MEETING NOTICE

Policy and Advocacy Committee
April 7, 2011

Department of Consumer Affairs
El Dorado Room
1625 North Market Blvd.
2nd 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
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.

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.
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.
To: Policy and Advocacy Committee  
From: Christina Kitamura  
Subject: Discussion and Possible Action Regarding Acceptance of Post-Degree Hours of Experience Toward Licensure as a Professional Clinical Counselor

Date: March 23, 2011  
Telephone: (916) 574-7835

Materials for this agenda item will be provided in a supplemental package and will be posted on the website at that time.
CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES
BILL ANALYSIS

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

AUTHOR: YAMADA SPONSOR: YAMADA

RECOMMENDED POSITION: NONE

SUBJECT: ELDER ABUSE: REPORTING

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 reporter 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)
An act to amend 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 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 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.

State-mandated local program: yes.

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

SECTION 1. Section 15630 of the Welfare and Institutions Code is amended to read:

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, 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, 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 both the local ombudsperson and 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) This subdivision shall not be construed to modify or limit a clergy member’s duty to report known or suspected elder and dependent adult abuse if 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 if 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, 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 if 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 ombudsman, 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 ombudsman program. Except in an emergency, the
local ombudsman 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 ombudsman.
Except in an emergency, the local ombudsman 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) If 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 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, 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, abandonment, abduction, isolation,
financial abuse, or neglect of an elder or dependent adult, in
violation of this section, if 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 discovers the offense.
(i) For purposes of this section, “dependent adult” shall have
the same meaning as in Section 15610.23.
SEC. 2. Section 15630.1 of the Welfare and Institutions Code
is amended to read:
15630.1. (a) As used in this section, “mandated reporter of
suspected financial abuse of an elder or dependent adult” means
all officers and employees of financial institutions.
(b) As used in this section, the term “financial institution” means
any of the following:
(1) A depository institution, as defined in Section 3(c) of the
Federal Deposit Insurance Act (12 U.S.C. Sec. 1813(c)).
(2) An institution-affiliated party, as defined in Section 3(u) of
the Federal Deposit Insurance Act (12 U.S.C. Sec. 1813(u)).
(3) A federal credit union or state credit union, as defined in
Section 101 of the Federal Credit Union Act (12 U.S.C. Sec. 1752),
including, but not limited to, an institution-affiliated party of a
credit union, as defined in Section 206(r) of the Federal Credit
Union Act (12 U.S.C. Sec. 1786(r)).
(c) As used in this section, “financial abuse” has the same
meaning as in Section 15610.30.
(d) (1) Any mandated reporter of suspected financial abuse of
an elder or dependent adult who has direct contact with the elder
or dependent adult or who reviews or approves the elder or
dependent adult’s financial documents, records, or transactions,
in connection with providing financial services with respect to an
er elder or dependent adult, and who, within the scope of his or her
employment or professional practice, has observed or has
knowledge of an incident, that is directly related to the transaction
or matter that is within that scope of employment or professional
practice, that reasonably appears to be financial abuse, or who
reasonably suspects that abuse, based solely on the information
before him or her at the time of reviewing or approving the
document, record, or transaction in the case of mandated reporters
who do not have direct contact with the elder or dependent adult,
shall report the known or suspected instance of financial abuse by
telephone immediately, or as soon as practicably possible, and by
written report sent within two working days to the local adult
protective services agency or the local law enforcement agency.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

However, if the Commission on State Mandates determines that this act contains other costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 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.
   (4) 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.
CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES
BILL ANALYSIS

BILL NUMBER: AB 154 VERSION: JANUARY 18, 2011

AUTHOR: BEALL SPONSOR: AUTHOR

RECOMMENDED POSITION: NONE
SUBJECT: MENTAL HEALTH AND SUBSTANCE ABUSE PARITY

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 Program 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.

ASSEMBLY BILL
No. 154

Introduced by Assembly Member Beall

January 18, 2011

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.


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

SECTION 1. Section 22856 is added to the Government Code, to read:

22856. The board may 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.

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

1374.74. (a) A health care service plan contract issued, amended, or renewed on or after January 1, 2012, that provides hospital, medical, or surgical coverage shall 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 as specified in subdivision (c) of Section 1374.72. The benefits provided under this section shall include all those set forth in subdivision (b) of Section 1374.72.

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

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

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

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

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

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

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

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

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

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

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

10144.8. (a) A policy of health insurance that covers hospital, medical, or surgical expenses in this state that is issued, amended, or renewed on or after January 1, 2012, shall 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 as specified in subdivision (c) of Section 10144.5. The benefits provided under
this section shall include all those set forth in subdivision (b) of Section 10144.5.

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

(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).

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

(3) Any revision to the definition of “mental illness” pursuant to paragraph (2) shall be established by regulation promulgated jointly by the department and the Department of Managed Health Care.
(c) (1) For the purpose of compliance with this section, a health insurer may provide coverage for all or part of the mental health services required by this section through a separate specialized health care service plan or mental health plan and shall not be required to obtain an additional or specialized license for this purpose.

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

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

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

(d) 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.

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

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIIIB of the California Constitution because the only costs that may be incurred by a local agency or school...
district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.
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.

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.
CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES

BILL ANALYSIS

BILL NUMBER: AB 171 VERSION: JANUARY 20, 2011

AUTHOR: BEALL SPONSOR: Alliance of California Autism Organizations

RECOMMENDED POSITION: NONE

SUBJECT: AUTISM SPECTRUM DISORDER

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.
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.


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

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

1374.73. (a) Every health care service plan contract issued, amended, or renewed on or after January 1, 2012, that provides hospital, medical, or surgical coverage shall provide coverage for the screening, diagnosis, and treatment of autism spectrum disorders. A health care service plan shall not terminate coverage, or refuse to deliver, execute, issue, amend, adjust, or renew coverage, to an enrollee solely because the individual is diagnosed with, or has received treatment for, an autism spectrum disorder.

(b) Coverage required to be provided under this section shall extend to all medically necessary services and shall not be subject to any limits regarding age, number of visits, or dollar amounts. Coverage required to be provided under this section shall not be subject to provisions relating to lifetime maximums, deductibles, copayments, or coinsurance or other terms and conditions that are less favorable to an enrollee than lifetime maximums, deductibles, copayments, or coinsurance or other terms and conditions that apply to physical illness generally under the plan contract.

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

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

(e) A health care service plan shall establish and maintain an adequate network of qualified autism service providers with appropriate training and experience in autism spectrum disorders to ensure that enrollees have a choice of providers, and have timely access, continuity of care, and ready referral to all services required.
to be provided by this section consistent with Sections 1367 and
1367.03 and the regulations adopted pursuant thereto.

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

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

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

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

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

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

(2) “Behavioral health treatment” means professional services
and treatment programs, including behavioral intervention therapy,
applied behavioral analysis, and other intensive behavioral
programs, that have demonstrated efficacy to develop, maintain,
or restore, to the maximum extent practicable, the functioning or
quality of life of an individual and that have been demonstrated
to treat the core symptoms associated with autism spectrum
disorder.
Behavioral intervention therapy” means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in behaviors, including the use of direct observation, measurement, and functional analyses of the relationship between environment and behavior.

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

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

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

“Psychiatric care” means direct or consultative psychiatric services provided by a psychiatrist or any other appropriately licensed or certified provider.

“Psychological care” means direct or consultative psychological services provided by a psychologist or any other appropriately licensed or certified provider.

“Therapeutic care” means services provided by licensed or certified speech therapists, occupational therapists, or physical therapists or any other appropriately licensed or certified provider.

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

(A) Behavioral health treatment.
(B) Pharmacy care.
(C) Psychiatric care.
(D) Psychological care.
(E) Therapeutic care.
(F) Any care for individuals with autism spectrum disorders that is demonstrated, based upon best practices or evidence-based research, to be medically necessary.
SEC. 2. Section 10144.51 is added to the Insurance Code, to read:

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

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

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

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

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

(f) (1) This section shall not be construed as reducing any obligation to provide services to an insured under an individualized family service plan, an individualized program plan, a prevention program plan, an individualized education program, or an individualized service plan.
(2) This section shall not be construed as limiting benefits that are otherwise available to an enrollee under a health insurance policy.

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

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

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

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

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

(3) “Behavioral intervention therapy” means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in behaviors, including the use of direct observation, measurement, and functional analyses of the relationship between environment and behavior.
(4) “Diagnosis of autism spectrum disorders” means medically necessary assessment, evaluations, or tests to diagnose whether an individual has one of the autism spectrum disorders.

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

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

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

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

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

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

(A) Behavioral health treatment.

(B) Pharmacy care.

(C) Psychiatric care.

(D) Psychological care.

(E) Therapeutic care.

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

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIIIB of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of...
the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.
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.
ASSEMBLY BILL No. 181

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

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.


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

SECTION 1. Section 16001.10 is added to the Welfare and Institutions Code, to read:

16001.10. (a) It is the policy of the state that all children in foster care and transition-age foster youth shall have the following rights relating to mental health services:

1. To receive needed mental health services.
2. To interview a therapist prior to commencing treatment.
3. To discontinue psychotropic medication, as deemed appropriate by a physician, if the youth experiences potentially dangerous side effects.
4. To be presented with mental health options, including, but not limited to, holistic or natural approaches, mentoring, peer counseling, therapy, and medication.
5. 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.
6. To be evaluated by a medical professional.
7. To have mental health services provided outside of the place of residence, if the child wishes.
8. 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.
9. To gain access to personal mental health records.
10. 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.
(11) To be given age-appropriate information on drug interactions if prescribed more than one medication.

(12) 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.

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

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

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

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

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

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

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

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

(5) Update the complainant on the progress of the investigation and notify the complainant of the final outcome.
(6) Document the number, source, origin, location, and nature of complaints.

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

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

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

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

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

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

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

(2) The office, counties, foster care providers, and others may use the information developed in paragraph (1) in carrying out their responsibilities to inform foster children and youth of their rights pursuant to Section 1530.91 of the Health and Safety Code, Sections 27 and 16501.1, and this section.
BILL ANALYSIS

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

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.
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.


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

SECTION 1. Section 15631.5 is added to the Welfare and Institutions Code, to read:

15631.5. Reports of suspected elder or dependent adult abuse pursuant to either subparagraph (C) of paragraph (1) of subdivision (b) of Section 15630 or subdivision (b) of Section 15631 may be made to any county adult protective services agency or local law enforcement agency. Any county adult protective services agency or local law enforcement agency shall accept the report of suspected elder or dependent adult abuse even if the agency to whom the report is being made lacks subject matter or geographical jurisdiction to investigate the reported case, unless the county adult protective services agency or the local law enforcement agency can immediately transfer the call reporting suspected elder or dependent adult abuse to a county adult protective services agency or a local law enforcement agency with proper jurisdiction. If a county adult protective services agency or a local law enforcement agency accepts a report about a case of suspected elder or dependent adult abuse in which that agency lacks jurisdiction, the agency shall immediately refer the case by telephone, facsimile, or electronic transmission to a county adult protective services agency or a local law enforcement agency with proper jurisdiction.
SEC. 2. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.
CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES
BILL ANALYSIS

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

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

Introduced by Assembly Member Portantino

February 17, 2011

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.

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

SECTION 1. It is the intent of the Legislature in enacting this act to improve outcomes and increase consumer protection in child welfare services by improving the educational standards of supervisors in child welfare services to ensure that each supervisor has the appropriate training, experience, and education.

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

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

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

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

(2) Both of the following:

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

(B) A certificate from an organization, accredited academic institution, or university-related entity that certifies supervisors in child welfare services. Certification pursuant to this paragraph shall include 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.

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

(c) A child welfare services social work supervisor employed before January 1, 2012, is exempt from the requirements of this section.
CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES
BILL ANALYSIS

BILL NUMBER: AB 675 VERSION: INTRODUCED FEBRUARY 17, 2011
AUTHOR: HAGMAN SPONSOR: AUTHOR
RECOMMENDED POSITION: NONE
SUBJECT: CONTINUING EDUCATION; PROHIBITION OF SPECIFIED COURSES

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.
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.

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

SECTION 1. Section 110.6 is added to the Business and Professions Code, to read:

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

(a) Continuing education courses shall contain only content relevant to the particular practice regulated by the board pursuant to its laws and regulations. Continuing education courses 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 continuing education requirements. For the purposes of this section, “courses” includes institutes, seminars, lectures, conferences, workshops, and any other public events.

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

(2) If, after the board provides the provider notice and an opportunity to be heard, the board finds that the provider violated the requirement in paragraph (1), the board shall withdraw approval of the provider for no less than five years.
To: Policy and Advocacy Committee  
Date: March 23, 2011  

From: Christina Kitamura  
Administrative Analyst  

Telephone: (916) 574-7835  

Subject: Assembly Bill 774  

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.
CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES

BILL ANALYSIS

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

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).
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.


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

SECTION 1. Section 4980.44 of the Business and Professions Code is amended to read:

4980.44. An unlicensed marriage and family therapist intern employed under this chapter shall comply with the following requirements:

(a) Possess, at a minimum, a master’s degree as specified in Section 4980.36 or 4980.37, as applicable.

(b) Register with the board prior to performing any duties, except as otherwise provided in subdivision (g) of Section 4980.43.

(c) Prior to performing any professional services, inform each client or patient that he or she is an unlicensed marriage and family therapist registered intern, provide 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 by the American Board of Psychiatry and Neurology.

(d) Any advertisement by or on behalf of a marriage and family therapist registered intern shall include, at a minimum, all of the following information:
(A) That he or she is a marriage and family therapist registered intern.

(B) The name of his or her employer.

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

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

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

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

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

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

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

(2) The name of his or her employer.

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

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

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

(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 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.

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

(d) (c) An unlicensed Associate Clinical Social Worker may advertise if such advertisement complies with Section 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.
To: Policy and Advocacy Committee  
From: Christina Kitamura  
Subject: Assembly Bill 958

Date: March 29, 2011  
Telephone: (916) 574-7835

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.
To: Policy and Advocacy Committee  
From: Christina Kitamura  
Subject: Assembly Bill 993  
Date: March 23, 2011  
Telephone: (916) 574-7835

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.
To: Policy and Advocacy Committee  
From: Christina Kitamura  
Subject: Assembly Bill 1205  

Date: March 23, 2011  
Telephone: (916) 574-7835

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.
CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES

BILL ANALYSIS

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

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.
SENATE BILL No. 146

Introduced by Senator Wyland

February 1, 2011

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


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.

State-mandated local program: yes.

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

SECTION 1. Section 25 of the Business and Professions Code is amended to read:

25. Any person applying for a license, registration, or the first renewal of a license, after the effective date of this section, as a licensed marriage and family therapist, a licensed clinical social worker, a licensed psychologist, or a licensed professional clinical counselor shall, in addition to any other requirements, show by evidence satisfactory to the agency regulating the business or profession, that he or she has completed training in human sexuality as a condition of licensure. The training shall be creditable toward continuing education requirements as deemed appropriate by the
agency regulating the business or profession, and the course shall not exceed more than 50 contact hours.

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

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

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

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

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

27. (a) Each entity specified in subdivision (b) shall provide on the Internet information regarding the status of every license issued by that entity in accordance with the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code) and the Information Practices Act of 1977 (Chapter 1 (commencing with Section 1798) of Title 1.8 of Part 4 of Division 3 of the Civil Code). The public information to be provided on the Internet shall include information on suspensions and revocations of licenses issued by the entity and other related enforcement action taken by the entity relative to persons, businesses, or facilities subject to licensure or regulation by the entity. In providing information on the Internet, each entity shall comply with the Department of Consumer Affairs Guidelines for Access to Public Records. The information may not include personal information, including home telephone number, date of birth, or social security number. Each entity shall disclose a licensee’s address of record. However, each entity shall allow a licensee to provide a post office box number or other alternate address, instead of his or her home address, as the address of
record. This section shall not preclude an entity from also requiring
a licensee, who has provided a post office box number or other
alternative mailing address as his or her address of record, to
provide a physical business address or residence address only for
the entity’s internal administrative use and not for disclosure as
the licensee’s address of record or disclosure on the Internet.
(b) Each of the following entities within the Department of
Consumer Affairs shall comply with the requirements of this
section:
(1) The Acupuncture Board shall disclose information on its
licensees.
(2) The Board of Behavioral Sciences shall disclose information
on its licensees, including marriage and family therapists, licensed
clinical social workers, licensed educational psychologists, and
licensed professional clinical counselors.
(3) The Dental Board of California shall disclose information
on its licensees.
(4) The State Board of Optometry shall disclose information
regarding certificates of registration to practice optometry,
statements of licensure, optometric corporation registrations, branch
office licenses, and fictitious name permits of its licensees.
(5) The Board for Professional Engineers and Land Surveyors
shall disclose information on its registrants and licensees.
(6) The Structural Pest Control Board shall disclose information
on its licensees, including applicators, field representatives, and
operators in the areas of fumigation, general pest and wood
destroying pests and organisms, and wood roof cleaning and
treatment.
(7) The Bureau of Automotive Repair shall disclose information
on its licensees, including auto repair dealers, smog stations, lamp
and brake stations, smog check technicians, and smog inspection
certification stations.
(8) The Bureau of Electronic and Appliance Repair shall disclose
information on its licensees, including major appliance repair
dealers, combination dealers (electronic and appliance), electronic
repair dealers, service contract sellers, and service contract
administrators.
(9) The Cemetery and Funeral Bureau shall disclose information
on its licensees, including cemetery brokers, cemetery salespersons,
cemetery managers, crematory managers, cemetery authorities,
crematories, cremated remains disposers, embalmers, funeral establishments, and funeral directors.

