and Family Therapist Registered Intern may advertise if such advertisement complies with Section ~~4980.44(a)(4)~~ 4980.44(c) of the Code making disclosures required by that section.

(d) (c) An unlicensed ~~A~~ registered Associate Clinical Social Worker may advertise if such advertisement complies with Section ~~4996.18 (e)~~ 4996.18(h) of the Code making disclosures required by that section.

(d) Registrants must include the name, the complete title or acceptable abbreviation of the supervisor's license and the supervisor's license number.

(e) It is permissible for a person to include academic credentials in advertising as long as the degree is earned, and the representations and statements regarding that degree are true and not misleading and in compliance with Section 651 of the Code. For purposes of this subdivision, "earned" shall not mean an honorary or other degree conferred without actual study in the educational field.

(f) The board may issue citations and fines containing a fine and an order of abatement for any violation of Section 651 of the Code.

(g) For the purposes of this section, “acceptable abbreviation” means the abbreviation listed in subsection (a)(2) of this Section.

Note: Authority cited: Sections 137, 650.4, 651, and 4980.60 ~~and 4990.14~~, Business and Professions Code. Reference: Sections 137, 651, 4980 and 4980.44 and 4996.18, Business and Professions Code.

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Sacramento, CA 95834  
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www.bbs.ca.gov

**To:** Policy and Advocacy Committee

**Date:** March 29, 2011

**From:** Christina Kitamura  
Administrative Analyst

**Telephone:** (916) 574-7835

**Subject:** **Assembly Bill 958**

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Materials for agenda item IV.j. (AB 958) will be provided in a supplemental package and will be posted on the website at that time.

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**To:** Policy and Advocacy Committee

**Date:** March 23, 2011

**From:** Christina Kitamura  
Administrative Analyst

**Telephone:** (916) 574-7835

**Subject:** **Assembly Bill 993**

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Materials for agenda item IV.k. (AB 993) will be provided in a supplemental package and will be posted on the website at that time.

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**To:** Policy and Advocacy Committee

**Date:** March 23, 2011

**From:** Christina Kitamura  
Administrative Analyst

**Telephone:** (916) 574-7835

**Subject:** **Assembly Bill 1205**

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Materials for agenda item IV.I. (AB 1205) will be provided in a supplemental package and will be posted on the website at that time.

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# CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES

## BILL ANALYSIS

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**BILL NUMBER:** SB 146

**VERSION:** AMENDED MARCH 15, 2011

**AUTHOR:** WYLAND

**SPONSOR:** CALIFORNIA ASSOCIATION FOR  
LICENSED PROFESSIONAL CLINICAL  
COUNSELORS

**RECOMMENDED POSITION:** NONE

**SUBJECT:** HEALING ARTS: PROFESSIONAL CLINICAL COUNSELORS

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**Existing Law:** Provides for the licensure of professional clinical counselors (LPCCs) by the Board of Behavioral Sciences. (Business and Professions Code (BPC) Chapter 16).

**This Bill:**

- 1) Includes LPCCs in existing law requiring certain licensees to complete training in human sexuality. Authorizes the Board to adopt education and training for LPCCs related to chemical dependency and the assessment and treatment of AIDS. (BPC §§ 25, 29, 32).
- 2) Includes LPCCs in the licensees for which Board must provide license status information on the internet. (BPC §27).
- 3) Includes LPCCs in the laws requiring insurers providing liability insurance and state or local government agencies that self insure to report certain settlement or arbitration awards, and requiring a licensee to report to the board certain settlements, judgments, or arbitration awards. (BPC §§ 801, 801.1, 802).
- 4) Includes LPCCs in the law that establishes a peer review process, requires peer review under certain circumstances, and requires a peer review body to make specified reports. (BPC §805).
- 5) Adds a section setting guidelines for professional clinical counselor corporations. (BCP §4990.20 and Article 7 commencing with §4999.123).
- 6) Includes LPCCs in laws prohibiting monetary liability or cause of action for damages against certain professional societies or its members acting within the scope of functions for that society. (Civil Code (CC) §§43.7, 43.8, 43.95).
- 7) Includes LPCCs, as well as registered clinical counselor interns and trainees, in the law providing a cause of action against a psychotherapist for injury caused by sexual contact with the psychotherapist. (CC §43.93).
- 8) Amends the Moscone-Knox Professional Corporation Act to allow LPCCs to be shareholders, officers, directors, or professional employees of other professional corporations. (Corporations Code §13401.5).

- 9)** Includes professional clinical counseling in the law requesting that the California State University, University of California, and California Community Colleges develop standards and guidelines for specified curriculum. (Education Code §66085).
- 10)** Adds testimony from a witness who has undergone hypnosis by an LPCC to admissible testimony in a criminal proceeding if specified conditions are met. (Evidence Code §795).
- 11)** Includes LPCCs and clinical counselor interns and trainees in the list of practitioners that are defined as a psychotherapist. (Evidence Code §1010).
- 12)** Extends the patient-psychotherapist privilege to confidential communications made between a patient and his or her LPCC, registered clinical counselor intern or trainee, or LPCC corporation. (Evidence Code §1014).
- 13)** Provides that the proceedings and records of committees or peer review bodies of professional clinical counselors are not subject to discovery. (Evidence Code §1157).
- 14)** Adds LPCCs to the list of eligible providers which the family law division of the superior court may contract with for supervised visitation and exchange services, education, and group counseling. (Family Code §3202).
- 15)** Extends the law governing provision of mental health treatment or counseling services and residential shelter services to minors by professional persons to LPCCs and LPCC interns. (Family Code §6924, 6929).
- 16)** Extends to LPCCs the law prohibiting the licensure requirements of healing arts personnel in the state and other government health facilities license by the state from being any less than those of professional personnel in health facilities under private ownership, subject to specified waivers. (Health and Safety Code (HSC) §1277).
- 17)** Requires a health care service plan that provides telephone medical advice services to ensure that any LPCCs providing those services are licensed. (HSC §1348.8).
- 18)** Amends the law requiring a health care service plan to provide an enrollee or prospective enrollee, upon request, a list of contracting providers within that person's geographic area, to include LPCCS on the list of contracting providers. (HSC §1367.26).
- 19)** Adds LPCCs to the list of healing arts professionals that a health care service plan may not prohibit an enrollee from selecting. (HSC §1373).
- 20)** Includes LPCCs in the provisions that apply to health insurance policies that are written or issued for delivery outside of California and where benefits are provided within the scope of practice of certain healing arts licensees. (HSC §§1373.8, 1373.95).
- 21)** Includes LPCCs in the definition of a health care provider and includes LPCCs in the law allowing health care providers to prohibit inspection of a minor's patient records under certain conditions. (HSC §§123105, 123115).
- 22)** Makes various technical amendments to add LPCCs the Insurance Code relating to disability insurance and self-insured employee welfare benefit plan (Insurance Code §§10133.55, 10176, 10176.7, 10177, 10177.8)

- 23)** Includes LPCCs, clinical counselor interns, and clinical counselor trainees in the list of mandated reporters. (Penal Code §11165.7).
- 24)** Includes LPCCs in provisions governing confidentiality of patient records when practicing at institutions for the developmentally disabled or mental hospitals. (Welfare & Institutions Code (W&IC) § 4514, 5256.1, 5328, 5328.04)
- 25)** Makes an amendment to law regulating the provision of community mental health services for the mentally disordered in every county. The law sets forth establishment of secure facilities and staffing requirements. The amendment would add LPCCs to certain provisions of staffing requirements. (W&IC 5696.5, 5751, 5751.2, 15610.37).

### **Comments:**

- 1) Author's Intent.** The purpose of this bill is to add LPCCs to statutory code sections where Marriage and Family Therapists (MFTs) are already included. Adding LPCCs to other codes where other Board licensees are already included will allow LPCCs to be more effectively utilized in California.
- 2) Codes Amended.** This bill makes clean up amendments to add LPCCs to several codes of law. Other minor, technical clean up was also made as needed. Affected codes are as follows:
- Business and Professions Code
  - Civil Code
  - Corporations Code
  - Education Code
  - Evidence Code
  - Family Code
  - Health & Safety Code
  - Insurance Code
  - Penal Code
  - Welfare & Institutions Code
- 3) Related Legislation.** This is a clean-up bill to follow SB 788 (Wyland) (Chapter 619, Statutes of 2009), which went into effect on January 1, 2010. This law requires the licensing and regulation of Licensed Professional Clinical Counselors (LPCCs) and professional counselor interns by the Board of Behavioral Sciences. However, this bill only added and amended certain sections of the Business and Professions Code. It did not amend all sections of California Code where the addition of LPCCs is necessary.

#### **4) Support and Opposition.**

None on file.

#### **5) History**

##### **2011**

Mar. 15 From committee with author's amendments. Read second time and amended. Re-referred to Com. on B., P. & E.D.

Feb. 10 Referred to Coms. on B., P. & E.D. and JUD.

Feb. 2 From printer. May be acted upon on or after March 4.

Feb. 1 Introduced. Read first time. To Com. on RLS. for assignment. To print.

AMENDED IN SENATE MARCH 15, 2011

**SENATE BILL**

**No. 146**

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**Introduced by Senator Wyland**

February 1, 2011

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An act to amend Sections 25, 27, 29, 32, 801, 801.1, 802, 805, 809, and 4990.20 of, and to add Article 7 (commencing with Section 4999.123) to Chapter 16 of Division 2 of, the Business and Professions Code, to amend Sections 43.7, 43.8, 43.93, and 43.95 of the Civil Code, to amend Section 13401.5 of the Corporations Code, to amend Section 66085 of the Education Code, to amend Sections 795, 1010, 1014, and 1157 of the Evidence Code, to amend Sections 3202, 6924, and 6929 of the Family Code, to amend Sections 1277, 1348.8, 1367.26, 1373, 1373.8, 1373.95, 123105, and 123115 of the Health and Safety Code, to amend Sections 10133.55, 10176, 10176.7, 10177, and 10177.8 of the Insurance Code, to amend Sections 5068.5 and Section 11165.7 of the Penal Code, and to amend Sections 4514, 5256.1, 5328, 5328.04, 5696.5, 5751, 5751.2, and 15610.37 of the Welfare and Institutions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 146, as amended, Wyland. Healing arts: professional clinical counselors.

Existing law, the Licensed Professional Clinical Counselor Act, provides for the licensure and regulation of professional clinical counselors by the Board of Behavioral Sciences. Existing law also governs the regulation of clinical counselor trainees and clinical counselor interns. A violation of the act is punishable as a crime.

This bill would make changes to various provisions concerning the practice of professional clinical counselors, clinical counselor trainees,

and clinical counselor interns, including, but not limited to, provisions relating to education and training. The bill would authorize the formation of professional clinical counselor corporations for purposes of rendering professional services, subject to specified requirements. The bill would make conforming changes to the Moscone-Knox Professional Corporation Act and would authorize professional clinical counselors to be shareholders, officers, directors, or professional employees of other professional corporations, as specified. The bill would provide that a violation of these provisions constitutes a violation of the Licensed Professional Clinical Counselor Act, the violation of which is punishable as a crime, thereby imposing a state-mandated local program.

Existing law requires certain licensees to complete training in human sexuality and authorizes the board to adopt education and training for licensees related to chemical dependency and the assessment and treatment of AIDS.

This bill would extend the application of these provisions to professional clinical counselors.

Existing law requires the board to provide on the Internet information regarding the status of every license issued by the board.

This bill would require the board to disclose information on licensed professional clinical counselors.

Existing law requires insurers that provide liability insurance to certain licensees, and state or local governmental agencies that self insure those licensees, to report to the board certain settlement or arbitration awards. Existing law requires certain licensees to report to the board certain settlements, judgments, or arbitration awards. The failure of a licensee to report this information constitutes a crime subject to specified fines.

This bill would extend the application of these provisions to professional clinical counselors. By expanding a crime, the bill would impose a state-mandated local program.

Existing law establishes a peer review process for certain healing arts licensees and requires peer review bodies to review licensee conduct under specified circumstances. The willful failure of a peer review body to make specified reports is punishable as a crime.

This bill would apply these provisions to professional clinical counselors and set forth the criteria for the establishment of a peer review body, as specified. Because the willful failure of such a peer review body to make specified reports would be punishable as a crime, the bill would impose a state-mandated local program.

Existing law provides that there shall be no monetary liability on the part of, and no cause of action for damages shall arise against, certain professional societies or its members for any act performed within the scope of the functions of that professional society or peer review or for the operation of a referral service, as specified.

This bill would extend the application of these provisions to a professional society consisting of professional clinical counselors and members of that society.

Existing law provides a cause of action against a psychotherapist, as defined, for injury caused by sexual contact with the psychotherapist.

This bill would extend the application of that cause of action to professional clinical counselors *and registered clinical counselor interns or trainees*, and ~~his or her~~ *their* patients.

Existing law requests that the California State University, the University of California, and the California Community Colleges develop standards and guidelines for curriculum in gerontology, nursing, social work, psychology, marriage and family therapy, and rehabilitation therapies.

This bill would add to that requested curriculum professional clinical counseling.

Existing law makes admissible in a criminal proceeding the testimony of a witness who has previously undergone hypnosis for the purpose of recalling events that are the subject of the witness's testimony, if specified conditions are met, including that the hypnosis was performed by a licensed physician and surgeon, psychologist, licensed clinical social worker, or a licensed marriage and family therapist experienced in the use of hypnosis.

This bill would make admissible the testimony from a witness who has undergone hypnosis by a professional clinical counselor.

Existing law provides that a patient has a privilege to refuse to disclose, and to prevent another from disclosing, a confidential communication between a patient and his or her psychotherapist, as defined.

This bill would extend the patient-psychotherapist privilege to confidential communications made between a patient and his or her professional clinical counselor, a registered clinical counselor intern or trainee, or a professional clinical counselor corporation. *The bill would make a technical change to provisions that apply to associate clinical social workers.*

Existing law provides that the proceedings and records of organized committees of healing arts professions or of a peer review body are not subject to discovery, except as specified.

This bill would provide that the proceedings and records of committees or peer review bodies of professional clinical counselors are not subject to discovery, except as specified.

Existing law authorizes the family law division of the superior court to contract with eligible providers of supervised visitation and exchange services, education, and group counseling to provide services.

This bill would authorize the family law division to contract with professional clinical counselors for those services.

Existing law sets forth the provisions that govern the provision of mental health treatment or counseling services and residential shelter services by professional persons, as defined.

This bill would extend the application of those provisions to professional clinical counselors and clinical counselor interns.

Existing law prohibits the licensure requirements of healing arts personnel in the state and other governmental health facilities licensed by the state from being any less than those of professional personnel in health facilities under private ownership, subject to specified waiver provisions.

This bill would extend the application of those provisions to professional clinical counselors who work in those facilities.

Existing law, the Knox-Keene Health Care Service 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 its provisions a crime. Existing law requires a health care service plan that provides, operates, or contracts for telephone medical advice services to ensure that the staff providing those services are properly licensed, as specified.

This bill would require a health care service plan that provides telephone medical advice services to ensure that any professional clinical counselors providing those services are licensed. Because a willful violation of these provisions would be punishable as a crime, the bill would impose a state-mandated local program.

Existing law requires a health care service plan to provide to an enrollee or prospective enrollee, upon request, a list of contracting providers within the enrollee's or prospective enrollee's general geographic area.

This bill would require a health care service plan to make that information available with regard to contracting providers who are professional clinical counselors. Because a willful violation of these provisions would be punishable as a crime, the bill would impose a state-mandated local program.

Under existing law, a health care service plan may not prohibit an enrollee from selecting certain healing art licensees for mental health services. Existing law also sets forth provisions that apply to health care service plan contracts or health insurance policies that are written or issued for delivery outside of California and where benefits are provided within the scope of practice of certain healing arts licensees.

This bill would add professional clinical counselors to the list of healing arts licensees in those provisions and would make similar changes to provisions that apply to insurance carriers. Because a willful violation of these provisions under the Knox-Keene Act would be punishable as a crime, the bill would impose a state-mandated local program.

Existing law sets forth provisions governing patient records and the responsibilities and duties of health care providers, as defined, with regard to those records, and as applied to other healing arts licensees when practicing at institutions for the developmentally disabled or mental hospitals.

This bill would apply the provisions that govern patient records to professional clinical counselors and clinical counselor interns.

Existing law requires a person who provides mental health services ~~in the state correctional system or in local mental health facilities to be licensed. Existing law allows that licensure requirement to be waived in the state system solely for persons in the professions of psychology or clinical social work who are gaining qualifying experience for licensure in those professions in this state, and in local facilities; for psychologists, clinical social workers, and marriage and family therapists who are gaining the experience required for licensure.~~

This bill would apply those waiver provisions to the profession of clinical counseling.

Under the Child Abuse Neglect and Reporting Act, certain persons are mandated reporters, as defined. Failure of a mandated reporter to report an incident of known or reasonably suspected child abuse or neglect is a misdemeanor.

This bill would make professional clinical counselors, clinical counselor interns, and clinical counselor trainees mandated reporters.

By expanding a crime, the bill would impose a state-mandated local program.

Existing law generally regulates the provision of community mental health services for the mentally disordered in every county. Existing law authorizes the establishment of regional, secure facilities, which are designed for the commitment and ongoing treatment of seriously emotionally disturbed minors who have been adjudged wards of the juvenile court. Among other things, existing law sets forth staffing requirements for the opening of one of these regional facilities, including requiring that the staff include a pediatrician, dentist, and a marriage and family therapist, on an as-needed basis.

This bill would revise the staffing requirements for a regional facility to include a *marriage and family therapist or* professional clinical counselor, *or both*, on an as-needed basis. The bill would also authorize the position of director of local mental health services to be a professional clinical counselor and would make other conforming changes to the certification review provisions.

This bill would make other conforming changes and enact related provisions.

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 25 of the Business and Professions Code  
2 is amended to read:  
3 25. Any person applying for a license, registration, or the first  
4 renewal of a license, after the effective date of this section, as a  
5 licensed marriage and family therapist, a licensed clinical social  
6 worker, a licensed psychologist, or a licensed professional clinical  
7 counselor shall, in addition to any other requirements, show by  
8 evidence satisfactory to the agency regulating the business or  
9 profession, that he or she has completed training in human sexuality  
10 as a condition of licensure. The training shall be creditable toward  
11 continuing education requirements as deemed appropriate by the

1 agency regulating the business or profession, and the course shall  
2 not exceed more than 50 contact hours.

3 The Board of Psychology shall exempt from the requirements  
4 of this section any persons whose field of practice is such that they  
5 are not likely to have use for this training.

6 “Human sexuality” as used in this section means the study of a  
7 human being as a sexual being and how he or she functions with  
8 respect thereto.

9 The content and length of the training shall be determined by  
10 the administrative agency regulating the business or profession  
11 and the agency shall proceed immediately upon the effective date  
12 of this section to determine what training, and the quality of staff  
13 to provide the training, is available and shall report its  
14 determination to the Legislature on or before July 1, 1977.

15 If a licensing board or agency proposes to establish a training  
16 program in human sexuality, the board or agency shall first consult  
17 with other licensing boards or agencies that have established or  
18 propose to establish a training program in human sexuality to  
19 ensure that the programs are compatible in scope and content.

20 SEC. 2. Section 27 of the Business and Professions Code is  
21 amended to read:

22 27. (a) Each entity specified in subdivision (b) shall provide  
23 on the Internet information regarding the status of every license  
24 issued by that entity in accordance with the California Public  
25 Records Act (Chapter 3.5 (commencing with Section 6250) of  
26 Division 7 of Title 1 of the Government Code) and the Information  
27 Practices Act of 1977 (Chapter 1 (commencing with Section 1798)  
28 of Title 1.8 of Part 4 of Division 3 of the Civil Code). The public  
29 information to be provided on the Internet shall include information  
30 on suspensions and revocations of licenses issued by the entity  
31 and other related enforcement action taken by the entity relative  
32 to persons, businesses, or facilities subject to licensure or regulation  
33 by the entity. In providing information on the Internet, each entity  
34 shall comply with the Department of Consumer Affairs Guidelines  
35 for Access to Public Records. The information may not include  
36 personal information, including home telephone number, date of  
37 birth, or social security number. Each entity shall disclose a  
38 licensee’s address of record. However, each entity shall allow a  
39 licensee to provide a post office box number or other alternate  
40 address, instead of his or her home address, as the address of

1 record. This section shall not preclude an entity from also requiring  
2 a licensee, who has provided a post office box number or other  
3 alternative mailing address as his or her address of record, to  
4 provide a physical business address or residence address only for  
5 the entity's internal administrative use and not for disclosure as  
6 the licensee's address of record or disclosure on the Internet.

7 (b) Each of the following entities within the Department of  
8 Consumer Affairs shall comply with the requirements of this  
9 section:

10 (1) The Acupuncture Board shall disclose information on its  
11 licensees.

12 (2) The Board of Behavioral Sciences shall disclose information  
13 on its licensees, including marriage and family therapists, licensed  
14 clinical social workers, licensed educational psychologists, and  
15 licensed professional clinical counselors.

16 (3) The Dental Board of California shall disclose information  
17 on its licensees.

18 (4) The State Board of Optometry shall disclose information  
19 regarding certificates of registration to practice optometry,  
20 statements of licensure, optometric corporation registrations, branch  
21 office licenses, and fictitious name permits of its licensees.

22 (5) The Board for Professional Engineers and Land Surveyors  
23 shall disclose information on its registrants and licensees.

24 (6) The Structural Pest Control Board shall disclose information  
25 on its licensees, including applicators, field representatives, and  
26 operators in the areas of fumigation, general pest and wood  
27 destroying pests and organisms, and wood roof cleaning and  
28 treatment.

29 (7) The Bureau of Automotive Repair shall disclose information  
30 on its licensees, including auto repair dealers, smog stations, lamp  
31 and brake stations, smog check technicians, and smog inspection  
32 certification stations.

33 (8) The Bureau of Electronic and Appliance Repair shall disclose  
34 information on its licensees, including major appliance repair  
35 dealers, combination dealers (electronic and appliance), electronic  
36 repair dealers, service contract sellers, and service contract  
37 administrators.

38 (9) The Cemetery and Funeral Bureau shall disclose information  
39 on its licensees, including cemetery brokers, cemetery salespersons,  
40 cemetery managers, crematory managers, cemetery authorities,

1 crematories, cremated remains disposers, embalmers, funeral  
2 establishments, and funeral directors.

3 (10) The Professional Fiduciaries Bureau shall disclose  
4 information on its licensees.

5 (11) The Contractors' State License Board shall disclose  
6 information on its licensees in accordance with Chapter 9  
7 (commencing with Section 7000) of Division 3. In addition to  
8 information related to licenses as specified in subdivision (a), the  
9 board shall also disclose information provided to the board by the  
10 Labor Commissioner pursuant to Section 98.9 of the Labor Code.

11 (12) The Board of Psychology shall disclose information on its  
12 licensees, including psychologists, psychological assistants, and  
13 registered psychologists.

14 (13) The Bureau for Private Postsecondary Education shall  
15 disclose information on private postsecondary institutions under  
16 its jurisdiction, including disclosure of notices to comply issued  
17 pursuant to Section 94935 of the Education Code.

18 (c) "Internet" for the purposes of this section has the meaning  
19 set forth in paragraph (6) of subdivision (e) of Section 17538.

20 SEC. 3. Section 29 of the Business and Professions Code is  
21 amended to read:

22 29. (a) The Board of Psychology and the Board of Behavioral  
23 Sciences shall consider adoption of continuing education  
24 requirements including training in the area of recognizing chemical  
25 dependency and early intervention for all persons applying for  
26 renewal of a license as a psychologist, clinical social worker,  
27 marriage and family therapist, or professional clinical counselor.

28 (b) Prior to the adoption of any regulations imposing continuing  
29 education relating to alcohol and other chemical dependency, the  
30 boards are urged to consider coursework to include, but not  
31 necessarily be limited to, the following topics:

32 (1) Historical and contemporary perspectives on alcohol and  
33 other drug abuse.

34 (2) Extent of the alcohol and drug abuse epidemic and its effects  
35 on the individual, family, and community.

36 (3) Recognizing the symptoms of alcoholism and drug addiction.

37 (4) Making appropriate interpretations, interventions, and  
38 referrals.

39 (5) Recognizing and intervening with affected family members.

1 (6) Learning about current programs of recovery, such as 12  
2 step programs, and how therapists can effectively utilize these  
3 programs.

4 SEC. 4. Section 32 of the Business and Professions Code is  
5 amended to read:

6 32. (a) The Legislature finds that there is a need to ensure that  
7 professionals of the healing arts who have or intend to have  
8 significant contact with patients who have, or are at risk to be  
9 exposed to, acquired immune deficiency syndrome (AIDS) are  
10 provided with training in the form of continuing education  
11 regarding the characteristics and methods of assessment and  
12 treatment of the condition.

13 (b) A board vested with the responsibility of regulating the  
14 following licensees shall consider including training regarding the  
15 characteristics and method of assessment and treatment of acquired  
16 immune deficiency syndrome (AIDS) in any continuing education  
17 or training requirements for those licensees: chiropractors, medical  
18 laboratory technicians, dentists, dental hygienists, dental assistants,  
19 physicians and surgeons, podiatrists, registered nurses, licensed  
20 vocational nurses, psychologists, physician assistants, respiratory  
21 therapists, acupuncturists, marriage and family therapists, licensed  
22 educational psychologists, clinical social workers, and professional  
23 clinical counselors.

24 SEC. 5. Section 801 of the Business and Professions Code is  
25 amended to read:

26 801. (a) Except as provided in Section 801.01 and subdivisions  
27 (b), (c), and (d) of this section, every insurer providing professional  
28 liability insurance to a person who holds a license, certificate, or  
29 similar authority from or under any agency specified in subdivision  
30 (a) of Section 800 shall send a complete report to that agency as  
31 to any settlement or arbitration award over three thousand dollars  
32 (\$3,000) of a claim or action for damages for death or personal  
33 injury caused by that person's negligence, error, or omission in  
34 practice, or by his or her rendering of unauthorized professional  
35 services. The report shall be sent within 30 days after the written  
36 settlement agreement has been reduced to writing and signed by  
37 all parties thereto or within 30 days after service of the arbitration  
38 award on the parties.

39 (b) Every insurer providing professional liability insurance to  
40 a person licensed pursuant to Chapter 13 (commencing with

1 Section 4980), Chapter 14 (commencing with Section 4990), or  
2 Chapter 16 (commencing with Section 4999.10) shall send a  
3 complete report to the Board of Behavioral Sciences as to any  
4 settlement or arbitration award over ten thousand dollars (\$10,000)  
5 of a claim or action for damages for death or personal injury caused  
6 by that person's negligence, error, or omission in practice, or by  
7 his or her rendering of unauthorized professional services. The  
8 report shall be sent within 30 days after the written settlement  
9 agreement has been reduced to writing and signed by all parties  
10 thereto or within 30 days after service of the arbitration award on  
11 the parties.

12 (c) Every insurer providing professional liability insurance to  
13 a dentist licensed pursuant to Chapter 4 (commencing with Section  
14 1600) shall send a complete report to the Dental Board of  
15 California as to any settlement or arbitration award over ten  
16 thousand dollars (\$10,000) of a claim or action for damages for  
17 death or personal injury caused by that person's negligence, error,  
18 or omission in practice, or rendering of unauthorized professional  
19 services. The report shall be sent within 30 days after the written  
20 settlement agreement has been reduced to writing and signed by  
21 all parties thereto or within 30 days after service of the arbitration  
22 award on the parties.

23 (d) Every insurer providing liability insurance to a veterinarian  
24 licensed pursuant to Chapter 11 (commencing with Section 4800)  
25 shall send a complete report to the Veterinary Medical Board of  
26 any settlement or arbitration award over ten thousand dollars  
27 (\$10,000) of a claim or action for damages for death or injury  
28 caused by that person's negligence, error, or omission in practice,  
29 or rendering of unauthorized professional service. The report shall  
30 be sent within 30 days after the written settlement agreement has  
31 been reduced to writing and signed by all parties thereto or within  
32 30 days after service of the arbitration award on the parties.

33 (e) The insurer shall notify the claimant, or if the claimant is  
34 represented by counsel, the insurer shall notify the claimant's  
35 attorney, that the report required by subdivision (a), (b), or (c) has  
36 been sent to the agency. If the attorney has not received this notice  
37 within 45 days after the settlement was reduced to writing and  
38 signed by all of the parties, the arbitration award was served on  
39 the parties, or the date of entry of the civil judgment, the attorney  
40 shall make the report to the agency.

1 (f) Notwithstanding any other provision of law, no insurer shall  
2 enter into a settlement without the written consent of the insured,  
3 except that this prohibition shall not void any settlement entered  
4 into without that written consent. The requirement of written  
5 consent shall only be waived by both the insured and the insurer.  
6 This section shall only apply to a settlement on a policy of  
7 insurance executed or renewed on or after January 1, 1971.

8 SEC. 6. Section 801.1 of the Business and Professions Code  
9 is amended to read:

10 801.1. (a) Every state or local governmental agency that  
11 self-insures a person who holds a license, certificate, or similar  
12 authority from or under any agency specified in subdivision (a) of  
13 Section 800 (except a person licensed pursuant to Chapter 3  
14 (commencing with Section 1200) or Chapter 5 (commencing with  
15 Section 2000) or the Osteopathic Initiative Act) shall send a  
16 complete report to that agency as to any settlement or arbitration  
17 award over three thousand dollars (\$3,000) of a claim or action  
18 for damages for death or personal injury caused by that person's  
19 negligence, error, or omission in practice, or rendering of  
20 unauthorized professional services. The report shall be sent within  
21 30 days after the written settlement agreement has been reduced  
22 to writing and signed by all parties thereto or within 30 days after  
23 service of the arbitration award on the parties.

24 (b) Every state or local governmental agency that self-insures  
25 a person licensed pursuant to Chapter 13 (commencing with  
26 Section 4980), Chapter 14 (commencing with Section 4990), or  
27 Chapter 16 (commencing with Section 4999.10) shall send a  
28 complete report to the Board of Behavioral Science Examiners as  
29 to any settlement or arbitration award over ten thousand dollars  
30 (\$10,000) of a claim or action for damages for death or personal  
31 injury caused by that person's negligence, error, or omission in  
32 practice, or rendering of unauthorized professional services. The  
33 report shall be sent within 30 days after the written settlement  
34 agreement has been reduced to writing and signed by all parties  
35 thereto or within 30 days after service of the arbitration award on  
36 the parties.

37 SEC. 7. Section 802 of the Business and Professions Code is  
38 amended to read:

39 802. (a) Every settlement, judgment, or arbitration award over  
40 three thousand dollars (\$3,000) of a claim or action for damages

1 for death or personal injury caused by negligence, error or omission  
2 in practice, or by the unauthorized rendering of professional  
3 services, by a person who holds a license, certificate, or other  
4 similar authority from an agency specified in subdivision (a) of  
5 Section 800 (except a person licensed pursuant to Chapter 3  
6 (commencing with Section 1200) or Chapter 5 (commencing with  
7 Section 2000) or the Osteopathic Initiative Act) who does not  
8 possess professional liability insurance as to that claim shall, within  
9 30 days after the written settlement agreement has been reduced  
10 to writing and signed by all the parties thereto or 30 days after  
11 service of the judgment or arbitration award on the parties, be  
12 reported to the agency that issued the license, certificate, or similar  
13 authority. A complete report shall be made by appropriate means  
14 by the person or his or her counsel, with a copy of the  
15 communication to be sent to the claimant through his or her counsel  
16 if the person is so represented, or directly if he or she is not. If,  
17 within 45 days of the conclusion of the written settlement  
18 agreement or service of the judgment or arbitration award on the  
19 parties, counsel for the claimant (or if the claimant is not  
20 represented by counsel, the claimant himself or herself) has not  
21 received a copy of the report, he or she shall himself or herself  
22 make the complete report. Failure of the licensee or claimant (or,  
23 if represented by counsel, their counsel) to comply with this section  
24 is a public offense punishable by a fine of not less than fifty dollars  
25 (\$50) or more than five hundred dollars (\$500). Knowing and  
26 intentional failure to comply with this section or conspiracy or  
27 collusion not to comply with this section, or to hinder or impede  
28 any other person in the compliance, is a public offense punishable  
29 by a fine of not less than five thousand dollars (\$5,000) nor more  
30 than fifty thousand dollars (\$50,000).

31 (b) Every settlement, judgment, or arbitration award over ten  
32 thousand dollars (\$10,000) of a claim or action for damages for  
33 death or personal injury caused by negligence, error or omission  
34 in practice, or by the unauthorized rendering of professional  
35 services, by a marriage and family therapist, a clinical social  
36 worker, or a professional clinical counselor licensed pursuant to  
37 Chapter 13 (commencing with Section 4980), Chapter 14  
38 (commencing with Section 4990), or Chapter 16 (commencing  
39 with Section 4999.10), respectively, who does not possess  
40 professional liability insurance as to that claim shall within 30

1 days after the written settlement agreement has been reduced to  
2 writing and signed by all the parties thereto or 30 days after service  
3 of the judgment or arbitration award on the parties be reported to  
4 the agency that issued the license, certificate, or similar authority.  
5 A complete report shall be made by appropriate means by the  
6 person or his or her counsel, with a copy of the communication to  
7 be sent to the claimant through his or her counsel if he or she is  
8 so represented, or directly if he or she is not. If, within 45 days of  
9 the conclusion of the written settlement agreement or service of  
10 the judgment or arbitration award on the parties, counsel for the  
11 claimant (or if he or she is not represented by counsel, the claimant  
12 himself or herself) has not received a copy of the report, he or she  
13 shall himself or herself make a complete report. Failure of the  
14 marriage and family therapist, clinical social worker, or  
15 professional clinical counselor or claimant (or, if represented by  
16 counsel, his or her counsel) to comply with this section is a public  
17 offense punishable by a fine of not less than fifty dollars (\$50) nor  
18 more than five hundred dollars (\$500). Knowing and intentional  
19 failure to comply with this section, or conspiracy or collusion not  
20 to comply with this section or to hinder or impede any other person  
21 in that compliance, is a public offense punishable by a fine of not  
22 less than five thousand dollars (\$5,000) nor more than fifty  
23 thousand dollars (\$50,000).

24 SEC. 8. Section 805 of the Business and Professions Code is  
25 amended to read:

26 805. (a) As used in this section, the following terms have the  
27 following definitions:

28 (1) (A) "Peer review" means both of the following:

29 (i) A process in which a peer review body reviews the basic  
30 qualifications, staff privileges, employment, medical outcomes,  
31 or professional conduct of licentiates to make recommendations  
32 for quality improvement and education, if necessary, in order to  
33 do either or both of the following:

34 (I) Determine whether a licentiate may practice or continue to  
35 practice in a health care facility, clinic, or other setting providing  
36 medical services, and, if so, to determine the parameters of that  
37 practice.

38 (II) Assess and improve the quality of care rendered in a health  
39 care facility, clinic, or other setting providing medical services.

1 (ii) Any other activities of a peer review body as specified in  
2 subparagraph (B).

3 (B) “Peer review body” includes:

4 (i) A medical or professional staff of any health care facility or  
5 clinic licensed under Division 2 (commencing with Section 1200)  
6 of the Health and Safety Code or of a facility certified to participate  
7 in the federal Medicare Program as an ambulatory surgical center.

8 (ii) A health care service plan licensed under Chapter 2.2  
9 (commencing with Section 1340) of Division 2 of the Health and  
10 Safety Code or a disability insurer that contracts with licentiates  
11 to provide services at alternative rates of payment pursuant to  
12 Section 10133 of the Insurance Code.

13 (iii) Any medical, psychological, marriage and family therapy,  
14 social work, professional clinical counselor, dental, or podiatric  
15 professional society having as members at least 25 percent of the  
16 eligible licentiates in the area in which it functions (which must  
17 include at least one county), which is not organized for profit and  
18 which has been determined to be exempt from taxes pursuant to  
19 Section 23701 of the Revenue and Taxation Code.

20 (iv) A committee organized by any entity consisting of or  
21 employing more than 25 licentiates of the same class that functions  
22 for the purpose of reviewing the quality of professional care  
23 provided by members or employees of that entity.

24 (2) “Licentiate” means a physician and surgeon, doctor of  
25 podiatric medicine, clinical psychologist, marriage and family  
26 therapist, clinical social worker, professional clinical counselor,  
27 or dentist. “Licentiate” also includes a person authorized to practice  
28 medicine pursuant to Section 2113 or 2168.

29 (3) “Agency” means the relevant state licensing agency having  
30 regulatory jurisdiction over the licentiates listed in paragraph (2).

31 (4) “Staff privileges” means any arrangement under which a  
32 licentiate is allowed to practice in or provide care for patients in  
33 a health facility. Those arrangements shall include, but are not  
34 limited to, full staff privileges, active staff privileges, limited staff  
35 privileges, auxiliary staff privileges, provisional staff privileges,  
36 temporary staff privileges, courtesy staff privileges, locum tenens  
37 arrangements, and contractual arrangements to provide professional  
38 services, including, but not limited to, arrangements to provide  
39 outpatient services.

1 (5) “Denial or termination of staff privileges, membership, or  
2 employment” includes failure or refusal to renew a contract or to  
3 renew, extend, or reestablish any staff privileges, if the action is  
4 based on medical disciplinary cause or reason.

5 (6) “Medical disciplinary cause or reason” means that aspect  
6 of a licentiate’s competence or professional conduct that is  
7 reasonably likely to be detrimental to patient safety or to the  
8 delivery of patient care.

9 (7) “805 report” means the written report required under  
10 subdivision (b).

11 (b) The chief of staff of a medical or professional staff or other  
12 chief executive officer, medical director, or administrator of any  
13 peer review body and the chief executive officer or administrator  
14 of any licensed health care facility or clinic shall file an 805 report  
15 with the relevant agency within 15 days after the effective date on  
16 which any of the following occur as a result of an action of a peer  
17 review body:

18 (1) A licentiate’s application for staff privileges or membership  
19 is denied or rejected for a medical disciplinary cause or reason.

20 (2) A licentiate’s membership, staff privileges, or employment  
21 is terminated or revoked for a medical disciplinary cause or reason.

22 (3) Restrictions are imposed, or voluntarily accepted, on staff  
23 privileges, membership, or employment for a cumulative total of  
24 30 days or more for any 12-month period, for a medical disciplinary  
25 cause or reason.

26 (c) If a licentiate takes any action listed in paragraph (1), (2),  
27 or (3) after receiving notice of a pending investigation initiated  
28 for a medical disciplinary cause or reason or after receiving notice  
29 that his or her application for membership or staff privileges is  
30 denied or will be denied for a medical disciplinary cause or reason,  
31 the chief of staff of a medical or professional staff or other chief  
32 executive officer, medical director, or administrator of any peer  
33 review body and the chief executive officer or administrator of  
34 any licensed health care facility or clinic where the licentiate is  
35 employed or has staff privileges or membership or where the  
36 licentiate applied for staff privileges or membership, or sought the  
37 renewal thereof, shall file an 805 report with the relevant agency  
38 within 15 days after the licentiate takes the action.

39 (1) Resigns or takes a leave of absence from membership, staff  
40 privileges, or employment.

1 (2) Withdraws or abandons his or her application for staff  
2 privileges or membership.

3 (3) Withdraws or abandons his or her request for renewal of  
4 staff privileges or membership.

5 (d) For purposes of filing an 805 report, the signature of at least  
6 one of the individuals indicated in subdivision (b) or (c) on the  
7 completed form shall constitute compliance with the requirement  
8 to file the report.

9 (e) An 805 report shall also be filed within 15 days following  
10 the imposition of summary suspension of staff privileges,  
11 membership, or employment, if the summary suspension remains  
12 in effect for a period in excess of 14 days.

13 (f) A copy of the 805 report, and a notice advising the licentiate  
14 of his or her right to submit additional statements or other  
15 information, electronically or otherwise, pursuant to Section 800,  
16 shall be sent by the peer review body to the licentiate named in  
17 the report. The notice shall also advise the licentiate that  
18 information submitted electronically will be publicly disclosed to  
19 those who request the information.

20 The information to be reported in an 805 report shall include the  
21 name and license number of the licentiate involved, a description  
22 of the facts and circumstances of the medical disciplinary cause  
23 or reason, and any other relevant information deemed appropriate  
24 by the reporter.

25 A supplemental report shall also be made within 30 days  
26 following the date the licentiate is deemed to have satisfied any  
27 terms, conditions, or sanctions imposed as disciplinary action by  
28 the reporting peer review body. In performing its dissemination  
29 functions required by Section 805.5, the agency shall include a  
30 copy of a supplemental report, if any, whenever it furnishes a copy  
31 of the original 805 report.

32 If another peer review body is required to file an 805 report, a  
33 health care service plan is not required to file a separate report  
34 with respect to action attributable to the same medical disciplinary  
35 cause or reason. If the Medical Board of California or a licensing  
36 agency of another state revokes or suspends, without a stay, the  
37 license of a physician and surgeon, a peer review body is not  
38 required to file an 805 report when it takes an action as a result of  
39 the revocation or suspension.

1 (g) The reporting required by this section shall not act as a  
2 waiver of confidentiality of medical records and committee reports.  
3 The information reported or disclosed shall be kept confidential  
4 except as provided in subdivision (c) of Section 800 and Sections  
5 803.1 and 2027, provided that a copy of the report containing the  
6 information required by this section may be disclosed as required  
7 by Section 805.5 with respect to reports received on or after  
8 January 1, 1976.

9 (h) The Medical Board of California, the Osteopathic Medical  
10 Board of California, and the Dental Board of California shall  
11 disclose reports as required by Section 805.5.

12 (i) An 805 report shall be maintained electronically by an agency  
13 for dissemination purposes for a period of three years after receipt.

14 (j) No person shall incur any civil or criminal liability as the  
15 result of making any report required by this section.

16 (k) A willful failure to file an 805 report by any person who is  
17 designated or otherwise required by law to file an 805 report is  
18 punishable by a fine not to exceed one hundred thousand dollars  
19 (\$100,000) per violation. The fine may be imposed in any civil or  
20 administrative action or proceeding brought by or on behalf of any  
21 agency having regulatory jurisdiction over the person regarding  
22 whom the report was or should have been filed. If the person who  
23 is designated or otherwise required to file an 805 report is a  
24 licensed physician and surgeon, the action or proceeding shall be  
25 brought by the Medical Board of California. The fine shall be paid  
26 to that agency but not expended until appropriated by the  
27 Legislature. A violation of this subdivision may constitute  
28 unprofessional conduct by the licentiate. A person who is alleged  
29 to have violated this subdivision may assert any defense available  
30 at law. As used in this subdivision, “willful” means a voluntary  
31 and intentional violation of a known legal duty.

32 (l) Except as otherwise provided in subdivision (k), any failure  
33 by the administrator of any peer review body, the chief executive  
34 officer or administrator of any health care facility, or any person  
35 who is designated or otherwise required by law to file an 805  
36 report, shall be punishable by a fine that under no circumstances  
37 shall exceed fifty thousand dollars (\$50,000) per violation. The  
38 fine may be imposed in any civil or administrative action or  
39 proceeding brought by or on behalf of any agency having  
40 regulatory jurisdiction over the person regarding whom the report

1 was or should have been filed. If the person who is designated or  
2 otherwise required to file an 805 report is a licensed physician and  
3 surgeon, the action or proceeding shall be brought by the Medical  
4 Board of California. The fine shall be paid to that agency but not  
5 expended until appropriated by the Legislature. The amount of the  
6 fine imposed, not exceeding fifty thousand dollars (\$50,000) per  
7 violation, shall be proportional to the severity of the failure to  
8 report and shall differ based upon written findings, including  
9 whether the failure to file caused harm to a patient or created a  
10 risk to patient safety; whether the administrator of any peer review  
11 body, the chief executive officer or administrator of any health  
12 care facility, or any person who is designated or otherwise required  
13 by law to file an 805 report exercised due diligence despite the  
14 failure to file or whether they knew or should have known that an  
15 805 report would not be filed; and whether there has been a prior  
16 failure to file an 805 report. The amount of the fine imposed may  
17 also differ based on whether a health care facility is a small or  
18 rural hospital as defined in Section 124840 of the Health and Safety  
19 Code.

20 (m) A health care service plan licensed under Chapter 2.2  
21 (commencing with Section 1340) of Division 2 of the Health and  
22 Safety Code or a disability insurer that negotiates and enters into  
23 a contract with licentiates to provide services at alternative rates  
24 of payment pursuant to Section 10133 of the Insurance Code, when  
25 determining participation with the plan or insurer, shall evaluate,  
26 on a case-by-case basis, licentiates who are the subject of an 805  
27 report, and not automatically exclude or deselect these licentiates.

28 SEC. 9. Section 809 of the Business and Professions Code is  
29 amended to read:

30 809. (a) The Legislature hereby finds and declares the  
31 following:

32 (1) In 1986, Congress enacted the federal Health Care Quality  
33 Improvement Act of 1986 (42 U.S.C. Sec. 11101 et seq.), to  
34 encourage physicians and surgeons to engage in effective  
35 professional peer review, but giving each state the opportunity to  
36 “opt-out” of some of the provisions of the federal act.

37 (2) Because of deficiencies in the federal act and the possible  
38 adverse interpretations by the courts of the federal act, it is  
39 preferable for California to “opt-out” of the federal act and design  
40 its own peer review system.

1 (3) Peer review, fairly conducted, is essential to preserving the  
2 highest standards of medical practice.

3 (4) Peer review that is not conducted fairly results in harm to  
4 both patients and healing arts practitioners by limiting access to  
5 care.

6 (5) Peer review, fairly conducted, will aid the appropriate state  
7 licensing boards in their responsibility to regulate and discipline  
8 errant healing arts practitioners.

9 (6) To protect the health and welfare of the people of California,  
10 it is the policy of the State of California to exclude, through the  
11 peer review mechanism as provided for by California law, those  
12 healing arts practitioners who provide substandard care or who  
13 engage in professional misconduct, regardless of the effect of that  
14 exclusion on competition.

15 (7) It is the intent of the Legislature that peer review of  
16 professional health care services be done efficiently, on an ongoing  
17 basis, and with an emphasis on early detection of potential quality  
18 problems and resolutions through informal educational  
19 interventions.

20 (8) Sections 809 to 809.8, inclusive, shall not affect the  
21 respective responsibilities of the organized medical staff or the  
22 governing body of an acute care hospital with respect to peer  
23 review in the acute care hospital setting. It is the intent of the  
24 Legislature that written provisions implementing Sections 809 to  
25 809.8, inclusive, in the acute care hospital setting shall be included  
26 in medical staff bylaws that shall be adopted by a vote of the  
27 members of the organized medical staff and shall be subject to  
28 governing body approval, which approval shall not be withheld  
29 unreasonably.

30 (9) (A) The Legislature thus finds and declares that the laws  
31 of this state pertaining to the peer review of healing arts  
32 practitioners shall apply in lieu of Section 11101 and following of  
33 Title 42 of the United States Code, because the laws of this state  
34 provide a more careful articulation of the protections for both those  
35 undertaking peer review activity and those subject to review, and  
36 better integrate public and private systems of peer review.  
37 Therefore, California exercises its right to opt out of specified  
38 provisions of the federal Health Care Quality Improvement Act  
39 relating to professional review actions, pursuant to Section  
40 11111(c)(2)(B) of Title 42 of the United States Code. This election

1 shall not affect the availability of any immunity under California  
2 law.

3 (B) The Legislature further declares that it is not the intent or  
4 purpose of Sections 809 to 809.8, inclusive, to opt out of any  
5 mandatory national data bank established pursuant to Section  
6 11131 and following of Title 42 of the United States Code.

7 (b) For the purpose of this section and Sections 809.1 to 809.8,  
8 inclusive, “healing arts practitioner” or “licentiate” means a  
9 physician and surgeon, podiatrist, clinical psychologist, marriage  
10 and family therapist, clinical social worker, professional clinical  
11 counselor, or dentist; and “peer review body” means a peer review  
12 body as specified in paragraph (1) of subdivision (a) of Section  
13 805, and includes any designee of the peer review body.

14 SEC. 10. Section 4990.20 of the Business and Professions  
15 Code is amended to read:

16 4990.20. (a) The board may adopt rules and regulations as  
17 necessary to administer and enforce the provisions of this chapter  
18 and the other chapters it administers and enforces. The adoption,  
19 amendment, or repeal of those rules and regulations shall be made  
20 in accordance with Chapter 3.5 (commencing with Section 11340)  
21 of Part 1 of Division 3 of Title 2 of the Government Code.

22 (b) The board may formulate and enforce rules and regulations  
23 requiring the following:

24 (1) That the articles of incorporation or bylaws of a marriage  
25 and family therapist corporation, a licensed clinical social worker  
26 corporation, or a professional clinical counselor corporation include  
27 a provision whereby the capital stock of that corporation owned  
28 by a disqualified person, as defined in the Moscone-Knox  
29 Professional Corporation Act (Part 4 (commencing with Section  
30 13400) of Division 3 of Title 1 of the Corporations Code), or a  
31 deceased person shall be sold to the corporation or to the remaining  
32 shareholders of that corporation within the time that the rules and  
33 regulations may provide.

34 (2) That a marriage and family therapist corporation, a licensed  
35 clinical social worker corporation, or a professional clinical  
36 counselor corporation shall provide adequate security by insurance  
37 or otherwise for claims against it by its patients arising out of the  
38 rendering of professional services.

1 SEC. 11. Article 7 (commencing with Section 4999.123) is  
2 added to Chapter 16 of Division 2 of the Business and Professions  
3 Code, to read:

4

5 Article 7. Professional Clinical Counselor Corporations

6

7 4999.123. A professional clinical counselor corporation is a  
8 corporation that is authorized to render professional services, as  
9 defined in Section 13401 of the Corporations Code, so long as that  
10 corporation and its shareholders, officers, directors, and employees  
11 who are rendering professional services and who are licensed  
12 professional clinical counselors, marriage and family therapists,  
13 physicians and surgeons, psychologists, licensed clinical social  
14 workers, registered nurses, chiropractors, or acupuncturists, are in  
15 compliance with the Moscone-Knox Professional Corporation Act  
16 (Part 4 (commencing with Section 13400) of Division 3 of Title  
17 1 of the Corporations Code), this article, and any other statute or  
18 regulation pertaining to that corporation and the conduct of its  
19 affairs. With respect to a professional clinical counselor  
20 corporation, the term “governmental agency” in the Moscone-Knox  
21 Professional Corporation Act (Part 4 (commencing with Section  
22 13400) of Division 3 of Title 1 of the Corporations Code) shall be  
23 construed to mean the Board of Behavioral Sciences.

24 4999.124. It shall constitute unprofessional conduct and a  
25 violation of this chapter for any person licensed under this chapter  
26 to violate, attempt to violate, directly or indirectly, or assist in, or  
27 abet the violation of, or conspire to violate, any provision or term  
28 of this article, the Moscone-Knox Professional Corporation Act  
29 (Part 4 (commencing with Section 13400) of Division 3 of Title  
30 1 of the Corporations Code), or any regulation adopted under those  
31 laws.

32 4999.125. The name of a professional clinical counselor  
33 corporation and any name or names under which it may be  
34 rendering professional services shall contain the words “licensed  
35 professional clinical counselor” or “professional clinical counselor”  
36 and wording or abbreviations denoting a corporate existence. A  
37 professional clinical counselor corporation that conducts business  
38 under a fictitious business name shall not use any name that is  
39 false, misleading, or deceptive, and shall inform each patient, prior

1 to commencement of treatment, that the business is conducted by  
2 a professional clinical counselor corporation.

3 4999.126. Except as provided in Section 13403 of the  
4 Corporations Code, each director, shareholder, and officer of a  
5 professional clinical counselor corporation shall be a licensed  
6 person, as defined in Section 13401 of the Corporations Code.

7 4999.127. The income of a professional clinical counselor  
8 corporation attributable to professional services rendered while a  
9 shareholder is a disqualified person, as defined in Section 13401  
10 of the Corporations Code, shall not in any manner accrue to the  
11 benefit of that shareholder or his or her shares in the professional  
12 clinical counselor corporation.

13 4999.128. A professional clinical counselor corporation shall  
14 not perform or fail to perform any act the performance of which,  
15 or for which the failure to perform, would constitute unprofessional  
16 conduct under any statute, rule, or regulation. In the conduct of its  
17 practice, a professional clinical counselor corporation shall observe  
18 and be bound by any statute, rule, or regulation that applies to a  
19 licensed professional clinical counselor.

20 4999.129. The board may formulate and enforce any rule or  
21 regulation to carry out the purposes and objectives of this article,  
22 including as follows:

23 (a) Any rule or regulation that requires that the articles of  
24 incorporation or bylaws of a professional clinical counselor  
25 corporation shall include a provision that requires the capital stock  
26 of the corporation owned by a disqualified person, as defined in  
27 Section 13401 of the Corporations Code, or a deceased person to  
28 be sold to the corporation or to the remaining shareholders of the  
29 corporation within the timeframe that the rule or regulation  
30 requires.

31 (b) Any rule or regulation that requires that a professional  
32 clinical counselor corporation shall provide adequate security by  
33 insurance or otherwise for claims against the corporation by its  
34 patients arising out of the rendering of professional services.

35 SEC. 12. Section 43.7 of the Civil Code is amended to read:

36 43.7. (a) There shall be no monetary liability on the part of,  
37 and no cause of action for damages shall arise against, any member  
38 of a duly appointed mental health professional quality assurance  
39 committee that is established in compliance with Section 4070 of  
40 the Welfare and Institutions Code, for any act or proceeding

1 undertaken or performed within the scope of the functions of the  
2 committee which is formed to review and evaluate the adequacy,  
3 appropriateness, or effectiveness of the care and treatment planned  
4 for, or provided to, mental health patients in order to improve  
5 quality of care by mental health professionals if the committee  
6 member acts without malice, has made a reasonable effort to obtain  
7 the facts of the matter as to which he or she acts, and acts in  
8 reasonable belief that the action taken by him or her is warranted  
9 by the facts known to him or her after the reasonable effort to  
10 obtain facts.

11 (b) There shall be no monetary liability on the part of, and no  
12 cause of action for damages shall arise against, any professional  
13 society, any member of a duly appointed committee of a medical  
14 specialty society, or any member of a duly appointed committee  
15 of a state or local professional society, or duly appointed member  
16 of a committee of a professional staff of a licensed hospital  
17 (provided the professional staff operates pursuant to written bylaws  
18 that have been approved by the governing board of the hospital),  
19 for any act or proceeding undertaken or performed within the scope  
20 of the functions of the committee which is formed to maintain the  
21 professional standards of the society established by its bylaws, or  
22 any member of any peer review committee whose purpose is to  
23 review the quality of medical, dental, dietetic, chiropractic,  
24 optometric, acupuncture, psychotherapy, or veterinary services  
25 rendered by physicians and surgeons, dentists, dental hygienists,  
26 podiatrists, registered dietitians, chiropractors, optometrists,  
27 acupuncturists, veterinarians, marriage and family therapists,  
28 professional clinical counselors, or psychologists, which committee  
29 is composed chiefly of physicians and surgeons, dentists, dental  
30 hygienists, podiatrists, registered dietitians, chiropractors,  
31 optometrists, acupuncturists, veterinarians, marriage and family  
32 therapists, professional clinical counselors, or psychologists for  
33 any act or proceeding undertaken or performed in reviewing the  
34 quality of medical, dental, dietetic, chiropractic, optometric,  
35 acupuncture, psychotherapy, or veterinary services rendered by  
36 physicians and surgeons, dentists, dental hygienists, podiatrists,  
37 registered dietitians, chiropractors, optometrists, acupuncturists,  
38 veterinarians, marriage and family therapists, professional clinical  
39 counselors, or psychologists or any member of the governing board  
40 of a hospital in reviewing the quality of medical services rendered

1 by members of the staff if the professional society, committee, or  
2 board member acts without malice, has made a reasonable effort  
3 to obtain the facts of the matter as to which he, she, or it acts, and  
4 acts in reasonable belief that the action taken by him, her, or it is  
5 warranted by the facts known to him, her, or it after the reasonable  
6 effort to obtain facts. “Professional society” includes legal, medical,  
7 psychological, dental, dental hygiene, dietetic, accounting,  
8 optometric, acupuncture, podiatric, pharmaceutical, chiropractic,  
9 physical therapist, veterinary, licensed marriage and family therapy,  
10 licensed clinical social work, licensed professional clinical  
11 counselor, and engineering organizations having as members at  
12 least 25 percent of the eligible persons or licentiates in the  
13 geographic area served by the particular society. However, if the  
14 society has fewer than 100 members, it shall have as members at  
15 least a majority of the eligible persons or licentiates in the  
16 geographic area served by the particular society.

17 “Medical specialty society” means an organization having as  
18 members at least 25 percent of the eligible physicians and surgeons  
19 within a given professionally recognized medical specialty in the  
20 geographic area served by the particular society.

21 (c) This section does not affect the official immunity of an  
22 officer or employee of a public corporation.

23 (d) There shall be no monetary liability on the part of, and no  
24 cause of action for damages shall arise against, any physician and  
25 surgeon, podiatrist, or chiropractor who is a member of an  
26 underwriting committee of an interindemnity or reciprocal or  
27 interinsurance exchange or mutual company for any act or  
28 proceeding undertaken or performed in evaluating physicians and  
29 surgeons, podiatrists, or chiropractors for the writing of  
30 professional liability insurance, or any act or proceeding undertaken  
31 or performed in evaluating physicians and surgeons for the writing  
32 of an interindemnity, reciprocal, or interinsurance contract as  
33 specified in Section 1280.7 of the Insurance Code, if the evaluating  
34 physician and surgeon, podiatrist, or chiropractor acts without  
35 malice, has made a reasonable effort to obtain the facts of the  
36 matter as to which he or she acts, and acts in reasonable belief that  
37 the action taken by him or her is warranted by the facts known to  
38 him or her after the reasonable effort to obtain the facts.

39 (e) This section shall not be construed to confer immunity from  
40 liability on any quality assurance committee established in

1 compliance with Section 4070 of the Welfare and Institutions Code  
2 or hospital. In any case in which, but for the enactment of the  
3 preceding provisions of this section, a cause of action would arise  
4 against a quality assurance committee established in compliance  
5 with Section 4070 of the Welfare and Institutions Code or hospital,  
6 the cause of action shall exist as if the preceding provisions of this  
7 section had not been enacted.

8 SEC. 13. Section 43.8 of the Civil Code is amended to read:

9 43.8. (a) In addition to the privilege afforded by Section 47,  
10 there shall be no monetary liability on the part of, and no cause of  
11 action for damages shall arise against, any person on account of  
12 the communication of information in the possession of that person  
13 to any hospital, hospital medical staff, veterinary hospital staff,  
14 professional society, medical, dental, podiatric, psychology,  
15 marriage and family therapy, professional clinical counselor, or  
16 veterinary school, professional licensing board or division,  
17 committee or panel of a licensing board, the Senior Assistant  
18 Attorney General of the Health Quality Enforcement Section  
19 appointed under Section 12529 of the Government Code, peer  
20 review committee, quality assurance committees established in  
21 compliance with Sections 4070 and 5624 of the Welfare and  
22 Institutions Code, or underwriting committee described in Section  
23 43.7 when the communication is intended to aid in the evaluation  
24 of the qualifications, fitness, character, or insurability of a  
25 practitioner of the healing or veterinary arts.

26 (b) The immunities afforded by this section and by Section 43.7  
27 shall not affect the availability of any absolute privilege that may  
28 be afforded by Section 47.

29 (c) Nothing in this section is intended in any way to affect the  
30 California Supreme Court's decision in *Hassan v. Mercy American*  
31 *River Hospital* (2003) 31 Cal.4th 709, holding that subdivision (a)  
32 provides a qualified privilege.

33 SEC. 14. Section 43.93 of the Civil Code is amended to read:

34 43.93. (a) For the purposes of this section the following  
35 definitions are applicable:

36 (1) "Psychotherapy" means the professional treatment,  
37 assessment, or counseling of a mental or emotional illness,  
38 symptom, or condition.

39 (2) "Psychotherapist" means a physician and surgeon  
40 specializing in the practice of psychiatry, a psychologist, a

1 psychological assistant, a marriage and family therapist, a  
2 registered marriage and family therapist intern or trainee, an  
3 educational psychologist, an associate clinical social worker, a  
4 licensed clinical social worker, ~~or~~ a professional clinical counselor,  
5 *or a registered clinical counselor intern or trainee.*

6 (3) “Sexual contact” means the touching of an intimate part of  
7 another person. “Intimate part” and “touching” have the same  
8 meanings as defined in subdivisions (f) and (d), respectively, of  
9 Section 243.4 of the Penal Code. For the purposes of this section,  
10 sexual contact includes sexual intercourse, sodomy, and oral  
11 copulation.

12 (4) “Therapeutic relationship” exists during the time the patient  
13 or client is rendered professional service by the psychotherapist.

14 (5) “Therapeutic deception” means a representation by a  
15 psychotherapist that sexual contact with the psychotherapist is  
16 consistent with or part of the patient’s or former patient’s treatment.

17 (b) A cause of action against a psychotherapist for sexual contact  
18 exists for a patient or former patient for injury caused by sexual  
19 contact with the psychotherapist, if the sexual contact occurred  
20 under any of the following conditions:

21 (1) During the period the patient was receiving psychotherapy  
22 from the psychotherapist.

23 (2) Within two years following termination of therapy.

24 (3) By means of therapeutic deception.

25 (c) The patient or former patient may recover damages from a  
26 psychotherapist who is found liable for sexual contact. It is not a  
27 defense to the action that sexual contact with a patient occurred  
28 outside a therapy or treatment session or that it occurred off the  
29 premises regularly used by the psychotherapist for therapy or  
30 treatment sessions. No cause of action shall exist between spouses  
31 within a marriage.

32 (d) In an action for sexual contact, evidence of the plaintiff’s  
33 sexual history is not subject to discovery and is not admissible as  
34 evidence except in either of the following situations:

35 (1) The plaintiff claims damage to sexual functioning.

36 (2) The defendant requests a hearing prior to conducting  
37 discovery and makes an offer of proof of the relevancy of the  
38 history, and the court finds that the history is relevant and the  
39 probative value of the history outweighs its prejudicial effect.

1 The court shall allow the discovery or introduction as evidence  
2 only of specific information or examples of the plaintiff's conduct  
3 that are determined by the court to be relevant. The court's order  
4 shall detail the information or conduct that is subject to discovery.

5 SEC. 15. Section 43.95 of the Civil Code is amended to read:

6 43.95. (a) There shall be no monetary liability on the part of,  
7 and no cause of action for damages shall arise against, any  
8 professional society or any nonprofit corporation authorized by a  
9 professional society to operate a referral service, or their agents,  
10 employees, or members, for referring any member of the public  
11 to any professional member of the society or service, or for acts  
12 of negligence or conduct constituting unprofessional conduct  
13 committed by a professional to whom a member of the public was  
14 referred, so long as any of the foregoing persons or entities has  
15 acted without malice, and the referral was made at no cost added  
16 to the initial referral fee as part of a public service referral system  
17 organized under the auspices of the professional society. Further,  
18 there shall be no monetary liability on the part of, and no cause of  
19 action for damages shall arise against, any professional society for  
20 providing a telephone information library available for use by the  
21 general public without charge, nor against any nonprofit  
22 corporation authorized by a professional society for providing a  
23 telephone information library available for use by the general  
24 public without charge. "Professional society" includes legal,  
25 psychological, architectural, medical, dental, dietetic, accounting,  
26 optometric, podiatric, pharmaceutical, chiropractic, veterinary,  
27 licensed marriage and family therapy, licensed clinical social work,  
28 professional clinical counselor, and engineering organizations  
29 having as members at least 25 percent of the eligible persons or  
30 licentiates in the geographic area served by the particular society.  
31 However, if the society has less than 100 members, it shall have  
32 as members at least a majority of the eligible persons or licentiates  
33 in the geographic area served by the particular society.  
34 "Professional society" also includes organizations with referral  
35 services that have been authorized by the State Bar of California  
36 and operated in accordance with its Minimum Standards for a  
37 Lawyer Referral Service in California, and organizations that have  
38 been established to provide free assistance or representation to  
39 needy patients or clients.

1 (b) This section shall not apply whenever the professional  
2 society, while making a referral to a professional member of the  
3 society, fails to disclose the nature of any disciplinary action of  
4 which it has actual knowledge taken by a state licensing agency  
5 against that professional member. However, there shall be no duty  
6 to disclose a disciplinary action in either of the following cases:

7 (1) Where a disciplinary proceeding results in no disciplinary  
8 action being taken against the professional to whom a member of  
9 the public was referred.

10 (2) Where a period of three years has elapsed since the  
11 professional to whom a member of the public was referred has  
12 satisfied any terms, conditions, or sanctions imposed upon the  
13 professional as disciplinary action; except that if the professional  
14 is an attorney, there shall be no time limit on the duty to disclose.

15 SEC. 16. Section 13401.5 of the Corporations Code is amended  
16 to read:

17 13401.5. Notwithstanding subdivision (d) of Section 13401  
18 and any other provision of law, the following licensed persons  
19 may be shareholders, officers, directors, or professional employees  
20 of the professional corporations designated in this section so long  
21 as the sum of all shares owned by those licensed persons does not  
22 exceed 49 percent of the total number of shares of the professional  
23 corporation so designated herein, and so long as the number of  
24 those licensed persons owning shares in the professional  
25 corporation so designated herein does not exceed the number of  
26 persons licensed by the governmental agency regulating the  
27 designated professional corporation:

28 (a) Medical corporation.

29 (1) Licensed doctors of podiatric medicine.

30 (2) Licensed psychologists.

31 (3) Registered nurses.

32 (4) Licensed optometrists.

33 (5) Licensed marriage and family therapists.

34 (6) Licensed clinical social workers.

35 (7) Licensed physician assistants.

36 (8) Licensed chiropractors.

37 (9) Licensed acupuncturists.

38 (10) Naturopathic doctors.

39 (11) Licensed professional clinical counselors.

40 (b) Podiatric medical corporation.

- 1 (1) Licensed physicians and surgeons.
- 2 (2) Licensed psychologists.
- 3 (3) Registered nurses.
- 4 (4) Licensed optometrists.
- 5 (5) Licensed chiropractors.
- 6 (6) Licensed acupuncturists.
- 7 (7) Naturopathic doctors.
- 8 (c) Psychological corporation.
- 9 (1) Licensed physicians and surgeons.
- 10 (2) Licensed doctors of podiatric medicine.
- 11 (3) Registered nurses.
- 12 (4) Licensed optometrists.
- 13 (5) Licensed marriage and family therapists.
- 14 (6) Licensed clinical social workers.
- 15 (7) Licensed chiropractors.
- 16 (8) Licensed acupuncturists.
- 17 (9) Naturopathic doctors.
- 18 (10) Licensed professional clinical counselors.
- 19 (d) Speech-language pathology corporation.
- 20 (1) Licensed audiologists.
- 21 (e) Audiology corporation.
- 22 (1) Licensed speech-language pathologists.
- 23 (f) Nursing corporation.
- 24 (1) Licensed physicians and surgeons.
- 25 (2) Licensed doctors of podiatric medicine.
- 26 (3) Licensed psychologists.
- 27 (4) Licensed optometrists.
- 28 (5) Licensed marriage and family therapists.
- 29 (6) Licensed clinical social workers.
- 30 (7) Licensed physician assistants.
- 31 (8) Licensed chiropractors.
- 32 (9) Licensed acupuncturists.
- 33 (10) Naturopathic doctors.
- 34 (11) Licensed professional clinical counselors.
- 35 (g) Marriage and family ~~therapy~~ *therapist* corporation.
- 36 (1) Licensed physicians and surgeons.
- 37 (2) Licensed psychologists.
- 38 (3) Licensed clinical social workers.
- 39 (4) Registered nurses.
- 40 (5) Licensed chiropractors.

- 1 (6) Licensed acupuncturists.
- 2 (7) Naturopathic doctors.
- 3 (8) Licensed professional clinical counselors.
- 4 (h) Licensed clinical social worker corporation.
- 5 (1) Licensed physicians and surgeons.
- 6 (2) Licensed psychologists.
- 7 (3) Licensed marriage and family therapists.
- 8 (4) Registered nurses.
- 9 (5) Licensed chiropractors.
- 10 (6) Licensed acupuncturists.
- 11 (7) Naturopathic doctors.
- 12 (8) Licensed professional clinical counselors.
- 13 (i) Physician assistants corporation.
- 14 (1) Licensed physicians and surgeons.
- 15 (2) Registered nurses.
- 16 (3) Licensed acupuncturists.
- 17 (4) Naturopathic doctors.
- 18 (j) Optometric corporation.
- 19 (1) Licensed physicians and surgeons.
- 20 (2) Licensed doctors of podiatric medicine.
- 21 (3) Licensed psychologists.
- 22 (4) Registered nurses.
- 23 (5) Licensed chiropractors.
- 24 (6) Licensed acupuncturists.
- 25 (7) Naturopathic doctors.
- 26 (k) Chiropractic corporation.
- 27 (1) Licensed physicians and surgeons.
- 28 (2) Licensed doctors of podiatric medicine.
- 29 (3) Licensed psychologists.
- 30 (4) Registered nurses.
- 31 (5) Licensed optometrists.
- 32 (6) Licensed marriage and family therapists.
- 33 (7) Licensed clinical social workers.
- 34 (8) Licensed acupuncturists.
- 35 (9) Naturopathic doctors.
- 36 (10) Licensed professional clinical counselors.
- 37 (l) Acupuncture corporation.
- 38 (1) Licensed physicians and surgeons.
- 39 (2) Licensed doctors of podiatric medicine.
- 40 (3) Licensed psychologists.

- 1 (4) Registered nurses.
- 2 (5) Licensed optometrists.
- 3 (6) Licensed marriage and family therapists.
- 4 (7) Licensed clinical social workers.
- 5 (8) Licensed physician assistants.
- 6 (9) Licensed chiropractors.
- 7 (10) Naturopathic doctors.
- 8 (11) Licensed professional clinical counselors.
- 9 (m) Naturopathic doctor corporation.
- 10 (1) Licensed physicians and surgeons.
- 11 (2) Licensed psychologists.
- 12 (3) Registered nurses.
- 13 (4) Licensed physician assistants.
- 14 (5) Licensed chiropractors.
- 15 (6) Licensed acupuncturists.
- 16 (7) Licensed physical therapists.
- 17 (8) Licensed doctors of podiatric medicine.
- 18 (9) Licensed marriage, ~~family, and child counselors~~ *and family*
- 19 *therapists.*
- 20 (10) Licensed clinical social workers.
- 21 (11) Licensed optometrists.
- 22 (12) Licensed professional clinical counselors.
- 23 (n) Dental corporation.
- 24 (1) Licensed physicians and surgeons.
- 25 (2) Dental assistants.
- 26 (3) Registered dental assistants.
- 27 (4) Registered dental assistants in extended functions.
- 28 (5) Registered dental hygienists.
- 29 (6) Registered dental hygienists in extended functions.
- 30 (7) Registered dental hygienists in alternative practice.
- 31 (o) Professional clinical counselor corporation.
- 32 (1) Licensed physicians and surgeons.
- 33 (2) Licensed psychologists.
- 34 (3) Licensed clinical social workers.
- 35 (4) Licensed marriage and family therapists.
- 36 (5) Registered nurses.
- 37 (6) Licensed chiropractors.
- 38 (7) Licensed acupuncturists.
- 39 (8) Naturopathic doctors.

1 SEC. 17. Section 66085 of the Education Code is amended to  
2 read:

3 66085. The Legislature requests that the Trustees of the  
4 California State University, the Regents of the University of  
5 California, and the Board of Governors of the California  
6 Community Colleges, in consultation with the California Council  
7 on Gerontology and Geriatrics and other qualified groups or  
8 individuals, develop standards and guidelines, based on standards  
9 developed by the Association for Gerontology in Higher Education,  
10 for the biological, social, and psychological aspects of aging for  
11 professional degree programs at the associate, bachelor, and  
12 graduate levels, including those programs in gerontology, nursing,  
13 social work, psychology, marriage and family therapy, professional  
14 clinical counseling, and the rehabilitation therapies. Nothing in  
15 this article shall be construed to require any additional coursework  
16 requirements for professional degree programs.

17 SEC. 18. Section 795 of the Evidence Code is amended to read:

18 795. (a) The testimony of a witness is not inadmissible in a  
19 criminal proceeding by reason of the fact that the witness has  
20 previously undergone hypnosis for the purpose of recalling events  
21 that are the subject of the witness's testimony, if all of the  
22 following conditions are met:

23 (1) The testimony is limited to those matters that the witness  
24 recalled and related prior to the hypnosis.

25 (2) The substance of the prehypnotic memory was preserved in  
26 a writing, audio recording, or video recording prior to the hypnosis.

27 (3) The hypnosis was conducted in accordance with all of the  
28 following procedures:

29 (A) A written record was made prior to hypnosis documenting  
30 the subject's description of the event, and information that was  
31 provided to the hypnotist concerning the subject matter of the  
32 hypnosis.

33 (B) The subject gave informed consent to the hypnosis.

34 (C) The hypnosis session, including the pre- and post-hypnosis  
35 interviews, was video recorded for subsequent review.

36 (D) The hypnosis was performed by a licensed physician and  
37 surgeon, psychologist, licensed clinical social worker, licensed  
38 marriage and family therapist, or licensed professional clinical  
39 counselor experienced in the use of hypnosis and independent of

1 and not in the presence of law enforcement, the prosecution, or  
2 the defense.

3 (4) Prior to admission of the testimony, the court holds a hearing  
4 pursuant to Section 402 at which the proponent of the evidence  
5 proves by clear and convincing evidence that the hypnosis did not  
6 so affect the witness as to render the witness's prehypnosis  
7 recollection unreliable or to substantially impair the ability to  
8 cross-examine the witness concerning the witness's prehypnosis  
9 recollection. At the hearing, each side shall have the right to present  
10 expert testimony and to cross-examine witnesses.

11 (b) Nothing in this section shall be construed to limit the ability  
12 of a party to attack the credibility of a witness who has undergone  
13 hypnosis, or to limit other legal grounds to admit or exclude the  
14 testimony of that witness.

15 SEC. 19. Section 1010 of the Evidence Code is amended to  
16 read:

17 1010. As used in this article, "psychotherapist" means a person  
18 who is, or is reasonably believed by the patient to be:

19 (a) A person authorized to practice medicine in any state or  
20 nation who devotes, or is reasonably believed by the patient to  
21 devote, a substantial portion of his or her time to the practice of  
22 psychiatry.

23 (b) A person licensed as a psychologist under Chapter 6.6  
24 (commencing with Section 2900) of Division 2 of the Business  
25 and Professions Code.

26 (c) A person licensed as a clinical social worker under Article  
27 4 (commencing with Section 4996) of Chapter 14 of Division 2  
28 of the Business and Professions Code, when he or she is engaged  
29 in applied psychotherapy of a nonmedical nature.

30 (d) A person who is serving as a school psychologist and holds  
31 a credential authorizing that service issued by the state.

32 (e) A person licensed as a marriage and family therapist under  
33 Chapter 13 (commencing with Section 4980) of Division 2 of the  
34 Business and Professions Code.

35 (f) A person registered as a psychological assistant who is under  
36 the supervision of a licensed psychologist or board certified  
37 psychiatrist as required by Section 2913 of the Business and  
38 Professions Code, or a person registered as a marriage and family  
39 therapist intern who is under the supervision of a licensed marriage  
40 and family therapist, a licensed clinical social worker, a licensed

1 psychologist, or a licensed physician and surgeon certified in  
2 psychiatry, as specified in Section 4980.44 of the Business and  
3 Professions Code.

4 ~~(g) A person registered as an associate clinical social worker  
5 who is under the supervision of a licensed clinical social worker,  
6 a licensed psychologist, or a board certified psychiatrist as required  
7 by Section 4996.20 or 4996.21 of the Business and Professions  
8 Code.~~

9 *(g) A person registered as an associate clinical social worker  
10 who is under the supervision of a licensed mental health  
11 professional as specified in Section 1874 of Article 6 of Division  
12 18 of Title 16 of the California Code of Regulations.*

13 (h) A person exempt from the Psychology Licensing Law  
14 pursuant to subdivision (d) of Section 2909 of the Business and  
15 Professions Code who is under the supervision of a licensed  
16 psychologist or board certified psychiatrist.

17 (i) A psychological intern as defined in Section 2911 of the  
18 Business and Professions Code who is under the supervision of a  
19 licensed psychologist or board certified psychiatrist.

20 (j) A trainee, as defined in subdivision (c) of Section 4980.03  
21 of the Business and Professions Code, who is fulfilling his or her  
22 supervised practicum required by subparagraph (B) of paragraph  
23 (1) of subdivision (d) of Section 4980.36 of, or subdivision (c) of  
24 Section 4980.37 of, the Business and Professions Code and is  
25 supervised by a licensed psychologist, a board certified psychiatrist,  
26 a licensed clinical social worker, a licensed marriage and family  
27 therapist, or a licensed professional clinical counselor.

28 (k) A person licensed as a registered nurse pursuant to Chapter  
29 6 (commencing with Section 2700) of Division 2 of the Business  
30 and Professions Code, who possesses a master's degree in  
31 psychiatric-mental health nursing and is listed as a  
32 psychiatric-mental health nurse by the Board of Registered  
33 Nursing.

34 (l) An advanced practice registered nurse who is certified as a  
35 clinical nurse specialist pursuant to Article 9 (commencing with  
36 Section 2838) of Chapter 6 of Division 2 of the Business and  
37 Professions Code and who participates in expert clinical practice  
38 in the specialty of psychiatric-mental health nursing.

1 (m) A person rendering mental health treatment or counseling  
2 services as authorized pursuant to Section 6924 of the Family  
3 Code.

4 (n) A person licensed as a professional clinical counselor under  
5 Chapter 16 (commencing with Section 4999.10) of Division 2 of  
6 the Business and Professions Code.

7 (o) A person registered as a clinical counselor intern who is  
8 under the supervision of a licensed professional clinical counselor,  
9 a licensed marriage and family therapist, a licensed clinical social  
10 worker, a licensed psychologist, or a licensed physician and  
11 surgeon certified in psychiatry, as specified in Sections 4999.42  
12 to 4999.46, inclusive, of the Business and Professions Code.

13 (p) A clinical counselor trainee, as defined in subdivision (g)  
14 of Section 4999.12 of the Business and Professions Code, who is  
15 fulfilling his or her supervised practicum required by paragraph  
16 (3) of subdivision (c) of Section 4999.32 of, or paragraph (3) of  
17 subdivision (c) of Section 4999.33 of, the Business and Professions  
18 Code, and is supervised by a licensed psychologist, a  
19 board-certified psychiatrist, a licensed clinical social worker, a  
20 licensed marriage and family therapist, or a licensed professional  
21 clinical counselor.

22 SEC. 20. Section 1014 of the Evidence Code is amended to  
23 read:

24 1014. Subject to Section 912 and except as otherwise provided  
25 in this article, the patient, whether or not a party, has a privilege  
26 to refuse to disclose, and to prevent another from disclosing, a  
27 confidential communication between patient and psychotherapist  
28 if the privilege is claimed by:

29 (a) The holder of the privilege.

30 (b) A person who is authorized to claim the privilege by the  
31 holder of the privilege.

32 (c) The person who was the psychotherapist at the time of the  
33 confidential communication, but the person may not claim the  
34 privilege if there is no holder of the privilege in existence or if he  
35 or she is otherwise instructed by a person authorized to permit  
36 disclosure.

37 The relationship of a psychotherapist and patient shall exist  
38 between a psychological corporation as defined in Article 9  
39 (commencing with Section 2995) of Chapter 6.6 of Division 2 of  
40 the Business and Professions Code, a marriage and family therapy

1 *therapist* corporation as defined in Article 6 (commencing with  
2 Section 4987.5) of Chapter 13 of Division 2 of the Business and  
3 Professions Code, a licensed clinical social workers corporation  
4 as defined in Article 5 (commencing with Section 4998) of Chapter  
5 14 of Division 2 of the Business and Professions Code, or a  
6 professional clinical counselor corporation as defined in Article 7  
7 (commencing with Section 4999.123) of Chapter 16 of Division  
8 2 of the Business and Professions Code, and the patient to whom  
9 it renders professional services, as well as between those patients  
10 and psychotherapists employed by those corporations to render  
11 services to those patients. The word “persons” as used in this  
12 subdivision includes partnerships, corporations, limited liability  
13 companies, associations, and other groups and entities.

14 SEC. 21. Section 1157 of the Evidence Code is amended to  
15 read:

16 1157. (a) Neither the proceedings nor the records of organized  
17 committees of medical, medical-dental, podiatric, registered  
18 dietitian, psychological, marriage and family therapist, licensed  
19 clinical social worker, professional clinical counselor, or veterinary  
20 staffs in hospitals, or of a peer review body, as defined in Section  
21 805 of the Business and Professions Code, having the responsibility  
22 of evaluation and improvement of the quality of care rendered in  
23 the hospital, or for that peer review body, or medical or dental  
24 review or dental hygienist review or chiropractic review or  
25 podiatric review or registered dietitian review or veterinary review  
26 or acupuncturist review committees of local medical, dental, dental  
27 hygienist, podiatric, dietetic, veterinary, acupuncture, or  
28 chiropractic societies, marriage and family therapist, licensed  
29 clinical social worker, professional clinical counselor, or  
30 psychological review committees of state or local marriage and  
31 family therapist, state or local licensed clinical social worker, state  
32 or local licensed professional clinical counselor, or state or local  
33 psychological associations or societies having the responsibility  
34 of evaluation and improvement of the quality of care, shall be  
35 subject to discovery.

36 (b) Except as hereinafter provided, no person in attendance at  
37 a meeting of any of those committees shall be required to testify  
38 as to what transpired at that meeting.

39 (c) The prohibition relating to discovery or testimony does not  
40 apply to the statements made by any person in attendance at a

1 meeting of any of those committees who is a party to an action or  
2 proceeding the subject matter of which was reviewed at that  
3 meeting, or to any person requesting hospital staff privileges, or  
4 in any action against an insurance carrier alleging bad faith by the  
5 carrier in refusing to accept a settlement offer within the policy  
6 limits.

7 (d) The prohibitions in this section do not apply to medical,  
8 dental, dental hygienist, podiatric, dietetic, psychological, marriage  
9 and family therapist, licensed clinical social worker, professional  
10 clinical counselor, veterinary, acupuncture, or chiropractic society  
11 committees that exceed 10 percent of the membership of the  
12 society, nor to any of those committees if any person serves upon  
13 the committee when his or her own conduct or practice is being  
14 reviewed.

15 (e) The amendments made to this section by Chapter 1081 of  
16 the Statutes of 1983, or at the 1985 portion of the 1985–86 Regular  
17 Session of the Legislature, at the 1990 portion of the 1989–90  
18 Regular Session of the Legislature, at the 2000 portion of the  
19 1999–2000 Regular Session of the Legislature, or at the 2011  
20 portion of the 2011–12 Regular Session of the Legislature, do not  
21 exclude the discovery or use of relevant evidence in a criminal  
22 action.

23 SEC. 22. Section 3202 of the Family Code is amended to read:

24 3202. (a) All supervised visitation and exchange programs  
25 funded pursuant to this chapter shall comply with all requirements  
26 of the Uniform Standards of Practice for Providers of Supervised  
27 Visitation set forth in Section 26.2 of the Standards of Judicial  
28 Administration as amended. The family law division of the superior  
29 court may contract with eligible providers of supervised visitation  
30 and exchange services, education, and group counseling to provide  
31 services under this chapter.

32 (b) As used in this section, “eligible provider” means:

33 (1) For providers of supervised visitation and exchange services,  
34 a local public agency or nonprofit entity that satisfies the Uniform  
35 Standards of Practice for Providers of Supervised Visitation.

36 (2) For providers of group counseling, a professional licensed  
37 to practice psychotherapy in this state, including, but not limited  
38 to, a licensed psychiatrist, licensed psychologist, licensed clinical  
39 social worker, licensed marriage and family therapist, or licensed  
40 professional clinical counselor; or a mental health intern working

1 under the direct supervision of a professional licensed to practice  
2 psychotherapy.

3 (3) For providers of education, a professional with a bachelor’s  
4 or master’s degree in human behavior, child development,  
5 psychology, counseling, family-life education, or a related field,  
6 having specific training in issues relating to child and family  
7 development, substance abuse, child abuse, domestic violence,  
8 effective parenting, and the impact of divorce and interparental  
9 conflict on children; or an intern working under the supervision  
10 of that professional.

11 SEC. 23. Section 6924 of the Family Code is amended to read:  
12 6924. (a) As used in this section:

13 (1) “Mental health treatment or counseling services” means the  
14 provision of mental health treatment or counseling on an outpatient  
15 basis by any of the following:

16 (A) A governmental agency.

17 (B) A person or agency having a contract with a governmental  
18 agency to provide the services.

19 (C) An agency that receives funding from community united  
20 funds.

21 (D) A runaway house or crisis resolution center.

22 (E) A professional person, as defined in paragraph (2).

23 (2) “Professional person” means any of the following:

24 (A) A person designated as a mental health professional in  
25 Sections 622 to 626, inclusive, of Article 8 of Subchapter 3 of  
26 Chapter 1 of Title 9 of the California Code of Regulations.

27 (B) A marriage and family therapist as defined in Chapter 13  
28 (commencing with Section 4980) of Division 2 of the Business  
29 and Professions Code.

30 (C) A licensed educational psychologist as defined in Article 5  
31 (commencing with Section 4986) of Chapter 13 of Division 2 of  
32 the Business and Professions Code.

33 (D) A credentialed school psychologist as described in Section  
34 49424 of the Education Code.

35 (E) A clinical psychologist as defined in Section 1316.5 of the  
36 Health and Safety Code.

37 (F) The chief administrator of an agency referred to in paragraph  
38 (1) or (3).

39 (G) A person registered as a marriage and family therapist intern,  
40 as defined in Chapter 13 (commencing with Section 4980) of

1 Division 2 of the Business and Professions Code, while working  
2 under the supervision of a licensed professional specified in  
3 subdivision (g) of Section 4980.03 of the Business and Professions  
4 Code.

5 (H) A licensed professional clinical counselor, as defined in  
6 Chapter 16 (commencing with Section 4999.10) of Division 2 of  
7 the Business and Professions Code.

8 (I) A person registered as a clinical counselor intern, as defined  
9 in Chapter 16 (commencing with Section 4999.10) of Division 2  
10 of the Business and Professions Code, while working under the  
11 supervision of a licensed professional specified in subdivision (h)  
12 of Section 4999.12 of the Business and Professions Code.

13 (3) “Residential shelter services” means any of the following:

14 (A) The provision of residential and other support services to  
15 minors on a temporary or emergency basis in a facility that services  
16 only minors by a governmental agency, a person or agency having  
17 a contract with a governmental agency to provide these services,  
18 an agency that receives funding from community funds, or a  
19 licensed community care facility or crisis resolution center.

20 (B) The provision of other support services on a temporary or  
21 emergency basis by any professional person as defined in paragraph  
22 (2).

23 (b) A minor who is 12 years of age or older may consent to  
24 mental health treatment or counseling on an outpatient basis, or  
25 to residential shelter services, if both of the following requirements  
26 are satisfied:

27 (1) The minor, in the opinion of the attending professional  
28 person, is mature enough to participate intelligently in the  
29 outpatient services or residential shelter services.

30 (2) The minor (A) would present a danger of serious physical  
31 or mental harm to self or to others without the mental health  
32 treatment or counseling or residential shelter services, or (B) is  
33 the alleged victim of incest or child abuse.