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

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

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

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

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

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

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

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

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

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

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

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

(5) Recognizing and intervening with affected family members.
(6) Learning about current programs of recovery, such as 12-step programs, and how therapists can effectively utilize these programs.

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

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

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

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

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

(b) Every insurer providing professional liability insurance to a person licensed pursuant to Chapter 13 (commencing with}
Section 4980), Chapter 14 (commencing with Section 4990), or Chapter 16 (commencing with Section 4999.10) shall send a complete report to the Board of Behavioral Sciences as to any settlement or arbitration award over ten thousand dollars ($10,000) of a claim or action for damages for death or personal injury caused by that person’s negligence, error, or omission in practice, or by his or her rendering of unauthorized professional services. The report shall be sent within 30 days after the written settlement agreement has been reduced to writing and signed by all parties thereto or within 30 days after service of the arbitration award on the parties.

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

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

(e) The insurer shall notify the claimant, or if the claimant is represented by counsel, the insurer shall notify the claimant’s attorney, that the report required by subdivision (a), (b), or (c) has been sent to the agency. If the attorney has not received this notice within 45 days after the settlement was reduced to writing and signed by all of the parties, the arbitration award was served on the parties, or the date of entry of the civil judgment, the attorney shall make the report to the agency.
(f) Notwithstanding any other provision of law, no insurer shall enter into a settlement without the written consent of the insured, except that this prohibition shall not void any settlement entered into without that written consent. The requirement of written consent shall only be waived by both the insured and the insurer. This section shall only apply to a settlement on a policy of insurance executed or renewed on or after January 1, 1971.

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

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

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

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

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

(b) Every settlement, judgment, or arbitration award over ten
thousand dollars ($10,000) of a claim or action for damages for
death or personal injury caused by negligence, error or omission
in practice, or by the unauthorized rendering of professional
services, by a marriage and family therapist, a clinical social
worker, or a professional clinical counselor licensed pursuant to
Chapter 13 (commencing with Section 4980), Chapter 14
(commencing with Section 4990), or Chapter 16 (commencing
with Section 4999.10), respectively, who does not possess
professional liability insurance as to that claim shall within 30
days after the written settlement agreement has been reduced to
writing and signed by all the parties thereto or 30 days after service
of the judgment or arbitration award on the parties be reported to
the agency that issued the license, certificate, or similar authority.
A complete report shall be made by appropriate means by the
person or his or her counsel, with a copy of the communication to
be sent to the claimant through his or her counsel if he or she is
so represented, or directly if he or she is not. If, within 45 days of
the conclusion of the written settlement agreement or service of
the judgment or arbitration award on the parties, counsel for the
claimant (or if he or she is not represented by counsel, the claimant
himself or herself) has not received a copy of the report, he or she
shall himself or herself make a complete report. Failure of the
marriage and family therapist, clinical social worker, or
professional clinical counselor or claimant (or, if represented by
counsel, his or her counsel) to comply with this section is a public
offense punishable by a fine of not less than fifty dollars ($50) nor
more than five hundred dollars ($500). Knowing and intentional
failure to comply with this section, or conspiracy or collusion not
to comply with this section or to hinder or impede any other person
in that compliance, is a public offense punishable by a fine of not
less than five thousand dollars ($5,000) nor more than fifty
thousand dollars ($50,000).
SEC. 8. Section 805 of the Business and Professions Code is
amended to read:
805. (a) As used in this section, the following terms have the
following definitions:
(A) “Peer review” means both of the following:
(i) A process in which a peer review body reviews the basic
qualifications, staff privileges, employment, medical outcomes,
or professional conduct of licentiates to make recommendations
for quality improvement and education, if necessary, in order to
do either or both of the following:
(I) Determine whether a licentiate may practice or continue to
practice in a health care facility, clinic, or other setting providing
medical services, and, if so, to determine the parameters of that
practice.
(II) Assess and improve the quality of care rendered in a health
care facility, clinic, or other setting providing medical services.
(ii) Any other activities of a peer review body as specified in subparagraph (B).

(B) “Peer review body” includes:

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

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

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

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

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

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

(4) “Staff privileges” means any arrangement under which a licentiate is allowed to practice in or provide care for patients in a health facility. Those arrangements shall include, but are not limited to, full staff privileges, active staff privileges, limited staff privileges, auxiliary staff privileges, provisional staff privileges, temporary staff privileges, courtesy staff privileges, locum tenens arrangements, and contractual arrangements to provide professional services, including, but not limited to, arrangements to provide outpatient services.
“Denial or termination of staff privileges, membership, or employment” includes failure or refusal to renew a contract or to renew, extend, or reestablish any staff privileges, if the action is based on medical disciplinary cause or reason.

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

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

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

1. A licentiate’s application for staff privileges or membership is denied or rejected for a medical disciplinary cause or reason.
2. A licentiate’s membership, staff privileges, or employment is terminated or revoked for a medical disciplinary cause or reason.
3. Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of 30 days or more for any 12-month period, for a medical disciplinary cause or reason.

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

1. Resigns or takes a leave of absence from membership, staff privileges, or employment.
(2) Withdraws or abandons his or her application for staff privileges or membership.

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

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

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

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

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

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

If another peer review body is required to file an 805 report, a health care service plan is not required to file a separate report with respect to action attributable to the same medical disciplinary cause or reason. If the Medical Board of California or a licensing agency of another state revokes or suspends, without a stay, the license of a physician and surgeon, a peer review body is not required to file an 805 report when it takes an action as a result of the revocation or suspension.
(g) The reporting required by this section shall not act as a waiver of confidentiality of medical records and committee reports. The information reported or disclosed shall be kept confidential except as provided in subdivision (c) of Section 800 and Sections 803.1 and 2027, provided that a copy of the report containing the information required by this section may be disclosed as required by Section 805.5 with respect to reports received on or after January 1, 1976.

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

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

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

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

(l) Except as otherwise provided in subdivision (k), any failure by the administrator of any peer review body, the chief executive officer or administrator of any health care facility, or any person who is designated or otherwise required by law to file an 805 report, shall be punishable by a fine that under no circumstances shall exceed fifty thousand dollars ($50,000) per violation. The fine may be imposed in any civil or administrative action or proceeding brought by or on behalf of any agency having regulatory jurisdiction over the person regarding whom the report
was or should have been filed. If the person who is designated or otherwise required to file an 805 report is a licensed physician and surgeon, the action or proceeding shall be brought by the Medical Board of California. The fine shall be paid to that agency but not expended until appropriated by the Legislature. The amount of the fine imposed, not exceeding fifty thousand dollars ($50,000) per violation, shall be proportional to the severity of the failure to report and shall differ based upon written findings, including whether the failure to file caused harm to a patient or created a risk to patient safety; whether the administrator of any peer review body, the chief executive officer or administrator of any health care facility, or any person who is designated or otherwise required by law to file an 805 report exercised due diligence despite the failure to file or whether they knew or should have known that an 805 report would not be filed; and whether there has been a prior failure to file an 805 report. The amount of the fine imposed may also differ based on whether a health care facility is a small or rural hospital as defined in Section 124840 of the Health and Safety Code.

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

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

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

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

(2) Because of deficiencies in the federal act and the possible adverse interpretations by the courts of the federal act, it is preferable for California to “opt-out” of the federal act and design its own peer review system.
(3) Peer review, fairly conducted, is essential to preserving the highest standards of medical practice.

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

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

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

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

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

(9) (A) The Legislature thus finds and declares that the laws of this state pertaining to the peer review of healing arts practitioners shall apply in lieu of Section 11101 and following of Title 42 of the United States Code, because the laws of this state provide a more careful articulation of the protections for both those undertaking peer review activity and those subject to review, and better integrate public and private systems of peer review. Therefore, California exercises its right to opt out of specified provisions of the federal Health Care Quality Improvement Act relating to professional review actions, pursuant to Section 11111(c)(2)(B) of Title 42 of the United States Code. This election
shall not affect the availability of any immunity under California law.

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

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

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

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

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

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

(2) That a marriage and family therapist corporation, a licensed clinical social worker corporation, or a professional clinical counselor corporation shall provide adequate security by insurance or otherwise for claims against it by its patients arising out of the rendering of professional services.
SEC. 11. Article 7 (commencing with Section 4999.123) is added to Chapter 16 of Division 2 of the Business and Professions Code, to read:

Article 7. Professional Clinical Counselor Corporations

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

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

4999.125. The name of a professional clinical counselor corporation and any name or names under which it may be rendering professional services shall contain the words “licensed professional clinical counselor” or “professional clinical counselor” and wording or abbreviations denoting a corporate existence. A professional clinical counselor corporation that conducts business under a fictitious business name shall not use any name that is false, misleading, or deceptive, and shall inform each patient, prior
to commencement of treatment, that the business is conducted by
a professional clinical counselor corporation.

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

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

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

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

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

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

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

43.7. (a) There shall be no monetary liability on the part of,
and no cause of action for damages shall arise against, any member
of a duly appointed mental health professional quality assurance
committee that is established in compliance with Section 4070 of
the Welfare and Institutions Code, for any act or proceeding
undertaken or performed within the scope of the functions of the committee which is formed to review and evaluate the adequacy, appropriateness, or effectiveness of the care and treatment planned for, or provided to, mental health patients in order to improve quality of care by mental health professionals if the committee member acts without malice, has made a reasonable effort to obtain the facts of the matter as to which he or she acts, and acts in reasonable belief that the action taken by him or her is warranted by the facts known to him or her after the reasonable effort to obtain facts.

(b) There shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any professional society, any member of a duly appointed committee of a medical specialty society, or any member of a duly appointed committee of a state or local professional society, or duly appointed member of a committee of a professional staff of a licensed hospital (provided the professional staff operates pursuant to written bylaws that have been approved by the governing board of the hospital), for any act or proceeding undertaken or performed within the scope of the functions of the committee which is formed to maintain the professional standards of the society established by its bylaws, or any member of any peer review committee whose purpose is to review the quality of medical, dental, dietetic, chiropractic, optometric, acupuncture, psychotherapy, or veterinary services rendered by physicians and surgeons, dentists, dental hygienists, podiatrists, registered dietitians, chiropractors, optometrists, acupuncturists, veterinarians, marriage and family therapists, professional clinical counselors, or psychologists, which committee is composed chiefly of physicians and surgeons, dentists, dental hygienists, podiatrists, registered dietitians, chiropractors, optometrists, acupuncturists, veterinarians, marriage and family therapists, professional clinical counselors, or psychologists for any act or proceeding undertaken or performed in reviewing the quality of medical, dental, dietetic, chiropractic, optometric, acupuncture, psychotherapy, or veterinary services rendered by physicians and surgeons, dentists, dental hygienists, podiatrists, registered dietitians, chiropractors, optometrists, acupuncturists, veterinarians, marriage and family therapists, professional clinical counselors, or psychologists or any member of the governing board of a hospital in reviewing the quality of medical services rendered.
by members of the staff if the professional society, committee, or
board member acts without malice, has made a reasonable effort
to obtain the facts of the matter as to which he, she, or it acts, and
acts in reasonable belief that the action taken by him, her, or it is
warranted by the facts known to him, her, or it after the reasonable
effort to obtain facts. “Professional society” includes legal, medical,
psychological, dental, dental hygiene, dietetic, accounting,
optometric, acupuncture, podiatric, pharmaceutic, chiropractic,
physical therapist, veterinary, licensed marriage and family therapy,
licensed clinical social work, licensed professional clinical
counselor, and engineering organizations having as members at
least 25 percent of the eligible persons or licentiates in the
geographic area served by the particular society. However, if the
society has fewer than 100 members, it shall have as members at
least a majority of the eligible persons or licentiates in the
geographic area served by the particular society.
“Medical specialty society” means an organization having as
members at least 25 percent of the eligible physicians and surgeons
within a given professionally recognized medical specialty in the
geographic area served by the particular society.
(c) This section does not affect the official immunity of an
officer or employee of a public corporation.
(d) There shall be no monetary liability on the part of, and no
cause of action for damages shall arise against, any physician and
surgeon, podiatrist, or chiropractor who is a member of an
underwriting committee of an interindemnity or reciprocal or
interinsurance exchange or mutual company for any act or
proceeding undertaken or performed in evaluating physicians and
surgeons, podiatrists, or chiropractors for the writing of professional liability insurance, or any act or proceeding undertaken
or performed in evaluating physicians and surgeons for the writing
of an interindemnity, reciprocal, or interinsurance contract as
specified in Section 1280.7 of the Insurance Code, if the evaluating
physician and surgeon, podiatrist, or chiropractor acts without
malice, has made a reasonable effort to obtain the facts of the
matter as to which he or she acts, and acts in reasonable belief that
the action taken by him or her is warranted by the facts known to
him or her after the reasonable effort to obtain the facts.
(e) This section shall not be construed to confer immunity from
liability on any quality assurance committee established in
compliance with Section 4070 of the Welfare and Institutions Code or hospital. In any case in which, but for the enactment of the preceding provisions of this section, a cause of action would arise against a quality assurance committee established in compliance with Section 4070 of the Welfare and Institutions Code or hospital, the cause of action shall exist as if the preceding provisions of this section had not been enacted.

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

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

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

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

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

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

(1) “Psychotherapy” means the professional treatment, assessment, or counseling of a mental or emotional illness, symptom, or condition.

(2) “Psychotherapist” means a physician and surgeon specializing in the practice of psychiatry, a psychologist, a
psychological assistant, a marriage and family therapist, a registered marriage and family therapist intern or trainee, an educational psychologist, an associate clinical social worker, a licensed clinical social worker, or a professional clinical counselor, or a registered clinical counselor intern or trainee.

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

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

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

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

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

(2) Within two years following termination of therapy.

(3) By means of therapeutic deception.

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

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

(1) The plaintiff claims damage to sexual functioning.

(2) The defendant requests a hearing prior to conducting discovery and makes an offer of proof of the relevancy of the history, and the court finds that the history is relevant and the probative value of the history outweighs its prejudicial effect.
The court shall allow the discovery or introduction as evidence only of specific information or examples of the plaintiff’s conduct that are determined by the court to be relevant. The court’s order shall detail the information or conduct that is subject to discovery.

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

43.95. (a) There shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any professional society or any nonprofit corporation authorized by a professional society to operate a referral service, or their agents, employees, or members, for referring any member of the public to any professional member of the society or service, or for acts of negligence or conduct constituting unprofessional conduct committed by a professional to whom a member of the public was referred, so long as any of the foregoing persons or entities has acted without malice, and the referral was made at no cost added to the initial referral fee as part of a public service referral system organized under the auspices of the professional society. Further, there shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any professional society for providing a telephone information library available for use by the general public without charge, nor against any nonprofit corporation authorized by a professional society for providing a telephone information library available for use by the general public without charge. “Professional society” includes legal, psychological, architectural, medical, dental, dietetic, accounting, optometric, podiatric, pharmaceutical, chiropractic, veterinary, licensed marriage and family therapy, licensed clinical social work, professional clinical counselor, and engineering organizations having as members at least 25 percent of the eligible persons or licentiates in the geographic area served by the particular society. However, if the society has less than 100 members, it shall have as members at least a majority of the eligible persons or licentiates in the geographic area served by the particular society. “Professional society” also includes organizations with referral services that have been authorized by the State Bar of California and operated in accordance with its Minimum Standards for a Lawyer Referral Service in California, and organizations that have been established to provide free assistance or representation to needy patients or clients.
(b) This section shall not apply whenever the professional society, while making a referral to a professional member of the society, fails to disclose the nature of any disciplinary action of which it has actual knowledge taken by a state licensing agency against that professional member. However, there shall be no duty to disclose a disciplinary action in either of the following cases:

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

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

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

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

(a) Medical corporation.

(1) Licensed doctors of podiatric medicine.

(2) Licensed psychologists.

(3) Registered nurses.

(4) Licensed optometrists.

(5) Licensed marriage and family therapists.

(6) Licensed clinical social workers.

(7) Licensed physician assistants.

(8) Licensed chiropractors.

(9) Licensed acupuncturists.

(10) Naturopathic doctors.

(11) Licensed professional clinical counselors.

(b) Podiatric medical corporation.
(1) Licensed physicians and surgeons.
(2) Licensed psychologists.
(3) Registered nurses.
(4) Licensed optometrists.
(5) Licensed chiropractors.
(6) Licensed acupuncturists.
(7) Naturopathic doctors.
(c) Psychological corporation.
(1) Licensed physicians and surgeons.
(2) Licensed doctors of podiatric medicine.
(3) Registered nurses.
(4) Licensed optometrists.
(5) Licensed marriage and family therapists.
(6) Licensed clinical social workers.
(7) Licensed chiropractors.
(8) Licensed acupuncturists.
(9) Naturopathic doctors.
(10) Licensed professional clinical counselors.
(d) Speech-language pathology corporation.
(1) Licensed audiologists.
(e) Audiology corporation.
(1) Licensed speech-language pathologists.
(f) Nursing corporation.
(1) Licensed physicians and surgeons.
(2) Licensed doctors of podiatric medicine.
(3) Licensed psychologists.
(4) Licensed optometrists.
(5) Licensed marriage and family therapists.
(6) Licensed clinical social workers.
(7) Licensed physician assistants.
(8) Licensed chiropractors.
(9) Licensed acupuncturists.
(10) Naturopathic doctors.
(11) Licensed professional clinical counselors.
(g) Marriage and family therapy therapist corporation.
(1) Licensed physicians and surgeons.
(2) Licensed psychologists.
(3) Licensed clinical social workers.
(4) Registered nurses.
(5) Licensed chiropractors.
(6) Licensed acupuncturists.
(7) Naturopathic doctors.
(8) Licensed professional clinical counselors.
(h) Licensed clinical social worker corporation.
(1) Licensed physicians and surgeons.
(2) Licensed psychologists.
(3) Licensed marriage and family therapists.
(4) Registered nurses.
(5) Licensed chiropractors.
(6) Licensed acupuncturists.
(7) Naturopathic doctors.
(8) Licensed professional clinical counselors.
(i) Physician assistants corporation.
(1) Licensed physicians and surgeons.
(2) Registered nurses.
(3) Licensed acupuncturists.
(4) Naturopathic doctors.
(j) Optometric corporation.
(1) Licensed physicians and surgeons.
(2) Licensed doctors of podiatric medicine.
(3) Licensed psychologists.
(4) Registered nurses.
(5) Licensed chiropractors.
(6) Licensed acupuncturists.
(7) Naturopathic doctors.
(k) Chiropractic corporation.
(1) Licensed physicians and surgeons.
(2) Licensed doctors of podiatric medicine.
(3) Licensed psychologists.
(4) Registered nurses.
(5) Licensed optometrists.
(6) Licensed marriage and family therapists.
(7) Licensed clinical social workers.
(8) Licensed acupuncturists.
(9) Naturopathic doctors.
(10) Licensed professional clinical counselors.
(l) Acupuncture corporation.
(1) Licensed physicians and surgeons.
(2) Licensed doctors of podiatric medicine.
(3) Licensed psychologists.
(4) Registered nurses.
(5) Licensed optometrists.
(6) Licensed marriage and family therapists.
(7) Licensed clinical social workers.
(8) Licensed physician assistants.
(9) Licensed chiropractors.
(10) Naturopathic doctors.
(11) Licensed professional clinical counselors.
(m) Naturopathic doctor corporation.
(1) Licensed physicians and surgeons.
(2) Licensed psychologists.
(3) Registered nurses.
(4) Licensed physician assistants.
(5) Licensed chiropractors.
(6) Licensed acupuncturists.
(7) Licensed physical therapists.
(8) Licensed doctors of podiatric medicine.
(9) Licensed marriage, family, and child counselors and family therapists.
(10) Licensed clinical social workers.
(11) Licensed optometrists.
(12) Licensed professional clinical counselors.
(n) Dental corporation.
(1) Licensed physicians and surgeons.
(2) Dental assistants.
(3) Registered dental assistants.
(4) Registered dental assistants in extended functions.
(5) Registered dental hygienists.
(6) Registered dental hygienists in extended functions.
(7) Registered dental hygienists in alternative practice.
(o) Professional clinical counselor corporation.
(1) Licensed physicians and surgeons.
(2) Licensed psychologists.
(3) Licensed clinical social workers.
(4) Licensed marriage and family therapists.
(5) Registered nurses.
(6) Licensed chiropractors.
(7) Licensed acupuncturists.
(8) Naturopathic doctors.
SEC. 17. Section 66085 of the Education Code is amended to read:

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

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

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

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

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

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

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

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

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

(D) The hypnosis was performed by a licensed physician and surgeon, psychologist, licensed clinical social worker, licensed marriage and family therapist, or licensed professional clinical counselor experienced in the use of hypnosis and independent of
and not in the presence of law enforcement, the prosecution, or the defense.

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

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

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

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

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

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

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

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

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

(f) A person registered as a psychological assistant who is under the supervision of a licensed psychologist or board certified psychiatrist as required by Section 2913 of the Business and Professions Code, or a person registered as a marriage and family therapist intern who is under the supervision of a licensed marriage and family therapist, a licensed clinical social worker, a licensed
psychologist, or a licensed physician and surgeon certified in
psychiatry, as specified in Section 4980.44 of the Business and
Professions Code.

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

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

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

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

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

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

(l) An advanced practice registered nurse who is certified as a
clinical nurse specialist pursuant to Article 9 (commencing with
Section 2838) of Chapter 6 of Division 2 of the Business and
Professions Code and who participates in expert clinical practice
in the specialty of psychiatric-mental health nursing.
(m) A person rendering mental health treatment or counseling services as authorized pursuant to Section 6924 of the Family Code.

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

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

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

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

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

(a) The holder of the privilege.

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

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

The relationship of a psychotherapist and patient shall exist between a psychological corporation as defined in Article 9 (commencing with Section 2995) of Chapter 6.6 of Division 2 of the Business and Professions Code, a marriage and family therapist...
therapist corporation as defined in Article 6 (commencing with Section 4987.5) of Chapter 13 of Division 2 of the Business and Professions Code, a licensed clinical social workers corporation as defined in Article 5 (commencing with Section 4998) of Chapter 14 of Division 2 of the Business and Professions Code, or a professional clinical counselor corporation as defined in Article 7 (commencing with Section 4999.123) of Chapter 16 of Division 2 of the Business and Professions Code, and the patient to whom it renders professional services, as well as between those patients and psychotherapists employed by those corporations to render services to those patients. The word “persons” as used in this subdivision includes partnerships, corporations, limited liability companies, associations, and other groups and entities.

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

1157. (a) Neither the proceedings nor the records of organized committees of medical, medical-dental, podiatric, registered dietitian, psychological, marriage and family therapist, licensed clinical social worker, professional clinical counselor, or veterinary staffs in hospitals, or of a peer review body, as defined in Section 805 of the Business and Professions Code, having the responsibility of evaluation and improvement of the quality of care rendered in the hospital, or for that peer review body, or medical or dental review or dental hygienist review or chiropractic review or podiatric review or registered dietitian review or veterinary review or acupuncturist review committees of local medical, dental, dental hygienist, podiatric, dietetic, veterinary, acupuncture, or chiropractic societies, marriage and family therapist, licensed clinical social worker, professional clinical counselor, or psychological review committees of state or local marriage and family therapist, state or local licensed clinical social worker, state or local licensed professional clinical counselor, or state or local psychological associations or societies having the responsibility of evaluation and improvement of the quality of care, shall be subject to discovery.

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

(c) The prohibition relating to discovery or testimony does not apply to the statements made by any person in attendance at a
meeting of any of those committees who is a party to an action or proceeding the subject matter of which was reviewed at that meeting, or to any person requesting hospital staff privileges, or in any action against an insurance carrier alleging bad faith by the carrier in refusing to accept a settlement offer within the policy limits.

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

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

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

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

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

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

(2) For providers of group counseling, a professional licensed to practice psychotherapy in this state, including, but not limited to, a licensed psychiatrist, licensed psychologist, licensed clinical social worker, licensed marriage and family therapist, or licensed professional clinical counselor; or a mental health intern working
under the direct supervision of a professional licensed to practice psychotherapy.

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

SEC. 23. Section 6924 of the Family Code is amended to read:

6924. (a) As used in this section:

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

(A) A governmental agency.

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

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

(D) A runaway house or crisis resolution center.

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

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

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

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

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

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

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

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

(G) A person registered as a marriage and family therapist intern, as defined in Chapter 13 (commencing with Section 4980) of
Division 2 of the Business and Professions Code, while working under the supervision of a licensed professional specified in subdivision (g) of Section 4980.03 of the Business and Professions Code.

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

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

(3) “Residential shelter services” means any of the following:

(A) The provision of residential and other support services to minors on a temporary or emergency basis in a facility that services only minors by a governmental agency, a person or agency having a contract with a governmental agency to provide these services, an agency that receives funding from community funds, or a licensed community care facility or crisis resolution center.

(B) The provision of other support services on a temporary or emergency basis by any professional person as defined in paragraph (2).

(b) A minor who is 12 years of age or older may consent to mental health treatment or counseling on an outpatient basis, or to residential shelter services, if both of the following requirements are satisfied:

(1) The minor, in the opinion of the attending professional person, is mature enough to participate intelligently in the outpatient services or residential shelter services.

(2) The minor (A) would present a danger of serious physical or mental harm to self or to others without the mental health treatment or counseling or residential shelter services, or (B) is the alleged victim of incest or child abuse.

(c) A professional person offering residential shelter services, whether as an individual or as a representative of an entity specified in paragraph (3) of subdivision (a), shall make his or her best efforts to notify the parent or guardian of the provision of services.

(d) The mental health treatment or counseling of a minor authorized by this section shall include involvement of the minor’s parent or guardian unless, in the opinion of the professional person
who is treating or counseling the minor, the involvement would
be inappropriate. The professional person who is treating or
counseling the minor shall state in the client record whether and
when the person attempted to contact the minor’s parent or
guardian, and whether the attempt to contact was successful or
unsuccessful, or the reason why, in the professional person’s
opinion, it would be inappropriate to contact the minor’s parent
or guardian.

(e) The minor’s parents or guardian are not liable for payment
for mental health treatment or counseling services provided
pursuant to this section unless the parent or guardian participates
in the mental health treatment or counseling, and then only for
services rendered with the participation of the parent or guardian.
The minor’s parents or guardian are not liable for payment for any
residential shelter services provided pursuant to this section unless
the parent or guardian consented to the provision of those services.

(f) This section does not authorize a minor to receive convulsive
therapy or psychosurgery as defined in subdivisions (f) and (g) of
Section 5325 of the Welfare and Institutions Code, or psychotropic
drugs without the consent of the minor’s parent or guardian.

SEC. 24. Section 6929 of the Family Code is amended to read:

6929. (a) As used in this section:

(1) “Counseling” means the provision of counseling services
by a provider under a contract with the state or a county to provide
alcohol or drug abuse counseling services pursuant to Part 2
(commencing with Section 5600) of Division 5 of the Welfare and
Institutions Code or pursuant to Division 10.5 (commencing with
Section 11750) of the Health and Safety Code.

(2) “Drug or alcohol” includes, but is not limited to, any
substance listed in any of the following:

(A) Section 380 or 381 of the Penal Code.

(B) Division 10 (commencing with Section 11000) of the Health
and Safety Code.

(C) Subdivision (f) of Section 647 of the Penal Code.

(3) “LAAM” means levoalphacetylmethadol as specified in
paragraph (10) of subdivision (c) of Section 11055 of the Health
and Safety Code.

(4) “Professional person” means a physician and surgeon,
registered nurse, psychologist, clinical social worker, professional
clinical counselor, marriage and family therapist, registered
marriage and family therapist intern when appropriately employed and supervised pursuant to Section 4980.43 of the Business and Professions Code, psychological assistant when appropriately employed and supervised pursuant to Section 2913 of the Business and Professions Code, associate clinical social worker when appropriately employed and supervised pursuant to Section 4996.18 of the Business and Professions Code, or registered clinical counselor intern when appropriately employed and supervised pursuant to Section 4999.42 of the Business and Professions Code.

(b) A minor who is 12 years of age or older may consent to medical care and counseling relating to the diagnosis and treatment of a drug- or alcohol-related problem.

(c) The treatment plan of a minor authorized by this section shall include the involvement of the minor’s parent or guardian, if appropriate, as determined by the professional person or treatment facility treating the minor. The professional person providing medical care or counseling to a minor shall state in the minor’s treatment record whether and when the professional person attempted to contact the minor’s parent or guardian, and whether the attempt to contact the parent or guardian was successful or unsuccessful, or the reason why, in the opinion of the professional person, it would not be appropriate to contact the minor’s parent or guardian.

(d) The minor’s parent or guardian is not liable for payment for any care provided to a minor pursuant to this section, except that if the minor’s parent or guardian participates in a counseling program pursuant to this section, the parent or guardian is liable for the cost of the services provided to the minor and the parent or guardian.

(e) This section does not authorize a minor to receive replacement narcotic abuse treatment, in a program licensed pursuant to Article 3 (commencing with Section 11875) of Chapter 1 of Part 3 of Division 10.5 of the Health and Safety Code, without the consent of the minor’s parent or guardian.

(f) It is the intent of the Legislature that the state shall respect the right of a parent or legal guardian to seek medical care and counseling for a drug- or alcohol-related problem of a minor child when the child does not consent to the medical care and counseling, and nothing in this section shall be construed to restrict or eliminate this right.
(g) Notwithstanding any other provision of law, in cases where a parent or legal guardian has sought the medical care and counseling for a drug- or alcohol-related problem of a minor child, the physician and surgeon shall disclose medical information concerning the care to the minor’s parent or legal guardian upon his or her request, even if the minor child does not consent to disclosure, without liability for the disclosure.

SEC. 25. Section 1277 of the Health and Safety Code is amended to read:

1277. (a) No license shall be issued by the state department unless it finds that the premises, the management, the bylaws, rules and regulations, the equipment, the staffing, both professional and nonprofessional, and the standards of care and services are adequate and appropriate, and that the health facility is operated in the manner required by this chapter and by the rules and regulations adopted hereunder.

(b) (1) Notwithstanding any provision of Part 2 (commencing with Section 5600) of, or Division 7 (commencing with Section 7100) of, the Welfare and Institutions Code or any other law to the contrary, except Sections 2072 and 2073 of the Business and Professions Code, the licensure requirements for professional personnel, including, but not limited to, physicians and surgeons, dentists, podiatrists, psychologists, marriage and family therapists, pharmacists, registered nurses, clinical social workers, and professional clinical counselors in the state and other governmental health facilities licensed by the state department shall not be less than for those professional personnel in health facilities under private ownership.

(2) Persons employed as psychologists and clinical social workers, while continuing in their employment in the same class as of January 1, 1979, in the same state or other governmental health facility licensed by the state department, including those persons on authorized leave, but not including intermittent personnel, shall be exempt from the requirements of paragraph (1).

(3) The requirements of paragraph (1) may be waived by the state department solely for persons in the professions of psychology, marriage and family therapy, clinical social work, or professional clinical counseling who are gaining qualifying experience for licensure in such profession in this state. A waiver
granted pursuant to this paragraph shall not exceed three years from the date the employment commences in this state in the case of psychologists, or four years from commencement of the employment in this state in the case of marriage and family therapists, clinical social workers, and professional clinical counselors, at which time licensure shall have been obtained or the employment shall be terminated, except that an extension of a waiver of licensure for marriage and family therapists, clinical social workers, and professional clinical counselors may be granted for one additional year, based on extenuating circumstances determined by the state department pursuant to subdivision (e). For persons employed as psychologists, clinical social workers, marriage and family therapists, or professional clinical counselors less than full time, an extension of a waiver of licensure may be granted for additional years proportional to the extent of part-time employment, as long as the person is employed without interruption in service, but in no case shall the waiver of licensure exceed six years in the case of clinical social workers, marriage and family therapists, or professional clinical counselors, or five years in the case of psychologists.

(4) The durational limitation upon waivers pursuant to paragraph (3) shall not apply to any of the following:

(A) Active candidates for a doctoral degree in social work, social welfare, or social science, who are enrolled at an accredited university, college, or professional school, but these limitations shall apply following completion of this training.

(B) Active candidates for a doctoral degree in marriage and family therapy who are enrolled at a school, college, or university, specified in subdivision (b) of Section 4980.36 of, or subdivision (b) of Section 4980.37 of, the Business and Professions Code, but the limitations shall apply following completion of the training.

(C) Active candidates for a doctoral degree in professional clinical counseling who are enrolled at a school, college, or university, specified in subdivision (b) of Section 4999.32 of, or subdivision (b) of Section 4999.33 of, the Business and Professions Code, but the limitations shall apply following the completion of the training.

(5) A waiver pursuant to paragraph (3) shall be granted only to the extent necessary to qualify for licensure, except that personnel recruited for employment from outside this state and whose
experience is sufficient to gain admission to a licensing examination shall nevertheless have one year from the date of their employment in California to become licensed, at which time licensure shall have been obtained or the employment shall be terminated, provided that the employee shall take the licensure examination at the earliest possible date after the date of his or her employment, and if the employee does not pass the examination at that time, he or she shall have a second opportunity to pass the next possible examination, subject to the one-year limit for marriage and family therapists, clinical social workers, and professional clinical counselors, and subject to a two-year limit for psychologists.

(c) A special permit shall be issued by the state department when it finds that the staff, both professional and nonprofessional, and the standards of care and services are adequate and appropriate, and that the special services unit is operated in the manner required in this chapter and by the rules and regulations adopted hereunder.

(d) The state department shall apply the same standards to state and other governmental health facilities that it licenses as it applies to health facilities in private ownership, including standards specifying the level of training and supervision of all unlicensed practitioners. Except for psychologists, the department may grant an extension of a waiver of licensure for personnel recruited from outside this state for one additional year, based upon extenuating circumstances as determined by the department pursuant to subdivision (e).

(e) The department shall grant a request for an extension of a waiver based on extenuating circumstances, pursuant to subdivision (b) or (d), if any of the following circumstances exist:

(1) The person requesting the extension has experienced a recent catastrophic event which may impair the person’s ability to qualify for and pass the license examination. Those events may include, but are not limited to, significant hardship caused by a natural disaster, serious and prolonged illness of the person, serious and prolonged illness or death of a child, spouse, or parent, or other stressful circumstances.

(2) The person requesting the extension has difficulty speaking or writing the English language, or other cultural and ethnic factors exist which substantially impair the person’s ability to qualify for and pass the license examination.
(3) The person requesting the extension has experienced other
personal hardship which the department, in its discretion,
determines to warrant the extension.