34 (c) A professional person offering residential shelter services,  
35 whether as an individual or as a representative of an entity specified  
36 in paragraph (3) of subdivision (a), shall make his or her best  
37 efforts to notify the parent or guardian of the provision of services.

38 (d) The mental health treatment or counseling of a minor  
39 authorized by this section shall include involvement of the minor’s  
40 parent or guardian unless, in the opinion of the professional person

1 who is treating or counseling the minor, the involvement would  
2 be inappropriate. The professional person who is treating or  
3 counseling the minor shall state in the client record whether and  
4 when the person attempted to contact the minor's parent or  
5 guardian, and whether the attempt to contact was successful or  
6 unsuccessful, or the reason why, in the professional person's  
7 opinion, it would be inappropriate to contact the minor's parent  
8 or guardian.

9 (e) The minor's parents or guardian are not liable for payment  
10 for mental health treatment or counseling services provided  
11 pursuant to this section unless the parent or guardian participates  
12 in the mental health treatment or counseling, and then only for  
13 services rendered with the participation of the parent or guardian.  
14 The minor's parents or guardian are not liable for payment for any  
15 residential shelter services provided pursuant to this section unless  
16 the parent or guardian consented to the provision of those services.

17 (f) This section does not authorize a minor to receive convulsive  
18 therapy or psychosurgery as defined in subdivisions (f) and (g) of  
19 Section 5325 of the Welfare and Institutions Code, or psychotropic  
20 drugs without the consent of the minor's parent or guardian.

21 SEC. 24. Section 6929 of the Family Code is amended to read:

22 6929. (a) As used in this section:

23 (1) "Counseling" means the provision of counseling services  
24 by a provider under a contract with the state or a county to provide  
25 alcohol or drug abuse counseling services pursuant to Part 2  
26 (commencing with Section 5600) of Division 5 of the Welfare and  
27 Institutions Code or pursuant to Division 10.5 (commencing with  
28 Section 11750) of the Health and Safety Code.

29 (2) "Drug or alcohol" includes, but is not limited to, any  
30 substance listed in any of the following:

31 (A) Section 380 or 381 of the Penal Code.

32 (B) Division 10 (commencing with Section 11000) of the Health  
33 and Safety Code.

34 (C) Subdivision (f) of Section 647 of the Penal Code.

35 (3) "LAAM" means levoalphacetylmethadol as specified in  
36 paragraph (10) of subdivision (c) of Section 11055 of the Health  
37 and Safety Code.

38 (4) "Professional person" means a physician and surgeon,  
39 registered nurse, psychologist, clinical social worker, professional  
40 clinical counselor, marriage and family therapist, registered

1 marriage and family therapist intern when appropriately employed  
2 and supervised pursuant to Section 4980.43 of the Business and  
3 Professions Code, psychological assistant when appropriately  
4 employed and supervised pursuant to Section 2913 of the Business  
5 and Professions Code, associate clinical social worker when  
6 appropriately employed and supervised pursuant to Section 4996.18  
7 of the Business and Professions Code, or registered clinical  
8 counselor intern when appropriately employed and supervised  
9 pursuant to Section 4999.42 of the Business and Professions Code.

10 (b) A minor who is 12 years of age or older may consent to  
11 medical care and counseling relating to the diagnosis and treatment  
12 of a drug- or alcohol-related problem.

13 (c) The treatment plan of a minor authorized by this section  
14 shall include the involvement of the minor's parent or guardian,  
15 if appropriate, as determined by the professional person or  
16 treatment facility treating the minor. The professional person  
17 providing medical care or counseling to a minor shall state in the  
18 minor's treatment record whether and when the professional person  
19 attempted to contact the minor's parent or guardian, and whether  
20 the attempt to contact the parent or guardian was successful or  
21 unsuccessful, or the reason why, in the opinion of the professional  
22 person, it would not be appropriate to contact the minor's parent  
23 or guardian.

24 (d) The minor's parent or guardian is not liable for payment for  
25 any care provided to a minor pursuant to this section, except that  
26 if the minor's parent or guardian participates in a counseling  
27 program pursuant to this section, the parent or guardian is liable  
28 for the cost of the services provided to the minor and the parent  
29 or guardian.

30 (e) This section does not authorize a minor to receive  
31 replacement narcotic abuse treatment, in a program licensed  
32 pursuant to Article 3 (commencing with Section 11875) of Chapter  
33 1 of Part 3 of Division 10.5 of the Health and Safety Code, without  
34 the consent of the minor's parent or guardian.

35 (f) It is the intent of the Legislature that the state shall respect  
36 the right of a parent or legal guardian to seek medical care and  
37 counseling for a drug- or alcohol-related problem of a minor child  
38 when the child does not consent to the medical care and counseling,  
39 and nothing in this section shall be construed to restrict or eliminate  
40 this right.

1 (g) Notwithstanding any other provision of law, in cases where  
2 a parent or legal guardian has sought the medical care and  
3 counseling for a drug- or alcohol-related problem of a minor child,  
4 the physician and surgeon shall disclose medical information  
5 concerning the care to the minor's parent or legal guardian upon  
6 his or her request, even if the minor child does not consent to  
7 disclosure, without liability for the disclosure.

8 SEC. 25. Section 1277 of the Health and Safety Code is  
9 amended to read:

10 1277. (a) No license shall be issued by the state department  
11 unless it finds that the premises, the management, the bylaws, rules  
12 and regulations, the equipment, the staffing, both professional and  
13 nonprofessional, and the standards of care and services are adequate  
14 and appropriate, and that the health facility is operated in the  
15 manner required by this chapter and by the rules and regulations  
16 adopted hereunder.

17 (b) (1) Notwithstanding any provision of Part 2 (commencing  
18 with Section 5600) of Division 5 of, or Division 7 (commencing  
19 with Section 7100) of, the Welfare and Institutions Code or any  
20 other law to the contrary, except Sections 2072 and 2073 of the  
21 Business and Professions Code, the licensure requirements for  
22 professional personnel, including, but not limited to, physicians  
23 and surgeons, dentists, podiatrists, psychologists, marriage and  
24 family therapists, pharmacists, registered nurses, clinical social  
25 workers, and professional clinical counselors in the state and other  
26 governmental health facilities licensed by the state department  
27 shall not be less than for those professional personnel in health  
28 facilities under private ownership.

29 (2) Persons employed as psychologists and clinical social  
30 workers, while continuing in their employment in the same class  
31 as of January 1, 1979, in the same state or other governmental  
32 health facility licensed by the state department, including those  
33 persons on authorized leave, but not including intermittent  
34 personnel, shall be exempt from the requirements of paragraph  
35 (1).

36 (3) The requirements of paragraph (1) may be waived by the  
37 state department solely for persons in the professions of  
38 psychology, marriage and family therapy, clinical social work, or  
39 professional clinical counseling who are gaining qualifying  
40 experience for licensure in such profession in this state. A waiver

1 granted pursuant to this paragraph shall not exceed three years  
2 from the date the employment commences in this state in the case  
3 of psychologists, or four years from commencement of the  
4 employment in this state in the case of marriage and family  
5 therapists, clinical social workers, and professional clinical  
6 counselors, at which time licensure shall have been obtained or  
7 the employment shall be terminated, except that an extension of  
8 a waiver of licensure for marriage and family therapists, clinical  
9 social workers, and professional clinical counselors may be granted  
10 for one additional year, based on extenuating circumstances  
11 determined by the state department pursuant to subdivision (e).  
12 For persons employed as psychologists, clinical social workers,  
13 marriage and family therapists, or professional clinical counselors  
14 less than full time, an extension of a waiver of licensure may be  
15 granted for additional years proportional to the extent of part-time  
16 employment, as long as the person is employed without interruption  
17 in service, but in no case shall the waiver of licensure exceed six  
18 years in the case of clinical social workers, marriage and family  
19 therapists, or professional clinical counselors, or five years in the  
20 case of psychologists.

21 (4) The durational limitation upon waivers pursuant to paragraph  
22 (3) shall not apply to any of the following:

23 (A) Active candidates for a doctoral degree in social work, social  
24 welfare, or social science, who are enrolled at an accredited  
25 university, college, or professional school, but these limitations  
26 shall apply following completion of this training.

27 (B) Active candidates for a doctoral degree in marriage and  
28 family therapy who are enrolled at a school, college, or university,  
29 specified in subdivision (b) of Section 4980.36 of, or subdivision  
30 (b) of Section 4980.37 of, the Business and Professions Code, but  
31 the limitations shall apply following completion of the training.

32 (C) Active candidates for a doctoral degree in professional  
33 clinical counseling who are enrolled at a school, college, or  
34 university, specified in subdivision (b) of Section 4999.32 of, or  
35 subdivision (b) of Section 4999.33 of, the Business and Professions  
36 Code, but the limitations shall apply following the completion of  
37 the training.

38 (5) A waiver pursuant to paragraph (3) shall be granted only to  
39 the extent necessary to qualify for licensure, except that personnel  
40 recruited for employment from outside this state and whose

1 experience is sufficient to gain admission to a licensing  
2 examination shall nevertheless have one year from the date of their  
3 employment in California to become licensed, at which time  
4 licensure shall have been obtained or the employment shall be  
5 terminated, provided that the employee shall take the licensure  
6 examination at the earliest possible date after the date of his or her  
7 employment, and if the employee does not pass the examination  
8 at that time, he or she shall have a second opportunity to pass the  
9 next possible examination, subject to the one-year limit for  
10 marriage and family therapists, clinical social workers, and  
11 professional clinical counselors, and subject to a two-year limit  
12 for psychologists.

13 (c) A special permit shall be issued by the state department  
14 when it finds that the staff, both professional and nonprofessional,  
15 and the standards of care and services are adequate and appropriate,  
16 and that the special services unit is operated in the manner required  
17 in this chapter and by the rules and regulations adopted hereunder.

18 (d) The state department shall apply the same standards to state  
19 and other governmental health facilities that it licenses as it applies  
20 to health facilities in private ownership, including standards  
21 specifying the level of training and supervision of all unlicensed  
22 practitioners. Except for psychologists, the department may grant  
23 an extension of a waiver of licensure for personnel recruited from  
24 outside this state for one additional year, based upon extenuating  
25 circumstances as determined by the department pursuant to  
26 subdivision (e).

27 (e) The department shall grant a request for an extension of a  
28 waiver based on extenuating circumstances, pursuant to subdivision  
29 (b) or (d), if any of the following circumstances exist:

30 (1) The person requesting the extension has experienced a recent  
31 catastrophic event which may impair the person's ability to qualify  
32 for and pass the license examination. Those events may include,  
33 but are not limited to, significant hardship caused by a natural  
34 disaster, serious and prolonged illness of the person, serious and  
35 prolonged illness or death of a child, spouse, or parent, or other  
36 stressful circumstances.

37 (2) The person requesting the extension has difficulty speaking  
38 or writing the English language, or other cultural and ethnic factors  
39 exist which substantially impair the person's ability to qualify for  
40 and pass the license examination.

1 (3) The person requesting the extension has experienced other  
2 personal hardship which the department, in its discretion,  
3 determines to warrant the extension.

4 SEC. 26. Section 1348.8 of the Health and Safety Code is  
5 amended to read:

6 1348.8. (a) A health care service plan that provides, operates,  
7 or contracts for telephone medical advice services to its enrollees  
8 and subscribers shall do all of the following:

9 (1) Ensure that the in-state or out-of-state telephone medical  
10 advice service is registered pursuant to Chapter 15 (commencing  
11 with Section 4999) of Division 2 of the Business and Professions  
12 Code.

13 (2) Ensure that the staff providing telephone medical advice  
14 services for the in-state or out-of-state telephone medical advice  
15 service are licensed as follows:

16 (A) For full service health care service plans, the staff hold a  
17 valid California license as a registered nurse or a valid license in  
18 the state within which they provide telephone medical advice  
19 services as a physician and surgeon or physician assistant, and are  
20 operating in compliance with the laws governing their respective  
21 scopes of practice.

22 (B) (i) For specialized health care service plans providing,  
23 operating, or contracting with a telephone medical advice service  
24 in California, the staff shall be appropriately licensed, registered,  
25 or certified as a dentist pursuant to Chapter 4 (commencing with  
26 Section 1600) of Division 2 of the Business and Professions Code,  
27 as a dental hygienist pursuant to Article 7 (commencing with  
28 Section 1740) of Chapter 4 of Division 2 of the Business and  
29 Professions Code, as a physician and surgeon pursuant to Chapter  
30 5 (commencing with Section 2000) of Division 2 of the Business  
31 and Professions Code or the Osteopathic Initiative Act, as a  
32 registered nurse pursuant to Chapter 6 (commencing with Section  
33 2700) of Division 2 of the Business and Professions Code, as a  
34 psychologist pursuant to Chapter 6.6 (commencing with Section  
35 2900) of Division 2 of the Business and Professions Code, as an  
36 optometrist pursuant to Chapter 7 (commencing with Section 3000)  
37 of Division 2 of the Business and Professions Code, as a marriage  
38 and family therapist pursuant to Chapter 13 (commencing with  
39 Section 4980) of Division 2 of the Business and Professions Code,  
40 as a licensed clinical social worker pursuant to Chapter 14

1 (commencing with Section 4991) of Division 2 of the Business  
2 and Professions Code, as a professional clinical counselor pursuant  
3 to Chapter 16 (commencing with Section 4999.10) of Division 2  
4 of the Business and Professions Code, or as a chiropractor pursuant  
5 to the Chiropractic Initiative Act, and operating in compliance  
6 with the laws governing their respective scopes of practice.

7 (ii) For specialized health care service plans providing,  
8 operating, or contracting with an out-of-state telephone medical  
9 advice service, the staff shall be health care professionals, as  
10 identified in clause (i), who are licensed, registered, or certified  
11 in the state within which they are providing the telephone medical  
12 advice services and are operating in compliance with the laws  
13 governing their respective scopes of practice. All registered nurses  
14 providing telephone medical advice services to both in-state and  
15 out-of-state business entities registered pursuant to this chapter  
16 shall be licensed pursuant to Chapter 6 (commencing with Section  
17 2700) of Division 2 of the Business and Professions Code.

18 (3) Ensure that every full service health care service plan  
19 provides for a physician and surgeon who is available on an on-call  
20 basis at all times the service is advertised to be available to  
21 enrollees and subscribers.

22 (4) Ensure that staff members handling enrollee or subscriber  
23 calls, who are not licensed, certified, or registered as required by  
24 paragraph (2), do not provide telephone medical advice. Those  
25 staff members may ask questions on behalf of a staff member who  
26 is licensed, certified, or registered as required by paragraph (2),  
27 in order to help ascertain the condition of an enrollee or subscriber  
28 so that the enrollee or subscriber can be referred to licensed staff.  
29 However, under no circumstances shall those staff members use  
30 the answers to those questions in an attempt to assess, evaluate,  
31 advise, or make any decision regarding the condition of an enrollee  
32 or subscriber or determine when an enrollee or subscriber needs  
33 to be seen by a licensed medical professional.

34 (5) Ensure that no staff member uses a title or designation when  
35 speaking to an enrollee or subscriber that may cause a reasonable  
36 person to believe that the staff member is a licensed, certified, or  
37 registered professional described in Section 4999.2 of the Business  
38 and Professions Code unless the staff member is a licensed,  
39 certified, or registered professional.

1 (6) Ensure that the in-state or out-of-state telephone medical  
2 advice service designates an agent for service of process in  
3 California and files this designation with the director.

4 (7) Requires that the in-state or out-of-state telephone medical  
5 advice service makes and maintains records for a period of five  
6 years after the telephone medical advice services are provided,  
7 including, but not limited to, oral or written transcripts of all  
8 medical advice conversations with the health care service plan's  
9 enrollees or subscribers in California and copies of all complaints.  
10 If the records of telephone medical advice services are kept out of  
11 state, the health care service plan shall, upon the request of the  
12 director, provide the records to the director within 10 days of the  
13 request.

14 (8) Ensure that the telephone medical advice services are  
15 provided consistent with good professional practice.

16 (b) The director shall forward to the Department of Consumer  
17 Affairs, within 30 days of the end of each calendar quarter, data  
18 regarding complaints filed with the department concerning  
19 telephone medical advice services.

20 (c) For purposes of this section, "telephone medical advice"  
21 means a telephonic communication between a patient and a health  
22 care professional in which the health care professional's primary  
23 function is to provide to the patient a telephonic response to the  
24 patient's questions regarding his or her or a family member's  
25 medical care or treatment. "Telephone medical advice" includes  
26 assessment, evaluation, or advice provided to patients or their  
27 family members.

28 SEC. 27. Section 1367.26 of the Health and Safety Code is  
29 amended to read:

30 1367.26. (a) A health care service plan shall provide, upon  
31 request, a list of the following contracting providers, within the  
32 enrollee's or prospective enrollee's general geographic area:

33 (1) Primary care providers.

34 (2) Medical groups.

35 (3) Independent practice associations.

36 (4) Hospitals.

37 (5) All other available contracting physicians and surgeons,  
38 psychologists, acupuncturists, optometrists, podiatrists,  
39 chiropractors, licensed clinical social workers, marriage and family  
40 therapists, professional clinical counselors, and nurse midwives

1 to the extent their services may be accessed and are covered  
2 through the contract with the plan.

3 (b) This list shall indicate which providers have notified the  
4 plan that they have closed practices or are otherwise not accepting  
5 new patients at that time.

6 (c) The list shall indicate that it is subject to change without  
7 notice and shall provide a telephone number that enrollees can  
8 contact to obtain information regarding a particular provider. This  
9 information shall include whether or not that provider has indicated  
10 that he or she is accepting new patients.

11 (d) A health care service plan shall provide this information in  
12 written form to its enrollees or prospective enrollees upon request.  
13 A plan may, with the permission of the enrollee, satisfy the  
14 requirements of this section by directing the enrollee or prospective  
15 enrollee to the plan's provider listings on its Internet Web site.  
16 Plans shall ensure that the information provided is updated at least  
17 quarterly. A plan may satisfy this update requirement by providing  
18 an insert or addendum to any existing provider listing. This  
19 requirement shall not mandate a complete republishing of a plan's  
20 provider directory.

21 (e) Each plan shall make information available, upon request,  
22 concerning a contracting provider's professional degree, board  
23 certifications, and any recognized subspecialty qualifications a  
24 specialist may have.

25 (f) Nothing in this section shall prohibit a plan from requiring  
26 its contracting providers, contracting provider groups, or  
27 contracting specialized health care plans to satisfy these  
28 requirements. If a plan delegates the responsibility of complying  
29 with this section to its contracting providers, contracting provider  
30 groups, or contracting specialized health care plans, the plan shall  
31 ensure that the requirements of this section are met.

32 (g) Every health care service plan shall allow enrollees to request  
33 the information required by this section through their toll-free  
34 telephone number or in writing.

35 SEC. 28. Section 1373 of the Health and Safety Code is  
36 amended to read:

37 1373. (a) A plan contract may not provide an exception for  
38 other coverage if the other coverage is entitlement to Medi-Cal  
39 benefits under Chapter 7 (commencing with Section 14000) or  
40 Chapter 8 (commencing with Section 14200) of Part 3 of Division

1 9 of the Welfare and Institutions Code, or Medicaid benefits under  
2 Subchapter 19 (commencing with Section 1396) of Chapter 7 of  
3 Title 42 of the United States Code.

4 Each plan contract shall be interpreted not to provide an  
5 exception for the Medi-Cal or Medicaid benefits.

6 A plan contract shall not provide an exemption for enrollment  
7 because of an applicant's entitlement to Medi-Cal benefits under  
8 Chapter 7 (commencing with Section 14000) or Chapter 8  
9 (commencing with Section 14200) of Part 3 of Division 9 of the  
10 Welfare and Institutions Code, or Medicaid benefits under  
11 Subchapter 19 (commencing with Section 1396) of Chapter 7 of  
12 Title 42 of the United States Code.

13 A plan contract may not provide that the benefits payable  
14 thereunder are subject to reduction if the individual insured has  
15 entitlement to the Medi-Cal or Medicaid benefits.

16 (b) A plan contract that provides coverage, whether by specific  
17 benefit or by the effect of general wording, for sterilization  
18 operations or procedures shall not impose any disclaimer,  
19 restriction on, or limitation of, coverage relative to the covered  
20 individual's reason for sterilization.

21 As used in this section, "sterilization operations or procedures"  
22 shall have the same meaning as that specified in Section 10120 of  
23 the Insurance Code.

24 (c) Every plan contract that provides coverage to the spouse or  
25 dependents of the subscriber or spouse shall grant immediate  
26 accident and sickness coverage, from and after the moment of  
27 birth, to each newborn infant of any subscriber or spouse covered  
28 and to each minor child placed for adoption from and after the date  
29 on which the adoptive child's birth parent or other appropriate  
30 legal authority signs a written document, including, but not limited  
31 to, a health facility minor release report, a medical authorization  
32 form, or a relinquishment form, granting the subscriber or spouse  
33 the right to control health care for the adoptive child or, absent  
34 this written document, on the date there exists evidence of the  
35 subscriber's or spouse's right to control the health care of the child  
36 placed for adoption. No plan may be entered into or amended if it  
37 contains any disclaimer, waiver, or other limitation of coverage  
38 relative to the coverage or insurability of newborn infants of, or  
39 children placed for adoption with, a subscriber or spouse covered  
40 as required by this subdivision.

1 (d) (1) Every plan contract that provides that coverage of a  
2 dependent child of a subscriber shall terminate upon attainment  
3 of the limiting age for dependent children specified in the plan,  
4 shall also provide that attainment of the limiting age shall not  
5 operate to terminate the coverage of the child while the child is  
6 and continues to meet both of the following criteria:

7 (A) Incapable of self-sustaining employment by reason of a  
8 physically or mentally disabling injury, illness, or condition.

9 (B) Chiefly dependent upon the subscriber for support and  
10 maintenance.

11 (2) The plan shall notify the subscriber that the dependent child's  
12 coverage will terminate upon attainment of the limiting age unless  
13 the subscriber submits proof of the criteria described in  
14 subparagraphs (A) and (B) of paragraph (1) to the plan within 60  
15 days of the date of receipt of the notification. The plan shall send  
16 this notification to the subscriber at least 90 days prior to the date  
17 the child attains the limiting age. Upon receipt of a request by the  
18 subscriber for continued coverage of the child and proof of the  
19 criteria described in subparagraphs (A) and (B) of paragraph (1),  
20 the plan shall determine whether the child meets that criteria before  
21 the child attains the limiting age. If the plan fails to make the  
22 determination by that date, it shall continue coverage of the child  
23 pending its determination.

24 (3) The plan may subsequently request information about a  
25 dependent child whose coverage is continued beyond the limiting  
26 age under this subdivision but not more frequently than annually  
27 after the two-year period following the child's attainment of the  
28 limiting age.

29 (4) If the subscriber changes carriers to another plan or to a  
30 health insurer, the new plan or insurer shall continue to provide  
31 coverage for the dependent child. The new plan or insurer may  
32 request information about the dependent child initially and not  
33 more frequently than annually thereafter to determine if the child  
34 continues to satisfy the criteria in subparagraphs (A) and (B) of  
35 paragraph (1). The subscriber shall submit the information  
36 requested by the new plan or insurer within 60 days of receiving  
37 the request.

38 (5) (A) Except as set forth in subparagraph (B), under no  
39 circumstances shall the limiting age be less than 26 years of age

1 with respect to plan years beginning on or after September 23,  
2 2010.

3 (B) For plan years beginning before January 1, 2014, a group  
4 health care service plan contract that qualifies as a grandfathered  
5 health plan under Section 1251 of the federal Patient Protection  
6 and Affordable Care Act (Public Law 111-148) and that makes  
7 available dependent coverage of children may exclude from  
8 coverage an adult child who has not attained ~~the age of 26 years~~  
9 *26 years of age* only if the adult child is eligible to enroll in an  
10 eligible employer-sponsored health plan, as defined in Section  
11 5000A(f)(2) of the Internal Revenue Code, other than a group  
12 health plan of a parent.

13 (C) (i) With respect to a child (I) whose coverage under a group  
14 or individual plan contract ended, or who was denied or not eligible  
15 for coverage under a group or individual plan contract, because  
16 under the terms of the contract the availability of dependent  
17 coverage of children ended before the attainment of 26 years of  
18 age, and (II) who becomes eligible for that coverage by reason of  
19 the application of this paragraph, the health care service plan shall  
20 give the child an opportunity to enroll that shall continue for at  
21 least 30 days. This opportunity and the notice described in clause  
22 (ii) shall be provided not later than the first day of the first plan  
23 year beginning on or after September 23, 2010, consistent with  
24 the federal Patient Protection and Affordable Care Act (Public  
25 Law 111-148), as amended by the federal Health Care and  
26 Education Reconciliation Act of 2010 (Public Law 111-152), and  
27 any additional federal guidance or regulations issued by the United  
28 States Secretary of Health and Human Services.

29 (ii) The health care service plan shall provide written notice  
30 stating that a dependent described in clause (i) who has not attained  
31 26 years of age is eligible to enroll in the plan for coverage. This  
32 notice may be provided to the dependent's parent on behalf of the  
33 dependent. If the notice is included with other enrollment materials  
34 for a group plan, the notice shall be prominent.

35 (iii) In the case of an individual who enrolls under this  
36 subparagraph, coverage shall take effect no later than the first day  
37 of the first plan year beginning on or after September 23, 2010.

38 (iv) A dependent enrolling in a group health plan for coverage  
39 pursuant to this subparagraph shall be treated as a special enrollee  
40 as provided under the rules of Section 146.117(d) of Title 45 of

1 the Code of Federal Regulations. The health care service plan shall  
2 offer the recipient of the notice all of the benefit packages available  
3 to similarly situated individuals who did not lose coverage by  
4 reason of cessation of dependent status. Any difference in benefits  
5 or cost-sharing requirements shall constitute a different benefit  
6 package. A dependent enrolling in a group health plan for coverage  
7 pursuant to this subparagraph shall not be required to pay more  
8 for coverage than similarly situated individuals who did not lose  
9 coverage by reason of cessation of dependent status.

10 (D) Nothing in this section shall require a health care service  
11 plan to make coverage available for a child of a child receiving  
12 dependent coverage. Nothing in this section shall be construed to  
13 modify the definition of “dependent” as used in the Revenue and  
14 Taxation Code with respect to the tax treatment of the cost of  
15 coverage.

16 (e) A plan contract that provides coverage, whether by specific  
17 benefit or by the effect of general wording, for both an employee  
18 and one or more covered persons dependent upon the employee  
19 and provides for an extension of the coverage for any period  
20 following a termination of employment of the employee shall also  
21 provide that this extension of coverage shall apply to dependents  
22 upon the same terms and conditions precedent as applied to the  
23 covered employee, for the same period of time, subject to payment  
24 of premiums, if any, as required by the terms of the policy and  
25 subject to any applicable collective bargaining agreement.

26 (f) A group contract shall not discriminate against handicapped  
27 persons or against groups containing handicapped persons. Nothing  
28 in this subdivision shall preclude reasonable provisions in a plan  
29 contract against liability for services or reimbursement of the  
30 handicap condition or conditions relating thereto, as may be  
31 allowed by rules of the director.

32 (g) Every group contract shall set forth the terms and conditions  
33 under which subscribers and enrollees may remain in the plan in  
34 the event the group ceases to exist, the group contract is terminated,  
35 or an individual subscriber leaves the group, or the enrollees’  
36 eligibility status changes.

37 (h) (1) A health care service plan or specialized health care  
38 service plan may provide for coverage of, or for payment for,  
39 professional mental health services, or vision care services, or for  
40 the exclusion of these services. If the terms and conditions include

1 coverage for services provided in a general acute care hospital or  
2 an acute psychiatric hospital as defined in Section 1250 and do  
3 not restrict or modify the choice of providers, the coverage shall  
4 extend to care provided by a psychiatric health facility as defined  
5 in Section 1250.2 operating pursuant to licensure by the State  
6 Department of Mental Health. A health care service plan that offers  
7 outpatient mental health services but does not cover these services  
8 in all of its group contracts shall communicate to prospective group  
9 contractholders as to the availability of outpatient coverage for the  
10 treatment of mental or nervous disorders.

11 (2) No plan shall prohibit the member from selecting any  
12 psychologist who is licensed pursuant to the Psychology Licensing  
13 Law (Chapter 6.6 (commencing with Section 2900) of Division 2  
14 of the Business and Professions Code), any optometrist who is the  
15 holder of a certificate issued pursuant to Chapter 7 (commencing  
16 with Section 3000) of Division 2 of the Business and Professions  
17 Code or, upon referral by a physician and surgeon licensed pursuant  
18 to the Medical Practice Act (Chapter 5 (commencing with Section  
19 2000) of Division 2 of the Business and Professions Code), (A)  
20 any marriage and family therapist who is the holder of a license  
21 under Section 4980.50 of the Business and Professions Code, (B)  
22 any licensed clinical social worker who is the holder of a license  
23 under Section 4996 of the Business and Professions Code, (C) any  
24 registered nurse licensed pursuant to Chapter 6 (commencing with  
25 Section 2700) of Division 2 of the Business and Professions Code,  
26 who possesses a master's degree in psychiatric-mental health  
27 nursing and is listed as a psychiatric-mental health nurse by the  
28 Board of Registered Nursing, (D) any advanced practice registered  
29 nurse certified as a clinical nurse specialist pursuant to Article 9  
30 (commencing with Section 2838) of Chapter 6 of Division 2 of  
31 the Business and Professions Code who participates in expert  
32 clinical practice in the specialty of psychiatric-mental health  
33 nursing, to perform the particular services covered under the terms  
34 of the plan, and the certificate holder is expressly authorized by  
35 law to perform these services, or (E) any professional clinical  
36 counselor who is the holder of a license under Chapter 16  
37 (commencing with Section 4999.10) of Division 2 of the Business  
38 and Professions Code.

39 (3) Nothing in this section shall be construed to allow any  
40 certificate holder or licensee enumerated in this section to perform

1 professional mental health services beyond his or her field or fields  
2 of competence as established by his or her education, training, and  
3 experience.

4 (4) For the purposes of this section:

5 (A) “Marriage and family therapist” means a licensed marriage  
6 and family therapist who has received specific instruction in  
7 assessment, diagnosis, prognosis, and counseling, and  
8 psychotherapeutic treatment of premarital, marriage, family, and  
9 child relationship dysfunctions, which is equivalent to the  
10 instruction required for licensure on January 1, 1981.

11 (B) “Professional clinical counselor” means a licensed  
12 professional clinical counselor who has received specific  
13 instruction in assessment, diagnosis, prognosis, counseling, and  
14 psychotherapeutic treatment of mental and emotional disorders,  
15 which is equivalent to the instruction required for licensure on  
16 January 1, 2012.

17 (5) Nothing in this section shall be construed to allow a member  
18 to select and obtain mental health or psychological or vision care  
19 services from a certificate holder or licenseholder who is not  
20 directly affiliated with or under contract to the health care service  
21 plan or specialized health care service plan to which the member  
22 belongs. All health care service plans and individual practice  
23 associations that offer mental health benefits shall make reasonable  
24 efforts to make available to their members the services of licensed  
25 psychologists. However, a failure of a plan or association to comply  
26 with the requirements of the preceding sentence shall not constitute  
27 a misdemeanor.

28 (6) As used in this subdivision, “individual practice association”  
29 means an entity as defined in subsection (5) of Section 1307 of  
30 the federal Public Health Service Act (42 U.S.C. Sec. 300e-1(5)).

31 (7) Health care service plan coverage for professional mental  
32 health services may include community residential treatment  
33 services that are alternatives to inpatient care and that are directly  
34 affiliated with the plan or to which enrollees are referred by  
35 providers affiliated with the plan.

36 (i) If the plan utilizes arbitration to settle disputes, the plan  
37 contracts shall set forth the type of disputes subject to arbitration,  
38 the process to be utilized, and how it is to be initiated.

39 (j) A plan contract that provides benefits that accrue after a  
40 certain time of confinement in a health care facility shall specify

1 what constitutes a day of confinement or the number of consecutive  
2 hours of confinement that are requisite to the commencement of  
3 benefits.

4 (k) If a plan provides coverage for a dependent child who is  
5 over 26 years of age and enrolled as a full-time student at a  
6 secondary or postsecondary educational institution, the following  
7 shall apply:

8 (1) Any break in the school calendar shall not disqualify the  
9 dependent child from coverage.

10 (2) If the dependent child takes a medical leave of absence, and  
11 the nature of the dependent child's injury, illness, or condition  
12 would render the dependent child incapable of self-sustaining  
13 employment, the provisions of subdivision (d) shall apply if the  
14 dependent child is chiefly dependent on the subscriber for support  
15 and maintenance.

16 (3) (A) If the dependent child takes a medical leave of absence  
17 from school, but the nature of the dependent child's injury, illness,  
18 or condition does not meet the requirements of paragraph (2), the  
19 dependent child's coverage shall not terminate for a period not to  
20 exceed 12 months or until the date on which the coverage is  
21 scheduled to terminate pursuant to the terms and conditions of the  
22 plan, whichever comes first. The period of coverage under this  
23 paragraph shall commence on the first day of the medical leave of  
24 absence from the school or on the date the physician and surgeon  
25 determines the illness prevented the dependent child from attending  
26 school, whichever comes first. Any break in the school calendar  
27 shall not disqualify the dependent child from coverage under this  
28 paragraph.

29 (B) Documentation or certification of the medical necessity for  
30 a leave of absence from school shall be submitted to the plan at  
31 least 30 days prior to the medical leave of absence from the school,  
32 if the medical reason for the absence and the absence are  
33 foreseeable, or 30 days after the start date of the medical leave of  
34 absence from school and shall be considered prima facie evidence  
35 of entitlement to coverage under this paragraph.

36 (4) This subdivision shall not apply to a specialized health care  
37 service plan or to a Medicare supplement plan.

38 SEC. 29. Section 1373.8 of the Health and Safety Code is  
39 amended to read:

1 1373.8. A health care service plan contract where the plan is  
2 licensed to do business in this state and the plan provides coverage  
3 that includes California residents, but that may be written or issued  
4 for delivery outside of California, and where benefits are provided  
5 within the scope of practice of a licensed clinical social worker, a  
6 registered nurse licensed pursuant to Chapter 6 (commencing with  
7 Section 2700) of Division 2 of the Business and Professions Code  
8 who possesses a master's degree in psychiatric-mental health  
9 nursing and is listed as a psychiatric-mental health nurse by the  
10 Board of Registered Nursing, an advanced practice registered nurse  
11 who is certified as a clinical nurse specialist pursuant to Article 9  
12 (commencing with Section 2838) of Chapter 6 of Division 2 of  
13 the Business and Professions Code who participates in expert  
14 clinical practice in the specialty of psychiatric-mental health  
15 nursing, a marriage and family therapist who is the holder of a  
16 license under Section 4980.50 of the Business and Professions  
17 Code, or a professional clinical counselor who is the holder of a  
18 license under Chapter 16 (commencing with Section 4999.10) of  
19 Division 2 of the Business and Professions Code shall not be  
20 deemed to prohibit persons covered under the contract from  
21 selecting those licensed persons in California to perform the  
22 services in California that are within the terms of the contract even  
23 though the licensees are not licensed in the state where the contract  
24 is written or issued for delivery.

25 It is the intent of the Legislature in amending this section in the  
26 1984 portion of the 1983–84 Legislative Session that persons  
27 covered by the contract and those providers of health care specified  
28 in this section who are licensed in California should be entitled to  
29 the benefits provided by the plan for services of those providers  
30 rendered to those persons.

31 SEC. 30. Section 1373.95 of the Health and Safety Code is  
32 amended to read:

33 1373.95. (a) (1) A health care service plan, other than a  
34 specialized health care service plan that offers professional mental  
35 health services on an employer-sponsored group basis, shall file  
36 a written continuity of care policy as a material modification with  
37 the department before March 31, 2004.

38 (2) A health care service plan shall include all of the following  
39 in its written continuity of care policy:

1 (A) A description of the plan’s process for the block transfer of  
2 enrollees from a terminated provider group or hospital to a new  
3 provider group or hospital.

4 (B) A description of the manner in which the plan facilitates  
5 the completion of covered services pursuant to Section 1373.96.

6 (C) A template of the notice the plan proposes to send to  
7 enrollees describing its policy and informing enrollees of their  
8 right to completion of covered services.

9 (D) A description of the plan’s process to review an enrollee’s  
10 request for the completion of covered services.

11 (E) A provision ensuring that reasonable consideration is given  
12 to the potential clinical effect on an enrollee’s treatment caused  
13 by a change of provider.

14 (3) If approved by the department, the provisions of the written  
15 continuity of care policy shall replace all prior continuity of care  
16 policies. The plan shall file a revision of the policy with the  
17 department if it makes a material change to it.

18 (b) (1) The provisions of this subdivision apply to a specialized  
19 health care service plan that offers professional mental health  
20 services on an employer-sponsored group basis.

21 (2) The plan shall file with the department a written policy  
22 describing the manner in which it facilitates the continuity of care  
23 for a new enrollee who has been receiving services from a  
24 nonparticipating mental health provider for an acute, serious, or  
25 chronic mental health condition when his or her employer changed  
26 health plans. The written policy shall allow the new enrollee a  
27 reasonable transition period to continue his or her course of  
28 treatment with the nonparticipating mental health provider prior  
29 to transferring to a participating provider and shall include the  
30 provision of mental health services on a timely, appropriate, and  
31 medically necessary basis from the nonparticipating provider. The  
32 policy may provide that the length of the transition period take  
33 into account on a case-by-case basis, the severity of the enrollee’s  
34 condition and the amount of time reasonably necessary to effect  
35 a safe transfer. The policy shall ensure that reasonable  
36 consideration is given to the potential clinical effect of a change  
37 of provider on the enrollee’s treatment for the condition. The policy  
38 shall describe the plan’s process to review an enrollee’s request  
39 to continue his or her course of treatment with a nonparticipating  
40 mental health provider. Nothing in this paragraph shall be construed

1 to require the plan to accept a nonparticipating mental health  
2 provider onto its panel for treatment of other enrollees. For  
3 purposes of the continuing treatment of the transferring enrollee,  
4 the plan may require the nonparticipating mental health provider,  
5 as a condition of the right conferred under this section, to enter  
6 into its standard mental health provider contract.

7 (3) A plan may require a nonparticipating mental health provider  
8 whose services are continued pursuant to the written policy, to  
9 agree in writing to the same contractual terms and conditions that  
10 are imposed upon the plan's participating providers, including  
11 location within the plan's service area, reimbursement  
12 methodologies, and rates of payment. If the plan determines that  
13 an enrollee's health care treatment should temporarily continue  
14 with his or her existing provider or nonparticipating mental health  
15 provider, the plan shall not be liable for actions resulting solely  
16 from the negligence, malpractice, or other tortious or wrongful  
17 acts arising out of the provisions of services by the existing  
18 provider or a nonparticipating mental health provider.

19 (4) The written policy shall not apply to an enrollee who is  
20 offered an out-of-network option or to an enrollee who had the  
21 option to continue with his or her previous specialized health care  
22 service plan that offers professional mental health services on an  
23 employer-sponsored group basis or mental health provider and  
24 instead voluntarily chose to change health plans.

25 (5) This subdivision shall not apply to a specialized health care  
26 service plan that offers professional mental health services on an  
27 employer-sponsored group basis if it includes out-of-network  
28 coverage that allows the enrollee to obtain services from his or her  
29 existing mental health provider or nonparticipating mental health  
30 provider.

31 (c) The health care service plan, including a specialized health  
32 care service plan that offers professional mental health services  
33 on an employer-sponsored group basis, shall provide to all new  
34 enrollees notice of its written continuity of care policy and  
35 information regarding the process for an enrollee to request a  
36 review under the policy and shall provide, upon request, a copy  
37 of the written policy to an enrollee.

38 (d) Nothing in this section shall require a health care service  
39 plan or a specialized health care service plan that offers  
40 professional mental health services on an employer-sponsored

1 group basis to cover services or provide benefits that are not  
2 otherwise covered under the terms and conditions of the plan  
3 contract.

4 (e) The following definitions apply for the purposes of this  
5 section:

6 (1) “Hospital” means a general acute care hospital.

7 (2) “Nonparticipating mental health provider” means a  
8 psychiatrist, licensed psychologist, licensed marriage and family  
9 therapist, licensed social worker, or licensed professional clinical  
10 counselor who does not contract with the specialized health care  
11 service plan that offers professional mental health services on an  
12 employer-sponsored group basis.

13 (3) “Provider group” means a medical group, independent  
14 practice association, or any other similar organization.

15 SEC. 31. Section 123105 of the Health and Safety Code is  
16 amended to read:

17 123105. As used in this chapter:

18 (a) “Health care provider” means any of the following:

19 (1) A health facility licensed pursuant to Chapter 2 (commencing  
20 with Section 1250) of Division 2.

21 (2) A clinic licensed pursuant to Chapter 1 (commencing with  
22 Section 1200) of Division 2.

23 (3) A home health agency licensed pursuant to Chapter 8  
24 (commencing with Section 1725) of Division 2.

25 (4) A physician and surgeon licensed pursuant to Chapter 5  
26 (commencing with Section 2000) of Division 2 of the Business  
27 and Professions Code or pursuant to the Osteopathic Act.

28 (5) A podiatrist licensed pursuant to Article 22 (commencing  
29 with Section 2460) of Chapter 5 of Division 2 of the Business and  
30 Professions Code.

31 (6) A dentist licensed pursuant to Chapter 4 (commencing with  
32 Section 1600) of Division 2 of the Business and Professions Code.

33 (7) A psychologist licensed pursuant to Chapter 6.6  
34 (commencing with Section 2900) of Division 2 of the Business  
35 and Professions Code.

36 (8) An optometrist licensed pursuant to Chapter 7 (commencing  
37 with Section 3000) of Division 2 of the Business and Professions  
38 Code.

39 (9) A chiropractor licensed pursuant to the Chiropractic Initiative  
40 Act.

1 (10) A marriage and family therapist licensed pursuant to  
2 Chapter 13 (commencing with Section 4980) of Division 2 of the  
3 Business and Professions Code.

4 (11) A clinical social worker licensed pursuant to Chapter 14  
5 (commencing with Section 4990) of Division 2 of the Business  
6 and Professions Code.

7 (12) A physical therapist licensed pursuant to Chapter 5.7  
8 (commencing with Section 2600) of Division 2 of the Business  
9 and Professions Code.

10 (13) An occupational therapist licensed pursuant to Chapter 5.6  
11 (commencing with Section 2570).

12 (14) A professional clinical counselor licensed pursuant to  
13 Chapter 16 (commencing with Section 4999.10) of Division 2 of  
14 the Business and Professions Code.

15 (b) “Mental health records” means patient records, or discrete  
16 portions thereof, specifically relating to evaluation or treatment of  
17 a mental disorder. “Mental health records” includes, but is not  
18 limited to, all alcohol and drug abuse records.

19 (c) “Patient” means a patient or former patient of a health care  
20 provider.

21 (d) “Patient records” means records in any form or medium  
22 maintained by, or in the custody or control of, a health care  
23 provider relating to the health history, diagnosis, or condition of  
24 a patient, or relating to treatment provided or proposed to be  
25 provided to the patient. “Patient records” includes only records  
26 pertaining to the patient requesting the records or whose  
27 representative requests the records. “Patient records” does not  
28 include information given in confidence to a health care provider  
29 by a person other than another health care provider or the patient,  
30 and that material may be removed from any records prior to  
31 inspection or copying under Section 123110 or 123115. “Patient  
32 records” does not include information contained in aggregate form,  
33 such as indices, registers, or logs.

34 (e) “Patient’s representative” or “representative” means any of  
35 the following:

36 (1) A parent or guardian of a minor who is a patient.

37 (2) The guardian or conservator of the person of an adult patient.

38 (3) An agent as defined in Section 4607 of the Probate Code,  
39 to the extent necessary for the agent to fulfill his or her duties as

1 set forth in Division 4.7 (commencing with Section 4600) of the  
2 Probate Code.