SEC. 26. Section 1348.8 of the Health and Safety Code is
amended to read:

1348.8. (a) A health care service plan that provides, operates,
or contracts for telephone medical advice services to its enrollees
and subscribers shall do all of the following:

(1) Ensure that the in-state or out-of-state telephone medical
advice service is registered pursuant to Chapter 15 (commencing
with Section 4999) of Division 2 of the Business and Professions
Code.

(2) Ensure that the staff providing telephone medical advice
services for the in-state or out-of-state telephone medical advice
service are licensed as follows:

(A) For full service health care service plans, the staff hold a
valid California license as a registered nurse or a valid license in
the state within which they provide telephone medical advice
services as a physician and surgeon or physician assistant, and are
operating in compliance with the laws governing their respective
scopes of practice.

(B) (i) For specialized health care service plans providing,
operating, or contracting with a telephone medical advice service
in California, the staff shall be appropriately licensed, registered,
or certified as a dentist pursuant to Chapter 4 (commencing with
Section 1600) of Division 2 of the Business and Professions Code,
as a dental hygienist pursuant to Article 7 (commencing with
Section 1740) of Chapter 4 of Division 2 of the Business and
Professions Code, as a physician and surgeon pursuant to Chapter
5 (commencing with Section 2000) of Division 2 of the Business
and Professions Code or the Osteopathic Initiative Act, as a
registered nurse pursuant to Chapter 6 (commencing with Section
2700) of Division 2 of the Business and Professions Code, as a
psychologist pursuant to Chapter 6.6 (commencing with Section
2900) of Division 2 of the Business and Professions Code, as an
optometrist pursuant to Chapter 7 (commencing with Section 3000)
of Division 2 of the Business and Professions Code, as a marriage
and family therapist pursuant to Chapter 13 (commencing with
Section 4980) of Division 2 of the Business and Professions Code,
as a licensed clinical social worker pursuant to Chapter 14
(commencing with Section 4991) of Division 2 of the Business and Professions Code, as a professional clinical counselor pursuant to Chapter 16 (commencing with Section 4999.10) of Division 2 of the Business and Professions Code, or as a chiropractor pursuant to the Chiropractic Initiative Act, and operating in compliance with the laws governing their respective scopes of practice.

(ii) For specialized health care service plans providing, operating, or contracting with an out-of-state telephone medical advice service, the staff shall be health care professionals, as identified in clause (i), who are licensed, registered, or certified in the state within which they are providing the telephone medical advice services and are operating in compliance with the laws governing their respective scopes of practice. All registered nurses providing telephone medical advice services to both in-state and out-of-state business entities registered pursuant to this chapter shall be licensed pursuant to Chapter 6 (commencing with Section 2700) of Division 2 of the Business and Professions Code.

(3) Ensure that every full service health care service plan provides for a physician and surgeon who is available on an on-call basis at all times the service is advertised to be available to enrollees and subscribers.

(4) Ensure that staff members handling enrollee or subscriber calls, who are not licensed, certified, or registered as required by paragraph (2), do not provide telephone medical advice. Those staff members may ask questions on behalf of a staff member who is licensed, certified, or registered as required by paragraph (2), in order to help ascertain the condition of an enrollee or subscriber so that the enrollee or subscriber can be referred to licensed staff. However, under no circumstances shall those staff members use the answers to those questions in an attempt to assess, evaluate, advise, or make any decision regarding the condition of an enrollee or subscriber or determine when an enrollee or subscriber needs to be seen by a licensed medical professional.

(5) Ensure that no staff member uses a title or designation when speaking to an enrollee or subscriber that may cause a reasonable person to believe that the staff member is a licensed, certified, or registered professional described in Section 4999.2 of the Business and Professions Code unless the staff member is a licensed, certified, or registered professional.
(6) Ensure that the in-state or out-of-state telephone medical advice service designates an agent for service of process in California and files this designation with the director.

(7) Requires that the in-state or out-of-state telephone medical advice service makes and maintains records for a period of five years after the telephone medical advice services are provided, including, but not limited to, oral or written transcripts of all medical advice conversations with the health care service plan’s enrollees or subscribers in California and copies of all complaints. If the records of telephone medical advice services are kept out of state, the health care service plan shall, upon the request of the director, provide the records to the director within 10 days of the request.

(8) Ensure that the telephone medical advice services are provided consistent with good professional practice.

(b) The director shall forward to the Department of Consumer Affairs, within 30 days of the end of each calendar quarter, data regarding complaints filed with the department concerning telephone medical advice services.

(c) For purposes of this section, “telephone medical advice” means a telephonic communication between a patient and a health care professional in which the health care professional’s primary function is to provide to the patient a telephonic response to the patient’s questions regarding his or her or a family member’s medical care or treatment. “Telephone medical advice” includes assessment, evaluation, or advice provided to patients or their family members.

SEC. 27. Section 1367.26 of the Health and Safety Code is amended to read:

(a) A health care service plan shall provide, upon request, a list of the following contracting providers, within the enrollee’s or prospective enrollee’s general geographic area:

(1) Primary care providers.

(2) Medical groups.

(3) Independent practice associations.

(4) Hospitals.

(5) All other available contracting physicians and surgeons, psychologists, acupuncturists, optometrists, podiatrists, chiropractors, licensed clinical social workers, marriage and family therapists, professional clinical counselors, and nurse midwives.
to the extent their services may be accessed and are covered through the contract with the plan.

(b) This list shall indicate which providers have notified the plan that they have closed practices or are otherwise not accepting new patients at that time.

(c) The list shall indicate that it is subject to change without notice and shall provide a telephone number that enrollees can contact to obtain information regarding a particular provider. This information shall include whether or not that provider has indicated that he or she is accepting new patients.

(d) A health care service plan shall provide this information in written form to its enrollees or prospective enrollees upon request. A plan may, with the permission of the enrollee, satisfy the requirements of this section by directing the enrollee or prospective enrollee to the plan’s provider listings on its Internet Web site. Plans shall ensure that the information provided is updated at least quarterly. A plan may satisfy this update requirement by providing an insert or addendum to any existing provider listing. This requirement shall not mandate a complete republishing of a plan’s provider directory.

(e) Each plan shall make information available, upon request, concerning a contracting provider’s professional degree, board certifications, and any recognized subspeciality qualifications a specialist may have.

(f) Nothing in this section shall prohibit a plan from requiring its contracting providers, contracting provider groups, or contracting specialized health care plans to satisfy these requirements. If a plan delegates the responsibility of complying with this section to its contracting providers, contracting provider groups, or contracting specialized health care plans, the plan shall ensure that the requirements of this section are met.

(g) Every health care service plan shall allow enrollees to request the information required by this section through their toll-free telephone number or in writing.

SEC. 28. Section 1373 of the Health and Safety Code is amended to read:

1373. (a) A plan contract may not provide an exception for other coverage if the other coverage is entitlement to Medi-Cal benefits under Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division
9 of the Welfare and Institutions Code, or Medicaid benefits under Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code.

Each plan contract shall be interpreted not to provide an exception for the Medi-Cal or Medicaid benefits.

A plan contract shall not provide an exemption for enrollment because of an applicant’s entitlement to Medi-Cal benefits under Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code, or Medicaid benefits under Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code.

A plan contract may not provide that the benefits payable thereunder are subject to reduction if the individual insured has entitlement to the Medi-Cal or Medicaid benefits.

(b) A plan contract that provides coverage, whether by specific benefit or by the effect of general wording, for sterilization operations or procedures shall not impose any disclaimer, restriction on, or limitation of, coverage relative to the covered individual’s reason for sterilization.

As used in this section, “sterilization operations or procedures” shall have the same meaning as that specified in Section 10120 of the Insurance Code.

(c) Every plan contract that provides coverage to the spouse or dependents of the subscriber or spouse shall grant immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of any subscriber or spouse covered and to each minor child placed for adoption from and after the date on which the adoptive child’s birth parent or other appropriate legal authority signs a written document, including, but not limited to, a health facility minor release report, a medical authorization form, or a relinquishment form, granting the subscriber or spouse the right to control health care for the adoptive child or, absent this written document, on the date there exists evidence of the subscriber’s or spouse’s right to control the health care of the child placed for adoption. No plan may be entered into or amended if it contains any disclaimer, waiver, or other limitation of coverage relative to the coverage or insurability of newborn infants of, or children placed for adoption with, a subscriber or spouse covered as required by this subdivision.
(d) (1) Every plan contract that provides that coverage of a dependent child of a subscriber shall terminate upon attainment of the limiting age for dependent children specified in the plan, shall also provide that attainment of the limiting age shall not operate to terminate the coverage of the child while the child is and continues to meet both of the following criteria:

   (A) Incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition.

   (B) Chiefly dependent upon the subscriber for support and maintenance.

   (2) The plan shall notify the subscriber that the dependent child’s coverage will terminate upon attainment of the limiting age unless the subscriber submits proof of the criteria described in subparagraphs (A) and (B) of paragraph (1) to the plan within 60 days of the date of receipt of the notification. The plan shall send this notification to the subscriber at least 90 days prior to the date the child attains the limiting age. Upon receipt of a request by the subscriber for continued coverage of the child and proof of the criteria described in subparagraphs (A) and (B) of paragraph (1), the plan shall determine whether the child meets that criteria before the child attains the limiting age. If the plan fails to make the determination by that date, it shall continue coverage of the child pending its determination.

   (3) The plan may subsequently request information about a dependent child whose coverage is continued beyond the limiting age under this subdivision but not more frequently than annually after the two-year period following the child’s attainment of the limiting age.

   (4) If the subscriber changes carriers to another plan or to a health insurer, the new plan or insurer shall continue to provide coverage for the dependent child. The new plan or insurer may request information about the dependent child initially and not more frequently than annually thereafter to determine if the child continues to satisfy the criteria in subparagraphs (A) and (B) of paragraph (1). The subscriber shall submit the information requested by the new plan or insurer within 60 days of receiving the request.

   (5) (A) Except as set forth in subparagraph (B), under no circumstances shall the limiting age be less than 26 years of age.
with respect to plan years beginning on or after September 23, 2010.

(B) For plan years beginning before January 1, 2014, a group health care service plan contract that qualifies as a grandfathered health plan under Section 1251 of the federal Patient Protection and Affordable Care Act (Public Law 111-148) and that makes available dependent coverage of children may exclude from coverage an adult child who has not attained the age of 26 years only if the adult child is eligible to enroll in an eligible employer-sponsored health plan, as defined in Section 5000A(f)(2) of the Internal Revenue Code, other than a group health plan of a parent.

(C) (i) With respect to a child (I) whose coverage under a group or individual plan contract ended, or who was denied or not eligible for coverage under a group or individual plan contract, because under the terms of the contract the availability of dependent coverage of children ended before the attainment of 26 years of age, and (II) who becomes eligible for that coverage by reason of the application of this paragraph, the health care service plan shall give the child an opportunity to enroll that shall continue for at least 30 days. This opportunity and the notice described in clause (ii) shall be provided not later than the first day of the first plan year beginning on or after September 23, 2010, consistent with the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any additional federal guidance or regulations issued by the United States Secretary of Health and Human Services.

(ii) The health care service plan shall provide written notice stating that a dependent described in clause (i) who has not attained 26 years of age is eligible to enroll in the plan for coverage. This notice may be provided to the dependent’s parent on behalf of the dependent. If the notice is included with other enrollment materials for a group plan, the notice shall be prominent.

(iii) In the case of an individual who enrolls under this subparagraph, coverage shall take effect no later than the first day of the first plan year beginning on or after September 23, 2010.

(iv) A dependent enrolling in a group health plan for coverage pursuant to this subparagraph shall be treated as a special enrollee as provided under the rules of Section 146.117(d) of Title 45 of
the Code of Federal Regulations. The health care service plan shall offer the recipient of the notice all of the benefit packages available to similarly situated individuals who did not lose coverage by reason of cessation of dependent status. Any difference in benefits or cost-sharing requirements shall constitute a different benefit package. A dependent enrolling in a group health plan for coverage pursuant to this subparagraph shall not be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of cessation of dependent status.

(D) Nothing in this section shall require a health care service plan to make coverage available for a child of a child receiving dependent coverage. Nothing in this section shall be construed to modify the definition of “dependent” as used in the Revenue and Taxation Code with respect to the tax treatment of the cost of coverage.

(e) A plan contract that provides coverage, whether by specific benefit or by the effect of general wording, for both an employee and one or more covered persons dependent upon the employee and provides for an extension of the coverage for any period following a termination of employment of the employee shall also provide that this extension of coverage shall apply to dependents upon the same terms and conditions precedent as applied to the covered employee, for the same period of time, subject to payment of premiums, if any, as required by the terms of the policy and subject to any applicable collective bargaining agreement.

(f) A group contract shall not discriminate against handicapped persons or against groups containing handicapped persons. Nothing in this subdivision shall preclude reasonable provisions in a plan contract against liability for services or reimbursement of the handicap condition or conditions relating thereto, as may be allowed by rules of the director.

(g) Every group contract shall set forth the terms and conditions under which subscribers and enrollees may remain in the plan in the event the group ceases to exist, the group contract is terminated, or an individual subscriber leaves the group, or the enrollees’ eligibility status changes.

(h) (1) A health care service plan or specialized health care service plan may provide for coverage of, or for payment for, professional mental health services, or vision care services, or for the exclusion of these services. If the terms and conditions include
coverage for services provided in a general acute care hospital or
an acute psychiatric hospital as defined in Section 1250 and do
not restrict or modify the choice of providers, the coverage shall
extend to care provided by a psychiatric health facility as defined
in Section 1250.2 operating pursuant to licensure by the State
Department of Mental Health. A health care service plan that offers
outpatient mental health services but does not cover these services
in all of its group contracts shall communicate to prospective group
contractholders as to the availability of outpatient coverage for the
treatment of mental or nervous disorders.

(2) No plan shall prohibit the member from selecting any
psychologist who is licensed pursuant to the Psychology Licensing
Law (Chapter 6.6 (commencing with Section 2900) of Division 2
of the Business and Professions Code), any optometrist who is the
holder of a certificate issued pursuant to Chapter 7 (commencing
with Section 3000) of Division 2 of the Business and Professions
Code or, upon referral by a physician and surgeon licensed pursuant
to the Medical Practice Act (Chapter 5 (commencing with Section
2000) of Division 2 of the Business and Professions Code), (A)
any marriage and family therapist who is the holder of a license
under Section 4980.50 of the Business and Professions Code, (B)
any licensed clinical social worker who is the holder of a license
under Section 4996 of the Business and Professions Code, (C) any
registered nurse licensed pursuant to Chapter 6 (commencing with
Section 2700) of Division 2 of the Business and Professions Code,
who possesses a master’s degree in psychiatric-mental health
nursing and is listed as a psychiatric-mental health nurse by the
Board of Registered Nursing, (D) any advanced practice registered
nurse certified as a clinical nurse specialist pursuant to Article 9
(commencing with Section 2838) of Chapter 6 of Division 2 of
the Business and Professions Code who participates in expert
clinical practice in the specialty of psychiatric-mental health
nursing, to perform the particular services covered under the terms
of the plan, and the certificate holder is expressly authorized by
law to perform these services, or (E) any professional clinical
counselor who is the holder of a license under Chapter 16
(commencing with Section 4999.10) of Division 2 of the Business
and Professions Code.

(3) Nothing in this section shall be construed to allow any
certificate holder or licensee enumerated in this section to perform
professional mental health services beyond his or her field or fields of competence as established by his or her education, training, and experience.

(4) For the purposes of this section:

(A) “Marriage and family therapist” means a licensed marriage and family therapist who has received specific instruction in assessment, diagnosis, prognosis, and counseling, and psychotherapeutic treatment of premarital, marriage, family, and child relationship dysfunctions, which is equivalent to the instruction required for licensure on January 1, 1981.

(B) “Professional clinical counselor” means a licensed professional clinical counselor who has received specific instruction in assessment, diagnosis, prognosis, counseling, and psychotherapeutic treatment of mental and emotional disorders, which is equivalent to the instruction required for licensure on January 1, 2012.

(5) Nothing in this section shall be construed to allow a member to select and obtain mental health or psychological or vision care services from a certificate holder or licenseholder who is not directly affiliated with or under contract to the health care service plan or specialized health care service plan to which the member belongs. All health care service plans and individual practice associations that offer mental health benefits shall make reasonable efforts to make available to their members the services of licensed psychologists. However, a failure of a plan or association to comply with the requirements of the preceding sentence shall not constitute a misdemeanor.

(6) As used in this subdivision, “individual practice association” means an entity as defined in subsection (5) of Section 1307 of the federal Public Health Service Act (42 U.S.C. Sec. 300e-1(5)).

(7) Health care service plan coverage for professional mental health services may include community residential treatment services that are alternatives to inpatient care and that are directly affiliated with the plan or to which enrollees are referred by providers affiliated with the plan.

(i) If the plan utilizes arbitration to settle disputes, the plan contracts shall set forth the type of disputes subject to arbitration, the process to be utilized, and how it is to be initiated.