3 (4) The beneficiary as defined in Section 24 of the Probate Code  
4 or personal representative as defined in Section 58 of the Probate  
5 Code, of a deceased patient.

6 (f) “Alcohol and drug abuse records” means patient records, or  
7 discrete portions thereof, specifically relating to evaluation and  
8 treatment of alcoholism or drug abuse.

9 SEC. 32. Section 123115 of the Health and Safety Code is  
10 amended to read:

11 123115. (a) The representative of a minor shall not be entitled  
12 to inspect or obtain copies of the minor’s patient records in either  
13 of the following circumstances:

14 (1) With respect to which the minor has a right of inspection  
15 under Section 123110.

16 (2) Where the health care provider determines that access to the  
17 patient records requested by the representative would have a  
18 detrimental effect on the provider’s professional relationship with  
19 the minor patient or the minor’s physical safety or psychological  
20 well-being. The decision of the health care provider as to whether  
21 or not a minor’s records are available for inspection or copying  
22 under this section shall not attach any liability to the provider,  
23 unless the decision is found to be in bad faith.

24 (b) When a health care provider determines there is a substantial  
25 risk of significant adverse or detrimental consequences to a patient  
26 in seeing or receiving a copy of mental health records requested  
27 by the patient, the provider may decline to permit inspection or  
28 provide copies of the records to the patient, subject to the following  
29 conditions:

30 (1) The health care provider shall make a written record, to be  
31 included with the mental health records requested, noting the date  
32 of the request and explaining the health care provider’s reason for  
33 refusing to permit inspection or provide copies of the records,  
34 including a description of the specific adverse or detrimental  
35 consequences to the patient that the provider anticipates would  
36 occur if inspection or copying were permitted.

37 (2) (A) The health care provider shall permit inspection by, or  
38 provide copies of the mental health records to, a licensed physician  
39 and surgeon, licensed psychologist, licensed marriage and family

1 therapist, licensed clinical social worker, or licensed professional  
2 clinical counselor, designated by request of the patient.

3 (B) Any person registered as a marriage and family therapist  
4 intern, as defined in Chapter 13 (commencing with Section 4980)  
5 of Division 2 of the Business and Professions Code, may not  
6 inspect the patient's mental health records or obtain copies thereof,  
7 except pursuant to the direction or supervision of a licensed  
8 professional specified in subdivision (g) of Section 4980.03 of the  
9 Business and Professions Code. Prior to providing copies of mental  
10 health records to a registered marriage and family therapist intern,  
11 a receipt for those records shall be signed by the supervising  
12 licensed professional.

13 (C) Any person registered as a clinical counselor intern, as  
14 defined in Chapter 16 (commencing with Section 4999.10) of  
15 Division 2 of the Business and Professions Code, may not inspect  
16 the patient's mental health records or obtain copies thereof, except  
17 pursuant to the direction or supervision of a licensed professional  
18 specified in subdivision (h) of Section 4999.12 of the Business  
19 and Professions Code. Prior to providing copies of mental health  
20 records to a person registered as a clinical counselor intern, a  
21 receipt for those records shall be signed by the supervising licensed  
22 professional.

23 (D) A licensed physician and surgeon, licensed psychologist,  
24 licensed marriage and family therapist, licensed clinical social  
25 worker, licensed professional clinical counselor, registered  
26 marriage and family therapist intern, or person registered as a  
27 clinical counselor intern to whom the records are provided for  
28 inspection or copying shall not permit inspection or copying by  
29 the patient.

30 (3) The health care provider shall inform the patient of the  
31 provider's refusal to permit him or her to inspect or obtain copies  
32 of the requested records, and inform the patient of the right to  
33 require the provider to permit inspection by, or provide copies to,  
34 a licensed physician and surgeon, licensed psychologist, licensed  
35 marriage and family therapist, licensed clinical social worker, or  
36 licensed professional clinical counselor designated by written  
37 authorization of the patient.

38 (4) The health care provider shall indicate in the mental health  
39 records of the patient whether the request was made under  
40 paragraph (2).

1 SEC. 33. Section 10133.55 of the Insurance Code is amended  
2 to read:

3 10133.55. (a) (1) Except as provided in paragraph (2), every  
4 disability insurer covering hospital, medical, and surgical expenses  
5 on a group basis that contracts with providers for alternative rates  
6 pursuant to Section 10133 and limits payments under those policies  
7 to services secured by insureds and subscribers from providers  
8 charging alternative rates pursuant to these contracts, shall file  
9 with the Department of Insurance, a written policy describing how  
10 the insurer shall facilitate the continuity of care for new insureds  
11 or enrollees receiving services during a current episode of care for  
12 an acute condition from a noncontracting provider. This written  
13 policy shall describe the process used to facilitate continuity of  
14 care, including the assumption of care by a contracting provider.

15 (2) On or before July 1, 2002, every disability insurer covering  
16 hospital, medical, and surgical expenses on a group basis that  
17 contracts with providers for alternative rates pursuant to Section  
18 10133 and limits payments under those policies to services secured  
19 by insureds and subscribers from providers charging alternative  
20 rates pursuant to these contracts, shall file with the department a  
21 written policy describing how the insurer shall facilitate the  
22 continuity of care for new enrollees who have been receiving  
23 services for an acute, serious, or chronic mental health condition  
24 from a nonparticipating mental health provider when the enrollee's  
25 employer has changed policies. Every written policy shall allow  
26 the new enrollee a reasonable transition period to continue his or  
27 her course of treatment with the nonparticipating mental health  
28 provider prior to transferring to another participating provider and  
29 shall include the provision of mental health services on a timely,  
30 appropriate, and medically necessary basis from the  
31 nonparticipating provider. The policy may provide that the length  
32 of the transition period take into account the severity of the  
33 enrollee's condition and the amount of time reasonably necessary  
34 to effect a safe transfer on a case-by-case basis. Nothing in this  
35 paragraph shall be construed to require the insurer to accept a  
36 nonparticipating mental health provider onto its panel for treatment  
37 of other enrollees. For purposes of the continuing treatment of the  
38 transferring enrollee, the insurer may require the nonparticipating  
39 mental health provider, as a condition of the right conferred under

1 this section, to enter into the standard mental health provider  
2 contract.

3 (b) Notice of the policy and information regarding how enrollees  
4 may request a review under the policy shall be provided to all new  
5 enrollees, except those enrollees who are not eligible as described  
6 in subdivision (e). A copy of the written policy shall be provided  
7 to eligible enrollees upon request. The written policy required to  
8 be filed under subdivision (a) shall describe how requests to  
9 continue services with an existing noncontracting provider are  
10 reviewed by the insurer. The policy shall ensure that reasonable  
11 consideration is given to the potential clinical effect that a change  
12 of provider would have on the insured's or subscriber's treatment  
13 for the acute condition.

14 (c) An insurer may require any nonparticipating provider whose  
15 services are continued pursuant to the written policy to agree in  
16 writing to meet the same contractual terms and conditions that are  
17 imposed upon the insurer's participating providers, including  
18 location within the service area, reimbursement methodologies,  
19 and rates of payment. If the insurer determines that a patient's  
20 health care treatment should temporarily continue with the patient's  
21 existing provider or nonparticipating mental health provider, the  
22 insurer shall not be liable for actions resulting solely from the  
23 negligence, malpractice, or other tortious or wrongful acts arising  
24 out of the provision of services by the existing provider or  
25 nonparticipating mental health provider.

26 (d) Nothing in this section shall require an insurer to cover  
27 services or provide benefits that are not otherwise covered under  
28 the terms and conditions of the policy contract.

29 (e) The written policy shall not apply to any insured or  
30 subscriber who is offered an out-of-network option, or who had  
31 the option to continue with his or her previous health benefits  
32 carrier or provider and instead voluntarily chose to change.

33 (f) This section shall not apply to insurer contracts that include  
34 out-of-network coverage under which the insured or subscriber is  
35 able to obtain services from the insured's or subscriber's existing  
36 provider or nonparticipating mental health provider.

37 (g) (1) For purposes of this section, "provider" refers to a person  
38 who is described in subdivision (f) of Section 900 of the Business  
39 and Professions Code.

1 (2) For purposes of this section, “nonparticipating mental health  
2 provider” refers to a psychiatrist, licensed psychologist, licensed  
3 marriage and family therapist, licensed clinical social worker, or  
4 licensed professional clinical counselor who is not part of the  
5 insurer’s contracted provider network.

6 (h) This section shall only apply to a group disability insurance  
7 policy if it provides coverage for hospital, medical, or surgical  
8 benefits.

9 SEC. 34. Section 10176 of the Insurance Code is amended to  
10 read:

11 10176. (a) In disability insurance, the policy may provide for  
12 payment of medical, surgical, chiropractic, physical therapy, speech  
13 pathology, audiology, acupuncture, professional mental health,  
14 dental, hospital, or optometric expenses upon a reimbursement  
15 basis, or for the exclusion of any of those services, and provision  
16 may be made therein for payment of all or a portion of the amount  
17 of charge for these services without requiring that the insured first  
18 pay the expenses. The policy shall not prohibit the insured from  
19 selecting any psychologist or other person who is the holder of a  
20 certificate or license under Section 1000, 1634, 2050, 2472, 2553,  
21 2630, 2948, 3055, or 4938 of the Business and Professions Code,  
22 to perform the particular services covered under the terms of the  
23 policy, the certificate holder or licensee being expressly authorized  
24 by law to perform those services.

25 (b) If the insured selects any person who is a holder of a  
26 certificate under Section 4938 of the Business and Professions  
27 Code, a disability insurer or nonprofit hospital service plan shall  
28 pay the bona fide claim of an acupuncturist holding a certificate  
29 pursuant to Section 4938 of the Business and Professions Code  
30 for the treatment of an insured person only if the insured’s policy  
31 or contract expressly includes acupuncture as a benefit and includes  
32 coverage for the injury or illness treated. Unless the policy or  
33 contract expressly includes acupuncture as a benefit, no person  
34 who is the holder of any license or certificate set forth in this  
35 section shall be paid or reimbursed under the policy for  
36 acupuncture.

37 (c) The policy shall not prohibit the insured, upon referral by a  
38 physician and surgeon licensed under Section 2050 of the Business  
39 and Professions Code, from selecting any licensed clinical social  
40 worker who is the holder of a license issued under Section 4996

1 of the Business and Professions Code, any occupational therapist  
2 as specified in Section 2570.2 of the Business and Professions  
3 Code, any marriage and family therapist who is the holder of a  
4 license under Section 4980.50 of the Business and Professions  
5 Code, or any professional clinical counselor who is the holder of a  
6 a license under Chapter 16 (commencing with Section 4999.10)  
7 of Division 2 of the Business and Professions Code, to perform  
8 the particular services covered under the terms of the policy, or  
9 from selecting any speech-language pathologist or audiologist  
10 licensed under Section 2532 of the Business and Professions Code  
11 or any registered nurse licensed pursuant to Chapter 6  
12 (commencing with Section 2700) of Division 2 of the Business  
13 and Professions Code who possesses a master's degree in  
14 psychiatric-mental health nursing and is listed as a  
15 psychiatric-mental health nurse by the Board of Registered  
16 Nursing, or any advanced practice registered nurse certified as a  
17 clinical nurse specialist pursuant to Article 9 (commencing with  
18 Section 2838) of Chapter 6 of Division 2 of the Business and  
19 Professions Code who participates in expert clinical practice in  
20 the specialty of psychiatric-mental health nursing, or any  
21 respiratory care practitioner certified pursuant to Chapter 8.3  
22 (commencing with Section 3700) of Division 2 of the Business  
23 and Professions Code to perform services deemed necessary by  
24 the referring physician and surgeon, that certificate holder, licensee  
25 or otherwise regulated person, being expressly authorized by law  
26 to perform the services.

27 (d) Nothing in this section shall be construed to allow any  
28 certificate holder or licensee enumerated in this section to perform  
29 professional mental health services beyond his or her field or fields  
30 of competence as established by his or her education, training, and  
31 experience.

32 (e) For the purposes of this section:

33 (1) "Marriage and family therapist" means a licensed marriage  
34 and family therapist who has received specific instruction in  
35 assessment, diagnosis, prognosis, and counseling, and  
36 psychotherapeutic treatment of premarital, marriage, family, and  
37 child relationship dysfunctions, which is equivalent to the  
38 instruction required for licensure on January 1, 1981.

39 (2) "Professional clinical counselor" means a licensed  
40 professional clinical counselor who has received specific

1 instruction in assessment, diagnosis, prognosis, counseling, and  
2 psychotherapeutic treatment of mental and emotional disorders,  
3 which is equivalent to the instruction required for licensure on  
4 January 1, 2012.

5 (f) An individual disability insurance policy, which is issued,  
6 renewed, or amended on or after January 1, 1988, which includes  
7 mental health services coverage may not include a lifetime waiver  
8 for that coverage with respect to any applicant. The lifetime waiver  
9 of coverage provision shall be deemed unenforceable.

10 SEC. 35. Section 10176.7 of the Insurance Code is amended  
11 to read:

12 10176.7. (a) Disability insurance where the insurer is licensed  
13 to do business in this state and which provides coverage under a  
14 contract of insurance which includes California residents but which  
15 may be written or issued for delivery outside of California where  
16 benefits are provided within the scope of practice of a licensed  
17 clinical social worker, a registered nurse licensed pursuant to  
18 Chapter 6 (commencing with Section 2700) of Division 2 of the  
19 Business and Professions Code who possesses a master's degree  
20 in psychiatric-mental health nursing and two years of supervised  
21 experience in psychiatric-mental health nursing, a marriage and  
22 family therapist who is the holder of a license under ~~Section 17805~~  
23 *Chapter 13 (commencing with Section 4980) of Division 2* of the  
24 Business and Professions Code, a professional clinical counselor  
25 who is the holder of a license under Chapter 16 (commencing with  
26 Section 4999.10) of Division 2 of the Business and Professions  
27 Code, or a respiratory care practitioner certified pursuant to Chapter  
28 8.3 (commencing with Section 3700) of Division 2 of the Business  
29 and Professions Code shall not be deemed to prohibit persons  
30 covered under the contract from selecting those licensees in  
31 California to perform the services in California that are within the  
32 terms of the contract even though the licensees are not licensed in  
33 the state where the contract is written or issued for delivery.

34 (b) It is the intent of the Legislature in amending this section in  
35 the 1984 portion of the 1983–84 Legislative Session that persons  
36 covered by the insurance and those providers of health care  
37 specified in this section who are licensed in California should be  
38 entitled to the benefits provided by the insurance for services of  
39 those providers rendered to those persons.

1 SEC. 36. Section 10177 of the Insurance Code is amended to  
2 read:

3 10177. (a) A self-insured employee welfare benefit plan may  
4 provide for payment of professional mental health expenses upon  
5 a reimbursement basis, or for the exclusion of those services, and  
6 provision may be made therein for payment of all or a portion of  
7 the amount of charge for those services without requiring that the  
8 employee first pay those expenses. The plan shall not prohibit the  
9 employee from selecting any psychologist who is the holder of a  
10 certificate issued under Section 2948 of the Business and  
11 Professions Code or, upon referral by a physician and surgeon  
12 licensed under Section 2135 of the Business and Professions Code,  
13 any licensed clinical social worker who is the holder of a license  
14 issued under Section 4996 of the Business and Professions Code  
15 or any marriage and family therapist who is the holder of a  
16 certificate or license under Section 4980.50 of the Business and  
17 Professions Code, any professional clinical counselor who is the  
18 holder of a license under Chapter 16 (commencing with Section  
19 4999.10) of Division 2 of the Business and Professions Code, or  
20 any registered nurse licensed pursuant to Chapter 6 (commencing  
21 with Section 2700) of Division 2 of the Business and Professions  
22 Code, who possesses a master's degree in psychiatric-mental health  
23 nursing and is listed as a psychiatric-mental health nurse by the  
24 Board of Registered Nursing or any advanced practice registered  
25 nurse certified as a clinical nurse specialist pursuant to Article 9  
26 (commencing with Section 2838) of Chapter 6 of Division 2 of  
27 the Business and Professions Code who participates in expert  
28 clinical practice in the specialty of psychiatric-mental health  
29 nursing, to perform the particular services covered under the terms  
30 of the plan, the certificate or license holder being expressly  
31 authorized by law to perform these services.

32 (b) Nothing in this section shall be construed to allow any  
33 certificate holder or licensee enumerated in this section to perform  
34 professional services beyond his or her field or fields of  
35 competence as established by his or her education, training, and  
36 experience.

37 (c) For the purposes of this section:

38 (1) "Marriage and family therapist" shall mean a licensed  
39 marriage and family therapist who has received specific instruction  
40 in assessment, diagnosis, prognosis, and counseling, and

1 psychotherapeutic treatment of premarital, marriage, family, and  
2 child relationship dysfunctions, which is equivalent to the  
3 instruction required for licensure on January 1, 1981.

4 (2) “Professional clinical counselor” means a licensed  
5 professional clinical counselor who has received specific  
6 instruction in assessment, diagnosis, prognosis, counseling, and  
7 psychotherapeutic treatment of mental and emotional disorders,  
8 which is equivalent to the instruction required for licensure on  
9 January 1, 2012.

10 (d) A self-insured employee welfare benefit plan, which is  
11 issued, renewed, or amended on or after January 1, 1988, that  
12 includes mental health services coverage in nongroup contracts  
13 may not include a lifetime waiver for that coverage with respect  
14 to any employee. The lifetime waiver of coverage provision shall  
15 be deemed unenforceable.

16 SEC. 37. Section 10177.8 of the Insurance Code is amended  
17 to read:

18 10177.8. (a) A self-insured employee welfare benefit plan  
19 doing business in this state and providing coverage that includes  
20 California residents but that may be written or issued for delivery  
21 outside of California where benefits are provided within the scope  
22 of practice of a licensed clinical social worker, a registered nurse  
23 licensed pursuant to Chapter 6 (commencing with Section 2700)  
24 of Division 2 of the Business and Professions Code who possesses  
25 a master’s degree in psychiatric-mental health nursing and two  
26 years of supervised experience in psychiatric-mental health nursing,  
27 a marriage and family therapist who is the holder of a license under  
28 ~~Section 17805 Chapter 13 (commencing with Section 4980) of~~  
29 *Division 2 of the Business and Professions Code*, or a professional  
30 clinical counselor who is the holder of a license under Chapter 16  
31 (commencing with Section 4999.10) of Division 2 of the Business  
32 and Professions Code, shall not be deemed to prohibit persons  
33 covered under the plan from selecting those licensees in California  
34 to perform the services in California that are within the terms of  
35 the contract even though the licensees are not licensed in the state  
36 where the contract is written or issued.

37 (b) It is the intent of the Legislature in amending this section in  
38 the 1984 portion of the 1983–84 Legislative Session that persons  
39 covered by the plan and those providers of health care specified  
40 in this section who are licensed in California should be entitled to

1 the benefits provided by the plan for services of those providers  
2 rendered to those persons.

3 ~~SEC. 38. Section 5068.5 of the Penal Code is amended to read:~~

4 ~~5068.5. (a) Notwithstanding any other law, except as provided~~  
5 ~~in subdivisions (b) and (c), any person employed or under contract~~  
6 ~~to provide diagnostic, treatment, or other mental health services~~  
7 ~~in the state or to supervise or provide consultation on these services~~  
8 ~~in the state correctional system shall be a physician and surgeon,~~  
9 ~~a psychologist, or other health professional, licensed to practice~~  
10 ~~in this state.~~

11 ~~(b) Notwithstanding Section 5068 or Section 704 of the Welfare~~  
12 ~~and Institutions Code, the following persons are exempt from the~~  
13 ~~requirements of subdivision (a), so long as they continue in~~  
14 ~~employment in the same class and in the same department:~~

15 ~~(1) Persons employed on January 1, 1985, as psychologists to~~  
16 ~~provide diagnostic or treatment services including those persons~~  
17 ~~on authorized leave but not including intermittent personnel.~~

18 ~~(2) Persons employed on January 1, 1989, to supervise or~~  
19 ~~provide consultation on the diagnostic or treatment services~~  
20 ~~including persons on authorized leave but not including intermittent~~  
21 ~~personnel.~~

22 ~~(c) (1) The requirements of subdivision (a) may be waived by~~  
23 ~~the secretary solely for persons in the professions of psychology,~~  
24 ~~clinical social work, or professional clinical counseling who are~~  
25 ~~gaining qualifying experience for licensure in those professions~~  
26 ~~in this state. Providers working in a licensed health care facility~~  
27 ~~operated by the department must receive a waiver in accordance~~  
28 ~~with Section 1277 of the Health and Safety Code.~~

29 ~~(2) (A) A waiver granted pursuant to this subdivision shall not~~  
30 ~~exceed three years from the date the employment commences in~~  
31 ~~this state in the case of psychologists, or four years from~~  
32 ~~commencement of the employment in this state in the case of~~  
33 ~~clinical social workers or professional clinical counselors, at which~~  
34 ~~time licensure shall have been obtained or the employment shall~~  
35 ~~be terminated, except that an extension of a waiver of licensure~~  
36 ~~for clinical social workers or professional clinical counselors may~~  
37 ~~be granted for one additional year, based on extenuating~~  
38 ~~circumstances determined by the department pursuant to~~  
39 ~~subdivision (d). For persons employed as psychologists, clinical~~  
40 ~~social workers, or professional clinical counselors less than full~~

1 time, an extension of a waiver of licensure may be granted for  
2 additional years proportional to the extent of part-time employment,  
3 as long as the person is employed without interruption in service,  
4 but in no case shall the waiver of licensure exceed six years in the  
5 case of clinical social workers or professional clinical counselors,  
6 or five years in the case of psychologists.

7 (B) The durational limitation upon waivers pursuant to this  
8 subdivision shall not apply to any of the following:

9 (i) Active candidates for a doctoral degree in social work, social  
10 welfare, or social science who are enrolled at an accredited  
11 university, college, or professional school, but these limitations  
12 shall apply following completion of that training.

13 (ii) Active candidates for a doctoral degree in professional  
14 clinical counseling who are enrolled at a school, college, or  
15 university, specified in subdivision (b) of Section 4999.32 of, or  
16 subdivision (b) of Section 4999.33 of, the Business and Professions  
17 Code, but the limitations shall apply following the completion of  
18 that training.

19 (3) A waiver pursuant to this subdivision shall be granted only  
20 to the extent necessary to qualify for licensure, except that  
21 personnel recruited for employment from outside this state and  
22 whose experience is sufficient to gain admission to a licensure  
23 examination shall nevertheless have one year from the date of their  
24 employment in California to become licensed, at which time  
25 licensure shall have been obtained or the employment shall be  
26 terminated, provided that the employee shall take the licensure  
27 examination at the earliest possible date after the date of his or her  
28 employment, and if the employee does not pass the examination  
29 at that time, he or she shall have a second opportunity to pass the  
30 next possible examination, subject to the one-year limit for clinical  
31 social workers and professional clinical counselors, and subject  
32 to a two-year limit for psychologists.

33 (d) The department shall grant a request for an extension of a  
34 waiver of licensure for a clinical social worker or professional  
35 clinical counselor pursuant to subdivision (c) based on extenuating  
36 circumstances if any of the following circumstances exist:

37 (1) The person requesting the extension has experienced a recent  
38 catastrophic event that may impair the person's ability to qualify  
39 for and pass the licensure examination. Those events may include,  
40 but are not limited to, significant hardship caused by a natural

1 ~~disaster; serious and prolonged illness of the person; serious and~~  
2 ~~prolonged illness or death of a child, spouse, or parent; or other~~  
3 ~~stressful circumstances.~~

4 ~~(2) The person requesting the extension has difficulty speaking~~  
5 ~~or writing the English language, or other cultural and ethnic factors~~  
6 ~~exist that substantially impair the person's ability to qualify for~~  
7 ~~and pass the license examination.~~

8 ~~(3) The person requesting the extension has experienced other~~  
9 ~~personal hardship that the department, in its discretion, determines~~  
10 ~~to warrant the extension.~~

11 ~~SEC. 39.~~

12 *SEC. 38.* Section 11165.7 of the Penal Code is amended to  
13 read:

14 11165.7. (a) As used in this article, "mandated reporter" is  
15 defined as any of the following:

- 16 (1) A teacher.
- 17 (2) An instructional aide.
- 18 (3) A teacher's aide or teacher's assistant employed by any  
19 public or private school.
- 20 (4) A classified employee of any public school.
- 21 (5) An administrative officer or supervisor of child welfare and  
22 attendance, or a certificated pupil personnel employee of any public  
23 or private school.
- 24 (6) An administrator of a public or private day camp.
- 25 (7) An administrator or employee of a public or private youth  
26 center, youth recreation program, or youth organization.
- 27 (8) An administrator or employee of a public or private  
28 organization whose duties require direct contact and supervision  
29 of children.
- 30 (9) Any employee of a county office of education or the State  
31 Department of Education, whose duties bring the employee into  
32 contact with children on a regular basis.
- 33 (10) A licensee, an administrator, or an employee of a licensed  
34 community care or child day care facility.
- 35 (11) A Head Start program teacher.
- 36 (12) A licensing worker or licensing evaluator employed by a  
37 licensing agency as defined in Section 11165.11.
- 38 (13) A public assistance worker.

- 1 (14) An employee of a child care institution, including, but not  
2 limited to, foster parents, group home personnel, and personnel of  
3 residential care facilities.
- 4 (15) A social worker, probation officer, or parole officer.
- 5 (16) An employee of a school district police or security  
6 department.
- 7 (17) Any person who is an administrator or presenter of, or a  
8 counselor in, a child abuse prevention program in any public or  
9 private school.
- 10 (18) A district attorney investigator, inspector, or local child  
11 support agency caseworker unless the investigator, inspector, or  
12 caseworker is working with an attorney appointed pursuant to  
13 Section 317 of the Welfare and Institutions Code to represent a  
14 minor.
- 15 (19) A peace officer, as defined in Chapter 4.5 (commencing  
16 with Section 830) of Title 3 of Part 2, who is not otherwise  
17 described in this section.
- 18 (20) A firefighter, except for volunteer firefighters.
- 19 (21) A physician and surgeon, psychiatrist, psychologist, dentist,  
20 resident, intern, podiatrist, chiropractor, licensed nurse, dental  
21 hygienist, optometrist, marriage and family therapist, clinical social  
22 worker, professional clinical counselor, or any other person who  
23 is currently licensed under Division 2 (commencing with Section  
24 500) of the Business and Professions Code.
- 25 (22) Any emergency medical technician I or II, paramedic, or  
26 other person certified pursuant to Division 2.5 (commencing with  
27 Section 1797) of the Health and Safety Code.
- 28 (23) A psychological assistant registered pursuant to Section  
29 2913 of the Business and Professions Code.
- 30 (24) A marriage and family therapist trainee, as defined in  
31 subdivision (c) of Section 4980.03 of the Business and Professions  
32 Code.
- 33 (25) An unlicensed marriage and family therapist intern  
34 registered under Section 4980.44 of the Business and Professions  
35 Code.
- 36 (26) A state or county public health employee who treats a minor  
37 for venereal disease or any other condition.
- 38 (27) A coroner.
- 39 (28) A medical examiner, or any other person who performs  
40 autopsies.

1 (29) A commercial film and photographic print processor, as  
2 specified in subdivision (e) of Section 11166. As used in this  
3 article, “commercial film and photographic print processor” means  
4 any person who develops exposed photographic film into negatives,  
5 slides, or prints, or who makes prints from negatives or slides, for  
6 compensation. The term includes any employee of such a person;  
7 it does not include a person who develops film or makes prints for  
8 a public agency.

9 (30) A child visitation monitor. As used in this article, “child  
10 visitation monitor” means any person who, for financial  
11 compensation, acts as monitor of a visit between a child and any  
12 other person when the monitoring of that visit has been ordered  
13 by a court of law.

14 (31) An animal control officer or humane society officer. For  
15 the purposes of this article, the following terms have the following  
16 meanings:

17 (A) “Animal control officer” means any person employed by a  
18 city, county, or city and county for the purpose of enforcing animal  
19 control laws or regulations.

20 (B) “Humane society officer” means any person appointed or  
21 employed by a public or private entity as a humane officer who is  
22 qualified pursuant to Section 14502 or 14503 of the Corporations  
23 Code.

24 (32) A clergy member, as specified in subdivision (d) of Section  
25 11166. As used in this article, “clergy member” means a priest,  
26 minister, rabbi, religious practitioner, or similar functionary of a  
27 church, temple, or recognized denomination or organization.

28 (33) Any custodian of records of a clergy member, as specified  
29 in this section and subdivision (d) of Section 11166.

30 (34) Any employee of any police department, county sheriff’s  
31 department, county probation department, or county welfare  
32 department.

33 (35) An employee or volunteer of a Court Appointed Special  
34 Advocate program, as defined in Rule 1424 of the California Rules  
35 of Court.

36 (36) A custodial officer as defined in Section 831.5.

37 (37) Any person providing services to a minor child under  
38 Section 12300 or 12300.1 of the Welfare and Institutions Code.

39 (38) An alcohol and drug counselor. As used in this article, an  
40 “alcohol and drug counselor” is a person providing counseling,

1 therapy, or other clinical services for a state licensed or certified  
2 drug, alcohol, or drug and alcohol treatment program. However,  
3 alcohol or drug abuse, or both alcohol and drug abuse, is not in  
4 and of itself a sufficient basis for reporting child abuse or neglect.

5 (39) A clinical counselor trainee, as defined in subdivision (g)  
6 of Section 4999.12 of the Business and Professions Code.

7 (40) A clinical counselor intern registered under Section 4999.42  
8 of the Business and Professions Code.

9 (b) Except as provided in paragraph (35) of subdivision (a),  
10 volunteers of public or private organizations whose duties require  
11 direct contact with and supervision of children are not mandated  
12 reporters but are encouraged to obtain training in the identification  
13 and reporting of child abuse and neglect and are further encouraged  
14 to report known or suspected instances of child abuse or neglect  
15 to an agency specified in Section 11165.9.

16 (c) Employers are strongly encouraged to provide their  
17 employees who are mandated reporters with training in the duties  
18 imposed by this article. This training shall include training in child  
19 abuse and neglect identification and training in child abuse and  
20 neglect reporting. Whether or not employers provide their  
21 employees with training in child abuse and neglect identification  
22 and reporting, the employers shall provide their employees who  
23 are mandated reporters with the statement required pursuant to  
24 subdivision (a) of Section 11166.5.

25 (d) School districts that do not train their employees specified  
26 in subdivision (a) in the duties of mandated reporters under the  
27 child abuse reporting laws shall report to the State Department of  
28 Education the reasons why this training is not provided.

29 (e) Unless otherwise specifically provided, the absence of  
30 training shall not excuse a mandated reporter from the duties  
31 imposed by this article.

32 (f) Public and private organizations are encouraged to provide  
33 their volunteers whose duties require direct contact with and  
34 supervision of children with training in the identification and  
35 reporting of child abuse and neglect.

36 ~~SEC. 40. Section 4514 of the Welfare and Institutions Code is~~  
37 ~~amended to read:~~

38 *SEC. 39. Section 4514 of the Welfare and Institutions Code,*  
39 *as amended by Section 100 of Chapter 178 of the Statutes of 2010,*  
40 *is amended to read:*

1 4514. All information and records obtained in the course of  
2 providing intake, assessment, and services under Division 4.1  
3 (commencing with Section 4400), Division 4.5 (commencing with  
4 Section 4500), Division 6 (commencing with Section 6000), or  
5 Division 7 (commencing with Section 7100) to persons with  
6 developmental disabilities shall be confidential. Information and  
7 records obtained in the course of providing similar services to  
8 either voluntary or involuntary recipients prior to 1969 shall also  
9 be confidential. Information and records shall be disclosed only  
10 in any of the following cases:

11 (a) In communications between qualified professional persons,  
12 whether employed by a regional center or state developmental  
13 center, or not, in the provision of intake, assessment, and services  
14 or appropriate referrals. The consent of the person with a  
15 developmental disability, or his or her guardian or conservator,  
16 shall be obtained before information or records may be disclosed  
17 by regional center or state developmental center personnel to a  
18 professional not employed by the regional center or state  
19 developmental center, or a program not vendored by a regional  
20 center or state developmental center.

21 (b) When the person with a developmental disability, who has  
22 the capacity to give informed consent, designates individuals to  
23 whom information or records may be released, except that nothing  
24 in this chapter shall be construed to compel a physician and  
25 surgeon, psychologist, social worker, marriage and family therapist,  
26 professional clinical counselor, nurse, attorney, or other  
27 professional to reveal information that has been given to him or  
28 her in confidence by a family member of the person unless a valid  
29 release has been executed by that family member.

30 (c) To the extent necessary for a claim, or for a claim or  
31 application to be made on behalf of a person with a developmental  
32 disability for aid, insurance, government benefit, or medical  
33 assistance to which he or she may be entitled.

34 (d) If the person with a developmental disability is a minor,  
35 ward, or conservatee, and his or her parent, guardian, conservator,  
36 or limited conservator with access to confidential records,  
37 designates, in writing, persons to whom records or information  
38 may be disclosed, except that nothing in this chapter shall be  
39 construed to compel a physician and surgeon, psychologist, social  
40 worker, marriage and family therapist, professional clinical

1 counselor, nurse, attorney, or other professional to reveal  
2 information that has been given to him or her in confidence by a  
3 family member of the person unless a valid release has been  
4 executed by that family member.

5 (e) For research, provided that the Director of Developmental  
6 Services designates by regulation rules for the conduct of research  
7 and requires the research to be first reviewed by the appropriate  
8 institutional review board or boards. These rules shall include, but  
9 need not be limited to, the requirement that all researchers shall  
10 sign an oath of confidentiality as follows:

11  
12 “ \_\_\_\_\_  
13 Date  
14

15 As a condition of doing research concerning persons with  
16 developmental disabilities who have received services from \_\_\_\_  
17 (fill in the facility, agency or person), I, \_\_\_\_\_, agree to obtain the  
18 prior informed consent of persons who have received services to  
19 the maximum degree possible as determined by the appropriate  
20 institutional review board or boards for protection of human  
21 subjects reviewing my research, or the person’s parent, guardian,  
22 or conservator, and I further agree not to divulge any information  
23 obtained in the course of the research to unauthorized persons, and  
24 not to publish or otherwise make public any information regarding  
25 persons who have received services so those persons who received  
26 services are identifiable.

27 I recognize that the unauthorized release of confidential  
28 information may make me subject to a civil action under provisions  
29 of the Welfare and Institutions Code.

30  
31 \_\_\_\_\_”  
32 Signed  
33

34 (f) To the courts, as necessary to the administration of justice.

35 (g) To governmental law enforcement agencies as needed for  
36 the protection of federal and state elective constitutional officers  
37 and their families.

38 (h) To the Senate Committee on Rules or the Assembly  
39 Committee on Rules for the purposes of legislative investigation  
40 authorized by the committee.

1 (i) To the courts and designated parties as part of a regional  
2 center report or assessment in compliance with a statutory or  
3 regulatory requirement, including, but not limited to, Section  
4 1827.5 of the Probate Code, Sections 1001.22 and 1370.1 of the  
5 Penal Code, Section 6502 of the Welfare and Institutions Code,  
6 and Section 56557 of Title 17 of the California Code of  
7 Regulations.

8 (j) To the attorney for the person with a developmental disability  
9 in any and all proceedings upon presentation of a release of  
10 information signed by the person, except that when the person  
11 lacks the capacity to give informed consent, the regional center or  
12 state developmental center director or designee, upon satisfying  
13 himself or herself of the identity of the attorney, and of the fact  
14 that the attorney represents the person, shall release all information  
15 and records relating to the person except that nothing in this article  
16 shall be construed to compel a physician and surgeon, psychologist,  
17 social worker, marriage and family therapist, professional clinical  
18 counselor, nurse, attorney, or other professional to reveal  
19 information that has been given to him or her in confidence by a  
20 family member of the person unless a valid release has been  
21 executed by that family member.

22 (k) Upon written consent by a person with a developmental  
23 disability previously or presently receiving services from a regional  
24 center or state developmental center, the director of the regional  
25 center or state developmental center, or his or her designee, may  
26 release any information, except information that has been given  
27 in confidence by members of the family of the person with  
28 developmental disabilities, requested by a probation officer charged  
29 with the evaluation of the person after his or her conviction of a  
30 crime if the regional center or state developmental center director  
31 or designee determines that the information is relevant to the  
32 evaluation. The consent shall only be operative until sentence is  
33 passed on the crime of which the person was convicted. The  
34 confidential information released pursuant to this subdivision shall  
35 be transmitted to the court separately from the probation report  
36 and shall not be placed in the probation report. The confidential  
37 information shall remain confidential except for purposes of  
38 sentencing. After sentencing, the confidential information shall be  
39 sealed.

1 (l) Between persons who are trained and qualified to serve on  
2 “multidisciplinary personnel” teams pursuant to subdivision (d)  
3 of Section 18951. The information and records sought to be  
4 disclosed shall be relevant to the prevention, identification,  
5 management, or treatment of an abused child and his or her parents  
6 pursuant to Chapter 11 (commencing with Section 18950) of Part  
7 6 of Division 9.

8 (m) When a person with a developmental disability dies from  
9 any cause, natural or otherwise, while hospitalized in a state  
10 developmental center, the State Department of Developmental  
11 Services, the physician and surgeon in charge of the client, or the  
12 professional in charge of the facility or his or her designee, shall  
13 release information and records to the coroner. The State  
14 Department of Developmental Services, the physician and surgeon  
15 in charge of the client, or the professional in charge of the facility  
16 or his or her designee, shall not release any notes, summaries,  
17 transcripts, tapes, or records of conversations between the resident  
18 and health professional personnel of the hospital relating to the  
19 personal life of the resident that is not related to the diagnosis and  
20 treatment of the resident’s physical condition. Any information  
21 released to the coroner pursuant to this section shall remain  
22 confidential and shall be sealed and shall not be made part of the  
23 public record.

24 (n) To authorized licensing personnel who are employed by, or  
25 who are authorized representatives of, the State Department of  
26 Health Services, and who are licensed or registered health  
27 professionals, and to authorized legal staff or special investigators  
28 who are peace officers who are employed by, or who are authorized  
29 representatives of, the State Department of Social Services, as  
30 necessary to the performance of their duties to inspect, license,  
31 and investigate health facilities and community care facilities, and  
32 to ensure that the standards of care and services provided in these  
33 facilities are adequate and appropriate and to ascertain compliance  
34 with the rules and regulations to which the facility is subject. The  
35 confidential information shall remain confidential except for  
36 purposes of inspection, licensing, or investigation pursuant to  
37 Chapter 2 (commencing with Section 1250) and Chapter 3  
38 (commencing with Section 1500) of Division 2 of the Health and  
39 Safety Code, or a criminal, civil, or administrative proceeding in  
40 relation thereto. The confidential information may be used by the

1 State Department of Health Services or the State Department of  
2 Social Services in a criminal, civil, or administrative proceeding.  
3 The confidential information shall be available only to the judge  
4 or hearing officer and to the parties to the case. Names which are  
5 confidential shall be listed in attachments separate to the general  
6 pleadings. The confidential information shall be sealed after the  
7 conclusion of the criminal, civil, or administrative hearings, and  
8 shall not subsequently be released except in accordance with this  
9 subdivision. If the confidential information does not result in a  
10 criminal, civil, or administrative proceeding, it shall be sealed after  
11 the State Department of Health Services or the State Department  
12 of Social Services decides that no further action will be taken in  
13 the matter of suspected licensing violations. Except as otherwise  
14 provided in this subdivision, confidential information in the  
15 possession of the State Department of Health Services or the State  
16 Department of Social Services shall not contain the name of the  
17 person with a developmental disability.

18 (o) To any board which licenses and certifies professionals in  
19 the fields of mental health and developmental disabilities pursuant  
20 to state law, when the Director of Developmental Services has  
21 reasonable cause to believe that there has occurred a violation of  
22 any provision of law subject to the jurisdiction of a board and the  
23 records are relevant to the violation. The information shall be  
24 sealed after a decision is reached in the matter of the suspected  
25 violation, and shall not subsequently be released except in  
26 accordance with this subdivision. Confidential information in the  
27 possession of the board shall not contain the name of the person  
28 with a developmental disability.

29 (p) To governmental law enforcement agencies by the director  
30 of a regional center or state developmental center, or his or her  
31 designee, when (1) the person with a developmental disability has  
32 been reported lost or missing or (2) there is probable cause to  
33 believe that a person with a developmental disability has  
34 committed, or has been the victim of, murder, manslaughter,  
35 mayhem, aggravated mayhem, kidnapping, robbery, carjacking,  
36 assault with the intent to commit a felony, arson, extortion, rape,  
37 forcible sodomy, forcible oral copulation, assault or battery, or  
38 unlawful possession of a weapon, as provided in any provision  
39 listed in Section 16590 of the Penal Code.

1 This subdivision shall be limited solely to information directly  
2 relating to the factual circumstances of the commission of the  
3 enumerated offenses and shall not include any information relating  
4 to the mental state of the patient or the circumstances of his or her  
5 treatment unless relevant to the crime involved.

6 This subdivision shall not be construed as an exception to, or in  
7 any other way affecting, the provisions of Article 7 (commencing  
8 with Section 1010) of Chapter 4 of Division 8 of the Evidence  
9 Code, or Chapter 11 (commencing with Section 15600) and  
10 Chapter 13 (commencing with Section 15750) of Part 3 of Division  
11 9.

12 (q) To the Division of Juvenile Facilities and Department of  
13 Corrections and Rehabilitation or any component thereof, as  
14 necessary to the administration of justice.

15 (r) To an agency mandated to investigate a report of abuse filed  
16 pursuant to either Section 11164 of the Penal Code or Section  
17 15630 of the Welfare and Institutions Code for the purposes of  
18 either a mandated or voluntary report or when those agencies  
19 request information in the course of conducting their investigation.

20 (s) When a person with developmental disabilities, or the parent,  
21 guardian, or conservator of a person with developmental disabilities  
22 who lacks capacity to consent, fails to grant or deny a request by  
23 a regional center or state developmental center to release  
24 information or records relating to the person with developmental  
25 disabilities within a reasonable period of time, the director of the  
26 regional or developmental center, or his or her designee, may  
27 release information or records on behalf of that person provided  
28 both of the following conditions are met:

29 (1) Release of the information or records is deemed necessary  
30 to protect the person's health, safety, or welfare.

31 (2) The person, or the person's parent, guardian, or conservator,  
32 has been advised annually in writing of the policy of the regional  
33 center or state developmental center for release of confidential  
34 client information or records when the person with developmental  
35 disabilities, or the person's parent, guardian, or conservator, fails  
36 to respond to a request for release of the information or records  
37 within a reasonable period of time. A statement of policy contained  
38 in the client's individual program plan shall be deemed to comply  
39 with the notice requirement of this paragraph.

1 (t) (1) When an employee is served with a notice of adverse  
2 action, as defined in Section 19570 of the Government Code, the  
3 following information and records may be released:

4 (A) All information and records that the appointing authority  
5 relied upon in issuing the notice of adverse action.

6 (B) All other information and records that are relevant to the  
7 adverse action, or that would constitute relevant evidence as  
8 defined in Section 210 of the Evidence Code.

9 (C) The information described in subparagraphs (A) and (B)  
10 may be released only if both of the following conditions are met:

11 (i) The appointing authority has provided written notice to the  
12 consumer and the consumer's legal representative or, if the  
13 consumer has no legal representative or if the legal representative  
14 is a state agency, to the clients' rights advocate, and the consumer,  
15 the consumer's legal representative, or the clients' rights advocate  
16 has not objected in writing to the appointing authority within five  
17 business days of receipt of the notice, or the appointing authority,  
18 upon review of the objection has determined that the circumstances  
19 on which the adverse action is based are egregious or threaten the  
20 health, safety, or life of the consumer or other consumers and  
21 without the information the adverse action could not be taken.

22 (ii) The appointing authority, the person against whom the  
23 adverse action has been taken, and the person's representative, if  
24 any, have entered into a stipulation that does all of the following:

25 (I) Prohibits the parties from disclosing or using the information  
26 or records for any purpose other than the proceedings for which  
27 the information or records were requested or provided.

28 (II) Requires the employee and the employee's legal  
29 representative to return to the appointing authority all records  
30 provided to them under this subdivision, including, but not limited  
31 to, all records and documents or copies thereof that are no longer  
32 in the possession of the employee or the employee's legal  
33 representative because they were from any source containing  
34 confidential information protected by this section, and all copies  
35 of those records and documents, within 10 days of the date that  
36 the adverse action becomes final except for the actual records and  
37 documents submitted to the administrative tribunal as a component  
38 of an appeal from the adverse action.

1 (III) Requires the parties to submit the stipulation to the  
2 administrative tribunal with jurisdiction over the adverse action  
3 at the earliest possible opportunity.

4 (2) For the purposes of this subdivision, the State Personnel  
5 Board may, prior to any appeal from adverse action being filed  
6 with it, issue a protective order, upon application by the appointing  
7 authority, for the limited purpose of prohibiting the parties from  
8 disclosing or using information or records for any purpose other  
9 than the proceeding for which the information or records were  
10 requested or provided, and to require the employee or the  
11 employee's legal representative to return to the appointing authority  
12 all records provided to them under this subdivision, including, but  
13 not limited to, all records and documents from any source  
14 containing confidential information protected by this section, and  
15 all copies of those records and documents, within 10 days of the  
16 date that the adverse action becomes final, except for the actual  
17 records and documents that are no longer in the possession of the  
18 employee or the employee's legal representatives because they  
19 were submitted to the administrative tribunal as a component of  
20 an appeal from the adverse action.

21 (3) Individual identifiers, including, but not limited to, names,  
22 social security numbers, and hospital numbers, that are not  
23 necessary for the prosecution or defense of the adverse action,  
24 shall not be disclosed.

25 (4) All records, documents, or other materials containing  
26 confidential information protected by this section that have been  
27 submitted or otherwise disclosed to the administrative agency or  
28 other person as a component of an appeal from an adverse action  
29 shall, upon proper motion by the appointing authority to the  
30 administrative tribunal, be placed under administrative seal and  
31 shall not, thereafter, be subject to disclosure to any person or entity  
32 except upon the issuance of an order of a court of competent  
33 jurisdiction.

34 (5) For purposes of this subdivision, an adverse action becomes  
35 final when the employee fails to answer within the time specified  
36 in Section 19575 of the Government Code, or, after filing an  
37 answer, withdraws the appeal, or, upon exhaustion of the  
38 administrative appeal or of the judicial review remedies as  
39 otherwise provided by law.

1     ~~SEC. 41.~~

2     *SEC. 40.* Section 5256.1 of the Welfare and Institutions Code  
3 is amended to read:

4     5256.1. The certification review hearing shall be conducted  
5 by either a court-appointed commissioner or a referee, or a  
6 certification review hearing officer. The certification review  
7 hearing officer shall be either a state qualified administrative law  
8 hearing officer, a physician and surgeon, a licensed psychologist,  
9 a registered nurse, a lawyer, a certified law student, a licensed  
10 clinical social worker, a licensed marriage and family therapist,  
11 or a licensed professional clinical counselor. Licensed  
12 psychologists, licensed clinical social workers, licensed marriage  
13 and family therapists, licensed professional clinical counselors,  
14 and registered nurses who serve as certification review hearing  
15 officers shall have had a minimum of five years' experience in  
16 mental health. Certification review hearing officers shall be selected  
17 from a list of eligible persons unanimously approved by a panel  
18 composed of the local mental health director, the county public  
19 defender, and the county counsel or district attorney designated  
20 by the county board of supervisors. No employee of the county  
21 mental health program or of any facility designated by the county  
22 and approved by the State Department of Mental Health as a  
23 facility for 72-hour treatment and evaluation may serve as a  
24 certification review hearing officer.

25     The location of the certification review hearing shall be  
26 compatible with, and least disruptive of, the treatment being  
27 provided to the person certified. In addition, hearings conducted  
28 by certification review officers shall be conducted at an appropriate  
29 place at the facility where the person certified is receiving  
30 treatment.

31     ~~SEC. 42.~~

32     *SEC. 41.* Section 5328 of the Welfare and Institutions Code is  
33 amended to read:

34     5328. All information and records obtained in the course of  
35 providing services under Division 4 (commencing with Section  
36 4000), Division 4.1 (commencing with Section 4400), Division  
37 4.5 (commencing with Section 4500), Division 5 (commencing  
38 with Section 5000), Division 6 (commencing with Section 6000),  
39 or Division 7 (commencing with Section 7100), to either voluntary  
40 or involuntary recipients of services shall be confidential.

1 Information and records obtained in the course of providing similar  
2 services to either voluntary or involuntary recipients prior to 1969  
3 shall also be confidential. Information and records shall be  
4 disclosed only in any of the following cases:

5 (a) In communications between qualified professional persons  
6 in the provision of services or appropriate referrals, or in the course  
7 of conservatorship proceedings. The consent of the patient, or his  
8 or her guardian or conservator, shall be obtained before information  
9 or records may be disclosed by a professional person employed  
10 by a facility to a professional person not employed by the facility  
11 who does not have the medical or psychological responsibility for  
12 the patient's care.

13 (b) When the patient, with the approval of the physician and  
14 surgeon, licensed psychologist, social worker with a master's  
15 degree in social work, licensed marriage and family therapist, or  
16 licensed professional clinical counselor who is in charge of the  
17 patient, designates persons to whom information or records may  
18 be released, except that nothing in this article shall be construed  
19 to compel a physician and surgeon, licensed psychologist, social  
20 worker with a master's degree in social work, licensed marriage  
21 and family therapist, licensed professional clinical counselor, nurse,  
22 attorney, or other professional person to reveal information that  
23 has been given to him or her in confidence by members of a  
24 patient's family. Nothing in this subdivision shall be construed to  
25 authorize a licensed marriage and family therapist or a licensed  
26 professional clinical counselor to provide services or to be in charge  
27 of a patient's care beyond his or her lawful scope of practice.

28 (c) To the extent necessary for a recipient to make a claim, or  
29 for a claim to be made on behalf of a recipient for aid, insurance,  
30 or medical assistance to which he or she may be entitled.

31 (d) If the recipient of services is a minor, ward, or conservatee,  
32 and his or her parent, guardian, guardian ad litem, or conservator  
33 designates, in writing, persons to whom records or information  
34 may be disclosed, except that nothing in this article shall be  
35 construed to compel a physician and surgeon, licensed  
36 psychologist, social worker with a master's degree in social work,  
37 licensed marriage and family therapist, licensed professional  
38 clinical counselor, nurse, attorney, or other professional person to  
39 reveal information that has been given to him or her in confidence  
40 by members of a patient's family.

1 (e) For research, provided that the Director of Mental Health  
2 or the Director of Developmental Services designates by regulation,  
3 rules for the conduct of research and requires the research to be  
4 first reviewed by the appropriate institutional review board or  
5 boards. The rules shall include, but need not be limited to, the  
6 requirement that all researchers shall sign an oath of confidentiality  
7 as follows:

8  
9  
10 \_\_\_\_\_  
Date

11  
12 As a condition of doing research concerning persons who have  
13 received services from \_\_\_\_ (fill in the facility, agency or person),  
14 I, \_\_\_\_, agree to obtain the prior informed consent of such persons  
15 who have received services to the maximum degree possible as  
16 determined by the appropriate institutional review board or boards  
17 for protection of human subjects reviewing my research, and I  
18 further agree not to divulge any information obtained in the course  
19 of such research to unauthorized persons, and not to publish or  
20 otherwise make public any information regarding persons who  
21 have received services such that the person who received services  
22 is identifiable.

23 I recognize that the unauthorized release of confidential  
24 information may make me subject to a civil action under provisions  
25 of the Welfare and Institutions Code.

26 (f) To the courts, as necessary to the administration of justice.

27 (g) To governmental law enforcement agencies as needed for  
28 the protection of federal and state elective constitutional officers  
29 and their families.

30 (h) To the Senate Committee on Rules or the Assembly  
31 Committee on Rules for the purposes of legislative investigation  
32 authorized by the committee.

33 (i) If the recipient of services who applies for life or disability  
34 insurance designates in writing the insurer to which records or  
35 information may be disclosed.

36 (j) To the attorney for the patient in any and all proceedings  
37 upon presentation of a release of information signed by the patient,  
38 except that when the patient is unable to sign the release, the staff  
39 of the facility, upon satisfying itself of the identity of the attorney,  
40 and of the fact that the attorney does represent the interests of the

1 patient, may release all information and records relating to the  
2 patient except that nothing in this article shall be construed to  
3 compel a physician and surgeon, licensed psychologist, social  
4 worker with a master's degree in social work, licensed marriage  
5 and family therapist, licensed professional clinical counselor, nurse,  
6 attorney, or other professional person to reveal information that  
7 has been given to him or her in confidence by members of a  
8 patient's family.

9 (k) Upon written agreement by a person previously confined in  
10 or otherwise treated by a facility, the professional person in charge  
11 of the facility or his or her designee may release any information,  
12 except information that has been given in confidence by members  
13 of the person's family, requested by a probation officer charged  
14 with the evaluation of the person after his or her conviction of a  
15 crime if the professional person in charge of the facility determines  
16 that the information is relevant to the evaluation. The agreement  
17 shall only be operative until sentence is passed on the crime of  
18 which the person was convicted. The confidential information  
19 released pursuant to this subdivision shall be transmitted to the  
20 court separately from the probation report and shall not be placed  
21 in the probation report. The confidential information shall remain  
22 confidential except for purposes of sentencing. After sentencing,  
23 the confidential information shall be sealed.

24 (l) (1) Between persons who are trained and qualified to serve  
25 on multidisciplinary personnel teams pursuant to subdivision (d)  
26 of Section 18951. The information and records sought to be  
27 disclosed shall be relevant to the provision of child welfare services  
28 or the investigation, prevention, identification, management, or  
29 treatment of child abuse or neglect pursuant to Chapter 11  
30 (commencing with Section 18950) of Part 6 of Division 9.  
31 Information obtained pursuant to this subdivision shall not be used  
32 in any criminal or delinquency proceeding. Nothing in this  
33 subdivision shall prohibit evidence identical to that contained  
34 within the records from being admissible in a criminal or  
35 delinquency proceeding, if the evidence is derived solely from  
36 means other than this subdivision, as permitted by law.

37 (2) As used in this subdivision, "child welfare services" means  
38 those services that are directed at preventing child abuse or neglect.

39 (m) To county patients' rights advocates who have been given  
40 knowing voluntary authorization by a client or a guardian ad litem.

1 The client or guardian ad litem, whoever entered into the  
2 agreement, may revoke the authorization at any time, either in  
3 writing or by oral declaration to an approved advocate.

4 (n) To a committee established in compliance with Section  
5 4070.

6 (o) In providing information as described in Section 7325.5.  
7 Nothing in this subdivision shall permit the release of any  
8 information other than that described in Section 7325.5.

9 (p) To the county mental health director or the director's  
10 designee, or to a law enforcement officer, or to the person  
11 designated by a law enforcement agency, pursuant to Sections  
12 5152.1 and 5250.1.

13 (q) If the patient gives his or her consent, information  
14 specifically pertaining to the existence of genetically handicapping  
15 conditions, as defined in Section 125135 of the Health and Safety  
16 Code, may be released to qualified professional persons for  
17 purposes of genetic counseling for blood relatives upon request of  
18 the blood relative. For purposes of this subdivision, "qualified  
19 professional persons" means those persons with the qualifications  
20 necessary to carry out the genetic counseling duties under this  
21 subdivision as determined by the genetic disease unit established  
22 in the State Department of Health Care Services under Section  
23 125000 of the Health and Safety Code. If the patient does not  
24 respond or cannot respond to a request for permission to release  
25 information pursuant to this subdivision after reasonable attempts  
26 have been made over a two-week period to get a response, the  
27 information may be released upon request of the blood relative.

28 (r) When the patient, in the opinion of his or her psychotherapist,  
29 presents a serious danger of violence to a reasonably foreseeable  
30 victim or victims, then any of the information or records specified  
31 in this section may be released to that person or persons and to  
32 law enforcement agencies and county child welfare agencies as  
33 the psychotherapist determines is needed for the protection of that  
34 person or persons. For purposes of this subdivision,  
35 "psychotherapist" means anyone so defined within Section 1010  
36 of the Evidence Code.

37 (s) (1) To the designated officer of an emergency response  
38 employee, and from that designated officer to an emergency  
39 response employee regarding possible exposure to HIV or AIDS,  
40 but only to the extent necessary to comply with provisions of the

1 federal Ryan White Comprehensive AIDS Resources Emergency  
2 Act of 1990~~(P.L. (Public Law 101-381; 42 U.S.C. Sec. 201).~~

3 (2) For purposes of this subdivision, “designated officer” and  
4 “emergency response employee” have the same meaning as these  
5 terms are used in the Ryan White Comprehensive AIDS Resources  
6 Emergency Act of 1990~~(P.L. (Public Law 101-381; 42 U.S.C.~~  
7 Sec. 201).

8 (3) The designated officer shall be subject to the confidentiality  
9 requirements specified in Section 120980, and may be personally  
10 liable for unauthorized release of any identifying information about  
11 the HIV results. Further, the designated officer shall inform the  
12 exposed emergency response employee that the employee is also  
13 subject to the confidentiality requirements specified in Section  
14 120980, and may be personally liable for unauthorized release of  
15 any identifying information about the HIV test results.

16 (t) (1) To a law enforcement officer who personally lodges with  
17 a facility, as defined in paragraph (2), a warrant of arrest or an  
18 abstract of such a warrant showing that the person sought is wanted  
19 for a serious felony, as defined in Section 1192.7 of the Penal  
20 Code, or a violent felony, as defined in Section 667.5 of the Penal  
21 Code. The information sought and released shall be limited to  
22 whether or not the person named in the arrest warrant is presently  
23 confined in the facility. This paragraph shall be implemented with  
24 minimum disruption to health facility operations and patients, in  
25 accordance with Section 5212. If the law enforcement officer is  
26 informed that the person named in the warrant is confined in the  
27 facility, the officer may not enter the facility to arrest the person  
28 without obtaining a valid search warrant or the permission of staff  
29 of the facility.

30 (2) For purposes of paragraph (1), a facility means all of the  
31 following:

32 (A) A state hospital, as defined in Section 4001.

33 (B) A general acute care hospital, as defined in subdivision (a)  
34 of Section 1250 of the Health and Safety Code, solely with regard  
35 to information pertaining to a mentally disordered person subject  
36 to this section.

37 (C) An acute psychiatric hospital, as defined in subdivision (b)  
38 of Section 1250 of the Health and Safety Code.

39 (D) A psychiatric health facility, as described in Section 1250.2  
40 of the Health and Safety Code.

1 (E) A mental health rehabilitation center, as described in Section  
2 5675.

3 (F) A skilled nursing facility with a special treatment program  
4 for chronically mentally disordered patients, as described in  
5 Sections 51335 and 72445 to 72475, inclusive, of Title 22 of the  
6 California Code of Regulations.

7 (u) Between persons who are trained and qualified to serve on  
8 multidisciplinary personnel teams pursuant to Section 15610.55,  
9 15753.5, or 15761. The information and records sought to be  
10 disclosed shall be relevant to the prevention, identification,  
11 management, or treatment of an abused elder or dependent adult  
12 pursuant to Chapter 13 (commencing with Section 15750) of Part  
13 3 of Division 9.

14 (v) The amendment of subdivision (d) enacted at the 1970  
15 Regular Session of the Legislature does not constitute a change  
16 in, but is declaratory of, the preexisting law.

17 (w) This section shall not be limited by Section 5150.05 or 5332.

18 (x) (1) When an employee is served with a notice of adverse  
19 action, as defined in Section 19570 of the Government Code, the  
20 following information and records may be released:

21 (A) All information and records that the appointing authority  
22 relied upon in issuing the notice of adverse action.

23 (B) All other information and records that are relevant to the  
24 adverse action, or that would constitute relevant evidence as  
25 defined in Section 210 of the Evidence Code.

26 (C) The information described in subparagraphs (A) and (B)  
27 may be released only if both of the following conditions are met:

28 (i) The appointing authority has provided written notice to the  
29 consumer and the consumer's legal representative or, if the  
30 consumer has no legal representative or if the legal representative  
31 is a state agency, to the clients' rights advocate, and the consumer,  
32 the consumer's legal representative, or the clients' rights advocate  
33 has not objected in writing to the appointing authority within five  
34 business days of receipt of the notice, or the appointing authority,  
35 upon review of the objection has determined that the circumstances  
36 on which the adverse action is based are egregious or threaten the  
37 health, safety, or life of the consumer or other consumers and  
38 without the information the adverse action could not be taken.

1 (ii) The appointing authority, the person against whom the  
2 adverse action has been taken, and the person's representative, if  
3 any, have entered into a stipulation that does all of the following:

4 (I) Prohibits the parties from disclosing or using the information  
5 or records for any purpose other than the proceedings for which  
6 the information or records were requested or provided.

7 (II) Requires the employee and the employee's legal  
8 representative to return to the appointing authority all records  
9 provided to them under this subdivision, including, but not limited  
10 to, all records and documents from any source containing  
11 confidential information protected by this section, and all copies  
12 of those records and documents, within 10 days of the date that  
13 the adverse action becomes final except for the actual records and  
14 documents or copies thereof that are no longer in the possession  
15 of the employee or the employee's legal representative because  
16 they were submitted to the administrative tribunal as a component  
17 of an appeal from the adverse action.

18 (III) Requires the parties to submit the stipulation to the  
19 administrative tribunal with jurisdiction over the adverse action  
20 at the earliest possible opportunity.

21 (2) For the purposes of this subdivision, the State Personnel  
22 Board may, prior to any appeal from adverse action being filed  
23 with it, issue a protective order, upon application by the appointing  
24 authority, for the limited purpose of prohibiting the parties from  
25 disclosing or using information or records for any purpose other  
26 than the proceeding for which the information or records were  
27 requested or provided, and to require the employee or the  
28 employee's legal representative to return to the appointing authority  
29 all records provided to them under this subdivision, including, but  
30 not limited to, all records and documents from any source  
31 containing confidential information protected by this section, and  
32 all copies of those records and documents, within 10 days of the  
33 date that the adverse action becomes final, except for the actual  
34 records and documents or copies thereof that are no longer in the  
35 possession of the employee or the employee's legal representatives  
36 because they were submitted to the administrative tribunal as a  
37 component of an appeal from the adverse action.

38 (3) Individual identifiers, including, but not limited to, names,  
39 social security numbers, and hospital numbers, that are not

1 necessary for the prosecution or defense of the adverse action,  
2 shall not be disclosed.

3 (4) All records, documents, or other materials containing  
4 confidential information protected by this section that have been  
5 submitted or otherwise disclosed to the administrative agency or  
6 other person as a component of an appeal from an adverse action  
7 shall, upon proper motion by the appointing authority to the  
8 administrative tribunal, be placed under administrative seal and  
9 shall not, thereafter, be subject to disclosure to any person or entity  
10 except upon the issuance of an order of a court of competent  
11 jurisdiction.

12 (5) For purposes of this subdivision, an adverse action becomes  
13 final when the employee fails to answer within the time specified  
14 in Section 19575 of the Government Code, or, after filing an  
15 answer, withdraws the appeal, or, upon exhaustion of the  
16 administrative appeal or of the judicial review remedies as  
17 otherwise provided by law.

18 ~~SEC. 43.~~

19 *SEC. 42.* Section 5328.04 of the Welfare and Institutions Code  
20 is amended to read:

21 5328.04. (a) Notwithstanding Section 5328, information and  
22 records made confidential under that section may be disclosed to  
23 a county social worker, a probation officer, or any other person  
24 who is legally authorized to have custody or care of a minor, for  
25 the purpose of coordinating health care services and medical  
26 treatment, as defined in subdivision (b) of Section 56.103 of the  
27 Civil Code, mental health services, or services for developmental  
28 disabilities, for the minor.

29 (b) Information disclosed under subdivision (a) shall not be  
30 further disclosed by the recipient unless the disclosure is for the  
31 purpose of coordinating health care services and medical treatment,  
32 or mental health or developmental disability services, for the minor  
33 and only to a person who would otherwise be able to obtain the  
34 information under subdivision (a) or any other provision of law.

35 (c) Information disclosed pursuant to this section shall not be  
36 admitted into evidence in any criminal or delinquency proceeding  
37 against the minor. Nothing in this subdivision shall prohibit  
38 identical evidence from being admissible in a criminal proceeding  
39 if that evidence is derived solely from lawful means other than  
40 this section and is permitted by law.

1 (d) Nothing in this section shall be construed to compel a  
2 physician and surgeon, licensed psychologist, social worker with  
3 a master's degree in social work, licensed marriage and family  
4 therapist, licensed professional clinical counselor, nurse, attorney,  
5 or other professional person to reveal information, including notes,  
6 that has been given to him or her in confidence by the minor or  
7 members of the minor's family.

8 (e) The disclosure of information pursuant to this section is not  
9 intended to limit disclosure of information when that disclosure  
10 is otherwise required by law.

11 (f) Nothing in this section shall be construed to expand the  
12 authority of a social worker, probation officer, or custodial  
13 caregiver beyond the authority provided under existing law to a  
14 parent or a patient representative regarding access to confidential  
15 information.

16 (g) As used in this section, "minor" means a minor taken into  
17 temporary custody or for whom a petition has been filed with the  
18 court, or who has been adjudged a dependent child or ward of  
19 juvenile court pursuant to Section 300 or 601.

20 (h) Information and records that may be disclosed pursuant to  
21 this section do not include psychotherapy notes, as defined in  
22 Section 164.501 of Title 45 of the Code of Federal Regulations.

23 ~~SEC. 44.~~

24 *SEC. 43.* Section 5696.5 of the Welfare and Institutions Code  
25 is amended to read:

26 5696.5. Prior to the opening of a facility, the board of directors  
27 shall establish written program standards and policies and  
28 procedures, approved by the Division of Juvenile Facilities that  
29 address and include, but are not limited to, the following:

30 (a) A staffing number and pattern that meets the special  
31 behavior, supervision, treatment, health, and educational needs of  
32 the population described in this chapter. Staff shall be qualified to  
33 provide intensive treatment and services and shall include, at a  
34 minimum:

35 (1) A project or clinical director, a psychiatrist or; psychologist,  
36 a social worker, a registered nurse, and a recreation or occupational  
37 therapist.

38 (2) A pediatrician; *and* a dentist, *and* a licensed marriage and  
39 family therapist, ~~and~~ *or* a licensed professional clinical counselor,  
40 *or both of those professionals*, on an as-needed basis.

1 (3) Educational staff in sufficient number and with the  
2 qualifications needed to meet the population served.

3 (4) Child care staff in sufficient numbers and with the  
4 qualifications needed to meet the special needs of the population.

5 (b) Programming to meet the needs of all wards admitted,  
6 including, but not limited to, all of the following:

7 (1) Physical examinations on admission and ongoing health  
8 care.

9 (2) Appropriate and closely monitored use of all behavioral  
10 management techniques.

11 (3) The establishment of written, individual treatment and  
12 educational plans and goals for each ward within 10 days of  
13 admission and which are updated at least quarterly.

14 (4) Written discharge planning that addresses each ward's  
15 continued treatment, educational, and supervision needs.

16 (5) Regular, written progress records regarding the care and  
17 treatment of each ward.

18 (6) Regular and structured treatment of all wards, including,  
19 but not limited to, individual, group and family therapy,  
20 psychological testing, medication, and occupational, or recreational  
21 therapy.

22 (7) Access to neurological testing and laboratory work as  
23 needed.

24 (8) The opportunity for regular family contact and involvement.

25 (9) A periodic review of the continued need for treatment within  
26 the facility.

27 (10) Educational programming, including special education as  
28 needed.

29 ~~SEC. 45.~~

30 *SEC. 44.* Section 5751 of the Welfare and Institutions Code is  
31 amended to read:

32 5751. (a) Regulations pertaining to the qualifications of  
33 directors of local mental health services shall be administered in  
34 accordance with Section 5607. These standards may include the  
35 maintenance of records of service which shall be reported to the  
36 State Department of Mental Health in a manner and at times as it  
37 may specify.

38 (b) Regulations pertaining to the position of director of local  
39 mental health services, where the local director is other than the  
40 local health officer or medical administrator of the county hospitals,

1 shall require that the director be a psychiatrist, psychologist,  
2 clinical social worker, marriage and family therapist, professional  
3 clinical counselor, registered nurse, or hospital administrator, who  
4 meets standards of education and experience established by the  
5 Director of Mental Health. Where the director is not a psychiatrist,  
6 the program shall have a psychiatrist licensed to practice medicine  
7 in this state and who shall provide to patients medical care and  
8 services as authorized by Section 2051 of the Business and  
9 Professions Code.

10 (c) The regulations shall be adopted in accordance with the  
11 Administrative Procedure Act, ~~Chapter~~ (*Chapter* 3.5 (commencing  
12 with Section 11340) of Part 1 of Division 3 of Title 2 of the  
13 Government ~~Code Code~~).

14 ~~SEC. 46.~~

15 *SEC. 45.* Section 5751.2 of the Welfare and Institutions Code  
16 is amended to read:

17 5751.2. (a) Except as provided in this section, persons  
18 employed or under contract to provide mental health services  
19 pursuant to this part shall be subject to all applicable requirements  
20 of law regarding professional licensure, and no person shall be  
21 employed in local mental health programs pursuant to this part to  
22 provide services for which a license is required, unless the person  
23 possesses a valid license.

24 (b) Persons employed as psychologists and clinical social  
25 workers, while continuing in their employment in the same class  
26 as of January 1, 1979, in the same program or facility, including  
27 those persons on authorized leave, but not including intermittent  
28 personnel, shall be exempt from the requirements of subdivision  
29 (a).

30 (c) While registered with the licensing board of jurisdiction for  
31 the purpose of acquiring the experience required for licensure,  
32 persons employed or under contract to provide mental health  
33 services pursuant to this part as clinical social workers, marriage  
34 and family therapists, or professional clinical counselors shall be  
35 exempt from subdivision (a). Registration shall be subject to  
36 regulations adopted by the appropriate licensing board.

37 (d) The requirements of subdivision (a) shall be waived by the  
38 department for persons employed or under contract to provide  
39 mental health services pursuant to this part as psychologists who  
40 are gaining the experience required for licensure. A waiver granted

1 under this subdivision may not exceed five years from the date of  
2 employment by, or contract with, a local mental health program  
3 for persons in the profession of psychology.

4 (e) The requirements of subdivision (a) shall be waived by the  
5 department for persons who have been recruited for employment  
6 from outside this state as psychologists, clinical social workers,  
7 marriage and family therapists, or professional clinical counselors  
8 and whose experience is sufficient to gain admission to a licensing  
9 examination. A waiver granted under this subdivision may not  
10 exceed three years from the date of employment by, or contract  
11 with, a local mental health program for persons in these ~~three~~ *four*  
12 professions who are recruited from outside this state.

13 ~~SEC. 47.~~

14 *SEC. 46.* Section 15610.37 of the Welfare and Institutions  
15 Code is amended to read:

16 15610.37. "Health practitioner" means a physician and surgeon,  
17 psychiatrist, psychologist, dentist, resident, intern, podiatrist,  
18 chiropractor, registered nurse, dental hygienist, licensed clinical  
19 social worker or associate clinical social worker, marriage and  
20 family therapist, licensed professional clinical counselor, or any  
21 other person who is currently licensed under Division 2  
22 (commencing with Section 500) of the Business and Professions  
23 Code, any emergency medical technician I or II, paramedic, or  
24 person certified pursuant to Division 2.5 (commencing with Section  
25 1797) of the Health and Safety Code, a psychological assistant  
26 registered pursuant to Section 2913 of the Business and Professions  
27 Code, a marriage and family therapist trainee, as defined in  
28 subdivision (c) of Section 4980.03 of the Business and Professions  
29 Code, an unlicensed marriage and family therapist intern registered  
30 under Section 4980.44 of the Business and Professions Code, a  
31 clinical counselor trainee, as defined in subdivision (g) of Section  
32 4999.12 of the Business and Professions Code, a clinical counselor  
33 intern registered under Section 4999.42 of the Business and  
34 Professions Code, a state or county public health or social service  
35 employee who treats an elder or a dependent adult for any  
36 condition, or a coroner.

37 ~~SEC. 48.~~

38 *SEC. 47.* No reimbursement is required by this act pursuant to  
39 Section 6 of Article XIII B of the California Constitution because  
40 the only costs that may be incurred by a local agency or school

1 district will be incurred because this act creates a new crime or  
2 infraction, eliminates a crime or infraction, or changes the penalty  
3 for a crime or infraction, within the meaning of Section 17556 of  
4 the Government Code, or changes the definition of a crime within  
5 the meaning of Section 6 of Article XIII B of the California  
6 Constitution.

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# CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES

## BILL ANALYSIS

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**BILL NUMBER:** SB 718                      **VERSION:** INTRODUCED FEBRUARY 18, 2011

**AUTHOR:** VARGAS                      **SPONSOR:** COUNTY OF SAN DIEGO

**RECOMMENDED POSITION:**

**SUBJECT:** ELDER ABUSE – MANDATED REPORTING

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### **Existing Law:**

- 1) Requires mandated reporters of elder or adult physical abuse, including Marriage Family Therapists, Licensed Clinical Social Workers, and Licensed Educational Psychologists, to report suspected instances of abuse by telephone immediately or as soon as possible and submit a written report within two working days (Welfare and Institutions Code [WIC], Section 15630).
- 2) Requires the written report to be on a form prescribed by the State Department of Social Services (WIC, Section 15658).
- 3) Requires each county adult protective services agency to submit monthly summary reports of the abuse reports received to the State Department of Social Services (WIC, Section 15658).
- 4) Requires each long-term care ombudsman program to submit monthly summary reports of the abuse reports received to the office of the Long-Term Care Ombudsman of the California Department of Aging and a copy of the summary report to the county adult protective services agency (WIC, Section 15658).

**This Bill** allows mandated reporters to send the required written report to the county adult protective service agencies through a confidential Internet reporting tool, if the county chooses to implement such a system.

### **Comments:**

- 1) **Author's Intent.** Due to a currently lengthy wait time for elder or dependent adult abuse reporters calling on San Diego County's abuse reporting phone line, there is concern that public callers may hang up and not report the abuse, thus leaving seniors or adults at risk of further abuse. San Diego County would like to allow mandated reporters to submit reports through either the phone line or a secure electronic web referral system in order to decrease the wait time on the phone line and reduce this risk to elders and adults.
- 2) **Background and Underlying Data.** According to the fact sheet from the author's office, the County of San Diego, Adult Protective Services currently receives reports of suspected elder and adult abuse from mandated reports and the public on the same phone line. Due to recent budget cuts, which led to decreased staffing, and a high volume of calls, wait time

has increased by 50 percent. As of November 2010, 27 percent of calls were abandoned.

- 3) **Impact.** This bill would have a minimal impact on reporting requirements for mandated reporters. This bill may benefit licensees by simplifying the reporting process.
- 4) **Language Unclear:** The bill's language appears to allow required written reports to be sent electronically. However, the language only refers to "reports" in general and does not clearly indicate whether or not the electronic report would be sent instead of the telephone call or the written report. The bill, as written, does not seem to change the requirement for mandated reporters to call immediately or as soon as possible (See Welfare and Institutions Code Section 15630). Subsequently, this bill would not reduce the number of calls San Diego County receives.

The County of San Diego Adult Protective Services Unit indicated that the bill will be amended to clarify the intent of the bill and allow a mandated reporter to submit a report electronically *instead of both* the telephone *and* written report. This would allow the mandated reporter to only submit an electronic report and would reduce county staff time dedicated to processing telephone calls and written reports. The San Diego County Adult Protective Services Unit also stated that telephone calls may be interpreted differently than the reporter's intent; therefore, allowing a single electronic report would reduce interpretation issues with the telephone reports.

The planned amendments would not significantly change the impact of the bill on licensees. The planned amendments could possibly reduce the number of reports that mandated reporters are required to submit by allowing only one electronic report submission instead of both a phone call and written report.

- 5) **Problems with Author's Intent:** San Diego County's budget cut led to an increase in wait time on the abuse reporting phone line due to a reduction in staff. The cost of the web referral system could only be justified if it cost less than hiring more staff.

The author's office stated that the funding for this web referral system would come out of San Diego County's existing budget. A County of San Diego, Adult Protective Services background paper states that the County is currently building a new software system that will include a component for web based reporting. If San Diego County is already creating a web referral system, then it may be able to use the system for the adult abuse reporting program at a minimal cost.

## 6) Support and Opposition.

*Support:* County of San Diego (Sponsor)

*Opposition:* None

## 7) History

### 2011

|         |  |
|---------|--|
| Mar. 3  | Referred to Com. on HUMAN S.   |
| Feb. 20 | From printer. May be acted upon on or after March 22.                  |
| Feb. 18 | Introduced. Read first time. To Com. on RLS. for assignment. To print. |

**8) Attachments**

- A. Welfare & Institutions Code Section 15630
- B. SB 718 Background Paper from the County of San Diego, Adult Protective Services

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**Introduced by Senator Vargas**

February 18, 2011

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An act to amend Section 15658 of the Welfare and Institutions Code, relating to public social services.

LEGISLATIVE COUNSEL'S DIGEST

SB 718, as introduced, Vargas. Elder abuse: mandated reporting.

Existing law requires specified people, known as mandated reporters, to report cases of elder abuse, as defined, to a county adult protective services agency. Existing law requires mandated reporters to send written reports to specified entities containing prescribed information.

This bill would authorize the required reports to be submitted to a county adult protective services agency through a confidential Internet reporting tool, if the county implements such a system, so long as the information gathered meets the existing requirements for written reports.

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 15658 of the Welfare and Institutions
- 2 Code is amended to read:
- 3 15658. (a) (1) The written abuse reports required for the
- 4 reporting of abuse, as defined in this chapter, shall be submitted
- 5 on forms adopted by the State Department of Social Services after
- 6 consultation with representatives of the various law enforcement
- 7 agencies, the California Department of Aging, the State Department
- 8 of Developmental Services, the State Department of Mental Health,
- 9 the bureau, professional medical and nursing agencies, hospital

1 associations, and county welfare departments. These reporting  
2 forms shall be distributed by the county adult protective services  
3 agencies and the long-term care ombudsman programs. This  
4 reporting form may also be used for documenting the telephone  
5 report of a known or suspected instance of abuse of an elder or  
6 dependent adult by the county adult protective services agency,  
7 local ombudsman program, and local law enforcement agencies.

8 (2) The forms required by this section shall contain the following  
9 items:

10 (A) The name, address, telephone number, and occupation of  
11 the person reporting.

12 (B) The name and address of the victim.

13 (C) The date, time, and place of the incident.

14 (D) Other details, including the reporter's observations and  
15 beliefs concerning the incident.

16 (E) Any statement relating to the incident made by the victim.

17 (F) The name of any individuals believed to have knowledge  
18 of the incident.

19 (G) The name of the individuals believed to be responsible for  
20 the incident and their connection to the victim.

21 (b) (1) Each county adult protective services agency shall report  
22 to the State Department of Social Services monthly on the reports  
23 received pursuant to this chapter. The reports shall be made on  
24 forms adopted by the department. The information reported shall  
25 include, but shall not be limited to, the number of incidents of  
26 abuse, the number of persons abused, the type of abuse sustained,  
27 and the actions taken on the reports. For purposes of these reports,  
28 sexual abuse shall be reported separately from physical abuse.

29 (2) The county's report to the department shall not include  
30 reports it receives from the long-term care ombudsman program  
31 pursuant to subdivision (c).

32 (3) The department shall refer to the bureau monthly data  
33 summaries of the reports of elder and dependent adult abuse,  
34 neglect, abandonment, isolation, and financial abuse, and other  
35 abuse it receives from county adult protective services agencies.

36 (c) Each long-term care ombudsman program shall report to the  
37 office of the Long-Term Care Ombudsman of the California  
38 Department of Aging monthly on the reports it receives pursuant  
39 to this chapter ~~with~~ *and shall send a copy sent* to the county adult  
40 protective services agency. The office of the state ombudsman

1 shall submit a summarized quarterly report to the department based  
2 on the monthly reports submitted by local long-term care  
3 ombudsman programs. The reports shall be on forms adopted by  
4 the department and the office of the state ombudsman. The  
5 information reported shall include, but shall not be limited to, the  
6 number of incidents of abuse, the numbers of persons abused, the  
7 type of abuse, and the actions taken on the reports. For purposes  
8 of these reports, sexual abuse shall be reported separately from  
9 physical abuse.

10 *(d) Reports required pursuant to this chapter may be submitted*  
11 *to a county adult protective services agency through a confidential*  
12 *Internet reporting tool, if the county chooses to implement such a*  
13 *system, so long as the information gathered meets the requirements*  
14 *of subdivision (a).*

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## Welfare and Institutions Code Section 15630

### §15630

(a) Any person who has assumed full or intermittent responsibility for the care or custody of an elder or dependent adult, whether or not he or she receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults, or any elder or dependent adult care custodian, health practitioner, clergy member, or employee of a county adult protective services agency or a local law enforcement agency, is a mandated reporter.

(b) (1) Any mandated reporter who, in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of an incident that reasonably appears to be physical abuse, as defined in Section 15610.63 of the Welfare and Institutions Code, abandonment, abduction, isolation, financial abuse, or neglect, or is told by an elder or dependent adult that he or she has experienced behavior, including an act or omission, constituting physical abuse, as defined in Section 15610.63 of the Welfare and Institutions Code, abandonment, abduction, isolation, financial abuse, or neglect, or reasonably suspects that abuse, shall report the known or suspected instance of abuse by telephone immediately or as soon as practicably possible, and by written report sent within two working days, as follows:

(A) If the abuse has occurred in a long-term care facility, except a state mental health hospital or a state developmental center, the report shall be made to the local ombudsperson or the local law enforcement agency.

The local ombudsperson and the local law enforcement agency shall, as soon as practicable, except in the case of an emergency or pursuant to a report required to be made pursuant to clause (v), in which case these actions shall be taken immediately, do all of the following:

(i) Report to the State Department of Public Health any case of known or suspected abuse occurring in a long-term health care facility, as defined in subdivision (a) of Section 1418 of the Health and Safety Code.

(ii) Report to the State Department of Social Services any case of known or suspected abuse occurring in a residential care facility for the elderly, as defined in Section 1569.2 of the Health and Safety Code, or in an adult day care facility, as defined in paragraph (2) of subdivision (a) of Section 1502.

(iii) Report to the State Department of Public Health and the California Department of Aging any case of known or suspected abuse occurring in an adult day health care center, as defined in subdivision (b) of Section 1570.7 of the Health and Safety Code.

(iv) Report to the Bureau of Medi-Cal Fraud and Elder Abuse any case of known or suspected criminal activity.

(v) Report all cases of known or suspected physical abuse and financial abuse to the local district attorney's office in the county where the abuse occurred.

(B) If the suspected or alleged abuse occurred in a state mental hospital or a state developmental center, the report shall be made to designated investigators of the State Department of Mental Health or the State Department of Developmental Services, or to the local law enforcement agency.

Except in an emergency, the local law enforcement agency shall, as soon as practicable, report any case of known or suspected criminal activity to the Bureau of Medi-Cal Fraud and Elder Abuse.

(C) If the abuse has occurred any place other than one described in subparagraph (A), the report shall be made to the adult protective services agency or the local law enforcement agency.

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

(B) Nothing in this subdivision shall be construed to modify or limit a clergy member's duty to report known or suspected elder and dependent adult abuse when he or she is acting in the capacity of a care custodian, health practitioner, or employee of an adult protective services agency.

(C) Notwithstanding any other provision in this section, a clergy member who is not regularly employed on either a full-time or part-time basis in a long-term care facility or does not have care or custody of an elder or dependent adult shall not be responsible for reporting abuse or neglect that is not reasonably observable or discernible to a reasonably prudent person having no specialized training or experience in elder or dependent care.

(3) (A) A mandated reporter who is a physician and surgeon, a registered nurse, or a psychotherapist, as defined in Section 1010 of the Evidence Code, shall not be required to report, pursuant to paragraph (1), an incident where all of the following conditions exist:

(i) The mandated reporter has been told by an elder or dependent adult that he or she has experienced behavior constituting physical abuse, as defined in Section 15610.63 of the Welfare and Institutions Code, abandonment, abduction, isolation, financial abuse, or neglect.

(ii) The mandated reporter is not aware of any independent evidence that corroborates the statement that the abuse has occurred.

(iii) The elder or dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservatorship because of a mental illness or dementia.

(iv) In the exercise of clinical judgment, the physician and surgeon, the registered nurse, or the psychotherapist, as defined in Section 1010 of the Evidence Code, reasonably believes that the abuse did not occur.

(B) This paragraph shall not be construed to impose upon mandated reporters a duty to investigate a known or suspected incident of abuse and shall not be construed to lessen or restrict any existing duty of mandated reporters.

(4) (A) In a long-term care facility, a mandated reporter shall not be required to report as a suspected incident of abuse, as defined in Section 15610.07, an incident where all of the following conditions exist:

- (i) The mandated reporter is aware that there is a proper plan of care.
- (ii) The mandated reporter is aware that the plan of care was properly provided or executed.
- (iii) A physical, mental, or medical injury occurred as a result of care provided pursuant to clause (i) or (ii).
- (iv) The mandated reporter reasonably believes that the injury was not the result of abuse.

(B) This paragraph shall not be construed to require a mandated reporter to seek, nor to preclude a mandated reporter from seeking, information regarding a known or suspected incident of abuse prior to reporting. This paragraph shall apply only to those categories of mandated reporters that the State Department of Public Health determines, upon approval by the Bureau of Medi-Cal Fraud and Elder Abuse and the state long-term care ombudsperson, have access to plans of care and have the training and experience necessary to determine whether the conditions specified in this section have been met.

(c) (1) Any mandated reporter who has knowledge, or reasonably suspects, that types of elder or dependent adult abuse for which reports are not mandated have been inflicted upon an elder or dependent adult, or that his or her emotional well-being is endangered in any other way, may report the known or suspected instance of abuse.

(2) If the suspected or alleged abuse occurred in a long-term care facility other than a state mental health hospital or a state developmental center, the report may be made to the long-term care ombudsperson program. Except in an emergency, the local ombudsperson shall report any case of known or suspected abuse to the State Department of Public Health and any case of known or suspected criminal activity to the Bureau of Medi-Cal Fraud and Elder Abuse, as soon as is practicable.

(3) If the suspected or alleged abuse occurred in a state mental health hospital or a state developmental center, the report may be made to the designated investigator of the State Department of Mental Health or the State Department of Developmental Services or to a local law enforcement agency or to the local ombudsperson. Except in an emergency, the local ombudsperson and the local law enforcement agency shall report any case of known or suspected criminal activity to the Bureau of Medi-Cal Fraud and Elder Abuse, as soon as is practicable.

(4) If the suspected or alleged abuse occurred in a place other than a place described in paragraph (2) or (3), the report may be made to the county adult protective services agency.

(5) If the conduct involves criminal activity not covered in subdivision (b), it may be immediately reported to the appropriate law enforcement agency.

(d) When two or more mandated reporters are present and jointly have knowledge or reasonably suspect that types of abuse of an elder or a dependent adult for which a report is or is not mandated have occurred, and when there is agreement among them, the telephone report may be made by a member of the team selected by mutual agreement, and a single

report may be made and signed by the selected member of the reporting team. Any member who has knowledge that the member designated to report has failed to do so shall thereafter make the report.