(j) A plan contract that provides benefits that accrue after a certain time of confinement in a health care facility shall specify
what constitutes a day of confinement or the number of consecutive
hours of confinement that are requisite to the commencement of
benefits.
(k) If a plan provides coverage for a dependent child who is
over 26 years of age and enrolled as a full-time student at a
secondary or postsecondary educational institution, the following
shall apply:
(1) Any break in the school calendar shall not disqualify the
dependent child from coverage.
(2) If the dependent child takes a medical leave of absence, and
the nature of the dependent child’s injury, illness, or condition
would render the dependent child incapable of self-sustaining
employment, the provisions of subdivision (d) shall apply if the
dependent child is chiefly dependent on the subscriber for support
and maintenance.
(3) (A) If the dependent child takes a medical leave of absence
from school, but the nature of the dependent child’s injury, illness,
or condition does not meet the requirements of paragraph (2), the
dependent child’s coverage shall not terminate for a period not to
exceed 12 months or until the date on which the coverage is
scheduled to terminate pursuant to the terms and conditions of the
plan, whichever comes first. The period of coverage under this
paragraph shall commence on the first day of the medical leave of
absence from the school or on the date the physician and surgeon
determines the illness prevented the dependent child from attending
school, whichever comes first. Any break in the school calendar
shall not disqualify the dependent child from coverage under this
paragraph.
(B) Documentation or certification of the medical necessity for
a leave of absence from school shall be submitted to the plan at
least 30 days prior to the medical leave of absence from the school,
if the medical reason for the absence and the absence are
foreseeable, or 30 days after the start date of the medical leave of
absence from school and shall be considered prima facie evidence
of entitlement to coverage under this paragraph.
(4) This subdivision shall not apply to a specialized health care
service plan or to a Medicare supplement plan.
SEC. 29. Section 1373.8 of the Health and Safety Code is
amended to read:
1373.8. A health care service plan contract where the plan is licensed to do business in this state and the plan provides coverage that includes California residents, but that may be written or issued for delivery outside of California, and where benefits are provided within the scope of practice of a licensed clinical social worker, a registered nurse licensed pursuant to Chapter 6 (commencing with Section 2700) of Division 2 of the Business and Professions Code who possesses a master’s degree in psychiatric-mental health nursing and is listed as a psychiatric-mental health nurse by the Board of Registered Nursing, an advanced practice registered nurse who is certified as a clinical nurse specialist pursuant to Article 9 (commencing with Section 2838) of Chapter 6 of Division 2 of the Business and Professions Code who participates in expert clinical practice in the specialty of psychiatric-mental health nursing, a marriage and family therapist who is the holder of a license under Section 4980.50 of the Business and Professions Code, or a professional clinical counselor who is the holder of a license under Chapter 16 (commencing with Section 4999.10) of Division 2 of the Business and Professions Code shall not be deemed to prohibit persons covered under the contract from selecting those licensed persons in California to perform the services in California that are within the terms of the contract even though the licensees are not licensed in the state where the contract is written or issued for delivery.

It is the intent of the Legislature in amending this section in the 1984 portion of the 1983–84 Legislative Session that persons covered by the contract and those providers of health care specified in this section who are licensed in California should be entitled to the benefits provided by the plan for services of those providers rendered to those persons.

SEC. 30. Section 1373.95 of the Health and Safety Code is amended to read:

1373.95. (a) (1) A health care service plan, other than a specialized health care service plan that offers professional mental health services on an employer-sponsored group basis, shall file a written continuity of care policy as a material modification with the department before March 31, 2004.

(2) A health care service plan shall include all of the following in its written continuity of care policy:
(A) A description of the plan’s process for the block transfer of enrollees from a terminated provider group or hospital to a new provider group or hospital.

(B) A description of the manner in which the plan facilitates the completion of covered services pursuant to Section 1373.96.

(C) A template of the notice the plan proposes to send to enrollees describing its policy and informing enrollees of their right to completion of covered services.

(D) A description of the plan’s process to review an enrollee’s request for the completion of covered services.

(E) A provision ensuring that reasonable consideration is given to the potential clinical effect on an enrollee’s treatment caused by a change of provider.

(3) If approved by the department, the provisions of the written continuity of care policy shall replace all prior continuity of care policies. The plan shall file a revision of the policy with the department if it makes a material change to it.

(b) (1) The provisions of this subdivision apply to a specialized health care service plan that offers professional mental health services on an employer-sponsored group basis.

(2) The plan shall file with the department a written policy describing the manner in which it facilitates the continuity of care for a new enrollee who has been receiving services from a nonparticipating mental health provider for an acute, serious, or chronic mental health condition when his or her employer changed health plans. The written policy shall allow the new enrollee a reasonable transition period to continue his or her course of treatment with the nonparticipating mental health provider prior to transferring to a participating provider and shall include the provision of mental health services on a timely, appropriate, and medically necessary basis from the nonparticipating provider. The policy may provide that the length of the transition period take into account on a case-by-case basis, the severity of the enrollee’s condition and the amount of time reasonably necessary to effect a safe transfer. The policy shall ensure that reasonable consideration is given to the potential clinical effect of a change of provider on the enrollee’s treatment for the condition. The policy shall describe the plan’s process to review an enrollee’s request to continue his or her course of treatment with a nonparticipating mental health provider. Nothing in this paragraph shall be construed
to require the plan to accept a nonparticipating mental health provider onto its panel for treatment of other enrollees. For purposes of the continuing treatment of the transferring enrollee, the plan may require the nonparticipating mental health provider, as a condition of the right conferred under this section, to enter into its standard mental health provider contract.

(3) A plan may require a nonparticipating mental health provider whose services are continued pursuant to the written policy, to agree in writing to the same contractual terms and conditions that are imposed upon the plan’s participating providers, including location within the plan’s service area, reimbursement methodologies, and rates of payment. If the plan determines that an enrollee’s health care treatment should temporarily continue with his or her existing provider or nonparticipating mental health provider, the plan shall not be liable for actions resulting solely from the negligence, malpractice, or other tortious or wrongful acts arising out of the provisions of services by the existing provider or a nonparticipating mental health provider.

(4) The written policy shall not apply to an enrollee who is offered an out-of-network option or to an enrollee who had the option to continue with his or her previous specialized health care service plan that offers professional mental health services on an employer-sponsored group basis or mental health provider and instead voluntarily chose to change health plans.

(5) This subdivision shall not apply to a specialized health care service plan that offers professional mental health services on an employer-sponsored group basis if it includes out-of-network coverage that allows the enrollee to obtain services from his or her existing mental health provider or nonparticipating mental health provider.

(c) The health care service plan, including a specialized health care service plan that offers professional mental health services on an employer-sponsored group basis, shall provide to all new enrollees notice of its written continuity of care policy and information regarding the process for an enrollee to request a review under the policy and shall provide, upon request, a copy of the written policy to an enrollee.

(d) Nothing in this section shall require a health care service plan or a specialized health care service plan that offers professional mental health services on an employer-sponsored
group basis to cover services or provide benefits that are not
otherwise covered under the terms and conditions of the plan
contract.

(e) The following definitions apply for the purposes of this
section:

(1) “Hospital” means a general acute care hospital.

(2) “Nonparticipating mental health provider” means a
psychiatrist, licensed psychologist, licensed marriage and family
therapist, licensed social worker, or licensed professional clinical
counselor who does not contract with the specialized health care
service plan that offers professional mental health services on an
employer-sponsored group basis.

(3) “Provider group” means a medical group, independent
practice association, or any other similar organization.

SEC. 31. Section 123105 of the Health and Safety Code is
amended to read:

123105. As used in this chapter:

(a) “Health care provider” means any of the following:

(1) A health facility licensed pursuant to Chapter 2 (commencing
with Section 1250) of Division 2.

(2) A clinic licensed pursuant to Chapter 1 (commencing with
Section 1200) of Division 2.

(3) A home health agency licensed pursuant to Chapter 8
(commencing with Section 1725) of Division 2.

(4) A physician and surgeon licensed pursuant to Chapter 5
(commencing with Section 2000) of Division 2 of the Business
and Professions Code or pursuant to the Osteopathic Act.

(5) A podiatrist licensed pursuant to Article 22 (commencing
with Section 2460) of Chapter 5 of Division 2 of the Business and
Professions Code.

(6) A dentist licensed pursuant to Chapter 4 (commencing with
Section 1600) of Division 2 of the Business and Professions Code.

(7) A psychologist licensed pursuant to Chapter 6.6
(commencing with Section 2900) of Division 2 of the Business
and Professions Code.

(8) An optometrist licensed pursuant to Chapter 7 (commencing
with Section 3000) of Division 2 of the Business and Professions
Code.

(9) A chiropractor licensed pursuant to the Chiropractic Initiative
Act.
(10) A marriage and family therapist licensed pursuant to Chapter 13 (commencing with Section 4980) of Division 2 of the Business and Professions Code.

(11) A clinical social worker licensed pursuant to Chapter 14 (commencing with Section 4990) of Division 2 of the Business and Professions Code.

(12) A physical therapist licensed pursuant to Chapter 5.7 (commencing with Section 2600) of Division 2 of the Business and Professions Code.

(13) An occupational therapist licensed pursuant to Chapter 5.6 (commencing with Section 2570).

(14) A professional clinical counselor licensed pursuant to Chapter 16 (commencing with Section 4999.10) of Division 2 of the Business and Professions Code.

(b) “Mental health records” means patient records, or discrete portions thereof, specifically relating to evaluation or treatment of a mental disorder. “Mental health records” includes, but is not limited to, all alcohol and drug abuse records.

(c) “Patient” means a patient or former patient of a health care provider.

(d) “Patient records” means records in any form or medium maintained by, or in the custody or control of, a health care provider relating to the health history, diagnosis, or condition of a patient, or relating to treatment provided or proposed to be provided to the patient. “Patient records” includes only records pertaining to the patient requesting the records or whose representative requests the records. “Patient records” does not include information given in confidence to a health care provider by a person other than another health care provider or the patient, and that material may be removed from any records prior to inspection or copying under Section 123110 or 123115. “Patient records” does not include information contained in aggregate form, such as indices, registers, or logs.

(e) “Patient’s representative” or “representative” means any of the following:

(1) A parent or guardian of a minor who is a patient.

(2) The guardian or conservator of the person of an adult patient.

(3) An agent as defined in Section 4607 of the Probate Code, to the extent necessary for the agent to fulfill his or her duties as
set forth in Division 4.7 (commencing with Section 4600) of the
Probate Code.

(4) The beneficiary as defined in Section 24 of the Probate Code
or personal representative as defined in Section 58 of the Probate
Code, of a deceased patient.

(f) “Alcohol and drug abuse records” means patient records, or
discrete portions thereof, specifically relating to evaluation and
treatment of alcoholism or drug abuse.

SEC. 32. Section 123115 of the Health and Safety Code is
amended to read:

123115. (a) The representative of a minor shall not be entitled
to inspect or obtain copies of the minor’s patient records in either
of the following circumstances:

(1) With respect to which the minor has a right of inspection
under Section 123110.

(2) Where the health care provider determines that access to the
patient records requested by the representative would have a
detrimental effect on the provider’s professional relationship with
the minor patient or the minor’s physical safety or psychological
well-being. The decision of the health care provider as to whether
or not a minor’s records are available for inspection or copying
under this section shall not attach any liability to the provider,
unless the decision is found to be in bad faith.

(b) When a health care provider determines there is a substantial
risk of significant adverse or detrimental consequences to a patient
in seeing or receiving a copy of mental health records requested
by the patient, the provider may decline to permit inspection or
provide copies of the records to the patient, subject to the following
conditions:

(1) The health care provider shall make a written record, to be
included with the mental health records requested, noting the date
of the request and explaining the health care provider’s reason for
refusing to permit inspection or provide copies of the records,
including a description of the specific adverse or detrimental
consequences to the patient that the provider anticipates would
occur if inspection or copying were permitted.

(2) (A) The health care provider shall permit inspection by, or
provide copies of the mental health records to, a licensed physician
and surgeon, licensed psychologist, licensed marriage and family
therapist, licensed clinical social worker, or licensed professional
clinical counselor, designated by request of the patient.

(B) Any person registered as a marriage and family therapist
intern, as defined in Chapter 13 (commencing with Section 4980)
of Division 2 of the Business and Professions Code, may not
inspect the patient’s mental health records or obtain copies thereof,
except pursuant to the direction or supervision of a licensed
professional specified in subdivision (g) of Section 4980.03 of the
Business and Professions Code. Prior to providing copies of mental
health records to a registered marriage and family therapist intern,
a receipt for those records shall be signed by the supervising
licensed professional.

(C) Any person registered as a clinical counselor intern, as
defined in Chapter 16 (commencing with Section 4999.10) of
Division 2 of the Business and Professions Code, may not inspect
the patient’s mental health records or obtain copies thereof, except
pursuant to the direction or supervision of a licensed professional
specified in subdivision (h) of Section 4999.12 of the Business
and Professions Code. Prior to providing copies of mental health
records to a person registered as a clinical counselor intern, a
receipt for those records shall be signed by the supervising licensed
professional.

(D) A licensed physician and surgeon, licensed psychologist,
licensed marriage and family therapist, licensed clinical social
worker, licensed professional clinical counselor, registered
marriage and family therapist intern, or person registered as a
clinical counselor intern to whom the records are provided for
inspection or copying shall not permit inspection or copying by
the patient.

(3) The health care provider shall inform the patient of the
provider’s refusal to permit him or her to inspect or obtain copies
of the requested records, and inform the patient of the right to
require the provider to permit inspection by, or provide copies to,
a licensed physician and surgeon, licensed psychologist, licensed
marriage and family therapist, licensed clinical social worker, or
licensed professional clinical counselor designated by written
authorization of the patient.

(4) The health care provider shall indicate in the mental health
records of the patient whether the request was made under
paragraph (2).
SEC. 33. Section 10133.55 of the Insurance Code is amended to read:

10133.55. (a) (1) Except as provided in paragraph (2), every disability insurer covering hospital, medical, and surgical expenses on a group basis that contracts with providers for alternative rates pursuant to Section 10133 and limits payments under those policies to services secured by insureds and subscribers from providers charging alternative rates pursuant to these contracts, shall file with the Department of Insurance, a written policy describing how the insurer shall facilitate the continuity of care for new insureds or enrollees receiving services during a current episode of care for an acute condition from a noncontracting provider. This written policy shall describe the process used to facilitate continuity of care, including the assumption of care by a contracting provider.

(2) On or before July 1, 2002, every disability insurer covering hospital, medical, and surgical expenses on a group basis that contracts with providers for alternative rates pursuant to Section 10133 and limits payments under those policies to services secured by insureds and subscribers from providers charging alternative rates pursuant to these contracts, shall file with the department a written policy describing how the insurer shall facilitate the continuity of care for new enrollees who have been receiving services for an acute, serious, or chronic mental health condition from a nonparticipating mental health provider when the enrollee’s employer has changed policies. Every written policy shall allow the new enrollee a reasonable transition period to continue his or her course of treatment with the nonparticipating mental health provider prior to transferring to another participating provider and shall include the provision of mental health services on a timely, appropriate, and medically necessary basis from the nonparticipating provider. The policy may provide that the length of the transition period take into account the severity of the enrollee’s condition and the amount of time reasonably necessary to effect a safe transfer on a case-by-case basis. Nothing in this paragraph shall be construed to require the insurer to accept a nonparticipating mental health provider onto its panel for treatment of other enrollees. For purposes of the continuing treatment of the transferring enrollee, the insurer may require the nonparticipating mental health provider, as a condition of the right conferred under
this section, to enter into the standard mental health provider contract.

(b) Notice of the policy and information regarding how enrollees may request a review under the policy shall be provided to all new enrollees, except those enrollees who are not eligible as described in subdivision (e). A copy of the written policy shall be provided to eligible enrollees upon request. The written policy required to be filed under subdivision (a) shall describe how requests to continue services with an existing noncontracting provider are reviewed by the insurer. The policy shall ensure that reasonable consideration is given to the potential clinical effect that a change of provider would have on the insured’s or subscriber’s treatment for the acute condition.

(c) An insurer may require any nonparticipating provider whose services are continued pursuant to the written policy to agree in writing to meet the same contractual terms and conditions that are imposed upon the insurer’s participating providers, including location within the service area, reimbursement methodologies, and rates of payment. If the insurer determines that a patient’s health care treatment should temporarily continue with the patient’s existing provider or nonparticipating mental health provider, the insurer shall not be liable for actions resulting solely from the negligence, malpractice, or other tortious or wrongful acts arising out of the provision of services by the existing provider or nonparticipating mental health provider.

(d) Nothing in this section shall require an insurer to cover services or provide benefits that are not otherwise covered under the terms and conditions of the policy contract.

(e) The written policy shall not apply to any insured or subscriber who is offered an out-of-network option, or who had the option to continue with his or her previous health benefits carrier or provider and instead voluntarily chose to change.

(f) This section shall not apply to insurer contracts that include out-of-network coverage under which the insured or subscriber is able to obtain services from the insured’s or subscriber’s existing provider or nonparticipating mental health provider.

(g) (1) For purposes of this section, “provider” refers to a person who is described in subdivision (f) of Section 900 of the Business and Professions Code.
(2) For purposes of this section, “nonparticipating mental health provider” refers to a psychiatrist, licensed psychologist, licensed marriage and family therapist, licensed clinical social worker, or licensed professional clinical counselor who is not part of the insurer’s contracted provider network.

(h) This section shall only apply to a group disability insurance policy if it provides coverage for hospital, medical, or surgical benefits.

SEC. 34. Section 10176 of the Insurance Code is amended to read:

10176. (a) In disability insurance, the policy may provide for payment of medical, surgical, chiropractic, physical therapy, speech pathology, audiology, acupuncture, professional mental health, dental, hospital, or optometric expenses upon a reimbursement basis, or for the exclusion of any of those services, and provision may be made therein for payment of all or a portion of the amount of charge for these services without requiring that the insured first pay the expenses. The policy shall not prohibit the insured from selecting any psychologist or other person who is the holder of a certificate or license under Section 1000, 1634, 2050, 2472, 2553, 2630, 2948, 3055, or 4938 of the Business and Professions Code, to perform the particular services covered under the terms of the policy, the certificate holder or licensee being expressly authorized by law to perform those services.

(b) If the insured selects any person who is a holder of a certificate under Section 4938 of the Business and Professions Code, a disability insurer or nonprofit hospital service plan shall pay the bona fide claim of an acupuncturist holding a certificate pursuant to Section 4938 of the Business and Professions Code for the treatment of an insured person only if the insured’s policy or contract expressly includes acupuncture as a benefit and includes coverage for the injury or illness treated. Unless the policy or contract expressly includes acupuncture as a benefit, no person who is the holder of any license or certificate set forth in this section shall be paid or reimbursed under the policy for acupuncture.

(c) The policy shall not prohibit the insured, upon referral by a physician and surgeon licensed under Section 2050 of the Business and Professions Code, from selecting any licensed clinical social worker who is the holder of a license issued under Section 4996
of the Business and Professions Code, any occupational therapist
as specified in Section 2570.2 of the Business and Professions
Code, any marriage and family therapist who is the holder of a
license under Section 4980.50 of the Business and Professions
Code, or any professional clinical counselor who is the holder of
a license under Chapter 16 (commencing with Section 4999.10)
of Division 2 of the Business and Professions Code, to perform
the particular services covered under the terms of the policy, or
from selecting any speech-language pathologist or audiologist
licensed under Section 2532 of the Business and Professions Code
or any registered nurse licensed pursuant to Chapter 6
(commencing with Section 2700) of Division 2 of the Business
and Professions Code who possesses a master’s degree in
psychiatric-mental health nursing and is listed as a
psychiatric-mental health nurse by the Board of Registered
Nursing, or any advanced practice registered nurse certified as a
clinical nurse specialist pursuant to Article 9 (commencing with
Section 2838) of Chapter 6 of Division 2 of the Business and
Professions Code who participates in expert clinical practice in
the specialty of psychiatric-mental health nursing, or any
respiratory care practitioner certified pursuant to Chapter 8.3
(commencing with Section 3700) of Division 2 of the Business
and Professions Code to perform services deemed necessary by
the referring physician and surgeon, that certificate holder, licensee
or otherwise regulated person, being expressly authorized by law
to perform the services.

(d) Nothing in this section shall be construed to allow any
certificate holder or licensee enumerated in this section to perform
professional mental health services beyond his or her field or fields
of competence as established by his or her education, training, and
experience.

(e) For the purposes of this section:

(1) “Marriage and family therapist” means a licensed marriage
and family therapist who has received specific instruction in
assessment, diagnosis, prognosis, and counseling, and
psychotherapeutic treatment of premarital, marriage, family, and
child relationship dysfunctions, which is equivalent to the
instruction required for licensure on January 1, 1981.

(2) “Professional clinical counselor” means a licensed
professional clinical counselor who has received specific
instruction in assessment, diagnosis, prognosis, counseling, and psychotherapeutic treatment of mental and emotional disorders, which is equivalent to the instruction required for licensure on January 1, 2012.

(f) An individual disability insurance policy, which is issued, renewed, or amended on or after January 1, 1988, which includes mental health services coverage may not include a lifetime waiver for that coverage with respect to any applicant. The lifetime waiver of coverage provision shall be deemed unenforceable.

SEC. 35. Section 10176.7 of the Insurance Code is amended to read:

10176.7. (a) Disability insurance where the insurer is licensed to do business in this state and which provides coverage under a contract of insurance which includes California residents but which may be written or issued for delivery outside of California where benefits are provided within the scope of practice of a licensed clinical social worker, a registered nurse licensed pursuant to Chapter 6 (commencing with Section 2700) of Division 2 of the Business and Professions Code who possesses a master’s degree in psychiatric-mental health nursing and two years of supervised experience in psychiatric-mental health nursing, a marriage and family therapist who is the holder of a license under Section 17805 Chapter 13 (commencing with Section 4980) of Division 2 of the Business and Professions Code, a professional clinical counselor who is the holder of a license under Chapter 16 (commencing with Section 4999.10) of Division 2 of the Business and Professions Code, or a respiratory care practitioner certified pursuant to Chapter 8.3 (commencing with Section 3700) of Division 2 of the Business and Professions Code shall not be deemed to prohibit persons covered under the contract from selecting those licensees in California to perform the services in California that are within the terms of the contract even though the licensees are not licensed in the state where the contract is written or issued for delivery.

(b) It is the intent of the Legislature in amending this section in the 1984 portion of the 1983–84 Legislative Session that persons covered by the insurance and those providers of health care specified in this section who are licensed in California should be entitled to the benefits provided by the insurance for services of those providers rendered to those persons.
SEC. 36. Section 10177 of the Insurance Code is amended to read:

10177. (a) A self-insured employee welfare benefit plan may provide for payment of professional mental health expenses upon a reimbursement basis, or for the exclusion of those services, and provision may be made therein for payment of all or a portion of the amount of charge for those services without requiring that the employee first pay those expenses. The plan shall not prohibit the employee from selecting any psychologist who is the holder of a certificate issued under Section 2948 of the Business and Professions Code or, upon referral by a physician and surgeon licensed under Section 2135 of the Business and Professions Code, any licensed clinical social worker who is the holder of a license issued under Section 4996 of the Business and Professions Code or any marriage and family therapist who is the holder of a certificate or license under Section 4980.50 of the Business and Professions Code, any professional clinical counselor who is the holder of a license under Chapter 16 (commencing with Section 4999.10) of Division 2 of the Business and Professions Code, or any registered nurse licensed pursuant to Chapter 6 (commencing with Section 2700) of Division 2 of the Business and Professions Code, who possesses a master’s degree in psychiatric-mental health nursing and is listed as a psychiatric-mental health nurse by the Board of Registered Nursing or any advanced practice registered nurse certified as a clinical nurse specialist pursuant to Article 9 (commencing with Section 2838) of Chapter 6 of Division 2 of the Business and Professions Code who participates in expert clinical practice in the specialty of psychiatric-mental health nursing, to perform the particular services covered under the terms of the plan, the certificate or license holder being expressly authorized by law to perform these services.

(b) Nothing in this section shall be construed to allow any certificate holder or licensee enumerated in this section to perform professional services beyond his or her field or fields of competence as established by his or her education, training, and experience.

(c) For the purposes of this section:

(1) “Marriage and family therapist” shall mean a licensed marriage and family therapist who has received specific instruction in assessment, diagnosis, prognosis, and counseling, and
psychotherapeutic treatment of premarital, marriage, family, and child relationship dysfunctions, which is equivalent to the
instruction required for licensure on January 1, 1981.

(2) “Professional clinical counselor” means a licensed professional clinical counselor who has received specific instruction in assessment, diagnosis, prognosis, counseling, and psychotherapeutic treatment of mental and emotional disorders, which is equivalent to the instruction required for licensure on January 1, 2012.

(d) A self-insured employee welfare benefit plan, which is issued, renewed, or amended on or after January 1, 1988, that includes mental health services coverage in nongroup contracts may not include a lifetime waiver for that coverage with respect to any employee. The lifetime waiver of coverage provision shall be deemed unenforceable.

SEC. 37. Section 10177.8 of the Insurance Code is amended to read:

10177.8. (a) A self-insured employee welfare benefit plan doing business in this state and providing coverage that includes California residents but that may be written or issued for delivery outside of California where benefits are provided within the scope of practice of a licensed clinical social worker, a registered nurse licensed pursuant to Chapter 6 (commencing with Section 2700) of Division 2 of the Business and Professions Code who possesses a master’s degree in psychiatric-mental health nursing and two years of supervised experience in psychiatric-mental health nursing, a marriage and family therapist who is the holder of a license under Section 17805 Chapter 13 (commencing with Section 4980) of Division 2 of the Business and Professions Code, or a professional clinical counselor who is the holder of a license under Chapter 16 (commencing with Section 4999.10) of Division 2 of the Business and Professions Code, shall not be deemed to prohibit persons covered under the plan from selecting those licensees in California to perform the services in California that are within the terms of the contract even though the licensees are not licensed in the state where the contract is written or issued.

(b) It is the intent of the Legislature in amending this section in the 1984 portion of the 1983–84 Legislative Session that persons covered by the plan and those providers of health care specified in this section who are licensed in California should be entitled to
the benefits provided by the plan for services of those providers
rendered to those persons.

SEC. 38. Section 5068.5 of the Penal Code is amended to read:
5068.5. (a) Notwithstanding any other law, except as provided
in subdivisions (b) and (c), any person employed or under contract
to provide diagnostic, treatment, or other mental health services
in the state or to supervise or provide consultation on these services
in the state correctional system shall be a physician and surgeon,
a psychologist, or other health professional, licensed to practice
in this state.

(b) Notwithstanding Section 5068 or Section 704 of the Welfare
and Institutions Code, the following persons are exempt from the
requirements of subdivision (a), so long as they continue in
employment in the same class and in the same department:

(1) Persons employed on January 1, 1985, as psychologists to
provide diagnostic or treatment services including those persons
on authorized leave but not including intermittent personnel.

(2) Persons employed on January 1, 1989, to supervise or
provide consultation on the diagnostic or treatment services
including persons on authorized leave but not including intermittent
personnel.

(c) (1) The requirements of subdivision (a) may be waived by
the secretary solely for persons in the professions of psychology,
clinical social work, or professional clinical counseling who are
gaining qualifying experience for licensure in those professions
in this state. Providers working in a licensed health care facility
operated by the department must receive a waiver in accordance
with Section 1277 of the Health and Safety Code.

(2) (A) A waiver granted pursuant to this subdivision shall not
exceed three years from the date the employment commences in
this state in the case of psychologists, or four years from
commencement of the employment in this state in the case of
clinical social workers or professional clinical counselors, at which
time licensure shall have been obtained or the employment shall
be terminated, except that an extension of a waiver of licensure
for clinical social workers or professional clinical counselors may
be granted for one additional year, based on extenuating
circumstances determined by the department pursuant to
subdivision (d). For persons employed as psychologists, clinical
social workers, or professional clinical counselors less than full
time, an extension of a waiver of licensure may be granted for additional years proportional to the extent of part-time employment, as long as the person is employed without interruption in service, but in no case shall the waiver of licensure exceed six years in the case of clinical social workers or professional clinical counselors, or five years in the case of psychologists.

(B) The durational limitation upon waivers pursuant to this subdivision shall not apply to any of the following:

(i) Active candidates for a doctoral degree in social work, social welfare, or social science who are enrolled at an accredited university, college, or professional school, but these limitations shall apply following completion of that training.

(ii) Active candidates for a doctoral degree in professional clinical counseling who are enrolled at a school, college, or university, specified in subdivision (b) of Section 4999.32 of, or subdivision (b) of Section 4999.33 of, the Business and Professions Code, but the limitations shall apply following the completion of that training.

(3) A waiver pursuant to this subdivision shall be granted only to the extent necessary to qualify for licensure, except that personnel recruited for employment from outside this state and whose experience is sufficient to gain admission to a licensure examination shall nevertheless have one year from the date of their employment in California to become licensed, at which time licensure shall have been obtained or the employment shall be terminated, provided that the employee shall take the licensure examination at the earliest possible date after the date of his or her employment, and if the employee does not pass the examination at that time, he or she shall have a second opportunity to pass the next possible examination, subject to the one-year limit for clinical social workers and professional clinical counselors, and subject to a two-year limit for psychologists.

(d) The department shall grant a request for an extension of a waiver of licensure for a clinical social worker or professional clinical counselor pursuant to subdivision (c) based on extenuating circumstances if any of the following circumstances exist:

(1) The person requesting the extension has experienced a recent catastrophic event that may impair the person’s ability to qualify for and pass the licensure examination. Those events may include, but are not limited to, significant hardship caused by a natural
disaster; serious and prolonged illness of the person; serious and
prolonged illness or death of a child, spouse, or parent; or other
stressful circumstances.
(2) The person requesting the extension has difficulty speaking
or writing the English language, or other cultural and ethnic factors
exist that substantially impair the person’s ability to qualify for
and pass the license examination.
(3) The person requesting the extension has experienced other
personal hardship that the department, in its discretion, determines
to warrant the extension.
SEC. 39.
SEC. 38. Section 11165.7 of the Penal Code is amended to
read:
11165.7. (a) As used in this article, “mandated reporter” is
defined as any of the following:
(1) A teacher.
(2) An instructional aide.
(3) A teacher’s aide or teacher’s assistant employed by any
public or private school.
(4) A classified employee of any public school.
(5) An administrative officer or supervisor of child welfare and
attendance, or a certificated pupil personnel employee of any public
or private school.
(6) An administrator of a public or private day camp.
(7) An administrator or employee of a public or private youth
center, youth recreation program, or youth organization.
(8) An administrator or employee of a public or private
organization whose duties require direct contact and supervision
of children.
(9) Any employee of a county office of education or the State
Department of Education, whose duties bring the employee into
contact with children on a regular basis.
(10) A licensee, an administrator, or an employee of a licensed
community care or child day care facility.
(11) A Head Start program teacher.
(12) A licensing worker or licensing evaluator employed by a
licensing agency as defined in Section 11165.11.
(13) A public assistance worker.
(14) An employee of a child care institution, including, but not limited to, foster parents, group home personnel, and personnel of residential care facilities.

(15) A social worker, probation officer, or parole officer.

(16) An employee of a school district police or security department.

(17) Any person who is an administrator or presenter of, or a counselor in, a child abuse prevention program in any public or private school.

(18) A district attorney investigator, inspector, or local child support agency caseworker unless the investigator, inspector, or caseworker is working with an attorney appointed pursuant to Section 317 of the Welfare and Institutions Code to represent a minor.

(19) A peace officer, as defined in Chapter 4.5 (commencing with Section 830) of Title 3 of Part 2, who is not otherwise described in this section.

(20) A firefighter, except for volunteer firefighters.

(21) A physician and surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, optometrist, marriage and family therapist, clinical social worker, professional clinical counselor, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.

(22) Any emergency medical technician I or II, paramedic, or other person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code.

(23) A psychological assistant registered pursuant to Section 2913 of the Business and Professions Code.

(24) A marriage and family therapist trainee, as defined in subdivision (c) of Section 4980.03 of the Business and Professions Code.

(25) An unlicensed marriage and family therapist intern registered under Section 4980.44 of the Business and Professions Code.

(26) A state or county public health employee who treats a minor for venereal disease or any other condition.

(27) A coroner.

(28) A medical examiner, or any other person who performs autopsies.
(29) A commercial film and photographic print processor, as specified in subdivision (e) of Section 11166. As used in this article, “commercial film and photographic print processor” means any person who develops exposed photographic film into negatives, slides, or prints, or who makes prints from negatives or slides, for compensation. The term includes any employee of such a person; it does not include a person who develops film or makes prints for a public agency.

(30) A child visitation monitor. As used in this article, “child visitation monitor” means any person who, for financial compensation, acts as monitor of a visit between a child and any other person when the monitoring of that visit has been ordered by a court of law.

(31) An animal control officer or humane society officer. For the purposes of this article, the following terms have the following meanings:

(A) “Animal control officer” means any person employed by a city, county, or city and county for the purpose of enforcing animal control laws or regulations.

(B) “Humane society officer” means any person appointed or employed by a public or private entity as a humane officer who is qualified pursuant to Section 14502 or 14503 of the Corporations Code.

(32) A clergy member, as specified in subdivision (d) of Section 11166. As used in this article, “clergy member” means a priest, minister, rabbi, religious practitioner, or similar functionary of a church, temple, or recognized denomination or organization.

(33) Any custodian of records of a clergy member, as specified in this section and subdivision (d) of Section 11166.

(34) Any employee of any police department, county sheriff’s department, county probation department, or county welfare department.

(35) An employee or volunteer of a Court Appointed Special Advocate program, as defined in Rule 1424 of the California Rules of Court.

(36) A custodial officer as defined in Section 831.5.

(37) Any person providing services to a minor child under Section 12300 or 12300.1 of the Welfare and Institutions Code.

(38) An alcohol and drug counselor. As used in this article, an “alcohol and drug counselor” is a person providing counseling,
therapy, or other clinical services for a state licensed or certified
drug, alcohol, or drug and alcohol treatment program. However,
alcohol or drug abuse, or both alcohol and drug abuse, is not in
and of itself a sufficient basis for reporting child abuse or neglect.

(39) A clinical counselor trainee, as defined in subdivision (g)
of Section 4999.12 of the Business and Professions Code.

(40) A clinical counselor intern registered under Section 4999.42
of the Business and Professions Code.

(b) Except as provided in paragraph (35) of subdivision (a),
volunteers of public or private organizations whose duties require
direct contact with and supervision of children are not mandated
reporters but are encouraged to obtain training in the identification
and reporting of child abuse and neglect and are further encouraged
to report known or suspected instances of child abuse or neglect
to an agency specified in Section 11165.9.

(c) Employers are strongly encouraged to provide their
employees who are mandated reporters with training in the duties
imposed by this article. This training shall include training in child
abuse and neglect identification and training in child abuse and
neglect reporting. Whether or not employers provide their
employees with training in child abuse and neglect identification
and reporting, the employers shall provide their employees who
are mandated reporters with the statement required pursuant to
subdivision (a) of Section 11166.5.

(d) School districts that do not train their employees specified
in subdivision (a) in the duties of mandated reporters under the
child abuse reporting laws shall report to the State Department of
Education the reasons why this training is not provided.