(e) A telephone report of a known or suspected instance of elder or dependent adult abuse shall include, if known, the name of the person making the report, the name and age of the elder or dependent adult, the present location of the elder or dependent adult, the names and addresses of family members or any other adult responsible for the elder's or dependent adult's care, the nature and extent of the elder's or dependent adult's condition, the date of the incident, and any other information, including information that led that person to suspect elder or dependent adult abuse, as requested by the agency receiving the report.

(f) The reporting duties under this section are individual, and no supervisor or administrator shall impede or inhibit the reporting duties, and no person making the report shall be subject to any sanction for making the report. However, internal procedures to facilitate reporting, ensure confidentiality, and apprise supervisors and administrators of reports may be established, provided they are not inconsistent with this chapter.

(g) (1) Whenever this section requires a county adult protective services agency to report to a law enforcement agency, the law enforcement agency shall, immediately upon request, provide a copy of its investigative report concerning the reported matter to that county adult protective services agency.

(2) Whenever this section requires a law enforcement agency to report to a county adult protective services agency, the county adult protective services agency shall, immediately upon request, provide to that law enforcement agency a copy of its investigative report concerning the reported matter.

(3) The requirement to disclose investigative reports pursuant to this subdivision shall not include the disclosure of social services records or case files that are confidential, nor shall this subdivision be construed to allow disclosure of any reports or records if the disclosure would be prohibited by any other provision of state or federal law.

(h) Failure to report, or impeding or inhibiting a report of, physical abuse, as defined in Section 15610.63 of the Welfare and Institutions Code, abandonment, abduction, isolation, financial abuse, or neglect of an elder or dependent adult, in violation of this section, is a misdemeanor, punishable by not more than six months in the county jail, by a fine of not more than one thousand dollars (\$1,000), or by both that fine and imprisonment. Any mandated reporter who willfully fails to report, or impedes or inhibits a report of, physical abuse, as defined in Section 15610.63 of the Welfare and Institutions Code, abandonment, abduction, isolation, financial abuse, or neglect of an elder or dependent adult, in violation of this section, where that abuse results in death or great bodily injury, shall be punished by not more than one year in a county jail, by a fine of not more than five thousand dollars (\$5,000), or by both that fine and imprisonment. If a mandated reporter intentionally conceals his or her failure to report an incident known by the mandated reporter to be abuse or severe neglect under this section, the failure to report is a continuing offense until a law enforcement agency specified in paragraph (1) of subdivision (b) of Section 15630 of the Welfare and Institutions Code discovers the offense.

(i) For purposes of this section, "dependent adult" shall have the same meaning as in Section 15610.23.

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## Adult Protective Services

# Secure Internet Reporting Option for Mandated Reports

2011 Legislative Sponsorship Proposal

The County of San Diego (County) is seeking a change in state law to provide mandated reporters of suspected elder and dependent adult abuse the option of filing a report over the Internet.

### Issue:

California law requires certain categories of persons, defined as "mandated reporters" which are including, but not limited to, licensed health practitioners, to report to appropriate authorities the known or reasonably suspected abuse or neglect of a child, elder, or dependent adult. A mandated reporter must report to appropriate authorities when, in the course and scope of his or her employment or professional capacity, he or she knows of, or reasonably suspects, that a child, elder or dependent adult has been the victim of abuse or neglect. Existing law requires mandated reporters to report known or suspected elder and dependent adult abuse by telephone immediately or as soon as practicably possible, and by written report sent within two working days (Welfare & Institutions Code §15630).

The County of San Diego, Adult Protective Services currently receives reports of suspected abuse from mandated reporters and from members of the community on the same phone line. Due to the high volume of callers, there can be a lengthy wait before a call is answered. There is some concern that due to the long wait, members of the community who are not required to report, may hang up and not report the abuse. This could leave seniors and/or dependent adults at further risk of abuse.

### Background:

In fiscal year 2008-09 the state reduced local assistance funding for the Adult Protective Services program by \$11.4 million statewide. This represented a 10 percent reduction to the program which had not received a cost of doing business increase since 2001. Due to the state cuts and the cumulative impact of no cost of doing business increase, the number of County staff answering calls was reduced by four positions. As a result, wait times for those calling to make a report of elder and dependent adult abuse has increased and the number of callers that hung up while waiting to report abuse grew by 50 percent. Since staff was reduced in April 2008, the percent of calls that are abandoned has increased by 24 percent.

### Proposal:

The County of San Diego is seeking a change in state law to authorize the submission of reports of suspected abuse through a secure electronic web referral system in addition to the current process (by telephone) for mandated reporters. In San Diego County, mandated reporters comprise more than 50 percent of the abuse calls. By allowing mandated reporters the option to file reports of suspected abuse through a secure electronic web referral system, it is estimated it could reduce the number of telephone reporters by half, thus reducing the wait time for phone reporting and the number of abandoned calls.

The County is requesting this web-based internet reporting option be made available for use by all counties in addition to existing telephone reporting for mandated reporters. The County of San Diego views this web referral system for reporting suspected abuse as a way to continue to improve the level of service to mandated reporters and to curtail further risk of abuse for seniors and/or dependent adults.

### Secure Internet System:

- There is no cost to the state for this system.
- The County of San Diego system will be password protected. Mandated reporters would receive a password allowing them to enter the web referral system to report elder/dependent abuse. Additionally, mandated reporters would not be able to view any data related to other potential abuse victims.
- Mandated reporters would report the same information that is currently required to be provided by law over the telephone.
- A county's timeframe for responding to reports of abuse is provided in law and would not change.

- The system would reduce the amount of County staff time required to take calls and process written reports.
- The County of San Diego currently uses a web referral process for In-Home Supportive Services and Case Management in Aging and Independent Services (AIS) and Public Health Services referrals to nurses
- The Department of AIS is currently building a new software system which will include this component for web based reporting. The system will be completed in 2011.

# CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES

## BILL ANALYSIS

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**BILL NUMBER:** SB 747                      **VERSION:** INTRODUCED FEBRUARY 18, 2011

**AUTHOR:** KEHOE                              **SPONSOR:** EQUALITY CALIFORNIA

**RECOMMENDED POSITION:** NONE

**SUBJECT:** CONTINUING EDUCATION: LESBIAN, GAY, BISEXUAL AND TRANSGENDER PATIENTS

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### Existing Law:

- 1) Requires the director of the Department of Consumer Affairs to establish, by regulation, guidelines to prescribe components for mandatory continuing education programs administered by any board within the department. The guidelines shall be developed to ensure that mandatory continuing education is used as a means to create a more competent licensing population, thereby enhancing public protection. ((Business and Professions Code §166)
- 2) Requires licensees of the Board of Behavioral Sciences (Board), upon renewal of their license, to certify to the Board that he or she has completed at least 36 hours of approved continuing education in or relevant to their field of practice. (BPC §§4980.54(c), 4989.34(a), 4996.22(a), 4999.76(a)).
- 3) States that the system of continuing education shall include courses directly related to the diagnosis, assessment, and treatment of the client population being served. (BPC §§ 4980.54(h)(3)(i), 4996.22(g), 4999.76(g))

### This Bill:

- 1) Requires physicians and surgeons, registered nurses, certified vocational nurses, psychologists, psychiatric technicians, and the Board's marriage and family therapist and clinical social worker licensees to take at least one continuing education course, between two and five hours in length, that provides instruction on cultural competency, sensitivity, and best practices for providing adequate care to lesbian, gay, bisexual, and transgender persons. (BPC §4980.54(j), 4996.22(i)).
- 2) Requires the content of the course be similar to the content described in the publication of the Gay and Lesbian Medical Association titled "Guidelines for Care of Lesbian, Gay, Bisexual and Transgender Patients." (BPC §4980.54(j), 4996.22(i)).
- 3) Requires the Board to establish the required contents of the course by regulation, and to enforce this requirement in the same manner as it enforces other required continuing education requirements. (BPC §4980.54(j), 4996.22(i)).
- 4) Makes the provisions of this bill effective January 1, 2012. Persons licensed by the Board before January 1, 2012 must complete the course no later than January 1, 2016. Persons newly licensed by the Board on and after January 1, 2012 must complete the course within

four years of their initial license issuance date, or their second license renewal date, whichever occurs first. (BPC §4980.54(j), 4996.22(i)).

**Comments:**

- 1) Author's Intent.** According to the author's office, research, studies and human experiences have demonstrated that members of the lesbian, gay, bisexual and transgender (LGBT) community receive sub-par quality medical and mental health care when compared with the health care quality provided to the general population. LGBT patients may require specialized care because of the unique nature of their medical and mental health problems.

The author notes the American Medical Association (AMA) made a public call in 1996 to improve the education of health care personnel regarding best practices for improving care provided to LGBT patients. A past president of the AMA reiterated that call in 2005. The goal of this bill is to ensure that medical and mental health care providers receive training on cultural competency, sensitivity, and best practices for providing adequate care to LGBT persons.

- 2) Current Educational Requirements.** The Board does have a requirement that may offer its licensees some exposure to LGBT issues. Applicants seeking an MFT or LPCC license who begin graduate study after August 1, 2012 or complete graduate study after December 31, 2018, must have a degree that includes instruction in "multicultural development and cross-cultural interaction, including experiences of race, ethnicity, class, spirituality, sexual orientation, gender, and disability, and their incorporation into the psychotherapeutic process." (BPC §§4980.36(d)(2)(E) and 4999.33(d)(5)). There is no equivalent educational requirement for students seeking an LCSW license.

- 3) Current Continuing Education Requirements.** There is currently no requirement that a licensee of the Board must have continuing education which covers treatment of LGBT populations.

The Board does have several one-time continuing educational requirements that must be completed by all MFT, LCSW, and LPCC licensees. These additional courses must be completed prior to licensure or at the first renewal, depending on when the applicant began graduate study. These courses are as follows:

- Spousal/partner abuse (7 hours);
- Human Sexuality (10 hours);
- Child Abuse (7 hours);
- Substance Abuse (15 hours);
- Aging/long term care (3 hours); and
- HIV/AIDS (7 hours, currently MFTs and LCSWs only, Board is pursuing regulations to require this for LPCCs also).

All licensees must take a 6-hour law and ethics course every renewal period. In total, a licensee must complete 36 hours of continuing education every renewal period.

- 4) Implementation Concerns.** This bill has an effective date of January 1, 2012. However, the Board will not know if this bill will pass and be signed into law until Fall 2011. Once passed, the Board would need to pass regulations to establish course content, as well as perform outreach to licensees to make them aware of the new requirements. In order to have time to do this, staff recommends implementation be delayed at least one year, until January 1, 2013.

**5) Qualifying Education.** This bill does not allow previous educational coursework covering LGBT issues to fulfill the requirements of this bill. Staff recommends that the following language be inserted in Sections 4980.54 and 4996.22:

§§4980.54(k), 4996.22(j) Coursework taken in fulfillment of other educational requirements for licensure, or in a separate course of study, may, at the discretion of the board, fulfill the requirement of this section. In order to satisfy the coursework requirement of this section, the applicant shall submit to the board a certification from the chief academic officer of the educational institution from which the applicant graduated stating that the coursework required by this section is included within the institution's required curriculum for graduation, or within the coursework, that was completed by the applicant.

**6) Addition of Other Board Licensees.** The Board is in the process of implementing the licensure of professional clinical counselors (LPCCs). LPCCs have the same continuing education requirements as MFTs and LCSWs, with the exception that they are not currently required take the one-time seven hour continuing education course covering the assessment and treatment of people living with HIV and AIDS. However, in February 2011 the Board directed staff to pursue regulations that would require LPCCs to complete this requirement.

LPCCs are as likely to work with LGBT patients as MFTs and LCSW licensees are, and therefore the Board recommends that an amendment be made to include LPCCs in the list of those who are required to take the course. This could best be done by adding the standard language requiring the course into B&P code section 4999.76.

Additionally, this bill does not include the Boards Licensed Educational Psychologist (LEP) licensees. LEPs are also likely to work with LGBT populations, and therefore staff recommends that they be included in the requirements of this bill.

**7) Support and Opposition.**

Support: Equality California (Sponsor)

Opposition:  
None on file.

**8) History**  
**2011**

Mar. 3 Referred to Com. on B., P. & E.D.

Feb. 20 From printer. May be acted upon on or after March 22.

Feb. 18 Introduced. Read first time. To Com. on RLS. for assignment. To print.

**9) Attachments**

A. *"Guidelines for Care of Lesbian, Gay, Bisexual and Transgender Patients"* published by the Gay and Lesbian Medical Association

B. *"Policy Options to Ensure that Lesbian, Gay, Bisexual and Transgender Persons in California Receive Competent Medical and Mental Health Care"* by Ted Muhlhauser, Legislative Analyst for California State Senator Christine Kehoe

C. Board of Behavioral Sciences Continuing Education Requirement Chart

**Introduced by Senator Kehoe**

February 18, 2011

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An act to amend Sections 2190.1, 2811.5, 2892.5, 2915, 4517, 4980.54, and 4996.22 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 747, as introduced, Kehoe. Continuing education: lesbian, gay, bisexual, and transgender patients.

Existing law provides for licensing and regulation of various healing arts professions and generally requires licensees to complete continuing education courses in order to remain eligible to renew their licenses or certifications.

This bill would require physicians and surgeons, registered nurses, certified vocational nurses, psychologists, marriage and family therapists, licensed clinical social workers, and psychiatric technicians to complete at least one course of 2 to 5 hours in duration that provides instruction on cultural competency, sensitivity, and best practices for providing adequate care to lesbian, gay, bisexual, and transgender persons, as specified. The bill would require the applicable licensing board to enforce these requirements.

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 2190.1 of the Business and Professions
- 2 Code is amended to read:

1 2190.1. (a) The continuing medical education standards of  
2 Section 2190 may be met by educational activities that meet the  
3 standards of the ~~Division of Licensing~~ *board* and serve to maintain,  
4 develop, or increase the knowledge, skills, and professional  
5 performance that a physician and surgeon uses to provide care, or  
6 improve the quality of care provided for patients, including, but  
7 not limited to, educational activities that meet any of the following  
8 criteria:

9 (1) Have a scientific or clinical content with a direct bearing on  
10 the quality or cost-effective provision of patient care, community  
11 or public health, or preventive medicine.

12 (2) Concern quality assurance or improvement, risk  
13 management, health facility standards, or the legal aspects of  
14 clinical medicine.

15 (3) Concern bioethics or professional ethics.

16 (4) Are designed to improve the physician-patient relationship.

17 (b) (1) On and after July 1, 2006, all continuing medical  
18 education courses shall contain curriculum that includes cultural  
19 and linguistic competency in the practice of medicine.

20 (2) Notwithstanding the provisions of paragraph (1), a  
21 continuing medical education course dedicated solely to research  
22 or other issues that does not include a direct patient care component  
23 and a course offered by a continuing medical education provider  
24 that is not located in this state are not required to contain  
25 curriculum that includes cultural and linguistic competency in the  
26 practice of medicine.

27 (3) Associations that accredit continuing medical education  
28 courses shall develop standards before July 1, 2006, for compliance  
29 with the requirements of paragraph (1). The associations may  
30 develop these standards in conjunction with an advisory group that  
31 has expertise in cultural and linguistic competency issues.

32 (4) A physician and surgeon who completes a continuing  
33 education course meeting the standards developed pursuant to  
34 paragraph (3) satisfies the continuing education requirement for  
35 cultural and linguistic competency.

36 (c) In order to satisfy the requirements of subdivision (b),  
37 continuing medical education courses shall address at least one or  
38 a combination of the following:

39 (1) Cultural competency. For the purposes of this section,  
40 “cultural competency” means a set of integrated attitudes,

1 knowledge, and skills that enables a health care professional or  
2 organization to care effectively for patients from diverse cultures,  
3 groups, and communities. At a minimum, cultural competency is  
4 recommended to include the following:

5 (A) Applying linguistic skills to communicate effectively with  
6 the target population.

7 (B) Utilizing cultural information to establish therapeutic  
8 relationships.

9 (C) Eliciting and incorporating pertinent cultural data in  
10 diagnosis and treatment.

11 (D) Understanding and applying cultural and ethnic data to the  
12 process of clinical care.

13 (2) Linguistic competency. For the purposes of this section,  
14 “linguistic competency” means the ability of a physician and  
15 surgeon to provide patients who do not speak English or who have  
16 limited ability to speak English, direct communication in the  
17 patient’s primary language.

18 (3) A review and explanation of relevant federal and state laws  
19 and regulations regarding linguistic access, including, but not  
20 limited to, the federal Civil Rights Act (42 U.S.C. Sec. 1981, et  
21 seq.), Executive Order 13166 of August 11, 2000, of the President  
22 of the United States, and the Dymally-Alatorre Bilingual Services  
23 Act (Chapter 17.5 (commencing with Section 7290) of Division  
24 7 of Title 1 of the Government Code).

25 (d) *On and after January 1, 2012, the board shall require all*  
26 *of its licensees to take at least one continuing education course*  
27 *that provides instruction on cultural competency, sensitivity, and*  
28 *best practices for providing adequate care to lesbian, gay, bisexual,*  
29 *and transgender persons. Persons licensed by the board before*  
30 *January 1, 2012, shall complete the course no later January 1,*  
31 *2016. Persons who are newly licensed by the board on and after*  
32 *January 1, 2012, shall complete the course within four years of*  
33 *their initial license issuance date or their second license renewal*  
34 *date, whichever occurs first. The course shall be between two and*  
35 *five hours in duration and shall contain content similar to the*  
36 *content described in the publication of the Gay and Lesbian*  
37 *Medical Association entitled “Guidelines for Care of Lesbian,*  
38 *Gay, Bisexual and Transgender Patients.” The board may specify*  
39 *the required contents of the course by regulation consistent with*  
40 *this subdivision. The board shall enforce this requirement in the*

1 *same manner as it enforces other required continuing education*  
2 *requirements.*

3 ~~(d)~~

4 (e) Notwithstanding subdivision (a), educational activities that  
5 are not directed toward the practice of medicine, or are directed  
6 primarily toward the business aspects of medical practice,  
7 including, but not limited to, medical office management, billing  
8 and coding, and marketing shall not be deemed to meet the  
9 continuing medical education standards for licensed physicians  
10 and surgeons.

11 ~~(e)~~

12 (f) Educational activities that meet the content standards set  
13 forth in this section and are accredited by the California Medical  
14 Association or the Accreditation Council for Continuing Medical  
15 Education may be deemed by the Division of Licensing to meet  
16 its continuing medical education standards.

17 SEC. 2. Section 2811.5 of the Business and Professions Code  
18 is amended to read:

19 2811.5. (a) Each person renewing his or her license under  
20 Section 2811 shall submit proof satisfactory to the board that,  
21 during the preceding two-year period, he or she has been informed  
22 of the developments in the registered nurse field or in any special  
23 area of practice engaged in by the licensee, occurring since the  
24 last renewal thereof, either by pursuing a course or courses of  
25 continuing education in the registered nurse field or relevant to  
26 the practice of the licensee, and approved by the board, or by other  
27 means deemed equivalent by the board.

28 (b) For purposes of this section, the board shall, by regulation,  
29 establish standards for continuing education. The standards shall  
30 be established in a manner to assure that a variety of alternative  
31 forms of continuing education are available to licensees, including,  
32 but not limited to, academic studies, in-service education, institutes,  
33 seminars, lectures, conferences, workshops, extension studies, and  
34 home study programs. The standards shall take cognizance of  
35 specialized areas of practice. The continuing education standards  
36 established by the board shall not exceed 30 hours of direct  
37 participation in a course or courses approved by the board, or its  
38 equivalent in the units of measure adopted by the board.

39 (c) The board shall encourage continuing education in spousal  
40 or partner abuse detection and treatment. In the event the board

1 establishes a requirement for continuing education coursework in  
2 spousal or partner abuse detection or treatment, that requirement  
3 shall be met by each licensee within no more than four years from  
4 the date the requirement is imposed.

5 (d) In establishing standards for continuing education, the board  
6 shall consider including a course in the special care needs of  
7 individuals and their families facing end-of-life issues, including,  
8 but not limited to, all of the following:

9 (1) Pain and symptom management.

10 (2) The psycho-social dynamics of death.

11 (3) Dying and bereavement.

12 (4) Hospice care.

13 (e) In establishing standards for continuing education, the board  
14 may include a course on pain management.

15 (f) This section shall not apply to licensees during the first two  
16 years immediately following their initial licensure in California  
17 or any other governmental jurisdiction.

18 (g) *On and after January 1, 2012, the board shall require all*  
19 *of its licensees to take at least one continuing education course*  
20 *that provides instruction on cultural competency, sensitivity, and*  
21 *best practices for providing adequate care to lesbian, gay, bisexual,*  
22 *and transgender persons. Persons licensed by the board before*  
23 *January 1, 2012, shall complete the course no later January 1,*  
24 *2016. Persons who are newly licensed by the board on and after*  
25 *January 1, 2012, shall complete the course within four years of*  
26 *their initial license issuance date or their second license renewal*  
27 *date, whichever occurs first. The course shall be between two and*  
28 *five hours in duration and shall contain content similar to the*  
29 *content described in the publication of the Gay and Lesbian*  
30 *Medical Association entitled "Guidelines for Care of Lesbian,*  
31 *Gay, Bisexual and Transgender Patients." The board may specify*  
32 *the required contents of the course by regulation consistent with*  
33 *this subdivision. The board shall enforce this requirement in the*  
34 *same manner as it enforces other required continuing education*  
35 *requirements.*

36 ~~(g)~~

37 (h) The board may, in accordance with the intent of this section,  
38 make exceptions from continuing education requirements for  
39 licensees residing in another state or country, or for reasons of  
40 health, military service, or other good cause.

1 SEC. 3. Section 2892.5 of the Business and Professions Code  
2 is amended to read:

3 2892.5. (a) Each person renewing his or her license under the  
4 provisions of this chapter shall submit proof satisfactory to the  
5 board that, during the preceding two-year period, he or she has  
6 informed himself or herself of developments in the vocational  
7 nurse field or in any special area of vocational nurse practice,  
8 occurring since the issuance of his or her certificate, or the last  
9 renewal thereof, whichever last occurred, either by pursuing a  
10 course or courses of continuing education approved by the board  
11 in the vocational nurse field or relevant to the practice of such  
12 licensee, and approved by the board; or by other means deemed  
13 equivalent by the board.

14 (b) For purposes of this section, the board shall, by regulation,  
15 establish standards for continuing education. The standards shall  
16 be established in a manner to assure that a variety of alternative  
17 forms of continuing education are available to licensees including,  
18 but not limited to, academic studies, in-service education, institutes,  
19 seminars, lectures, conferences, workshops, extension studies, and  
20 home study programs. The standards shall take cognizance of  
21 specialized areas of practice. The continuing education standards  
22 established by the board shall not exceed 30 hours of direct  
23 participation in a course or courses approved by the board, or its  
24 equivalent in the units of measure adopted by the board.

25 (c) This section shall not apply to the first license renewal  
26 following the initial issuance of a license.

27 (d) *On and after January 1, 2012, the board shall require all*  
28 *of its licensees to take at least one continuing education course*  
29 *that provides instruction on cultural competency, sensitivity, and*  
30 *best practices for providing adequate care to lesbian, gay, bisexual,*  
31 *and transgender persons. Persons licensed by the board before*  
32 *January 1, 2012, shall complete the course no later January 1,*  
33 *2016. Persons who are newly licensed by the board on and after*  
34 *January 1, 2012, shall complete the course within four years of*  
35 *their initial license issuance date or their second license renewal*  
36 *date, whichever occurs first. The course shall be between two and*  
37 *five hours in duration and shall contain content similar to the*  
38 *content described in the publication of the Gay and Lesbian*  
39 *Medical Association entitled "Guidelines for Care of Lesbian,*  
40 *Gay, Bisexual and Transgender Patients." The board may specify*

1 *the required contents of the course by regulation consistent with*  
2 *this subdivision. The board shall enforce this requirement in the*  
3 *same manner as it enforces other required continuing education*  
4 *requirements.*

5 (d)

6 (e) The board may, in accordance with the intent of this section,  
7 make exceptions from continuing education for licensees residing  
8 in another state or country, or for reasons of health, military service,  
9 or other good cause.

10 ~~This section shall become operative on July 1, 1980.~~

11 SEC. 4. Section 2915 of the Business and Professions Code is  
12 amended to read:

13 2915. (a) Except as provided in this section, on or after January  
14 1, 1996, the board shall not issue any renewal license unless the  
15 applicant submits proof that he or she has completed no less than  
16 18 hours of approved continuing education in the preceding year.  
17 On or after January 1, 1997, except as provided in this section, the  
18 board shall issue renewal licenses only to those applicants who  
19 have completed 36 hours of approved continuing education in the  
20 preceding two years.

21 (b) Each person renewing his or her license issued pursuant to  
22 this chapter shall submit proof of compliance with this section to  
23 the board. False statements submitted pursuant to this section shall  
24 be a violation of Section 2970.

25 (c) A person applying for relicensure or for reinstatement to an  
26 active license status shall certify under penalty of perjury that he  
27 or she is in compliance with this section.

28 (d) (1) The continuing education requirement shall include, but  
29 shall not be limited to, courses required pursuant to Sections 25  
30 and 28. The requirement may include courses pursuant to Sections  
31 32 and 2914.1.

32 (2) (A) The board shall require a licensed psychologist who  
33 began graduate study prior to January 1, 2004, to take a continuing  
34 education course during his or her first renewal period after the  
35 operative date of this section in spousal or partner abuse  
36 assessment, detection, and intervention strategies, including  
37 community resources, cultural factors, and same gender abuse  
38 dynamics. Equivalent courses in spousal or partner abuse  
39 assessment, detection, and intervention strategies taken prior to  
40 the operative date of this section or proof of equivalent teaching

1 or practice experience may be submitted to the board and at its  
2 discretion, may be accepted in satisfaction of this requirement.

3 (B) Continuing education courses taken pursuant to this  
4 paragraph shall be applied to the 36 hours of approved continuing  
5 education required under subdivision (a).

6 (C) A licensed psychologist whose practice does not include  
7 the direct provision of mental health services may apply to the  
8 board for an exemption from the requirements of this paragraph.

9 (3) Continuing education instruction approved to meet the  
10 requirements of this section shall be completed within the State  
11 of California, or shall be approved for continuing education credit  
12 by the American Psychological Association or its equivalent as  
13 approved by the board.

14 (e) The board may establish a policy for exceptions from the  
15 continuing education requirement of this section.

16 (f) The board may recognize continuing education courses that  
17 have been approved by one or more private nonprofit organizations  
18 that have at least 10 years' experience managing continuing  
19 education programs for psychologists on a statewide basis,  
20 including, but not limited to:

21 (1) Maintaining and managing related records and data.

22 (2) Monitoring and approving courses.

23 (g) The board shall adopt regulations as necessary for  
24 implementation of this section.

25 (h) A licensed psychologist shall choose continuing education  
26 instruction that is related to the assessment, diagnosis, and  
27 intervention for the client population being served or to the fields  
28 of psychology in which the psychologist intends to provide  
29 services, that may include new theoretical approaches, research,  
30 and applied techniques. Continuing education instruction shall  
31 include required courses specified in subdivision (d).

32 (i) A psychologist shall not practice outside his or her particular  
33 field or fields of competence as established by his or her education,  
34 training, continuing education, and experience.

35 (j) *On and after January 1, 2012, the board shall require every*  
36 *person licensed under this chapter to take at least one continuing*  
37 *education course that provides instruction on cultural competency,*  
38 *sensitivity, and best practices for providing adequate care to*  
39 *lesbian, gay, bisexual, and transgender persons. Persons licensed*  
40 *by the board before January 1, 2012, shall complete the course*

1 *no later January 1, 2016. Persons who are newly licensed by the*  
2 *board under this chapter on and after January 1, 2012, shall*  
3 *complete the course within four years of their initial license*  
4 *issuance date or their second license renewal date, whichever*  
5 *occurs first. The course shall be between two and five hours in*  
6 *duration and shall contain content similar to the content described*  
7 *in the publication of the Gay and Lesbian Medical Association*  
8 *entitled “Guidelines for Care of Lesbian, Gay, Bisexual and*  
9 *Transgender Patients.” The board may specify the required*  
10 *contents of the course by regulation consistent with this*  
11 *subdivision. The board shall enforce this requirement in the same*  
12 *manner as it enforces other required continuing education*  
13 *requirements.*

14 ~~(j)~~

15 (k) The administration of this section may be funded through  
16 professional license fees and continuing education provider and  
17 course approval fees, or both. The fees related to the administration  
18 of this section shall not exceed the costs of administering the  
19 corresponding provisions of this section.

20 ~~(k)~~

21 (l) Continuing education credit may be approved for those  
22 licensees who serve as commissioners on any examination pursuant  
23 to Section 2947, subject to limitations established by the board.

24 ~~(l) This section shall become operative on January 1, 2004.~~

25 SEC. 5. Section 4517 of the Business and Professions Code is  
26 amended to read:

27 4517. (a) The board may, in its discretion, provide for a  
28 continuing education program in connection with the professional  
29 functions and courses described in this chapter. The number of  
30 course hours that the board may require in a continuing education  
31 program shall not exceed the number of course hours prescribed  
32 for licensed vocational nurses pursuant to Section 2892.5.

33 (b) *On and after January 1, 2012, the board shall require all*  
34 *of its licensees to take at least one continuing education course*  
35 *that provides instruction on cultural competency, sensitivity, and*  
36 *best practices for providing adequate care to lesbian, gay, bisexual,*  
37 *and transgender persons. Persons licensed by the board before*  
38 *January 1, 2012, shall complete the course no later January 1,*  
39 *2016. Persons who are newly licensed by the board on and after*  
40 *January 1, 2012, shall complete the course within four years of*

1 *their initial license issuance date or their second license renewal*  
2 *date, whichever occurs first. The course shall be between two and*  
3 *five hours in duration and shall contain content similar to the*  
4 *content described in the publication of the Gay and Lesbian*  
5 *Medical Association entitled “Guidelines for Care of Lesbian,*  
6 *Gay, Bisexual and Transgender Patients.” The board may specify*  
7 *the required contents of the course by regulation consistent with*  
8 *this subdivision. The board shall enforce this requirement in the*  
9 *same manner as it enforces other required continuing education*  
10 *requirements.*

11 SEC. 6. Section 4980.54 of the Business and Professions Code  
12 is amended to read:

13 4980.54. (a) The Legislature recognizes that the education and  
14 experience requirements in this chapter constitute only minimal  
15 requirements to assure that an applicant is prepared and qualified  
16 to take the licensure examinations as specified in subdivision (d)  
17 of Section 4980.40 and, if he or she passes those examinations, to  
18 begin practice.

19 (b) In order to continuously improve the competence of licensed  
20 marriage and family therapists and as a model for all  
21 psychotherapeutic professions, the Legislature encourages all  
22 licensees to regularly engage in continuing education related to  
23 the profession or scope of practice as defined in this chapter.

24 (c) Except as provided in subdivision (e), the board shall not  
25 renew any license pursuant to this chapter unless the applicant  
26 certifies to the board, on a form prescribed by the board, that he  
27 or she has completed not less than 36 hours of approved continuing  
28 education in or relevant to the field of marriage and family therapy  
29 in the preceding two years, as determined by the board.

30 (d) The board shall have the right to audit the records of any  
31 applicant to verify the completion of the continuing education  
32 requirement. Applicants shall maintain records of completion of  
33 required continuing education coursework for a minimum of two  
34 years and shall make these records available to the board for  
35 auditing purposes upon request.

36 (e) The board may establish exceptions from the continuing  
37 education requirements of this section for good cause, as defined  
38 by the board.

39 (f) The continuing education shall be obtained from one of the  
40 following sources:

1 (1) An accredited school or state-approved school that meets  
2 the requirements set forth in Section 4980.36 or 4980.37. Nothing  
3 in this paragraph shall be construed as requiring coursework to be  
4 offered as part of a regular degree program.

5 (2) Other continuing education providers, including, but not  
6 limited to, a professional marriage and family therapist association,  
7 a licensed health facility, a governmental entity, a continuing  
8 education unit of an accredited four-year institution of higher  
9 learning, or a mental health professional association, approved by  
10 the board.

11 (g) The board shall establish, by regulation, a procedure for  
12 approving providers of continuing education courses, and all  
13 providers of continuing education, as described in paragraphs (1)  
14 and (2) of subdivision (f), shall adhere to procedures established  
15 by the board. The board may revoke or deny the right of a provider  
16 to offer continuing education coursework pursuant to this section  
17 for failure to comply with the requirements of this section or any  
18 regulation adopted pursuant to this section.

19 (h) Training, education, and coursework by approved providers  
20 shall incorporate one or more of the following:

21 (1) Aspects of the discipline that are fundamental to the  
22 understanding or the practice of marriage and family therapy.

23 (2) Aspects of the discipline of marriage and family therapy in  
24 which significant recent developments have occurred.

25 (3) Aspects of other disciplines that enhance the understanding  
26 or the practice of marriage and family therapy.

27 (i) A system of continuing education for licensed marriage and  
28 family therapists shall include courses directly related to the  
29 diagnosis, assessment, and treatment of the client population being  
30 served.

31 (j) *On and after January 1, 2012, the board shall require all of*  
32 *its licensees to take at least one continuing education course that*  
33 *provides instruction on cultural competency, sensitivity, and best*  
34 *practices for providing adequate care to lesbian, gay, bisexual,*  
35 *and transgender persons. Persons licensed by the board before*  
36 *January 1, 2012, shall complete the course no later January 1,*  
37 *2016. Persons who are newly licensed by the board on and after*  
38 *January 1, 2012, shall complete the course within four years of*  
39 *their initial license issuance date or their second license renewal*  
40 *date, whichever occurs first. The course shall be between two and*

1 *five hours in duration and shall contain content similar to the*  
 2 *content described in the publication of the Gay and Lesbian*  
 3 *Medical Association entitled “Guidelines for Care of Lesbian,*  
 4 *Gay, Bisexual and Transgender Patients.” The board may specify*  
 5 *the required contents of the course by regulation consistent with*  
 6 *this subdivision. The board shall enforce this requirement in the*  
 7 *same manner as it enforces other required continuing education*  
 8 *requirements.*

9 ~~(j)~~

10 (k) The board shall, by regulation, fund the administration of  
 11 this section through continuing education provider fees to be  
 12 deposited in the Behavioral Sciences Fund. The fees related to the  
 13 administration of this section shall be sufficient to meet, but shall  
 14 not exceed, the costs of administering the corresponding provisions  
 15 of this section. For purposes of this subdivision, a provider of  
 16 continuing education as described in paragraph (1) of subdivision  
 17 (f) shall be deemed to be an approved provider.

18 ~~(k)~~

19 (l) The continuing education requirements of this section shall  
 20 comply fully with the guidelines for mandatory continuing  
 21 education established by the Department of Consumer Affairs  
 22 pursuant to Section 166.

23 SEC. 7. Section 4996.22 of the Business and Professions Code  
 24 is amended to read:

25 4996.22. (a) (1) Except as provided in subdivision (c), the  
 26 board shall not renew any license pursuant to this chapter unless  
 27 the applicant certifies to the board, on a form prescribed by the  
 28 board, that he or she has completed not less than 36 hours of  
 29 approved continuing education in or relevant to the field of social  
 30 work in the preceding two years, as determined by the board.

31 (2) The board shall not renew any license of an applicant who  
 32 began graduate study prior to January 1, 2004, pursuant to this  
 33 chapter unless the applicant certifies to the board that during the  
 34 applicant’s first renewal period after the operative date of this  
 35 section, he or she completed a continuing education course in  
 36 spousal or partner abuse assessment, detection, and intervention  
 37 strategies, including community resources, cultural factors, and  
 38 same gender abuse dynamics. On and after January 1, 2005, the  
 39 course shall consist of not less than seven hours of training.  
 40 Equivalent courses in spousal or partner abuse assessment,

1 detection, and intervention strategies taken prior to the operative  
2 date of this section or proof of equivalent teaching or practice  
3 experience may be submitted to the board and at its discretion,  
4 may be accepted in satisfaction of this requirement. Continuing  
5 education courses taken pursuant to this paragraph shall be applied  
6 to the 36 hours of approved continuing education required under  
7 paragraph (1).

8 (b) The board shall have the right to audit the records of any  
9 applicant to verify the completion of the continuing education  
10 requirement. Applicants shall maintain records of completion of  
11 required continuing education coursework for a minimum of two  
12 years and shall make these records available to the board for  
13 auditing purposes upon request.

14 (c) The board may establish exceptions from the continuing  
15 education requirement of this section for good cause as defined  
16 by the board.

17 (d) The continuing education shall be obtained from one of the  
18 following sources:

19 (1) An accredited school of social work, as defined in Section  
20 4991.2, or a school or department of social work that is a candidate  
21 for accreditation by the Commission on Accreditation of the  
22 Council on Social Work Education. Nothing in this paragraph shall  
23 be construed as requiring coursework to be offered as part of a  
24 regular degree program.

25 (2) Other continuing education providers, including, but not  
26 limited to, a professional social work association, a licensed health  
27 facility, a governmental entity, a continuing education unit of an  
28 accredited four-year institution of higher learning, and a mental  
29 health professional association, approved by the board.

30 (e) The board shall establish, by regulation, a procedure for  
31 approving providers of continuing education courses, and all  
32 providers of continuing education, as described in paragraphs (1)  
33 and (2) of subdivision (d), shall adhere to the procedures  
34 established by the board. The board may revoke or deny the right  
35 of a provider to offer continuing education coursework pursuant  
36 to this section for failure to comply with the requirements of this  
37 section or any regulation adopted pursuant to this section.

38 (f) Training, education, and coursework by approved providers  
39 shall incorporate one or more of the following:

1 (1) Aspects of the discipline that are fundamental to the  
2 understanding, or the practice, of social work.

3 (2) Aspects of the social work discipline in which significant  
4 recent developments have occurred.

5 (3) Aspects of other related disciplines that enhance the  
6 understanding, or the practice, of social work.

7 (g) A system of continuing education for licensed clinical social  
8 workers shall include courses directly related to the diagnosis,  
9 assessment, and treatment of the client population being served.

10 (h) The continuing education requirements of this section shall  
11 comply fully with the guidelines for mandatory continuing  
12 education established by the Department of Consumer Affairs  
13 pursuant to Section 166.

14 (i) *On and after January 1, 2012, the board shall require all of*  
15 *its licensees to take at least one continuing education course that*  
16 *provides instruction on cultural competency, sensitivity, and best*  
17 *practices for providing adequate care to lesbian, gay, bisexual,*  
18 *and transgender persons. Persons licensed by the board before*  
19 *January 1, 2012, shall complete the course no later January 1,*  
20 *2016. Persons who are newly licensed by the board on and after*  
21 *January 1, 2012, shall complete the course within four years of*  
22 *their initial license issuance date or their second license renewal*  
23 *date, whichever occurs first. The course shall be between two and*  
24 *five hours in duration and shall contain content similar to the*  
25 *content described in the publication of the Gay and Lesbian*  
26 *Medical Association entitled “Guidelines for Care of Lesbian,*  
27 *Gay, Bisexual and Transgender Patients.” The board may specify*  
28 *the required contents of the course by regulation consistent with*  
29 *this subdivision. The board shall enforce this requirement in the*  
30 *same manner as it enforces other required continuing education*  
31 *requirements.*

32 (i)

33 (j) The board may adopt regulations as necessary to implement  
34 this section.

35 (j)

36 (k) The board shall, by regulation, fund the administration of  
37 this section through continuing education provider fees to be  
38 deposited in the Behavioral Science Examiners Fund. The fees  
39 related to the administration of this section shall be sufficient to  
40 meet, but shall not exceed, the costs of administering the

1 corresponding provisions of this section. For purposes of this  
2 subdivision, a provider of continuing education as described in  
3 paragraph (1) of subdivision (d) shall be deemed to be an approved  
4 provider.

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**GLMA**  
GAY & LESBIAN MEDICAL ASSOCIATION

**GUIDELINES**

**FOR CARE OF**

**LESBIAN, GAY,**

**BISEXUAL, AND**

**TRANSGENDER**

**PATIENTS**





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CREATING  
A WELCOMING  
CLINICAL  
ENVIRONMENT

1



# CREATING A WELCOMING CLINICAL ENVIRONMENT FOR LESBIAN, GAY, BISEXUAL, AND TRANSGENDER (LGBT) PATIENTS

## ▶ **Background**

**Studies show that lesbian, gay, bisexual, transgender and (LGBT) populations, in addition to having the same basic health needs as the general population, experience health disparities and barriers related to sexual orientation\* and/or gender identity or expression. Many avoid or delay care or receive inappropriate or inferior care because of perceived or real homophobia, biphobia, transphobia, and discrimination by health care providers and institutions.**

Homophobia in medical practice is a reality. A 1998 survey of nursing students showed that 8–12% “despised” lesbian, gay, and bisexual (LGB) people, 5–12% found them “disgusting,” and 40–43% thought LGB people should keep their sexuality private.<sup>1</sup>

Health care providers can take positive steps to promote the health of their LGBT patients by examining their practices, offices, policies and staff training for ways to improve access to quality health care for LGBT people.

*\*the term sexual orientation is used in this document to mean sexual orientation identities, behaviors, and/or attractions, all of which are important in the health care context.*



There are some simple ways to make your practice environment more welcoming and safe for your LGBT patients. Here are a few ideas to update your physical environment, add or change intake and health history form questions, improve provider-patient discussions, and increase staff's knowledge about and sensitivity to your LGBT patients. We hope you find this tool useful.

## ▶ **Create a Welcoming Environment**

**Lesbian, gay, bisexual, and transgender (LGBT) patients often “scan” an office for clues to help them determine what information they feel comfortable sharing with their health care provider.**

Participating in provider referral programs through LGBT organizations (e.g., [www.glma.org](http://www.glma.org), [www.gayhealth.com](http://www.gayhealth.com), or local LGBT organizations) or advertising your practice in LGBT media can create a welcoming environment even before a patient enters the door.

If your office develops brochures or other educational materials, or conducts trainings, make sure that these include relevant information for LGBT patients.

Open dialogue with a patient about their gender identity/expression, sexual orientation, and/or sexual practices means more relevant and effective care.

You may want to implement some of the following suggestions as appropriate for the type and location of your office:

- ◆ Post rainbow flag, pink triangle, unisex bathroom signs, or other LGBT-friendly symbols or stickers.
  - ◆ Exhibit posters showing racially and ethnically diverse same-sex couples or transgender people. Or posters from non-profit LGBT or HIV/AIDS organizations.
  - ◆ Display brochures (multilingual when possible and appropriate) about LGBT health concerns, such as breast cancer, safe sex, hormone therapy, mental health, substance use, and sexually transmitted diseases (STDs—also called sexually transmitted infections or STIs such as HIV/AIDS, syphilis, and Hepatitis A and B).
- See Resources section for where to find brochures and other materials.**
- ◆ Disseminate or visibly post a non-discrimination statement stating that equal care will be provided to all patients, regardless of age, race, ethnicity, physical ability or attributes, religion, sexual orientation, or gender identity/expression.
  - ◆ Acknowledge relevant days of observance in your practice such as World AIDS Day, LGBT Pride Day, and National Transgender Day of Remembrance.
  - ◆ Display LGBT-specific media, including local or national magazines or newsletters about and for LGBT and HIV-positive individuals.

**See Resources section**



## ▶ **General Guidelines for Forms and Patient-Provider Discussions**

**Filling out the intake form gives patients one of their first and most important impressions of your office. The experience sets the tone for how comfortable a patient feels being open about their sexual orientation or gender identity/expression.**

On page xx are recommendations for questions you may want to consider adding to your standard intake and health history forms, or—ideally—discuss with the patient while taking an oral history. Examples include more inclusive choices for answers to questions, open-ended questions, and adding “partner” wherever the word “spouse” is used. The following are additional topics for possible inclusion in health history forms or to help a provider with in-person discussions with LGBT patients:

- ◆ Intake forms should use the term “relationship status” instead of “marital status,” including options like “partnered.” When asking—on the form or verbally—about a patient’s significant other, use terms such as “partner,” in addition to “spouse” and/or “husband/wife.”
- ◆ Adding a “transgender” option to the male/female check boxes on your intake form can help capture better information about transgender patients, and will be an immediate sign of acceptance to that person.
- ◆ As with all patient contacts, approach the interview showing empathy, open-mindedness, and without rendering judgment.