(e) Unless otherwise specifically provided, the absence of
training shall not excuse a mandated reporter from the duties
imposed by this article.

(f) Public and private organizations are encouraged to provide
their volunteers whose duties require direct contact with and
supervision of children with training in the identification and
reporting of child abuse and neglect.

SEC. 40. Section 4514 of the Welfare and Institutions Code is
amended to read:

SEC. 39. Section 4514 of the Welfare and Institutions Code,
as amended by Section 100 of Chapter 178 of the Statutes of 2010,
is amended to read:
4514. All information and records obtained in the course of providing intake, assessment, and services under Division 4.1 (commencing with Section 4400), Division 4.5 (commencing with Section 4500), Division 6 (commencing with Section 6000), or Division 7 (commencing with Section 7100) to persons with developmental disabilities shall be confidential. Information and records obtained in the course of providing similar services to either voluntary or involuntary recipients prior to 1969 shall also be confidential. Information and records shall be disclosed only in any of the following cases:

(a) In communications between qualified professional persons, whether employed by a regional center or state developmental center, or not, in the provision of intake, assessment, and services or appropriate referrals. The consent of the person with a developmental disability, or his or her guardian or conservator, shall be obtained before information or records may be disclosed by regional center or state developmental center personnel to a professional not employed by the regional center or state developmental center, or a program not vended by a regional center or state developmental center.

(b) When the person with a developmental disability, who has the capacity to give informed consent, designates individuals to whom information or records may be released, except that nothing in this chapter shall be construed to compel a physician and surgeon, psychologist, social worker, marriage and family therapist, professional clinical counselor, nurse, attorney, or other professional to reveal information that has been given to him or her in confidence by a family member of the person unless a valid release has been executed by that family member.

(c) To the extent necessary for a claim, or for a claim or application to be made on behalf of a person with a developmental disability for aid, insurance, government benefit, or medical assistance to which he or she may be entitled.

(d) If the person with a developmental disability is a minor, ward, or conservatee, and his or her parent, guardian, conservator, or limited conservator with access to confidential records, designates, in writing, persons to whom records or information may be disclosed, except that nothing in this chapter shall be construed to compel a physician and surgeon, psychologist, social worker, marriage and family therapist, professional clinical
counselor, nurse, attorney, or other professional to reveal 
information that has been given to him or her in confidence by a 
family member of the person unless a valid release has been 
executed by that family member.

(e) For research, provided that the Director of Developmental 
Services designates by regulation rules for the conduct of research 
and requires the research to be first reviewed by the appropriate 
institutional review board or boards. These rules shall include, but 
need not be limited to, the requirement that all researchers shall 
sign an oath of confidentiality as follows:

“ _____________________________________________
                      Date

As a condition of doing research concerning persons with 
developmental disabilities who have received services from ___ 
(fill in the facility, agency or person), I, _____, agree to obtain the 
prior informed consent of persons who have received services to 
the maximum degree possible as determined by the appropriate 
institutional review board or boards for protection of human 
subjects reviewing my research, or the person’s parent, guardian, 
or conservator, and I further agree not to divulge any information 
obtained in the course of the research to unauthorized persons, and 
not to publish or otherwise make public any information regarding 
persons who have received services so those persons who received 
services are identifiable. 

I recognize that the unauthorized release of confidential 
information may make me subject to a civil action under provisions 
of the Welfare and Institutions Code.

_________________________________________”

Signed

(f) To the courts, as necessary to the administration of justice.

(g) To governmental law enforcement agencies as needed for 
the protection of federal and state elective constitutional officers 
and their families.

(h) To the Senate Committee on Rules or the Assembly 
Committee on Rules for the purposes of legislative investigation 
authorized by the committee.
(i) To the courts and designated parties as part of a regional center report or assessment in compliance with a statutory or regulatory requirement, including, but not limited to, Section 1827.5 of the Probate Code, Sections 1001.22 and 1370.1 of the Penal Code, Section 6502 of the Welfare and Institutions Code, and Section 56557 of Title 17 of the California Code of Regulations.

(j) To the attorney for the person with a developmental disability in any and all proceedings upon presentation of a release of information signed by the person, except that when the person lacks the capacity to give informed consent, the regional center or state developmental center director or designee, upon satisfying himself or herself of the identity of the attorney, and of the fact that the attorney represents the person, shall release all information and records relating to the person except that nothing in this article shall be construed to compel a physician and surgeon, psychologist, social worker, marriage and family therapist, professional clinical counselor, nurse, attorney, or other professional to reveal information that has been given to him or her in confidence by a family member of the person unless a valid release has been executed by that family member.

(k) Upon written consent by a person with a developmental disability previously or presently receiving services from a regional center or state developmental center, the director of the regional center or state developmental center, or his or her designee, may release any information, except information that has been given in confidence by members of the family of the person with developmental disabilities, requested by a probation officer charged with the evaluation of the person after his or her conviction of a crime if the regional center or state developmental center director or designee determines that the information is relevant to the evaluation. The consent shall only be operative until sentence is passed on the crime of which the person was convicted. The confidential information released pursuant to this subdivision shall be transmitted to the court separately from the probation report and shall not be placed in the probation report. The confidential information shall remain confidential except for purposes of sentencing. After sentencing, the confidential information shall be sealed.
(l) Between persons who are trained and qualified to serve on “multidisciplinary personnel” teams pursuant to subdivision (d) of Section 18951. The information and records sought to be disclosed shall be relevant to the prevention, identification, management, or treatment of an abused child and his or her parents pursuant to Chapter 11 (commencing with Section 18950) of Part 6 of Division 9.

(m) When a person with a developmental disability dies from any cause, natural or otherwise, while hospitalized in a state developmental center, the State Department of Developmental Services, the physician and surgeon in charge of the client, or the professional in charge of the facility or his or her designee, shall release information and records to the coroner. The State Department of Developmental Services, the physician and surgeon in charge of the client, or the professional in charge of the facility or his or her designee, shall not release any notes, summaries, transcripts, tapes, or records of conversations between the resident and health professional personnel of the hospital relating to the personal life of the resident that is not related to the diagnosis and treatment of the resident’s physical condition. Any information released to the coroner pursuant to this section shall remain confidential and shall be sealed and shall not be made part of the public record.

(n) To authorized licensing personnel who are employed by, or who are authorized representatives of, the State Department of Health Services, and who are licensed or registered health professionals, and to authorized legal staff or special investigators who are peace officers who are employed by, or who are authorized representatives of, the State Department of Social Services, as necessary to the performance of their duties to inspect, license, and investigate health facilities and community care facilities, and to ensure that the standards of care and services provided in these facilities are adequate and appropriate and to ascertain compliance with the rules and regulations to which the facility is subject. The confidential information shall remain confidential except for purposes of inspection, licensing, or investigation pursuant to Chapter 2 (commencing with Section 1250) and Chapter 3 (commencing with Section 1500) of Division 2 of the Health and Safety Code, or a criminal, civil, or administrative proceeding in relation thereto. The confidential information may be used by the
State Department of Health Services or the State Department of Social Services in a criminal, civil, or administrative proceeding. The confidential information shall be available only to the judge or hearing officer and to the parties to the case. Names which are confidential shall be listed in attachments separate to the general pleadings. The confidential information shall be sealed after the conclusion of the criminal, civil, or administrative hearings, and shall not subsequently be released except in accordance with this subdivision. If the confidential information does not result in a criminal, civil, or administrative proceeding, it shall be sealed after the State Department of Health Services or the State Department of Social Services decides that no further action will be taken in the matter of suspected licensing violations. Except as otherwise provided in this subdivision, confidential information in the possession of the State Department of Health Services or the State Department of Social Services shall not contain the name of the person with a developmental disability.

(o) To any board which licenses and certifies professionals in the fields of mental health and developmental disabilities pursuant to state law, when the Director of Developmental Services has reasonable cause to believe that there has occurred a violation of any provision of law subject to the jurisdiction of a board and the records are relevant to the violation. The information shall be sealed after a decision is reached in the matter of the suspected violation, and shall not subsequently be released except in accordance with this subdivision. Confidential information in the possession of the board shall not contain the name of the person with a developmental disability.

(p) To governmental law enforcement agencies by the director of a regional center or state developmental center, or his or her designee, when (1) the person with a developmental disability has been reported lost or missing or (2) there is probable cause to believe that a person with a developmental disability has committed, or has been the victim of, murder, manslaughter, mayhem, aggravated mayhem, kidnapping, robbery, carjacking, assault with the intent to commit a felony, arson, extortion, rape, forcible sodomy, forcible oral copulation, assault or battery, or unlawful possession of a weapon, as provided in any provision listed in Section 16590 of the Penal Code.
This subdivision shall be limited solely to information directly relating to the factual circumstances of the commission of the enumerated offenses and shall not include any information relating to the mental state of the patient or the circumstances of his or her treatment unless relevant to the crime involved. This subdivision shall not be construed as an exception to, or in any other way affecting, the provisions of Article 7 (commencing with Section 1010) of Chapter 4 of Division 8 of the Evidence Code, or Chapter 11 (commencing with Section 15600) and Chapter 13 (commencing with Section 15750) of Part 3 of Division 9.

(q) To the Division of Juvenile Facilities and Department of Corrections and Rehabilitation or any component thereof, as necessary to the administration of justice.

(r) To an agency mandated to investigate a report of abuse filed pursuant to either Section 11164 of the Penal Code or Section 15630 of the Welfare and Institutions Code for the purposes of either a mandated or voluntary report or when those agencies request information in the course of conducting their investigation.

(s) When a person with developmental disabilities, or the parent, guardian, or conservator of a person with developmental disabilities who lacks capacity to consent, fails to grant or deny a request by a regional center or state developmental center to release information or records relating to the person with developmental disabilities within a reasonable period of time, the director of the regional or developmental center, or his or her designee, may release information or records on behalf of that person provided both of the following conditions are met:

1. Release of the information or records is deemed necessary to protect the person’s health, safety, or welfare.
2. The person, or the person’s parent, guardian, or conservator, has been advised annually in writing of the policy of the regional center or state developmental center for release of confidential client information or records when the person with developmental disabilities, or the person’s parent, guardian, or conservator, fails to respond to a request for release of the information or records within a reasonable period of time. A statement of policy contained in the client’s individual program plan shall be deemed to comply with the notice requirement of this paragraph.
(t) (1) When an employee is served with a notice of adverse action, as defined in Section 19570 of the Government Code, the following information and records may be released:

(A) All information and records that the appointing authority relied upon in issuing the notice of adverse action.

(B) All other information and records that are relevant to the adverse action, or that would constitute relevant evidence as defined in Section 210 of the Evidence Code.

(C) The information described in subparagraphs (A) and (B) may be released only if both of the following conditions are met:

(i) The appointing authority has provided written notice to the consumer and the consumer’s legal representative or, if the consumer has no legal representative or if the legal representative is a state agency, to the clients’ rights advocate, and the consumer, the consumer’s legal representative, or the clients’ rights advocate has not objected in writing to the appointing authority within five business days of receipt of the notice, or the appointing authority, upon review of the objection has determined that the circumstances on which the adverse action is based are egregious or threaten the health, safety, or life of the consumer or other consumers and without the information the adverse action could not be taken.

(ii) The appointing authority, the person against whom the adverse action has been taken, and the person’s representative, if any, have entered into a stipulation that does all of the following:

(I) Prohibits the parties from disclosing or using the information or records for any purpose other than the proceedings for which the information or records were requested or provided.

(II) Requires the employee and the employee’s legal representative to return to the appointing authority all records provided to them under this subdivision, including, but not limited to, all records and documents or copies thereof that are no longer in the possession of the employee or the employee’s legal representative because they were from any source containing confidential information protected by this section, and all copies of those records and documents, within 10 days of the date that the adverse action becomes final except for the actual records and documents submitted to the administrative tribunal as a component of an appeal from the adverse action.
(III) Requires the parties to submit the stipulation to the administrative tribunal with jurisdiction over the adverse action at the earliest possible opportunity.

(2) For the purposes of this subdivision, the State Personnel Board may, prior to any appeal from adverse action being filed with it, issue a protective order, upon application by the appointing authority, for the limited purpose of prohibiting the parties from disclosing or using information or records for any purpose other than the proceeding for which the information or records were requested or provided, and to require the employee or the employee's legal representative to return to the appointing authority all records provided to them under this subdivision, including, but not limited to, all records and documents from any source containing confidential information protected by this section, and all copies of those records and documents, within 10 days of the date that the adverse action becomes final, except for the actual records and documents that are no longer in the possession of the employee or the employee's legal representatives because they were submitted to the administrative tribunal as a component of an appeal from the adverse action.

(3) Individual identifiers, including, but not limited to, names, social security numbers, and hospital numbers, that are not necessary for the prosecution or defense of the adverse action, shall not be disclosed.

(4) All records, documents, or other materials containing confidential information protected by this section that have been submitted or otherwise disclosed to the administrative agency or other person as a component of an appeal from an adverse action shall, upon proper motion by the appointing authority to the administrative tribunal, be placed under administrative seal and shall not, thereafter, be subject to disclosure to any person or entity except upon the issuance of an order of a court of competent jurisdiction.

(5) For purposes of this subdivision, an adverse action becomes final when the employee fails to answer within the time specified in Section 19575 of the Government Code, or, after filing an answer, withdraws the appeal, or, upon exhaustion of the administrative appeal or of the judicial review remedies as otherwise provided by law.
SEC. 41.

SEC. 40. Section 5256.1 of the Welfare and Institutions Code is amended to read:

5256.1. The certification review hearing shall be conducted by either a court-appointed commissioner or a referee, or a certification review hearing officer. The certification review hearing officer shall be either a state qualified administrative law hearing officer, a physician and surgeon, a licensed psychologist, a registered nurse, a lawyer, a certified law student, a licensed clinical social worker, a licensed marriage and family therapist, or a licensed professional clinical counselor. Licensed psychologists, licensed clinical social workers, licensed marriage and family therapists, licensed professional clinical counselors, and registered nurses who serve as certification review hearing officers shall have had a minimum of five years’ experience in mental health. Certification review hearing officers shall be selected from a list of eligible persons unanimously approved by a panel composed of the local mental health director, the county public defender, and the county counsel or district attorney designated by the county board of supervisors. No employee of the county mental health program or of any facility designated by the county and approved by the State Department of Mental Health as a facility for 72-hour treatment and evaluation may serve as a certification review hearing officer.

The location of the certification review hearing shall be compatible with, and least disruptive of, the treatment being provided to the person certified. In addition, hearings conducted by certification review hearing officers shall be conducted at an appropriate place at the facility where the person certified is receiving treatment.

SEC. 42.

SEC. 41. Section 5328 of the Welfare and Institutions Code is amended to read:

5328. All information and records obtained in the course of providing services under Division 4 (commencing with Section 4000), Division 4.1 (commencing with Section 4400), Division 4.5 (commencing with Section 4500), Division 5 (commencing with Section 5000), Division 6 (commencing with Section 6000), or Division 7 (commencing with Section 7100), to either voluntary or involuntary recipients of services shall be confidential.
Information and records obtained in the course of providing similar services to either voluntary or involuntary recipients prior to 1969 shall also be confidential. Information and records shall be disclosed only in any of the following cases:

(a) In communications between qualified professional persons in the provision of services or appropriate referrals, or in the course of conservatorship proceedings. The consent of the patient, or his or her guardian or conservator, shall be obtained before information or records may be disclosed by a professional person employed by a facility to a professional person not employed by the facility who does not have the medical or psychological responsibility for the patient’s care.

(b) When the patient, with the approval of the physician and surgeon, licensed psychologist, social worker with a master’s degree in social work, licensed marriage and family therapist, or licensed professional clinical counselor who is in charge of the patient, designates persons to whom information or records may be released, except that nothing in this article shall be construed to compel a physician and surgeon, licensed psychologist, social worker with a master’s degree in social work, licensed marriage and family therapist, licensed professional clinical counselor, nurse, attorney, or other professional person to reveal information that has been given to him or her in confidence by members of a patient’s family. Nothing in this subdivision shall be construed to authorize a licensed marriage and family therapist or a licensed professional clinical counselor to provide services or to be in charge of a patient’s care beyond his or her lawful scope of practice.

(c) To the extent necessary for a recipient to make a claim, or for a claim to be made on behalf of a recipient for aid, insurance, or medical assistance to which he or she may be entitled.

(d) If the recipient of services is a minor, ward, or conservatee, and his or her parent, guardian, guardian ad litem, or conservator designates, in writing, persons to whom records or information may be disclosed, except that nothing in this article shall be construed to compel a physician and surgeon, licensed psychologist, social worker with a master’s degree in social work, licensed marriage and family therapist, licensed professional clinical counselor, nurse, attorney, or other professional person to reveal information that has been given to him or her in confidence by members of a patient’s family.
(e) For research, provided that the Director of Mental Health or the Director of Developmental Services designates by regulation, rules for the conduct of research and requires the research to be first reviewed by the appropriate institutional review board or boards. The rules shall include, but need not be limited to, the requirement that all researchers shall sign an oath of confidentiality as follows:

________________________________________

Date

As a condition of doing research concerning persons who have received services from ____ (fill in the facility, agency or person), I, ____, agree to obtain the prior informed consent of such persons who have received services to the maximum degree possible as determined by the appropriate institutional review board or boards for protection of human subjects reviewing my research, and I further agree not to divulge any information obtained in the course of such research to unauthorized persons, and not to publish or otherwise make public any information regarding persons who have received services such that the person who received services is identifiable.