- ◆ Prepare now to treat a transgender patient someday. Health care providers’ ignorance, surprise, or discomfort as they treat transgender people may alienate patients and result in lower quality or inappropriate care, as well as deter them from seeking future medical care.
- ◆ Transgender individuals may have had traumatic past experiences with doctors causing fear or mistrust. Therefore, developing rapport and trust with transgender patients may take longer and require added sensitivity from the provider.
- ◆ When talking with transgender people, ask questions necessary to assess the issue, but avoid unrelated probing. Explaining why you need information can help avoid the perception of intrusion, for example: “To help assess your health risks, can you tell me about any history you have had with hormone use?”
- ◆ Be aware of additional barriers caused by differences in socioeconomic status, cultural norms, racial/ethnic discrimination, age, physical ability, and geography. Do not make assumptions about literacy, language capacity, and comfort with direct communication.
- ◆ When talking about sexual or relationship partners, use gender-neutral language such as “partner(s)” or “significant other(s).” Ask open-ended questions, and avoid making assumptions about the gender of a patient’s partner(s) or about sexual behavior(s). Use the same language that a patient does to describe self, sexual partners, relationships, and identity.



- ◆ When discussing sexual history, it is very important to reflect patients' language and terminology about their partners and behaviors. Many people do not define themselves through a sexual orientation label, yet may have sex with persons of their same sex or gender, or with more than one sex. For example: some men who have sex with men (MSM), especially African American and Latino men, may identify as heterosexual and have both female and male partners.
- ◆ When assessing the sexual history of transgender people, there are several special considerations:
  - 1 do not make assumptions about their behavior or bodies based on their presentation;
  - 2 ask if they have had any gender confirmation surgeries to understand what risk behaviors might be possible; and
  - 3 understand that discussion of genitals or sex acts may be complicated by a disassociation with their body, and this can make the conversation particularly sensitive or stressful to the patient.
- ◆ Ask the patient to clarify any terms or behaviors with which you are unfamiliar, or repeat a patient's term with your own understanding of its meaning, to make sure you have no miscommunication.
- ◆ It is important to discuss sexual health issues openly with your patients. Non-judgmental questions about sexual practices and behaviors

are more important than asking about sexual orientation or gender identity/expression.

**For additional information on sexual risk assessment for LGBT populations, see Resources section.**

- ◆ Be aware that sexual behavior of a bisexual person may not differ significantly from that of heterosexual or lesbian/gay people. They may be monogamous for long periods of time and still identify as bisexual; they may be in multiple relationships with the full knowledge and consent of their partners. However, they may have been treated as confused, promiscuous, or even dangerous. They may be on guard against health care providers who assume that they are "sick" simply because they have sexual relationships with more than one sex. Yet they may also, in fact, lack comprehensive safer-sex information that reflects their sexual practices and attitudes, and may benefit from thorough discussions about sexual safety.
- ◆ When discussing sexual practices and safer sex avoid language that may presume heterosexuality or discriminate.

There are so few trained experts in transgender health that you will often have to become that expert. Likewise, providers who treat transgender patients often have to build the base of specialty-care referrals by pre-screening other providers for sensitivity or guiding them to educational resources. Do not be afraid to tell your patient of your inexperience. Your willingness to become educated will often stand out from their previous healthcare experiences.



## ► Confidentiality

Encourage openness by explaining that the patient-provider discussion is confidential and that you need complete and accurate information to have an understanding of the patient's life in order to provide appropriate care. Ensure that the conversation will remain confidential and specify what, if any, information will be retained in the individual's medical records.

Developing and distributing a written confidentiality statement will encourage LGBT and other patients to disclose information pertinent to their health knowing that it is protected. Key elements of such a policy include:

- 1 The information covered
- 2 Who has access to the medical record
- 3 How test results remain confidential
- 4 Policy on sharing information with insurance companies
- 5 Instances when maintaining confidentiality is not possible<sup>2</sup>

Display the confidentiality statement prominently and provide it in writing to every patient. Consider having staff agree to the statement in writing.

## ► Some Specific Issues to Discuss with LGBT Patients

Homophobia, biphobia, transphobia, discrimination, harassment, stigma and isolation related to sexual orientation and/or gender identity/expression can contribute to depression, stress and anxiety in LGBT people. Conduct depression and mental health screening as appropriate, and do not discount these sources of stress for your LGBT patients.

- ◆ Explore the degree to which LGBT patients are “out” to their employers, family, and friends, and/or the extent of social support or participation in community. One's level of identification with community in many cases strongly correlates with decreased risk for STDs (including HIV) and improved mental health.
- ◆ Understand that LGBT people are particularly vulnerable to social stresses that lead to increased tobacco and substance use. A recent large study showed LGBT men smoked 50% more than other men, and LGBT women smoked almost 200% more than other women. Emphasis on other health issues may leave many people unaware of the disproportionate impact of tobacco in this population. Be prepared to intervene and provide treatment options. Likewise, explore whether LGBT patients are dealing with social stress through alcohol or drug use and be prepared to present treatment options. Social stress may also contribute to body image, exercise, and eating habits.
- ◆ Discuss safer sex techniques and be prepared to answer questions about STDs and HIV transmission risk for various sexual activities relevant to LGBT people.



- ◆ If a female patient identifies as lesbian, or indicates a female sexual partner, do not assume that she has never had a male sexual partner, has no children, has never been pregnant, or has little or no risk of STDs. If a male patient identifies as gay or bisexual, or identifies a male sexual partner, do not assume that the patient has never had a female sexual partner or has no children. Do not make assumptions about past, current, and future sexual behavior.
- ◆ Rates of syphilis are rising among MSM in some areas. Other STDs among MSM continue to be of concern to public health officials. The CDC now recommends annual screening of MSM for syphilis, gonorrhea, chlamydia, HIV, and immunization against hepatitis A and B for those MSM who are not already immune. If patients do not have coverage for vaccination, refer them to a community clinic or STD clinic offering free or low-cost vaccination.
- ◆ Transgender people are sometimes subject to the most extreme levels of social exclusion. This can destabilize individuals and create a host of adverse health outcomes. Risks and response behaviors to watch out for include: cycling in and out of employment (and therefore health insurance); having a history of interrupted medical care; avoiding medical care; pursuing alternate gender confirmation therapies (like injecting silicone or taking black market hormones); engaging in survival sex; interrupted education; social isolation; trauma; and extreme poverty. Health interventions will need to consider the aggregate impact of health risks resulting from this stigma.

- ◆ Conduct violence screening: LGBT people are often targets of harassment and violence, and LGBT people are not exempt from intimate partner/domestic violence. Individuals being battered may fear being “outed,” i.e., that if they report the violence to providers or authorities, their batterer could retaliate by telling employers, family, or others that they are gay. Assure the patient of confidentiality to the extent possible depending on your state laws regarding mandatory reporting.

**Ask all patients—men and women—violence screening questions in a gender neutral way:**

- ◆ Have you ever been hurt (physically or sexually) by someone you are close to or involved with, or by a stranger?
- ◆ Are you currently being hurt by someone you are close to or involved with?
- ◆ Have you ever experienced violence or abuse?
- ◆ Have you ever been sexually assaulted/raped?

Transgender people who are visibly gender variant may be exposed to a very high routine level of violence. For this population, the assessment of risk should be much more in-depth. If a person reports frequent violence, be sure to explore health issues related to long-term and post-traumatic stress.

Regardless of whether a transgender person is visibly gender variant, they may experience trauma, increased stress, and direct grief as a result of violence against other community



members. Asking about possible associative trauma can help identify health risks.

## ▶ **Language**

- ◆ Listen to your patients and how they describe their own sexual orientation, partner(s) and relationship(s), and reflect their choice of language. Be aware that although many LGBT people may use words such as “queer,” “dyke,” and “fag” to describe themselves, these and other words have been derogatory terms used against LGBT individuals. Although individuals may have reclaimed the terms for themselves, they are not appropriate for use by health care providers who have not yet established a trusting and respectful rapport with LGBT patients. If you are in doubt as to how to refer to a patient, ask what word or phrase they prefer.
- ◆ Avoid using the term “gay” with patients even if they have indicated a same-sex or same-gender sexual partner. If patients themselves have not indicated a particular identity or have indicated a sexual orientation other than “gay,” using this term may cause alienation and mistrust that will interfere with information-gathering and appropriate care. The key is to follow the patient’s lead about their self-description (which builds respect and trust) while exploring how this relates to their current and potential medical needs.
- ◆ Young people as well as adults may be unlikely to self-identify using traditional sexual orientation labels such as gay, lesbian, or

bisexual. While some may identify as “queer,” others may not choose any label at all.

- ◆ Respect transgender patients by making sure all office staff is trained to use their preferred pronoun and name. Clearly indicate this information on their medical record in a manner that allows you to easily reference it for future visits.

The Resources section includes [web sites and documents that provide definitions and background information related to sexual orientation and gender identity/expression](#).

## ▶ **Staff Sensitivity and Training**

- ◆ When possible, it is helpful to have openly lesbian, gay, bisexual, and transgender people as staff. They can provide valuable knowledge and perspectives about serving LGBT patients, as well as help patients feel represented and comfortable.
- ◆ It is especially important to train all front-line staff in office standards of respect towards transgender people, including: using their chosen name, and referring to them by their chosen pronoun.
- ◆ Circulate these Guidelines to all administrative, nursing, and clinical staff. Training for all staff is critical to creating and maintaining practice environments deemed safe for LGBT patients. Training should be periodic to address staff changes and keep all staff up-to-date. Designate an on-site LGBT resource person to answer any questions that arise in the interim.

Topics to include in a staff training program should include:

- 1 Use of appropriate language when addressing or referring to patients and/or their significant others
- 2 Learning how to identify and challenge any internalized discriminatory beliefs about LGBT people
- 3 Basic familiarity with important LGBT health issues (e.g., impacts of homophobia, discrimination, harassment, and violence; mental health and depression; substance abuse; safe sex; partner violence; HIV/STDs)
- 4 Indications and mechanisms for referral to LGBT-identified or LGBT-friendly providers

Developing resource lists and guidelines for patient interactions can reduce possible staff anxiety in dealing with LGBT patients.

- ◆ All employees need to understand that discrimination against LGBT patients, whether overt or subtle, is as unethical and unacceptable—and in many states as illegal—as any other kind of discrimination. Employers should make it clear to employees that discrimination against LGBT patients “will not be tolerated.” It is also important to monitor compliance and provide a mechanism for patients to report any disrespectful behavior.
- ◆ Some of your employees may have long-standing prejudices or negative feelings about LGBT patients due to ignorance or lack of familiarity with LGBT issues. Some may also feel that their religious beliefs require them to condemn LGBT people.

- ◆ Some employees may need individual training and counseling.

See Resources section.

### ▶ Other Suggestions

- ◆ A universal gender-inclusive “Restroom” is recommended. Many transgender and other people not conforming to physical gender stereotypes have been harassed for entering the “wrong” bathroom, so at least one restroom without Men or Women labels would help create a safer and more comfortable atmosphere.
- ◆ Be aware of other resources for LGBT individuals in your local community, as well as national/internet resources, and build collaborative relationships between your office and local lesbian, gay, bisexual, and transgender organizations and support groups.

See Resources section.

### ▶ Sample Recommended Questions for LGBT-Sensitive Intake Forms

These are sample questions to include as part of your intake form or ideally when taking a patient’s oral history as part of a comprehensive intake; please do NOT use this list as an intake form.

Legal name

Name I prefer to be called (if different)

Preferred pronoun?

- She
- He

**Gender:** Check as many as are appropriate (An alternative is to leave a blank line next to Gender, to be completed by the patient as desired)

- Female
- Male
- Transgender
  - Female to Male
  - Male to Female
  - Other
- Other (*leave space for patient to fill in*)

**Are your current sexual partners men, women, or both?**

**In the past, have your sexual partners been men, women, or both?**

**Current relationship status** (An alternative is to leave a blank line next to current relationship status)

- Single
- Married
- Domestic Partnership/Civil Union
- Partnered
- Involved with multiple partners
- Separated from spouse/partner
- Divorced/permanently separated from spouse/partner
- Other (*leave space for patient to fill in*)

#### Living situation

- Live alone
- Live with spouse or partner
- Live with roommate(s)
- Live with parents or other family members
- Other (*leave space for patient to fill in*)

#### Children in home

- No children in home
- My own children live with me/us
- My spouse or partner's children live with me/us
- Shared custody with ex-spouse or partner

#### Sexual Orientation Identity

- Bisexual
- Gay
- Heterosexual/Straight
- Lesbian
- Queer
- Other (state "please feel free to explain" and leave space for patient to fill in)
- Not Sure
- Don't Know

#### What safer sex methods do you use, if any?

**Do you need any information about safer-sex techniques? If yes, with:**

- Men
- Women
- Both

**Are you currently experiencing any sexual problems?**

**Do you want to start a family?**

**Are there any questions you have or information you would like with respect to starting a family?**

**Do you have any concerns related to your gender identity/expression or your sex of assignment?**

**Do you currently use or have you used hormones (e.g., testosterone, estrogen, etc.)?**

**Do you need any information about hormone therapy?**

### Have you been tested for HIV?

- Yes  
most recent test (space for date)
- No

### Are you HIV-positive?

- Yes  
when did you test positive? (space for date)
- No
- Unknown

### I have been diagnosed with and/or treated for:

- Bacterial Vaginosis
- Chlamydia
- Gonorrhea
- Herpes
- HPV/human papilloma virus (causes genital warts & abnormal pap smear)
- Syphilis
- None

### Have you ever been diagnosed with or treated for hepatitis A, B, and/or C?

- Hepatitis A
- Hepatitis B
- Hepatitis C

### Have you ever been told that you have chronic hepatitis B or C, or are a “hepatitis B or C carrier?”

- If yes, which and when?

### Have you ever been vaccinated against hepatitis A or B?

- Vaccinated against hepatitis A
- Vaccinated against hepatitis B

### Below is a list of risk factors for hepatitis A, B, and C.

#### Check any that apply to you.

- Sexual activity that draws blood or fluid
- Multiple sex partners
- Oral-fecal contact
- Sexual activity during menstrual period
- Travel extensively
- Dine out extensively
- Tattooing, piercing
- Use intravenous or snorted drugs
- Ever been diagnosed with or treated for an STD
- Close contact with someone who has chronic hepatitis B or C
- None apply
- Not sure if any apply

## ▶ Reference and Resource Documents

### Chapter 1 Endnotes

- 1 Kaiser Permanente National Diversity Council and Kaiser Permanente National Diversity Department. A Provider's Handbook on Culturally Competent Care: Lesbian, Gay, Bisexual, and Transgender Population, 2nd ed. 2004.
- 2 Gay Men's Health. Small Effort, Big Change. [www.gmhp.demon.co.uk/guides/gp](http://www.gmhp.demon.co.uk/guides/gp)

### Chapter 1 Resource Documents

Dean, L., et. al. Lesbian, Gay, Bisexual, and Transgender Health: Findings and Concerns. *Journal of the Gay and Lesbian Medical Association*, Vol. 4, No. 3, 2000. [www.glma.org](http://www.glma.org)

Feldman J, Bockting W. Transgender Health.(review) *Minn Med* 2003;86(7):25–32. Available online at <http://www.mmaonline.net/publications/MNMed2003/July/Feldman.html>.

Gay and Lesbian Medical Association and LGBT Health Experts. Healthy People 2010 Companion Document for LGBT Health (2001). [www.glma.org](http://www.glma.org)

Harry Benjamin International Gender Dysphoria Association. The Standards of Care for Gender Identity Disorders, Sixth Version. Dusseldorf: Symposion Publishing, 2001. [www.hbgda.org/soc.cfm](http://www.hbgda.org/soc.cfm)



International Journal of Transgenderism  
[www.symposion.com/ijtl/](http://www.symposion.com/ijtl/)

**Kaiser Permanente National Diversity Council and Kaiser Permanente National Diversity Department.** A Provider's Handbook on Culturally Competent Care: Lesbian, Gay, Bisexual and Transgender Population (2nd ed., 2004). 510-271-6663

**Lombardi E.** Enhancing Transgender Health Care. *Am J Public Health* 2001;91(6):869–72.

**National Coalition of Anti-Violence Programs (NCAVP).** Lesbian, Gay, Bisexual, Transgender Domestic Violence: 2003 Supplement. [www.avp.org](http://www.avp.org)

**Oriel, Kathleen A.** Clinical Update: Medical Care of Transsexual Patients, *Journal of the Gay and Lesbian Medical Association*, Volume 4, Issue 4, Dec 2000, Pages 185–194

**Schatz, B, O'Hanlan, K.** Anti-Gay Discrimination in Medicine: Results of a National Survey of Lesbian, Gay and Bisexual Physicians (1994). Copies available from the Gay and Lesbian Medical Association [www.glma.org](http://www.glma.org) or 415-255-4547

**Scout.** Social Determinants of Transgender Health. Dissertation at Columbia University. New York, NY. 2005. Available online at [www.scoutout.org](http://www.scoutout.org)

**Telex, C., et. al.** Attitudes of Physicians in New Mexico Toward Gay Men and Lesbians. *Journal of the Gay and Lesbian Medical Association*, Vol. 3, No. 3, 1999.

**U.S. Department of Health and Human Services Administration, Center for Substance Abuse Prevention.** CSAP Substance Abuse Resource Guide: Lesbian, Gay, Bisexual, and Transgender Populations (2001). <http://www.health.org/referrals/resguides.aspx?InvNum=M5489>

**U.S. Department of Health and Human Services Administration, Center for Substance Abuse Treatment.** A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals (2000). Inventory No. BKD392. <http://www.kap.samhsa.gov/products/manuals/pdfs/lgbt.pdf>

See also Resources section, pages 53–59.

CARING FOR  
LESBIANS  
AND BISEXUAL  
WOMEN:  
ADDITIONAL  
CONSIDERATIONS  
FOR CLINICIANS

2



# CARING FOR LESBIANS AND BISEXUAL, WOMEN: ADDITIONAL CONSIDERATIONS FOR CLINICIANS

## ▶ Introduction

Lesbians and bisexual women are an infinitely diverse group and comprise the full spectrum of women. Lesbians and bisexual women are part of every age group, ethnicity, race, geographic area, income stratum, and cultural and linguistic group, and can be of any size, education level, profession, and gender expression, from very traditionally feminine to androgynous to very masculine or “butch”. The health care needs of lesbians and bisexual women are similar to those of all women. However, many experience additional risk factors and barriers to care that can impact their health status. This section is to help you understand how common physical and mental health issues and risk factors may be particularly relevant in the context of the lives of lesbian and bisexual women.

Coming out safely to a health care provider may be the single most important thing lesbians and bisexual women can do in order to maximize the quality of their health care and reduce the associated risk factors for health problems. Therefore, the most important thing for health care providers to do is make it safe, comfortable and easy for all women to make honest disclosures



about their health-related behaviors, including sexual histories and practices. As many as 45% of lesbian and bisexual women are not out to their providers.<sup>1</sup> Establishing a lesbian and bisexual-friendly practice will ensure that your patients can be honest with you about all health-related matters.

The risk factors discussed below are meant to convey the general context of health for lesbians and bisexual women. It should be noted that most lesbians and bisexual women are healthy and well-adjusted. Care should be taken to avoid further stigmatizing lesbians and bisexual women as inherently sicker or more “difficult” than heterosexual patients.

## ▶ Risk Factors

**The risk factors that lesbians and bisexual women disproportionately experience are primarily social and behavioral. Many result from marginalized social status and accompanying history of discrimination and harassment.**

### ◆ Homophobia and stigma based on sexual orientation and gender expression

Lifelong stigma, harassment, and/or discrimination—or fear of them—is a major cause of chronic stress, depression, anxiety, and other mental health problems for lesbians and bisexual women.<sup>2</sup> In addition to the direct health impacts of societal homophobia, perceived or real homophobia from health care providers may discourage lesbians and bisexual women from seeking care. Without evidence to the contrary, lesbian and bisexual

patients may expect discrimination in the health care environment. Therefore, it is important to take the steps suggested elsewhere in this pamphlet to make your practice environment visibly welcoming.

### ◆ Avoidance or underutilization of medical care

Due to fear of discrimination, past negative experiences with health care providers, and/or false beliefs that pap smears and other health screenings are not necessary for lesbians, many do not seek needed medical care. This avoidance can result in failure to detect and treat health problems early, including cancer. It also limits lesbians’ access to health information and preventive care.

### ◆ Lack of health insurance

Because legally sanctioned marriage is one of the primary routes to health insurance in the U.S. (along with employment), lesbians experience lower health insurance rates than heterosexual women. Studies have estimated that between 20% and 30% of lesbians do not have health insurance<sup>1,3</sup> compared to 15% of the general population.<sup>4</sup> If your insured patient is partnered with a woman, her partner is much less likely to also be insured as compared to the spouses of your married partners. This may limit the opportunity for lesbian partners to both be treated for a communicable disease, increasing the chance of re-infection. Lack of insurance among your lesbian and bisexual women patients may also mean that follow-up visits, and expensive prescriptions and treatments are not feasible, so be sure to talk with your patients about all options.



◆ **Overweight or obesity**

There is evidence that lesbians are more likely to be overweight than their heterosexual counterparts,<sup>5</sup> possibly because of cultural norms within the lesbian community and because lesbians may relate differently to, not accept or not internalize mainstream notions of ideal beauty and thinness. While lesbians as a group tend to have better body image than heterosexual women<sup>6</sup>—a positive health characteristic—they may consequently be less motivated to avoid being overweight. The prevalence of overweight among lesbians raises the risk of heart disease, diabetes, hypertension, and other health problems.

◆ **Smoking and substance abuse**

Lesbians and bisexual women, especially young women, may drink alcohol and use other drugs, and smoke at higher rates than heterosexual women, again increasing the risk of heart disease, chronic obstructive pulmonary disease (COPD), and other health problems. Reasons for the increased prevalence of these risk factors among lesbians and bisexual women include the chronic stress and other mental health challenges of discrimination and homophobia, as well as the prominent role that bars and clubs have played in lesbian subcultures and as women-only spaces.

◆ **Lower rates of pregnancy**

Lesbians as a group have fewer pregnancies, and when they do bear children, it tends to be at older ages than heterosexual women. Because of this absence of or delayed childbearing, lesbians and bisexual women may be at greater risk for some cancers, such as breast cancer.

▶ **Screenings and Health Concerns**

**Provide the age-appropriate screenings to lesbians and bisexual women that you would offer to any woman in your practice. Remember to focus on actual behaviors and practices more than your patient's lesbian or bisexual identity when discussing risk, especially regarding sexually transmitted diseases (STDs):**

◆ **Colon Cancer**

Lesbians and bisexual women should receive colon cancer screenings on the same age-appropriate screening schedule as heterosexual women. Because there is often discomfort and lack of familiarity with these procedures among the general public, it is especially important to ensure that lesbian and bisexual patients feel comfortable with their providers so that they will be more likely to ask about and take advantage of all screenings available to them.

◆ **Depression**

Research has shown lesbians and bisexual women to have higher rates of depression than heterosexual women, often due to stigma-related stress.<sup>7</sup> Depression can interfere with disease treatment and negatively affect all aspects of life and health. Be aware that being subject to the chronic stresses of discrimination, isolation, lack of acceptance by family, hiding aspects of one's life and identity, and other challenges faced by lesbians and bisexual women can cause severe depression. Depression screening should be taken seriously. Lesbians and bisexual women of color face a “double jeopardy” due to the added stress of racial or ethnic discrimination that may place them at even higher risk.



#### ◆ **Diabetes**

The prevalence of overweight and other risk factors for diabetes among lesbians and bisexual women makes screening for diabetes another important step in improving health outcomes and reducing disparities in this population.

#### ◆ **Fertility and Pregnancy**

Lesbians are increasingly choosing to become pregnant and have children, with or without partners. Do not assume that the lesbian in your office has no plans to bear children, or that she has never been pregnant. Be prepared to discuss options for conception and pregnancy with your lesbian patients. Include women's partners in those discussions regardless of gender.

#### ◆ **Heart Health**

Heart disease is the top killer of women, and there is no evidence to suggest that this statistic is any different for lesbians and bisexual women. In fact, they may have additional risk factors for heart disease, such as higher rates of overweight, smoking, and elevated stress levels. Therefore, be careful to include heart health screenings when appropriate.

#### ◆ **HIV/AIDS**

While documentation of female-to-female HIV transmission has been controversial and not definitive, lesbians can become infected through other risk behaviors, such as intravenous drug use, accidental needle sticks, and sex with men. Be able to talk openly with your lesbian and bisexual women patients about risk behaviors and offer HIV testing and

counseling when appropriate. Remember to focus on actual behaviors rather than sexual orientation identity when discussing STD and HIV risk.

#### ◆ **Hypertension**

Many of the same factors that put women at risk for heart disease also contribute to high blood pressure, which increases the risk of heart disease, stroke, and congestive heart failure. This problem is even more prevalent among African Americans. Because lesbians and bisexual women as a group experience risk factors such as overweight, lack of exercise, and high stress they may be at greater risk; with African American lesbians likely being at greater risk than any other group.

#### ◆ **Intimate Partner Violence/ Domestic Violence**

It is estimated that 50,000 to 100,000 women are battered by a same-sex partner each year in the U.S.<sup>8</sup> However, they are offered fewer protections and services than heterosexual women who are battered. Seven states exclude same-sex violence from their definitions of domestic violence, which can prevent lesbian victims from getting help. Battered women's shelters, if uneducated about lesbians' and bisexual women's lives, may also discriminate. Be sure to extend domestic violence screening to your lesbian patients by using gender-neutral language that avoids assuming that the batterer is male. In addition, be aware of domestic violence services in your area that do not discriminate against women who have been abused by women.



### ◆ **Mammograms**

Lesbians and bisexual women should receive mammograms on the same age-appropriate screening schedule as heterosexual women. Gender variant or butch women may especially avoid mammograms. Because delayed detection and diagnosis are associated with poorer outcomes, it is important to ensure that all women in your practice are aware of the need, feel comfortable receiving mammograms, and do receive this screening.

### ◆ **Papanicolaou “Pap” Screening**

Pap smears are no less important for lesbians and bisexual women than they are for heterosexual women. Human papilloma virus (HPV) can be transmitted among women who exclusively have sex with women. Women who partner with women may also have (past or present) sexual contact with men. Unfortunately, many lesbians and some health care practitioners mistakenly assume that lesbians are not at risk for HPV or cervical cancer, and that Pap smears are unnecessary.

### ◆ **STD Screening**

Most sexually transmitted diseases and infections can be transmitted by lesbians’ sexual practices. In addition, women who identify as lesbian may have had male sexual partners (past or current), or have experienced sexual abuse. Additionally, do not assume that older lesbians and bisexual women are not sexually active or that they don’t need STD screening or safer sex information. Women can “come out” or begin sexual relationships with women at any age.

### ◆ **Substance Abuse**

Lesbians may drink alcohol and use other drugs at higher rates, especially young lesbians and bisexual women. Because of homophobia and heterosexism, lesbians may not be comfortable in or helped by mainstream cessation and treatment programs. In addition, factors that contribute to substance abuse among lesbians may differ from those for heterosexual women, and interventions that do not target these factors may not be effective.

There are often lesbian- and gay-specific Alcoholics Anonymous, Narcotics Anonymous,, and other treatment programs available locally. Find out if your area offers any. See Resources section.

### ◆ **Tobacco Use**

Not only is tobacco the number one cause of mortality for the full population, but lesbians and bisexual women rank among the top groups in the country who smoke at disproportionately high rates. Lesbians and bisexual women are more likely to smoke than heterosexual women,<sup>9</sup> and are the only demographic group whose smoking actually increases with age.<sup>10</sup> A recent large study showed LBT women smoked almost 200% more than other women.<sup>11</sup> Again, it is important that smoking cessation interventions are sensitive to the unique factors that contribute to these higher smoking rates among LBT women. If possible, refer patients to local LGBT-specific smoking cessation programs.



## Other Recommendations

**In addition to general health screenings, be sure to talk with your patients about diet, exercise, and other general health behaviors that can improve health status. Find out what each patient considers to be barriers to a healthier lifestyle and help her problem-solve. For instance, if a gender-variant lesbian feels uncomfortable in gyms or walking/jogging/swimming alone for fear of harassment, suggest that she recruit a work-out buddy or group to make physical activity safer. Other ways lesbians can get more engaged in physical activity that may be safer and more fun are organized sports and activity clubs. The use of the Internet and online communities may help lesbians find each other and organize such groups, although be aware that not everyone has easy access to the Internet.**

It is important to treat each patient appropriately for her own particular risk factors, health history, and needs. Knowledge about the common risk factors of lesbians, or any group, should inform your general concept of what may be important concerns of your lesbian and bisexual patients. However, it is important to not assume that just because a patient is lesbian or bisexual she has all or even any of the risk factors outlined above. Asking open-ended questions in a non-judgmental manner is the best way to ascertain the actual risks and health concerns of your patient. Seek to acquire information that you would gather about any female patient, doing so without assuming heterosexuality. Because of the fluidity of sexuality, it is critical to remain open to changes in patients' sexual orientation and behaviors over time. Keep questions open-ended, gender-neutral,

and non-judgmental throughout your relationship with a patient, knowing that people can come out at any time of life.

Remember that many mainstream women's health organizations and resources can be unaware about and insensitive to lesbians and bisexual women. Do not assume that the same referral you give out regularly to your heterosexual patients will be helpful to a lesbian or bisexual woman. It may be helpful to offer LGBT-specific resources along with traditional resources to all women in your practice in an integrated way. This integration will further establish you as lesbian- and bi-friendly; signal to closeted patients that it would be safe and beneficial to come out to you; and help you develop a fluency and comfort with the resources in your community. Many areas have local LGBT community centers. As part of your efforts to maintain a lesbian-friendly practice, contact your local community center and check the Resources section of this guide to gather information about lesbian and bisexual-specific health resources. These can range from a lesbian-only cancer support group to a battered women's shelter that is inclusive to women in same-sex relationships. Have these referrals on hand in your office to give to lesbian and bisexual women patients when appropriate.

### Chapter 2 Endnotes

- 1 Witeck-Combs Communications and Harris International, 2002. National survey; sample size=2221 adults.
- 2 Meyer, Ilan H. 2003. Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations: Conceptual Issues and Research Evidence. *Psychological Bulletin* 129(5):674–697.
- 3 Berberet, Heather M. 2005. San Diego Lesbian, Bisexual and Transgender Women Needs Assessment, 2005.
- 4 Kaiser Commission on Medicaid and the Uninsured, 2004. The Uninsured and Their Access to Health Care. <http://www.kff.org/uninsured/upload/The-Uninsured-and-Their-Access-to-Health-Care-November-2004-Fact-Sheet.pdf>



- 5 Aaron, D.J., et. al. 2001. Behavioral Risk Factors for Disease and Preventive Health Practices Among Lesbians. *Am J of Public Health* 91:972–975.
- 6 Neumark-Sztainer, D. et al. 1998. Lessons Learned About Adolescent Nutrition from the Minnesota Adolescent Health Survey. *J Am Dietet Assoc.* 98:1449–56
- 7 Solarz, A., ed. 1999. *Lesbian Health: Current Assessment and Directions for the Future*. Washington, DC: Institute of Medicine. National Academy Press.
- 8 Murphy, NE. 1995. Queer Justice: Equal Protection for Victims of Same-sex Domestic Violence. *Valparaiso University Law Review*, 30. 335–379.
- 9 Ryan, H. et. al. 2001. Smoking Among Lesbians, Gays, and Bisexuals: A Review of the Literature. *American Journal of Preventive Medicine* 21(2).
- 10 Bradford, J. & Ryan, C. 1988. *The National Lesbian Health Care Survey: Final report*. Washington, DC: National Lesbian and Gay Health Foundation.
- 11 Bye, L., Gruskin, E., Greenwood, G., Albright, V., and Krotki, K. *The 2003 California Lesbian, Gays, Bisexuals, and Transgender (LGBT) Tobacco Survey*, Field Research Corporation, San Francisco, CA. 2004

#### **Chapter 2 Resource Documents**

Mautner Project, the National Lesbian Health Organization. [www.mautnerproject.org](http://www.mautnerproject.org) Coordinates Removing the Barriers project, training more than 3000 providers since 1997. Also has informational documents on a variety of lesbian health issues, appropriate for consumers or providers: <http://www.mautnerproject.org/health%5Finformation/Lesbian%5FHealth%5F101/>

- Barriers to Care for Women
- Facts about Lesbians and Smoking
- Health Factors for Lesbians
- Nutrition and Obesity
- The Heart Truth for Lesbians
- Why Lesbians Are Medically Underserved—White Paper

**Solarz, A., Ed.** *Lesbian Health: Current Assessment and Directions for the Future*. Institute of Medicine. National Academies Press, Washington, DC. 1999. [www.nap.edu](http://www.nap.edu) or 1-800-624-6242.

**U.S. Department of Health and Human Services Office on Women's Health, National Institutes of Health Office of Research on Women's Health, Gay and Lesbian Medical Association, and the Lesbian Health Fund.** *Scientific Workshop on Lesbian Health 2000: Steps for Implementing the IOM Report (2000)*. [www.glima.org](http://www.glima.org)

See also Resources section, pages 53–59.

CARING FOR GAY  
AND BISEXUAL  
MEN: ADDITIONAL  
CONSIDERATIONS  
FOR CLINICIANS

3



# CARING FOR GAY AND BISEXUAL MEN: ADDITIONAL CONSIDERATIONS FOR CLINICIANS

## ▶ Introduction

**Gay and bisexual men's health care needs are similar to the needs of all men, however, they also may experience additional risk factors and barriers to care that can impact their health.**

In a 1992 study, 44% of self-identified gay men had not told their primary care physician about their sexual orientation.<sup>1</sup> However, if health care providers know that a male patient is gay, bisexual, or has sex with men, they can properly screen for risk factors and provide more comprehensive care. Also, gay and bisexual men may sometimes consciously avoid medical care because of fear of discrimination.<sup>2</sup>

Therefore, it is vital that health care providers create a safe and welcoming environment for gay and bisexual men to self-identify and discuss their sexual histories and behaviors and other health-related issues. Establishing a gay and bisexual-friendly practice will encourage your patients to seek care and address all health-related matters openly.



## ▶ Risk Factors

**The risk factors that gay and bisexual men experience disproportionately are sexual, social, and behavioral. Clinicians must consider social and cultural variables, mental health, and substance abuse, in addition to specific risk behaviors when discussing health issues or tailoring prevention messages to gay and bisexual men. These variables can create barriers to the effectiveness of prevention messages in helping patients to enact behavior changes.**

### ◆ Stigma

Gay and bisexual men often face stigma in every aspect of their lives. This stigma creates a higher level of lifelong stress, which has been linked to an array of mental and physical health problems.<sup>3</sup>

African-American, Asian and Pacific Islander (A&PI), Latino, and other gay and bisexual men face additional stigma, and have to contend with racial discrimination from society at large. The twin effects of homophobia within their own racial/ethnic groups and racism within the mainstream gay community often combine to enhance their level of social exclusion. Fear of alienation and lack of community support often prevent these men of color from identifying with the gay community, which in turn serves to isolate them from the protective benefits of social support and limits their exposure to prevention messages.<sup>4</sup>

Fear of identifying as gay, bisexual, or as a man who has sex with men may keep some patients from addressing specific health issues.

Perception of a clinician's stigmatization can irrevocably harm the therapeutic relationship, preventing honest disclosure and delivery of appropriate prevention messages.

### ◆ Socioeconomic status

Lower socioeconomic status often results in poorer health outcomes. A 1998 analysis of data from the General Social Survey, the 1990 Census and the Yankelovich Monitor indicated that gay and lesbian people earn less than their heterosexual counterparts.<sup>5</sup> African-American gay and bisexual men are disproportionately affected by homelessness, substance abuse, and sexually transmitted diseases, all correlated with a lower socioeconomic status.<sup>6</sup> Native American/Alaskan gay and bisexual men are at both economic and geographical disadvantages when considering access to prevention messages.<sup>7</sup> While A&PI communities are often stereotyped as highly educated and economically successful, one demographic profile of a major urban area found that by per capita income, APIs make 19% less than the general population and about 20% of A&PIs live in poverty.<sup>8</sup>

### ◆ Lack of health insurance

Generally, gay men lack access to health insurance through marriage, and many employers and jurisdictions do not recognize domestic partnership, further reducing their ability to secure coverage. Lack of insurance among gay and bisexual men patients limit their ability to access ongoing care and treatment for health conditions as well as prevention messages.



◆ **Homophobia and harassment based on sexual orientation**

Discrimination and harassment have been shown to be factors in causing stress, anxiety, depression, and mental illnesses for gay and bisexual men.<sup>9</sup>

◆ **Cultural norms.**

Cultural norms can affect the way gay and bisexual men disclose information and incorporate prevention messages into the health care setting. Some Latino gay and bisexual men may not be open about their sexuality in order to avoid potential shame or embarrassment.<sup>10</sup> Homosexuality conflicts with machismo, or masculinity, which has a high value in many Latino cultures. A diverse range of cultures and languages prevents A&PIs from receiving appropriate prevention messages,<sup>11</sup> and discussions of sexual health, including homosexuality, are not part of their cultural norms.<sup>12</sup>

◆ **False assumptions**

HIV prevention messages targeting gay and bisexual men are seen as becoming less effective. In surveys, gay and bisexual men report difficulty in sustaining behavior change for a lifetime. In addition, false beliefs among gay and bisexual men create barriers to behavior change based on prevention messages. Studies have shown that newer HIV treatments lead some gay and bisexual men to be more optimistic about treatment options if they were to seroconvert, and to take more sexual risks. Similarly, the false assumption that HIV-positive men on antiretroviral therapy are unlikely to transmit

the virus contributes to risk-taking and unprotected anal sex among some gay and bisexual men.<sup>14</sup>

▶ **Incorporating Sexual Risk Assessment in Routine Visits for Gay and Bisexual Men**

**Despite significant reductions in HIV incidence among gay and bisexual men, they are still disproportionately affected—with an estimated 42% of new HIV infections each year. A recent rise in sexually transmitted diseases and risk behaviors among gay and bisexual men, documented in several cities, is concerning, since it may herald a resurgence of HIV infections.<sup>15</sup>**

With these trends there remains a great need for clinicians to address sexual health issues. One survey showed only 20% of patients had discussed risk factors for HIV with their provider in the last five years. Of those respondents only 21% reported that the provider had started the discussion.<sup>16</sup> In another study, only 35% of providers reported often or always taking a sexual history.<sup>17</sup> One study documented physician awkwardness around issues of sexual health and HIV, leading to incomplete discussion of these topics.<sup>18</sup> Routine health maintenance visits are opportunities for clinicians to practice primary prevention for HIV and other sexually transmitted infection through sexual risk assessments.



### ◆ **What Can Be Done?**

Asking about sexual behavior should be part of every routine visit, regardless of the patient's identified sexual orientation or marital status. Sexual behavior exists on a continuum. Eliciting specific risk behaviors can direct the clinician in assessing the patient's knowledge, selecting appropriate prevention messages, and determining the need for testing for sexually transmitted disease or HIV. Knowing that there are significant barriers in place between clinician and patient in addressing sexual health and utilizing a sensitive approach is key to attaining pertinent information.

### ◆ **Tips For A Successful Patient Sexual Risk Assessment:**

Discussing information about sexual behavior can be difficult for the patient and the clinician. Tailoring prevention messages to the individual patient requires that they feel comfortable in discussing these topics and revealing sensitive information. During an initial visit with a clinician, gay and bisexual men may withhold important information. Becoming comfortable in raising and discussing such topics comes only with repeated experience.

*When discussing sexual health during an initial visit, or if indicated, in subsequent visits:*

Begin with a statement that taking a sexual history is routine for your practice.

Focus on sexual behavior rather than sexual orientation/identity.

Assess knowledge of the risk of sexually transmitted diseases in relation to sexual behavior early on. Some well-informed gay

and bisexual men may resent a discussion of HIV risk; for example, assuming a clinician is equating homosexuality with HIV.

Ask the patient to clarify terms or behavior with which you are unfamiliar.

Respect a patient's desire to withhold answers to sensitive questions. Offer to discuss the issue at a later time.

### ◆ **What Is The Best Approach?**

The Mountain-Plains Regional AIDS Education Training Center developed a useful model for approaching sexual risk assessment,<sup>19</sup> modified below:

- 1 Assess risk at every new patient visit and when there is evidence that behavior is changing.
- 2 Sexual risk assessment should be part of a comprehensive health risk assessment, including use of seatbelts and firearms, domestic violence, and substance abuse.
- 3 Qualify the discussion of sexual health, emphasizing that it is a routine part of the interview and underscore the importance of understanding sexual behavior for providing quality care. Remind the patient that your discussion is confidential. You may need to negotiate what ultimately becomes part of the medical record.
  - a. "In order to take the best possible care of you, I need to understand in what ways you are sexually active."
  - b. "Anything we discuss stays in this room."

- 
- 4 Avoid use of labels like “straight,” “gay,” or “queer” that do not related to behaviors because they may lead to misinformation. For example, a significant percentage of both African-American and Latino men who have sex with men identify as heterosexual, even though they may engage in anal intercourse with other men.<sup>20</sup>
  - 5 Be careful while taking a history to not make assumptions about behavior based on age, marital status, disability or other characteristics.
  - 6 Ask specific questions regarding behavior in a direct and non-judgmental way.
    - a “Are you sexually active?”
    - b “When was the last time you were sexually active?”
    - c “Do you have sex with men, women, or both?”
    - d Determine the number of partners, the frequency of condom use, and the type of sexual contact (e.g., oral, anal, genital).
  - 7 Honest responses may be more forthcoming if the question is worded in such a way as to “normalize” the behavior: “Some people (inject drugs, have anal intercourse, exchange sex for drugs, money, or other services). Have you ever done this?”
  - 8 Assess the patient’s history of STDs.
  - 9 If the patient’s responses indicate a high level of risk (e.g., unprotected sexual activity,

significant history of STDs), determine the context in which these behaviors occur, including concurrent substance use and mood state.

- a “I want to get an understanding of when you use alcohol or drugs in relation to sex.”
- b “How often are you high or drunk when you’re sexually active? How does what you do change in that case?”
- c “How often do you feel down or depressed when you’re sexually active? Do you act differently?”

- 10 Summarize the patient’s responses at the end of the interview.

## ▶ Other Screening and Health Concerns

**Along with sexual risk assessments, gay and bisexual men should receive the same screenings that you would offer to any man in your practice. In addition, you should pay attention to health issues that disproportionately affect gay and bisexual men.**

### ◆ Anal Cancer

Gay and bisexual men are at risk for human papilloma virus infection, which plays a role in the increased risk of anal cancers. Some health professionals now recommend routine screening with anal Pap smears, similar to the test done for women to detect early cancers.



#### ◆ **Depression/Anxiety**

Depression and anxiety appear to affect gay men at a higher rate than in the general population, especially if they are not out and lack significant social support.<sup>21</sup> Adolescents and young adults may be at particularly high risk of suicide because of these concerns. Being able to refer your gay and bisexual clients to culturally sensitive mental health services may be more effective in the prevention, early detection, and treatment of depression and anxiety.

#### ◆ **Fitness (Diet and Exercise)**

Gay men are more likely to have body image problems and to experience eating disorders than heterosexual men.<sup>22</sup> On the opposite end of the spectrum, overweight and obesity are problems that also affect a large segment of the gay community. Be able to discuss your patient's fitness and diet regimen and provide adequate and culturally sensitive counseling.

#### ◆ **Heart Health**

Gay and bisexual men may have additional risk factors for heart disease, given higher rates of smoking, alcohol, and substance use. Heart screenings should be included when appropriate.

#### ◆ **Hepatitis Immunization**

Gay and bisexual men are at an increased risk of contracting hepatitis A and B.<sup>23</sup> Universal immunization for hepatitis A and B viruses is recommended for all sexually active gay and bisexual men.

#### ◆ **Intimate Partner Violence/Domestic Violence**

Gay and bisexual men can experience domestic violence, but are rarely screened.<sup>24</sup> Appropriate and sensitive screening for domestic violence should occur in the health care setting. Be prepared to refer to domestic violence services in your area that serve gay and bisexual men.

#### ◆ **Prostate, Testicular, and Colon Cancer**

Gay and bisexual men may not receive adequate screening for these cancers because of challenges in receiving culturally sensitive care. All gay and bisexual men should undergo these screenings routinely as recommended for the general population.

#### ◆ **Substance and Alcohol Use**

Studies show that gay men use substances and alcohol at higher rates than heterosexual men.<sup>25</sup> Gay and bisexual men might not be comfortable with mainstream treatment programs. Find out if there are any gay-specific or gay-friendly alcohol/substance abuse treatment programs in your area and be prepared to refer patients to culturally sensitive services.

#### ◆ **Tobacco Use**

Not only is tobacco the number one cause of mortality for the full population, gay males rank among the top groups in the country disproportionately affected by this issue. A recent population-based study found that gay, bisexual and transgender males smoked at rates 50% higher than the general population.<sup>26</sup> Emphasis on other health issues has often eclipsed the impact of tobacco on this group, leaving individuals less educated about the need

to quit or resources to assist the process.

For all gay male patients, be prepared to assess tobacco use, advise quitting, discuss medication options, and refer the person to the local quitline or culturally competent cessation groups.

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## Chapter 3 Resource Documents

AIDS Action. What Works in HIV Prevention for Gay Men, 2001. Available online at <http://www.aidsaction.org/>

CDC MSM Information Center: Addresses increased risk of MSM for multiple STDs including HIV/AIDS syphilis, gonorrhea, chlamydia, hepatitis B and hepatitis A. Many resources including CDC's Four Division 'Dear Colleague' letter highlighting the 2002 STD Treatment Guidelines recommendations for MSM—March 8, 2004. [www.cdc.gov/ncidod/diseases/hepatitis/msm/](http://www.cdc.gov/ncidod/diseases/hepatitis/msm/)

CDC National Prevention Information Network (NPIN): reference and referral service for information on HIV/AIDS, STDs, and TB. [www.cdcnpin.org](http://www.cdcnpin.org) Helpline: 800-458-5231 (also Spanish)



Medline Plus Gay and Lesbian Health Webpage.  
Accessible at  
<http://www.nlm.nih.gov/medlineplus/gayandlesbianhealth.html>

**Wolfe D**, Gay Men's Health Crisis Inc. Men like us: the GMHC complete guide to gay men's sexual, physical, and emotional well-being. 1st ed. New York: Ballantine Books; 2000.

**See also Resources section, pages 53–59.**





## Resources

### **General Background: LGBT Health**

Gay and Lesbian Medical Association

[www.glma.org](http://www.glma.org)

*Suggested sections:*

- ◆ Hepatitis section
- ◆ Publications, such as:
  - LGBT Health: Findings and Concerns (includes transgender health section with definitions)
- ◆ Healthy People 2010 Companion Document for LGBT Health (see resources chapter for potential referrals)

The GLBT Health Access Project

[www.glbthealth.org](http://www.glbthealth.org)

*Suggested sections:*

- ◆ Community Standards of Practice For Provision of Quality Health Care Services For Gay, Lesbian, Bisexual and Transgendered Clients
- ◆ Educational posters

National Coalition for LGBT Health

[www.lgbthealth.net](http://www.lgbthealth.net)

Seattle/King County GLBT Health Web Pages

[www.metrokc.gov/health/lgbt](http://www.metrokc.gov/health/lgbt)

National Association of Gay and Lesbian Community Centers

[www.lgbtcenters.org](http://www.lgbtcenters.org)

*Suggested sections:*

- ◆ Directory (for centers throughout the U.S. which will have additional referrals for local LGBT-sensitive services—e.g. counseling services, support groups, health educations, and legal resources)

GLBT National Help Center

[www.glnh.org](http://www.glnh.org)

National non-profit organization offering toll-free peer counseling, information, and local resources, including local switchboard numbers and gay-related links  
888-THE-GNLH (843-4564)

GLBT National Youth Talkline

Youth peer counseling, information, and local resources, through age 25  
800-246-PRIDE (7743)

Substance Abuse Mental Health Services Administration/National Clearinghouse for Alcohol and Drug Information—LGBT site

[www.health.org/features/lgbt](http://www.health.org/features/lgbt)

## General Information: National LGBT Rights

### Human Rights Campaign

[www.hrc.org](http://www.hrc.org)

(national organization working for LGBT equal rights on federal government level)

### Lambda Legal

[www.lambdalegal.org](http://www.lambdalegal.org)

(national LGBT legal and policy organization protecting civil rights of LGBT and people living with HIV)  
legal helpdesk: 212-809-8585

### National Center for Lesbian Rights

[www.nclrights.org](http://www.nclrights.org)

(national legal resource center advancing the rights and safety of lesbians and their families, and representing gay men and bisexual and transgender individuals on legal issues that also advance lesbian rights.  
or hotline: 415-392-6257

### National Gay and Lesbian Task Force

[www.nglftf.org](http://www.nglftf.org)

(national grassroots organization supporting LGBT advocacy efforts at state and federal levels)

## Media (for waiting room)

### BROCHURES

#### American Cancer Society

- ◆ Cancer Facts for Gay and Bisexual Men
- ◆ Cancer Facts for Lesbians and Bisexual Women
- ◆ Tobacco and the LGBT Community

Place order for free brochures by phone:  
800-ACS-2345

#### American College Health Association

[http://www.acha.org/info\\_resources/his\\_brochures.cfm](http://www.acha.org/info_resources/his_brochures.cfm)

Numerous brochures, such as:

- ◆ Man to Man: Three Steps to Health for Gay, Bisexual, or Any Men Who Have Sex With Men
- ◆ Woman to Woman: Three Steps to Health for Lesbian, Bisexual, or Any Women Who Have Sex With Women

#### Mautner Project, the National Lesbian Health Organization

<http://www.mautnerproject.org/health%5Finformation/Lesbian%5FHealth%5F101/>

Informational documents on various lesbian health issues, appropriate for consumers or providers, for example:

- ◆ Facts about Lesbians and Smoking
- ◆ Nutrition and Obesity
- ◆ The Heart Truth for Lesbians

### PERIODICALS

- ◆ Advocate
- ◆ Curve
- ◆ Girlfriends
- ◆ Instinct
- ◆ Out
- ◆ Out Traveler
- ◆ Renaissance News (formerly Transgender Community News)
- ◆ Your local LGBT newspapers or other publication(s)

## General Lesbian Health

### The Lesbian Health Research Center at UCSF

[www.lesbianhealthinfo.org](http://www.lesbianhealthinfo.org)

### Mautner Project, the National Lesbian Health Organization

[www.mautnerproject.org](http://www.mautnerproject.org)

### Planned Parenthood Lesbian Health section

<http://www.plannedparenthood.org/pp2/portal/files/portal/medicalinfo/femalesexualhealth/pub-lesbian-health.xml>

### Verbena Health

[www.verbenahealth.org](http://www.verbenahealth.org)

### U.S. Department of Health and Human Services

[womenshealth.org](http://www.womenshealth.org)

Screening Schedule for Women:

[www.4woman.gov/screeningcharts](http://www.4woman.gov/screeningcharts)

## General Gay Men's Health

[GayHealth.com](http://GayHealth.com)

[www.gayhealth.com](http://www.gayhealth.com)

### The Institute for Gay Men's Health

A project of Gay Men's Health Crisis and AIDS Project Los Angeles

<http://www.gmhc.org/programs/institute.html>

### Gay City—Seattle, WA

[www.gaycity.org](http://www.gaycity.org)

## General Bisexual Health

### Bisexual Resource Center Health Resources

[www.biresource.org/health](http://www.biresource.org/health)

### Bi Health Program, Fenway Community Health

[www.biresource.org/health/bihealth.html](http://www.biresource.org/health/bihealth.html)

"Safer Sex For Bisexuals and Their Partners" pamphlet

contact: [bihealth@fenwayhealth.org](mailto:bihealth@fenwayhealth.org)

## Transgender Health

FTM International  
[www.ftmi.org](http://www.ftmi.org)

International Foundation for Gender Education  
[www.ifge.org](http://www.ifge.org)

TransGenderCare  
[www.transgendercare.com](http://www.transgendercare.com)

Transgender Forum's Community Center  
[www.transgender.org](http://www.transgender.org)

Transgender Law Center  
*Recommendations for Transgender Health Care*  
[www.transgenderlaw.org/resources/tlchealth.htm](http://www.transgenderlaw.org/resources/tlchealth.htm)

Transgender Resource and Neighborhood Space (TRANS)  
[www.caps.ucsf.edu/TRANS](http://www.caps.ucsf.edu/TRANS)

Transgender Health Care Conference (2000)  
<http://hivinsite.ucsf.edu/InSite.jsp?doc=2098.473a>

Trans-Health.com (online magazine)  
[www.trans-health.com](http://www.trans-health.com)

Transsexual Road Map  
[www.tsroadmap.com](http://www.tsroadmap.com)

Transsexual Women's Resources  
[www.annelawrence.com/twrl](http://www.annelawrence.com/twrl)

## Intersex Health

Intersex Society of North America  
[www.isna.org](http://www.isna.org)

## Sexually Transmitted Diseases (STDs) STDs AND LESBIANS AND BISEXUAL WOMEN

LesbianSTD  
[www.lesbianstd.com](http://www.lesbianstd.com)

Planned Parenthood  
[www.plannedparenthood.org/stillesbian.html](http://www.plannedparenthood.org/stillesbian.html)

## STDs AND MEN WHO HAVE SEX WITH MEN (MSM)

CDC MSM Information Center  
This includes various resources for MSM about HIV/AIDS, syphilis, gonorrhea, chlamydia, hepatitis B and hepatitis A, such as fact sheets, posters, booklet, and pocket card.  
[www.cdc.gov/ncidod/diseases/hepatitis/msm/](http://www.cdc.gov/ncidod/diseases/hepatitis/msm/)

Gay City  
[www.gaycity.org](http://www.gaycity.org)

## HEPATITIS

Gay and Lesbian Medical Association  
They have a campaign on Hepatitis A and B and MSM addressing the importance of vaccination, including poster and brochures. For more information or to order copies, email: [info@glma.org](mailto:info@glma.org)

Free and low-cost hepatitis clinics:  
[www.hepclinics.com](http://www.hepclinics.com)

Centers for Disease Control and Prevention Division of Viral Hepatitis  
[www.cdc.gov/ncidod/diseases/hepatitis/msm/](http://www.cdc.gov/ncidod/diseases/hepatitis/msm/)

Model programs for MSM and hepatitis A, B, and C prevention:  
[www.hepprograms.org/msm/](http://www.hepprograms.org/msm/)

## HIV/AIDS:

### HIV/AIDS—GENERAL RESOURCES

National HIV and AIDS Hotline  
800-342-AIDS; 800-344-SIDA (7432) (Spanish); TDD: 800-243-7889

AEGIS  
(largest keyword-searchable online database for HIV/AIDS)  
[www.aegis.com](http://www.aegis.com)

American Foundation for AIDS Research (amfar)  
[www.amfar.org](http://www.amfar.org)

The Body: an AIDS and HIV information resource  
[www.thebody.com](http://www.thebody.com)

Center for AIDS Prevention Studies  
[www.caps.ucsf.edu](http://www.caps.ucsf.edu)

Centers for Disease Control and Prevention  
[www.cdc.gov/hiv/dhap.htm](http://www.cdc.gov/hiv/dhap.htm)

HIVandHepatitis.com  
[www.hivandhepatitis.com](http://www.hivandhepatitis.com)

National AIDS Treatment Advocacy Project  
[www.natap.org](http://www.natap.org)

New Mexico AIDSNet  
(online fact sheets in English and Spanish regarding various aspects of HIV/AIDS)  
[www.aidsinonet.org](http://www.aidsinonet.org)

Project Inform  
(HIV/AIDS health information and treatment options) Hotline:  
800-822-7422  
[www.projectinform.org](http://www.projectinform.org)

Youth HIV: a project of Advocates for Youth  
[www.youthhiv.org](http://www.youthhiv.org)

National Association on HIV over 50 (NAHOF)  
[www.hivoverfifty.org](http://www.hivoverfifty.org)

## HIV AND PEOPLE OF COLOR

Asian and Pacific Islander Wellness Center  
[www.apiwellness.org](http://www.apiwellness.org)

Black AIDS Institute  
[www.blackaids.org](http://www.blackaids.org)

Latino Coalition on AIDS  
[www.latinoaids.com](http://www.latinoaids.com)

National Minority AIDS Coalition  
[www.nmac.org](http://www.nmac.org)

National Native American AIDS Prevention Center  
[www.nnaapc.org](http://www.nnaapc.org)

## HIV AND LESBIANS

TheBody.com  
[www.thebody.com/whatis/lesbians.html](http://www.thebody.com/whatis/lesbians.html)

Lesbian AIDS Project, Gay Men's Health Crisis  
[www.gmhc.org/programs/wfs.html#lap](http://www.gmhc.org/programs/wfs.html#lap)

## HIV AND TRANSGENDER POPULATIONS

AEGIS  
[www.aegis.com](http://www.aegis.com)

HIV InSite  
<http://hivinsite.ucsf.edu/InSite.jsp?page+kbr-07-04-16>

## HIV RESOURCES FOR PROVIDERS

HIV InSite: University of California San Francisco  
<http://hivinsite.ucsf.edu>

Medscape: resource for clinicians and CME credit  
[www.medscape.com](http://www.medscape.com)

U.S. DHHS HIV/AIDS Education and Resource Center  
[www.aidsinfo.nih.gov](http://www.aidsinfo.nih.gov)  
Helpline: 800-448-0440 (also Spanish); 888-480-3739 (TTY)

AEGIS: HIV news from around the world  
[www.aegis.com](http://www.aegis.com)

Infectious Diseases Society of America  
[www.idsociety.org](http://www.idsociety.org)

## Intimate Partner Violence

Community United Against Violence  
[www.cuav.org](http://www.cuav.org)

Family Violence Prevention Fund Health Care Program  
[www.endabuse.org/programs/healthcare/](http://www.endabuse.org/programs/healthcare/)

National Domestic Violence Hotline  
(local referrals, including LGBT-sensitive) 800-799-SAFE (7233) (24 hours in English and Spanish); TDD: 800-787-3224

Network for Battered Lesbians and Bisexual Women Hotline  
[info@thenetworklared.org](mailto:info@thenetworklared.org)  
617-423-SAFE

New York City Gay and Lesbian Anti-Violence Project  
212-714-1141 (local referrals; Spanish-speaking services)

Stop Partner Abuse/Domestic Violence Program, Los Angeles Gay and Lesbian Center  
[www.laglc.org/domesticviolence/](http://www.laglc.org/domesticviolence/)

See also [References and Other Resource Documents](#).

## Substance Abuse

Sober Dykes  
[www.soberdykes.org](http://www.soberdykes.org)

Stonewall Project  
[www.tweaker.org](http://www.tweaker.org)

Substance Abuse Mental Health Services Administration/National Clearinghouse for Alcohol and Drug Information—LGBT site  
[www.health.org/features/lgbt](http://www.health.org/features/lgbt)

## Youth

National Gay, Lesbian, Bisexual Youth Hotline  
800-347-TEEN

Youth Guardian Services: on-line support  
[www.youth-guard.org](http://www.youth-guard.org)

Youth Resource: a project of Advocates for Youth  
[www.youthresource.com](http://www.youthresource.com)

National Youth Advocacy Coalition  
[www.nyacyouth.org](http://www.nyacyouth.org)

Seattle and King County Public Health  
[www.metrokc.gov/health/glbtyouth.htm](http://www.metrokc.gov/health/glbtyouth.htm)

See also [HIV/AIDS and General Bisexual Health sections](#)

## Elders

SAGE: Services and Advocacy for Gay, Lesbian, Bisexual, and Transgender Elders  
[www.sageusa.org](http://www.sageusa.org)

National Gay and Lesbian Task Force  
[www.thetaskforce.org/theissues](http://www.thetaskforce.org/theissues)  
Outing Age: Public Policy Issues Affecting GLBT Elders, November 9, 2000  
[www.thetaskforce.org/theissues/library.cfm?issueID=24&pubTypeID=2](http://www.thetaskforce.org/theissues/library.cfm?issueID=24&pubTypeID=2)

See also [HIV/AIDS section](#)



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The Gay and Lesbian Medical Association is a national organization committed to ensuring equality in health care for lesbian, gay, bisexual, and transgender (LGBT) individuals and health care professionals. GLMA achieves its goals by using medical expertise in professional education, public policy work, patient education and referrals, and the promotion of research. To join GLMA or for more information, please visit [www.glma.org](http://www.glma.org).

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**POLICY OPTIONS TO ENSURE THAT LESBIAN,  
GAY, BISEXUAL AND TRANSGENDER PERSONS  
IN CALIFORNIA RECEIVE COMPETENT MEDICAL  
AND MENTAL HEALTH CARE**

**Prepared by Ted Muhlhauser**

**Legislative Analyst for California State Senator Christine Kehoe**

## **POLICY MEMO: ENSURE THAT LESBIAN, GAY, BISEXUAL AND TRANSGENDER PERSONS IN CALIFORNIA RECEIVE COMPETENT MEDICAL AND MENTAL HEALTH CARE**

### MEMO PURPOSE, CONTENTS AND POLICY QUESTION

This memo addresses a health policy question that has gained increasing focus among state legislators, medical and mental health care providers, academic experts, and affected patients: *Should state legislators take affirmative steps toward improving medical and mental health care received by lesbian, gay, bisexual and transgender (LGBT) persons in California? And if so, what steps should be taken?*

### APPROACH TO POLICY QUESTION

Research, studies and human experiences have demonstrated that lesbian, gay, bisexual and transgender persons receive sub-par quality medical and mental health care when compared with the health care quality provided to the general population. Moreover, LGBT persons require unique provision of care; many medical and mental health problems or disease rates that LGBT persons experience are significantly different than health issues that affect non-LGBT patients.

This memo serves three purposes: 1) provide recent information on equity based considerations regarding the need to improve quality of care for LGBT persons, 2) explore whether improving LGBT health care has public value on economic efficiency grounds, and 3) provide a recommendation for policymaker action to enhance the quality medical and mental health care received by LGBT patients. There is precedence for using legislative authority to improve health treatment of minority or other poorly served patient populations. Prior legislative action in similar issue areas will be presented in the section on policy options.

### CLARIFYING THE SCOPE OF THIS MEMO

The scope of this memo is limited to the topic of whether improving LGBT cultural competency of health care providers is a public policy issue that warrants legislative action. “Culturally competent” care, in this sense, means providing types and levels of health care quality for LGBT patients that address their unique medical and mental health care needs. Although the issue of visitation rights for unmarried LGBT partners is not addressed in this memo, readers should be aware that LGBT patients will be unlikely to appreciate the benefits of improved health care quality if they and their partners do not enjoy full visitation rights. Another cautionary note about terminology: this memo presumes that the term “health care” is inclusive of both medical and mental health care; the term “medical” includes medical and psychiatric care, but does not refer to dental or eye care.

### BACKGROUND INFORMATION: THE CURRENT STATE OF HEALTH CARE QUALITY AND EQUITY FOR LGBT PERSONS

The American Medical Association (AMA) made a public call in 1996 to improve the education of health care personnel regarding best practices for improving care provided to LGBT patients. Unfortunately, from 1996-2005, the quality of care provided to LGBT patients in the U.S. did not improve substantially. As a result of the continuing disparity of care received by LGBT patients, a president of the AMA publicly apologized for poor health care received by LGBT persons during a 2005 speech<sup>1</sup> to a conference of the

Gay and Lesbian Medical Association. With that background in mind, this section of the memo will explore some of the specific barriers to high-quality health care that LGBT persons have experienced.

***What portion of the population is affected by LGBT health issues?***

There have been numerous studies and surveys that seek to estimate the lesbian and gay populations in the United States and elsewhere, but estimates of bisexual and transgender populations are few and far between. Using a large random sample size of 6000 people, a recent survey of the National Survey of Sexual Health and Behavior at Indiana University estimates that 7% of U.S. women are lesbian and 8% of U.S. men are gay<sup>2</sup>. That estimate differs from other estimates, but may arguably be more accurate than other surveys or studies due to the large random sample size used. Regardless of the exact size of LGBT populations in the U.S., one academic study on this topic concludes that a majority of doctors can be expected to encounter LGBT patients during their careers<sup>3</sup>.

***Do attitudes of health care providers toward LGBT patients create a barrier to adequate medical care?***

Kaiser Permanente, which has received high ratings for ensuring culturally competent care for LGBT clients, indicates<sup>4</sup> in a report issued in 2000 that LGBT persons are likely at some point in their lives to confront bias from health care providers. The report cited surveys of nursing students and physicians who stated bias or discomfort with LGBT patients or doctors. Another survey of medical students confirmed the presence of negative attitudes toward LGBT patients<sup>2</sup>.

Even if bias is not a barrier to adequate medical care, LGBT persons can miss out on having their health issues properly understood, diagnosed and treated because health care providers or health care office staff persons often neglect to ascertain the sexual orientation or gender identity of LGBT patients. Reports cited in subsequent sections of this memo cite research that demonstrates LGBT persons are confronted by medical and mental health issues that are directly tied to their status as a lesbian, gay, bisexual, or transgender person. Therefore, it appears that LGBT patients are disserved by both bias against LGBT persons, and the inability of health care professionals to fully recognize the importance of understanding whether they are serving patients who have a propensity to suffer from ailments associated with people who exhibit attributes of the LGBT population.

***A Brief Review of LGBT Health Care Quality in California***

California has numerous health facilities that appear to do well when it comes to preparing their medical staff to provide culturally competent care to LGBT patients<sup>5</sup>. Unfortunately, available data is limited to few hospitals and even fewer health care networks, clinics or offices and mental health providers. The lack of comprehensive data makes it impossible to conclude that California care providers are providing the type of care that LGBT clients really need, but policy makers seeking to improve LGBT cultural competency among care providers would benefit from considering the success stories of some California health facilities.

The Human Rights Campaign – an advocacy and research group committed to the promotion of LGBT equality – manages an annual survey of U.S. health care facilities called the Health Equality Index (HEI). The HEI rates hospitals and other medical health care providers, which are not required to participate in the survey, for the quality of LGBT health care that they provide based on seven criteria, including:

- “Sexual Orientation” in Patients’ Bill of Rights and/or Non-Discrimination Policy;
- “Gender Identity” in Patients’ Bill of Rights and/or Non-Discrimination Policy;
- Equal Visitation Access for Same-Sex Couples;
- Equal Visitation Access for Same-Sex Parents;
- LGBT Cultural Competency Training for Staff;
- “Sexual Orientation” in Equal Employment Opportunity Policy; and,
- “Gender Identity” in Equal Employment Opportunity Policy.

One criterion is specific to the subject of this memo: whether a health care facility provides training in LGBT cultural competency. The survey data was collected from 178 hospitals nationwide and 35 hospitals in California; however, most of the hospitals reviewed in California (29 of 35) were from one health system, Kaiser Permanente. All 29 Kaiser Permanente facilities inside California received a top score on each of the seven criteria, including the criterion relating to cultural competency. Of the remaining six facilities that responded to the survey, two received “top performer” status for high marks in all seven criteria, and all but one of the six facilities received high marks for providing LGBT cultural competency training.

Although these results show that many California facilities have strong LGBT cultural competency training, there are hundreds of hospitals, and thousands of medical offices and mental health facilities, whose policies and procedures regarding LGBT health care are not readily known. Based on the fact that the AMA recognized in 2005 that treatment disparities for LGBT patients are pervasive and ongoing, it seems unlikely that the high scores for the facilities surveyed in the HEI are indicative of California health care providers.

#### IN THE BEST INTEREST OF ECONOMIC EFFICIENCY? LEGISLATING LGBT HEALTH CARE SERVICE QUALITY

As evidenced in the previous section, improving overall healthcare experiences for LGBT patients is a policy issue that is gaining attention in both the public and private sectors. In most of those cases, the policy changes have been initiated by equity-based concerns. Equity is one factor to consider in pursuing legislation to improve LGBT cultural competency in health care.

Inequitable social and economic conditions sometimes produce economic inefficiencies. In those cases, government often institutes public sector reforms to improve economic efficiency. This section presents evidence that legislation regarding LGBT cultural competency could also improve the economic efficiency of the overall health care system.

#### ***Economic Considerations for LGBT patients***

Due to disparities in health insurance coverage, LGBT patients – especially those in partnered relationships – are likely to experience a substantially greater economic burden than non-LGBT patients experience when it comes to paying for health care treatment. Therefore, when LGBT patients obtain health care, they are in particular need of competent care because the numbers of their initial and return visits to medical care providers – and their ability to pay for prescription drugs – are limited by the enhanced financial burden that they may experience.

A recent study found that uninsured gay men in a two-person relationship are 42% less likely to receive dependent health insurance through their insured partner than are uninsured men in a married

heterosexual relationship. Uninsured lesbians have even less access to health coverage; those who are in a two-person lesbian relationship are 28% less likely to receive dependent health insurance through their partner than are uninsured women in a married heterosexual relationship<sup>6</sup>.

***Economic and public health efficiency considerations for LGBT patients and the general population***

LGBT patients are already less likely to receive medical care due to insurance barriers. For those with or without medical insurance who receive poor quality care, culturally incompetent care means that it is entirely possible that the health problems of LGBT patients will go unresolved; they would have to spend more individual financial resources to get sufficient care or use publicly funded health facilities.

Cost barriers, including opportunity costs, for LGBT patients who receive inadequate care and must continually seek improved care adequate care are exacerbated by the marginal increase in money that LGBT persons need to spend on health care as a result of the fact that they suffer from high propensities of certain health conditions. Many of those health problems can be costly and longstanding. For example, gay men experience severe medical challenges associated with high rates of AIDS and HIV cases – including the communicable diseases that accompany immunodeficiency conditions – and other sexually transmitted diseases. Lesbians are more than twice as likely as heterosexual men or women to receive mental health treatment. Evidence indicates that mental health problems among lesbians – and perhaps other LGBT persons – can exacerbate physical health problems<sup>7</sup>.

The overall medical expenses of LGBT patients are affected by both general human health problems and LGBT-specific health issues. According to the Gay and Lesbian Medical Association<sup>8</sup> and other expert research<sup>7</sup>, LGBT patients experience direct and associative mental health problems that can lead to physical health problems, which, in turn, can lead to increased medical costs if treated incorrectly or incompetently. Those physical and mental health problems, and other social bias problems, include: enhanced levels of substance abuse – including tobacco; enhanced risk of diseases associated with enhanced levels of substance abuse – such as heart disease, lung cancer and pancreatic disorders like diabetes; safe sex barriers; violent assaults, depression, stress, anxiety, post-traumatic stress and substance abuse associated with stigma and isolation related to sexual orientation and/or gender identity – such as homophobia; biphobia; transphobia; discrimination and harassment; non-traditional sexual history; and, sexually transmitted diseases.

**POLICY OPTIONS TO ENHANCE THE QUALITY OF HEALTH CARE RECEIVED BY LGBT PATIENTS**

This memo has provided background on several economic, political and policy aspects of the policy question posed at the beginning of this memo. The previous sections have explored rationale for taking legislative action to improve the cultural competency of health care professionals in California. This section recommends a policy option for addressing this topic.

***Policy Action Recommendation: Statutorily require regulatory boards that license or certify health care personnel to mandate continuing education on LGBT cultural competency in health care***

This recommendation has the greatest possible public value among other potential policy options because it ensures that current and future health care providers would be trained to provide culturally competent care to LGBT patients. There is precedence for this approach. Business and Professions Code stipulates certain types of continuing education (i.e., pain management, palliative care) that some

health care professionals must obtain. Moreover, other non-LGBT cultural competency is already offered through continuing education (CE) based on legislative and regulatory requirements. There has also been legislation (Assembly Bill 1195, Coto, 2005) that encouraged (but did not require) boards that certify and license medical and mental health professionals to allow CME credit for courses designed to improve another form of health care cultural competency. AB 1195 encouraged certain regulatory boards to encourage their licensees to obtain CE regarding culturally and linguistically competent care for race and ethnic minorities.

CE does not put onerous cost burdens on educational institutions, hospitals or clinics, but it would place minor costs on health care providers required to take the course if they are statutorily mandated to obtain CE training above and beyond current CE requirements. Some minor burdens may also be presented to state regulatory entities. However, the recommended approach is unlikely to present substantive financial burdens on the state, which is an important distinction because legislative fiscal committees – that are required to reduce state fiscal impact resulting from all proposed legislation – are unlikely to have a fiscal justification to keep the recommended statutory proposal from advancing.

The probability of bill passage is an issue that requires consideration. Gauging the likelihood of bill passage, however, is difficult because the membership and chairships of relevant policy committees has changed significantly this year and the effects of those changes are unknown. A statutory mandate regarding CE is likely to attract opposition from the affected health care professionals and may elicit concern or opposition from boards that regulate those professionals.

## ENDNOTES

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- <sup>2</sup>Center for Sexual Health Promotion at Indiana University – Bloomington. (2010). National Survey of Sexual Health and Behavior. Last retrieved January 21, 2011 from <http://www.nationalsexstudy.indiana.edu/>
- <sup>3</sup>Sanchez, N et al. (2003). Medical Students' Ability to Care for Lesbian, Gay, Bisexual, and Transgendered Patients. *Medical Student Education*, 38 (1), 21-27. Last retrieved January 21, 2011 from <http://www.stfm.org/fmhub/fm2006/January/Nelson21.pdf>
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- <sup>5</sup>Human Rights Commission Foundation (2010). Healthcare Equality Index 2010. Last retrieved January 21, 2011 from <http://www.hrc.org/documents/HRC-Healthcare-Equality-Index-2010.pdf>
- <sup>6</sup>Ponce, et al. (2010). The Effects of Unequal Access to Health Insurance for Same-Sex Couples in California. *Health Affairs*, 29 (1), 1539-1548.
- <sup>7</sup>Cochran, S. and Mays, V. (2007). Physical Health Complaints Among Lesbians, Gay Men, and Bisexual and Homosexually Experienced Heterosexual Individuals: Results From the California Quality of Life Survey. *American Journal of Public Health*, 97 (11), 2048-2055. Last retrieved January 21, 2011 from <http://ajph.aphapublications.org/cgi/reprint/97/11/2048.pdf>
- <sup>8</sup>Gay and Lesbian Medical Association. (2006). Guidelines for Care of Lesbian, Gay, Bisexual and Transgender Patients. Last retrieved January 21, 2011 from <http://www.glma.org/index.cfm?fuseaction=document.showDocumentByID&DocumentID=16&d:\CFusionMX7\verity\Data\dummy.txt>

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**BOARD OF BEHAVIORAL SCIENCES**  
**Continuing Education Requirement**

| <b>MFT</b>  | <b>LCSW</b>  |
|---|--|
| <p><b>36 CE hours required to renew</b><br/>           Business and Professions Code: 4980.54(c)(1)<br/>           California Code of Regulations: 1887.3(a)</p>  | <p><b>36 CE hours required to renew</b><br/>           Business and Professions Code: 4996.22(a)(1)<br/>           California Code of Regulations: 1887.3(a)</p>   |
| <p><b>Spousal/Partner Abuse</b><br/>           If course is taken <u>before</u> January 1, 2005<br/>           there is not hour length specified<br/>           If the course is taken <u>after</u> January 1, 2005<br/>           It must be seven hours in length</p> <p align="center">B&amp;P Code: 4980.57(a)</p>   | <p><b>Spousal/Partner Abuse</b><br/>           If course is taken <u>before</u> January 1, 2005<br/>           there is not hour length specified<br/>           If the course is taken <u>after</u> January 1, 2005<br/>           It must be seven hours in length</p> <p align="center">B&amp;P Code: 4996.22(a)(3)</p> |
| <p><b>Aging and Long Term Care</b><br/>           Three hour requirement</p> <p align="center">B&amp;P Code: 4980.395(a)</p>  | <p><b>Aging and Long Term Care</b><br/>           Three hour requirement</p> <p align="center">B&amp;P Code: 4996.26(a)</p>  |
| <p><b>HIV/AIDS</b><br/>           Seven hour requirement</p> <p align="center">California Code of Regulations 1887.3(c)</p>   | <p><b>HIV/AIDS</b><br/>           Seven hour requirement</p> <p align="center">California Code of Regulations 1887.3(c)</p>  |
| <p><b>Law and Ethics</b><br/>           Six hours for every renewal period</p> <p align="center">California Code of Regulations 1887.3(d)</p>   | <p><b>Law and Ethics</b><br/>           Six hours for every renewal period</p> <p align="center">California Code of Regulations 1887.3(d)</p>  |
| <p>Mandated courses are one-time only courses, and once taken, need not be taken again.<br/>           The only exception is the Law and Ethics course<br/>           Law and Ethics must be taken for each renewal.</p>  |  |
| <p>18 hours of CE are required for your first renewal, but that is a MINIMUM, not a maximum.<br/>           All mandated courses are required for your first renewal. If you have taken any of the mandated<br/>           courses in the past, you are not required to repeat it. The only exception is the Law and Ethics<br/>           course. Law and Ethics must be taken for each renewal.</p> |  |
| <p>Supervisors of Associate Clinical Social Workers and Marriage and Family Therapist Interns<br/>           may apply their supervisor course training hours to their continuing education requirement as<br/>           long as the training has been taken by an approved continuing education provider.</p>   |  |
| <p>(chart updated: 10/06)</p>   |  |

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**To:** Policy and Advocacy Committee

**Date:** March 23, 2011

**From:** Christina Kitamura  
Administrative Analyst

**Telephone:** (916) 574-7835

**Subject:** Discussion and Possible Action Regarding Other Legislation Affecting the Board

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This page serves as a placeholder for other legislation that may need to be discussed.

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**To:** Policy and Advocacy Committee

**Date:** March 23, 2011

**From:** Rosanne Helms  
Legislative Analyst

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

**Subject:** **Legislative Update**

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Board staff is currently pursuing the following legislative proposals:

**SB 363 (Emmerson) MFT Experience and Supervision**

This bill seeks to clarify and amend supervision and experience requirements for those seeking licensure as a Marriage and Family Therapist (MFT). This proposal does the following:

1. **MFT Trainee Practicum Requirements:** Allows an MFT trainee to continue to counsel clients while not enrolled in practicum if that lapse of enrollment is less than 45 days.
2. **Client-Centered Advocacy:** Limits the client centered advocacy allowed for an MFT intern to 500 hours.
3. **Supervision of MFT Interns:** Allows Licensed Professional Clinical Counselors (LPCCs) to supervise MFT interns, but clarifies that they must first meet additional training and education requirements in order to do so.

**SB 704 (Negrete-McLeod) Examination Re-Structure**

The proposed exam re-structure would change the exam process for applicants seeking MFT and Clinical Social Worker (LCSW) licensure on or after January 1, 2013. If this legislation is successful, then effective January 1, 2013, applicants for MFT and LCSW licensure would need to pass two exams: a California law and ethics examination (law and ethics exam) and a clinical examination (clinical exam). These new exams would replace the standard written and the clinical vignette exams currently in place.

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

The omnibus bill proposes several non-substantive amendments which will add clarity and consistency to licensing law. The changes being proposed can be organized into two major categories:

- 1) Technical clean-up; and
- 2) Amendments either including LPCCs in statute where the Board's other licensees are included, or making LPCC law consistent with the law for the Board's other licenses.

To date, staff has submitted the following amendments and additions to the legislature to be included in this year's omnibus legislation:

**1) Amend BPC Sections 4980.36, 4980.37, 4980.40.5, and 4999.12: Bureau for Private Postsecondary Education**

Background: BPC sections 4980.36, 4980.37, 4980.40.5, and 4999.12 refer to the Bureau for Private Postsecondary and Vocational Education (BPPVE). As a result of AB 48, Chapter 310, Statutes of 2009, the Bureau for Private Postsecondary Education (BPPE) was created, which replaced the former BPPVE.

Amendment: Correct errant references to BPPVE by amending sections 4980.36, 4980.37, 4980.40.5, and 4999.12 to reflect the Bureau's new name.

**2) Amend BPC Sections 4980.36, 4980.37, 4980.40.5: Couple and Family Therapy Degree Title**

Background: A growing number of graduate programs nationwide have begun offering degrees in "Couple and Family Therapy." This degree title reflects a growing trend to acknowledge a greater diversity of relationships with which Marriage and Family Therapists (MFTs) work. A degree in Couple and Family Therapy is currently not listed in statute as one of the degrees the Board may accept in order to qualify for an MFT license.

Amendment: Add the degree title "Couple and Family Therapy" to the list of degrees titles in BPC sections 4980.36, 4980.37, and 4980.40.5 that are accepted to qualify for MFT licensure.

**3) Amend BPC Section 4980.36: MFT Client Centered Advocacy Hours**

Background: BPC section 4980.36(d)(1)(B)(ii) requires that a qualifying degree for licensure include practicum that includes a minimum of 225 hours of face-to-face experience counseling individuals, couples, families or groups, and states that up to 75 of these hours may be gained performing client centered advocacy as defined in section 4980.03. However, client centered advocacy, as defined in section 4980.03, does not consist of face-to-face contact.

Amendment: In order to clarify the type of experience required, the proposed amendment to section 4980.36 (d)(1)(B) separates the 225 hours into 150 hours of face-to-face experience and 75 hours of either client centered advocacy or face-to-face experience.

**4) Amend BPC Section 4980.42: Trainee Work Setting**

Background: BPC section 4980.42(a) discusses the conditions of a trainee's services. The section incorrectly references section 4980.43(e), which outlines requirements of work settings for interns. It should reference 4980.43(d), which discusses the requirements of work settings for trainees.

Amendment: Amend section 4980.42(a) to correctly reference 4980.43(d) relating to trainees' work settings.

**5) Amend BPC Section 4980.45 and 4996.24; Add BPC Section 4999.455: Supervision of Registrants Limitation**

Background: Last year the Board voted to limit the number of registrants a supervisor can supervise in a private practice setting. Current MFT and LCSW law now limits the number of registrants that a licensed professional in private practice may supervise or employ to two individuals registered either as an MFT intern or an ASW. Additionally, an MFT, LCSW, or LPCC corporation may currently employ no more than ten individuals registered either as MFT interns or ASWs at any one time. There is currently no limit on the number of clinical counselor interns that may be supervised in private practice.

Amendment: The proposed amendments to sections 4980.45 and 4996.24 impose a limitation of three registrants for a supervisor in private practice. Additionally, the corporation may currently employ no more than fifteen individuals registered by the Board at any one time. Section 4999.455 is added in order to apply these same limitations to LPCCs.

**6) Amend BPC Sections 4982.25, 4989.54, and 4992.36; Add Section 4999.91: Disciplinary Action**

Background: Currently sections 4982.25(b) (for MFTs), 4989.54(i) (for Licensed Educational Psychologists (LEPs)), and 4992.36 (for LCSWs) discuss grounds for denial of application or disciplinary action for unprofessional conduct. Each section lists the various licenses the Board issues and states that actions against any of these licenses constitute grounds for disciplinary action against the license that is the subject of that particular code. However, each code section leaves out action against its own license as grounds for disciplinary conduct.

Additionally, there is no equivalent section in LPCC law stating that action against a Board license or registration constitutes grounds for disciplinary action against an LPCC license or registration.

Amendment: For consistency, amend sections 4982.25(b), 4989.54(i), and 4992.36 to list all four of the Board's license types. This would clarify the intention that disciplinary action against any one of the Board's license types would constitute grounds for disciplinary action against any other of the Board's licenses if an individual held more than one license with the Board. Add section 4999.91 to LPCC code to mirror the above listed codes.

**7) Amend BPC Section 4990.38: Disciplinary Action Taken by the State of California**

Background: BPC section 4990.38 currently allows the Board to deny an application or suspend or revoke a license or application if disciplinary action has been taken by another state, territory or governmental agency against a license, certificate or registration to practice marriage and family therapy, clinical social work, educational psychology or any other healing art.

As written, the code does not allow the Board to deny or suspend a license or application based on disciplinary action taken by the State of California.

Amendment: Amend section 4990.38 to include disciplinary action taken by the State of California.

**8) Amend BPC Section 4992.3: LCSW Scope of Competence**

Background: BPC section 4992.3(m) of the LCSW code states that holding one's self out as being able to perform any service beyond the scope of one's license is unprofessional conduct. However,

the equivalent code sections in MFT, LEP, and LPCC law state that it is considered unprofessional conduct to perform any professional services beyond the scope of one's competence.

Amendment: Amend BPC section 4992.3(m) of the LCSW code to include scope of competence in order to make it consistent with MFT, LEP, and LPCC code.

**9) Amend BPC Section 4996.13: LCSW Work of a Psychosocial Nature**

Background: Current law allows certain other professional groups to practice work of a psychosocial nature as long as they don't hold themselves out to be a LCSW. The professional groups that are allowed to practice social work are listed in section 4996.13. Licensed professional clinical counselors are not included in the list.

Amendment: Add licensed professional clinical counselors to the list in section 4996.13 of professional groups allowed to practice work of a psychosocial nature.

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**To:** Policy and Advocacy Committee **Date:** March 22, 2011  
**From:** Rosanne Helms **Telephone:** (916) 574-7897  
Legislative/Regulatory Analyst  
**Subject: Rulemaking Update**

## PENDING REGULATORY PROPOSALS

*Title 16, CCR Sections 1800, 1802, 1803, 1804, 1805, 1805.1, 1806, 1807, 1807.2, 1810, 1811, 1812, 1813, 1814, 1815, 1816, 1816.1, 1816.2, 1816.3, 1816.4, 1816.5, 1816.6, 1816.7, 1819.1, 1832, 1833.1, 1850.6, 1850.7, 1870, 1870.1, 1874, 1877, 1880, 1881, 1886, 1886.10, 1886.20, 1886.30, 1886.40, 1886.50, 1886.60, 1886.70, 1886.80, 1887, 1887.1, 1887.2, 1887.3, 1887.4, 1887.5, 1887.6, 1887.7, 1887.8, 1887.9, 1887.10, 1887.11, 1887.12, 1887.13, 1887.14, 1888, and adding 1820, 1821, and 1822, Licensed Professional Clinical Counselors, Exceptions to Continuing Education Requirements*

### **Background**

This proposal would implement all provisions related to SB 788, Chapter 619, Statutes of 2009, and the creation of Licensed Professional Clinical Counselors. Additionally, this rulemaking incorporates changes approved by the Board relating to Continuing Education requirements for licensed educational psychologists. The Board approved the proposed text at its September 1, 2010 meeting.

### **Status**

The rulemaking package was approved by the State and Consumer Services Agency (Agency) on March 18, 2011. Next, it must be reviewed by the Department of Finance and then by the Office of Administrative Law.

### *Title 16, CCR Section 1811, Revision of Advertising Regulations*

This proposal revises the regulatory provisions related to advertising by Board Licensees. The Board approved the originally proposed text at its meeting on November 18, 2008. Staff will address this rulemaking proposal in 2011 after the current pending regulatory proposal is approved.

### *Title 16, CCR Section 1887.3, HIV/AIDS Continuing Education Course for LPCCs*

This proposal revises current Board regulations to include LPCCs in the requirement to take a one-time, seven hour continuing education course covering the assessment and treatment of

people living with HIV/AIDS. The Board approved the proposed text at its February 23, 2011 meeting and directed staff to submit a regulation package to make the proposed change. Staff will address this rulemaking proposal after the current pending regulatory proposal is approved.