I recognize that the unauthorized release of confidential information may make me subject to a civil action under provisions of the Welfare and Institutions Code.

(f) To the courts, as necessary to the administration of justice.

(g) To governmental law enforcement agencies as needed for the protection of federal and state elective constitutional officers and their families.

(h) To the Senate Committee on Rules or the Assembly Committee on Rules for the purposes of legislative investigation authorized by the committee.

(i) If the recipient of services who applies for life or disability insurance designates in writing the insurer to which records or information may be disclosed.

(j) To the attorney for the patient in any and all proceedings upon presentation of a release of information signed by the patient, except that when the patient is unable to sign the release, the staff of the facility, upon satisfying itself of the identity of the attorney, and of the fact that the attorney does represent the interests of the
patient, may release all information and records relating to the
patient except that nothing in this article shall be construed to
compel a physician and surgeon, licensed psychologist, social
worker with a master’s degree in social work, licensed marriage
and family therapist, licensed professional clinical counselor, nurse,
attorney, or other professional person to reveal information that
has been given to him or her in confidence by members of a
patient’s family.

(k) Upon written agreement by a person previously confined in
or otherwise treated by a facility, the professional person in charge
of the facility or his or her designee may release any information,
except information that has been given in confidence by members
of the person’s family, requested by a probation officer charged
with the evaluation of the person after his or her conviction of a
crime if the professional person in charge of the facility determines
that the information is relevant to the evaluation. The agreement
shall only be operative until sentence is passed on the crime of
which the person was convicted. The confidential information
released pursuant to this subdivision shall be transmitted to the
court separately from the probation report and shall not be placed
in the probation report. The confidential information shall remain
confidential except for purposes of sentencing. After sentencing,
the confidential information shall be sealed.

(l) (1) Between persons who are trained and qualified to serve
on multidisciplinary personnel teams pursuant to subdivision (d)
of Section 18951. The information and records sought to be
disclosed shall be relevant to the provision of child welfare services
or the investigation, prevention, identification, management, or
treatment of child abuse or neglect pursuant to Chapter 11
(commencing with Section 18950) of Part 6 of Division 9.
Information obtained pursuant to this subdivision shall not be used
in any criminal or delinquency proceeding. Nothing in this
subdivision shall prohibit evidence identical to that contained
within the records from being admissible in a criminal or
delinquency proceeding, if the evidence is derived solely from
means other than this subdivision, as permitted by law.

(2) As used in this subdivision, “child welfare services” means
those services that are directed at preventing child abuse or neglect.

(m) To county patients’ rights advocates who have been given
knowing voluntary authorization by a client or a guardian ad litem.
The client or guardian ad litem, whoever entered into the agreement, may revoke the authorization at any time, either in writing or by oral declaration to an approved advocate.

(n) To a committee established in compliance with Section 4070.

(o) In providing information as described in Section 7325.5. Nothing in this subdivision shall permit the release of any information other than that described in Section 7325.5.

(p) To the county mental health director or the director’s designee, or to a law enforcement officer, or to the person designated by a law enforcement agency, pursuant to Sections 5152.1 and 5250.1.

(q) If the patient gives his or her consent, information specifically pertaining to the existence of genetically handicapping conditions, as defined in Section 125135 of the Health and Safety Code, may be released to qualified professional persons for purposes of genetic counseling for blood relatives upon request of the blood relative. For purposes of this subdivision, “qualified professional persons” means those persons with the qualifications necessary to carry out the genetic counseling duties under this subdivision as determined by the genetic disease unit established in the State Department of Health Care Services under Section 125000 of the Health and Safety Code. If the patient does not respond or cannot respond to a request for permission to release information pursuant to this subdivision after reasonable attempts have been made over a two-week period to get a response, the information may be released upon request of the blood relative.

(r) When the patient, in the opinion of his or her psychotherapist, presents a serious danger of violence to a reasonably foreseeable victim or victims, then any of the information or records specified in this section may be released to that person or persons and to law enforcement agencies and county child welfare agencies as the psychotherapist determines is needed for the protection of that person or persons. For purposes of this subdivision, “psychotherapist” means anyone so defined within Section 1010 of the Evidence Code.

(s) (1) To the designated officer of an emergency response employee, and from that designated officer to an emergency response employee regarding possible exposure to HIV or AIDS, but only to the extent necessary to comply with provisions of the

(2) For purposes of this subdivision, “designated officer” and “emergency response employee” have the same meaning as these terms are used in the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (Public Law 101-381; 42 U.S.C. Sec. 201).

(3) The designated officer shall be subject to the confidentiality requirements specified in Section 120980, and may be personally liable for unauthorized release of any identifying information about the HIV results. Further, the designated officer shall inform the exposed emergency response employee that the employee is also subject to the confidentiality requirements specified in Section 120980, and may be personally liable for unauthorized release of any identifying information about the HIV test results.

(t) (1) To a law enforcement officer who personally lodges with a facility, as defined in paragraph (2), a warrant of arrest or an abstract of such a warrant showing that the person sought is wanted for a serious felony, as defined in Section 1192.7 of the Penal Code, or a violent felony, as defined in Section 667.5 of the Penal Code. The information sought and released shall be limited to whether or not the person named in the arrest warrant is presently confined in the facility. This paragraph shall be implemented with minimum disruption to health facility operations and patients, in accordance with Section 5212. If the law enforcement officer is informed that the person named in the warrant is confined in the facility, the officer may not enter the facility to arrest the person without obtaining a valid search warrant or the permission of staff of the facility.

(2) For purposes of paragraph (1), a facility means all of the following:

(A) A state hospital, as defined in Section 4001.
(B) A general acute care hospital, as defined in subdivision (a) of Section 1250 of the Health and Safety Code, solely with regard to information pertaining to a mentally disordered person subject to this section.
(C) An acute psychiatric hospital, as defined in subdivision (b) of Section 1250 of the Health and Safety Code.
(D) A psychiatric health facility, as described in Section 1250.2 of the Health and Safety Code.
(E) A mental health rehabilitation center, as described in Section 5675.

(F) A skilled nursing facility with a special treatment program for chronically mentally disordered patients, as described in Sections 51335 and 72445 to 72475, inclusive, of Title 22 of the California Code of Regulations.

(u) Between persons who are trained and qualified to serve on multidisciplinary personnel teams pursuant to Section 15610.55, 15753.5, or 15761. The information and records sought to be disclosed shall be relevant to the prevention, identification, management, or treatment of an abused elder or dependent adult pursuant to Chapter 13 (commencing with Section 15750) of Part 3 of Division 9.

(v) The amendment of subdivision (d) enacted at the 1970 Regular Session of the Legislature does not constitute a change in, but is declaratory of, the preexisting law.

(w) This section shall not be limited by Section 5150.05 or 5332.

(x) (1) When an employee is served with a notice of adverse action, as defined in Section 19570 of the Government Code, the following information and records may be released:

(A) All information and records that the appointing authority relied upon in issuing the notice of adverse action.

(B) All other information and records that are relevant to the adverse action, or that would constitute relevant evidence as defined in Section 210 of the Evidence Code.

(C) The information described in subparagraphs (A) and (B) may be released only if both of the following conditions are met:

(i) The appointing authority has provided written notice to the consumer and the consumer’s legal representative or, if the consumer has no legal representative or if the legal representative is a state agency, to the clients’ rights advocate, and the consumer, the consumer’s legal representative, or the clients’ rights advocate has not objected in writing to the appointing authority within five business days of receipt of the notice, or the appointing authority, upon review of the objection has determined that the circumstances on which the adverse action is based are egregious or threaten the health, safety, or life of the consumer or other consumers and without the information the adverse action could not be taken.
(ii) The appointing authority, the person against whom the adverse action has been taken, and the person’s representative, if any, have entered into a stipulation that does all of the following:

(I) Prohibits the parties from disclosing or using the information or records for any purpose other than the proceedings for which the information or records were requested or provided.

(II) Requires the employee and the employee’s legal representative to return to the appointing authority all records provided to them under this subdivision, including, but not limited to, all records and documents from any source containing confidential information protected by this section, and all copies of those records and documents, within 10 days of the date that the adverse action becomes final except for the actual records and documents or copies thereof that are no longer in the possession of the employee or the employee’s legal representative because they were submitted to the administrative tribunal as a component of an appeal from the adverse action.

(III) Requires the parties to submit the stipulation to the administrative tribunal with jurisdiction over the adverse action at the earliest possible opportunity.

(2) For the purposes of this subdivision, the State Personnel Board may, prior to any appeal from adverse action being filed with it, issue a protective order, upon application by the appointing authority, for the limited purpose of prohibiting the parties from disclosing or using information or records for any purpose other than the proceeding for which the information or records were requested or provided, and to require the employee or the employee’s legal representative to return to the appointing authority all records provided to them under this subdivision, including, but not limited to, all records and documents from any source containing confidential information protected by this section, and all copies of those records and documents, within 10 days of the date that the adverse action becomes final, except for the actual records and documents or copies thereof that are no longer in the possession of the employee or the employee’s legal representatives because they were submitted to the administrative tribunal as a component of an appeal from the adverse action.

(3) Individual identifiers, including, but not limited to, names, social security numbers, and hospital numbers, that are not
necessary for the prosecution or defense of the adverse action, shall not be disclosed.

(4) All records, documents, or other materials containing confidential information protected by this section that have been submitted or otherwise disclosed to the administrative agency or other person as a component of an appeal from an adverse action shall, upon proper motion by the appointing authority to the administrative tribunal, be placed under administrative seal and shall not, thereafter, be subject to disclosure to any person or entity except upon the issuance of an order of a court of competent jurisdiction.

(5) For purposes of this subdivision, an adverse action becomes final when the employee fails to answer within the time specified in Section 19575 of the Government Code, or, after filing an answer, withdraws the appeal, or, upon exhaustion of the administrative appeal or of the judicial review remedies as otherwise provided by law.

SEC. 42. Section 5328.04 of the Welfare and Institutions Code is amended to read:

5328.04. (a) Notwithstanding Section 5328, information and records made confidential under that section may be disclosed to a county social worker, a probation officer, or any other person who is legally authorized to have custody or care of a minor, for the purpose of coordinating health care services and medical treatment, as defined in subdivision (b) of Section 56.103 of the Civil Code, mental health services, or services for developmental disabilities, for the minor.

(b) Information disclosed under subdivision (a) shall not be further disclosed by the recipient unless the disclosure is for the purpose of coordinating health care services and medical treatment, or mental health or developmental disability services, for the minor and only to a person who would otherwise be able to obtain the information under subdivision (a) or any other provision of law.

(c) Information disclosed pursuant to this section shall not be admitted into evidence in any criminal or delinquency proceeding against the minor. Nothing in this subdivision shall prohibit identical evidence from being admissible in a criminal proceeding if that evidence is derived solely from lawful means other than this section and is permitted by law.
(d) Nothing in this section shall be construed to compel a physician and surgeon, licensed psychologist, social worker with a master's degree in social work, licensed marriage and family therapist, licensed professional clinical counselor, nurse, attorney, or other professional person to reveal information, including notes, that has been given to him or her in confidence by the minor or members of the minor's family.

(e) The disclosure of information pursuant to this section is not intended to limit disclosure of information when that disclosure is otherwise required by law.

(f) Nothing in this section shall be construed to expand the authority of a social worker, probation officer, or custodial caregiver beyond the authority provided under existing law to a parent or a patient representative regarding access to confidential information.

(g) As used in this section, “minor” means a minor taken into temporary custody or for whom a petition has been filed with the court, or who has been adjudged a dependent child or ward of juvenile court pursuant to Section 300 or 601.

(h) Information and records that may be disclosed pursuant to this section do not include psychotherapy notes, as defined in Section 164.501 of Title 45 of the Code of Federal Regulations.

SEC. 44.
SEC. 43. Section 5696.5 of the Welfare and Institutions Code is amended to read:

5696.5. Prior to the opening of a facility, the board of directors shall establish written program standards and policies and procedures, approved by the Division of Juvenile Facilities that address and include, but are not limited to, the following:

(a) A staffing number and pattern that meets the special behavior, supervision, treatment, health, and educational needs of the population described in this chapter. Staff shall be qualified to provide intensive treatment and services and shall include, at a minimum:

(1) A project or clinical director, a psychiatrist or psychologist, a social worker, a registered nurse, and a recreation or occupational therapist.

(2) A pediatrician, and a dentist, and a licensed marriage and family therapist, and or a licensed professional clinical counselor, or both of those professionals, on an as-needed basis.
(3) Educational staff in sufficient number and with the qualifications needed to meet the population served.

(4) Child care staff in sufficient numbers and with the qualifications needed to meet the special needs of the population.

(b) Programming to meet the needs of all wards admitted, including, but not limited to, all of the following:

(1) Physical examinations on admission and ongoing health care.

(2) Appropriate and closely monitored use of all behavioral management techniques.

(3) The establishment of written, individual treatment and educational plans and goals for each ward within 10 days of admission and which are updated at least quarterly.

(4) Written discharge planning that addresses each ward’s continued treatment, educational, and supervision needs.

(5) Regular, written progress records regarding the care and treatment of each ward.

(6) Regular and structured treatment of all wards, including, but not limited to, individual, group and family therapy, psychological testing, medication, and occupational, or recreational therapy.

(7) Access to neurological testing and laboratory work as needed.

(8) The opportunity for regular family contact and involvement.

(9) A periodic review of the continued need for treatment within the facility.

(10) Educational programming, including special education as needed.

SEC. 45.

SEC. 44. Section 5751 of the Welfare and Institutions Code is amended to read:

5751. (a) Regulations pertaining to the qualifications of directors of local mental health services shall be administered in accordance with Section 5607. These standards may include the maintenance of records of service which shall be reported to the State Department of Mental Health in a manner and at times as it may specify.

(b) Regulations pertaining to the position of director of local mental health services, where the local director is other than the local health officer or medical administrator of the county hospitals,
shall require that the director be a psychiatrist, psychologist, clinical social worker, marriage and family therapist, professional clinical counselor, registered nurse, or hospital administrator, who meets standards of education and experience established by the Director of Mental Health. Where the director is not a psychiatrist, the program shall have a psychiatrist licensed to practice medicine in this state and who shall provide to patients medical care and services as authorized by Section 2051 of the Business and Professions Code.

(c) The regulations shall be adopted in accordance with the Administrative Procedure Act, Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 46.

SEC. 45. Section 5751.2 of the Welfare and Institutions Code is amended to read:

5751.2. (a) Except as provided in this section, persons employed or under contract to provide mental health services pursuant to this part shall be subject to all applicable requirements of law regarding professional licensure, and no person shall be employed in local mental health programs pursuant to this part to provide services for which a license is required, unless the person possesses a valid license.

(b) Persons employed as psychologists and clinical social workers, while continuing in their employment in the same class as of January 1, 1979, in the same program or facility, including those persons on authorized leave, but not including intermittent personnel, shall be exempt from the requirements of subdivision (a).

(c) While registered with the licensing board of jurisdiction for the purpose of acquiring the experience required for licensure, persons employed or under contract to provide mental health services pursuant to this part as clinical social workers, marriage and family therapists, or professional clinical counselors shall be exempt from subdivision (a). Registration shall be subject to regulations adopted by the appropriate licensing board.

(d) The requirements of subdivision (a) shall be waived by the department for persons employed or under contract to provide mental health services pursuant to this part as psychologists who are gaining the experience required for licensure. A waiver granted
under this subdivision may not exceed five years from the date of
employment by, or contract with, a local mental health program
for persons in the profession of psychology.
(e) The requirements of subdivision (a) shall be waived by the
department for persons who have been recruited for employment
from outside this state as psychologists, clinical social workers,
marrige and family therapists, or professional clinical counselors
and whose experience is sufficient to gain admission to a licensing
examination. A waiver granted under this subdivision may not
exceed three years from the date of employment by, or contract
with, a local mental health program for persons in these three
professions who are recruited from outside this state.

SEC. 47.
SEC. 46. Section 15610.37 of the Welfare and Institutions
Code is amended to read:
15610.37. “Health practitioner” means a physician and surgeon,
psychiatrist, psychologist, dentist, resident, intern, podiatrist,
chiropractor, licensed social worker or associate clinical social worker, marriage and
family therapist, licensed professional clinical counselor, or any
other person who is currently licensed under Division 2
(commencing with Section 500) of the Business and Professions
Code, any emergency medical technician I or II, paramedic, or
person certified pursuant to Division 2.5 (commencing with Section
1797) of the Health and Safety Code, a psychological assistant
registered pursuant to Section 2913 of the Business and Professions
Code, a marriage and family therapist trainee, as defined in
subdivision (c) of Section 4980.03 of the Business and Professions
Code, an unlicensed marriage and family therapist intern registered
under Section 4980.44 of the Business and Professions Code, a
clinical counselor trainee, as defined in subdivision (g) of Section
4999.12 of the Business and Professions Code, a clinical counselor
intern registered under Section 4999.42 of the Business and
Professions Code, a state or county public health or social service
employee who treats an elder or a dependent adult for any
condition, or a coroner.

SEC. 48.
SEC. 47. No reimbursement is required by this act pursuant to
Section 6 of Article XIII B of the California Constitution because
the only costs that may be incurred by a local agency or school
district will be incurred because this act creates a new crime or
infraction, eliminates a crime or infraction, or changes the penalty
for a crime or infraction, within the meaning of Section 17556 of
the Government Code, or changes the definition of a crime within
the meaning of Section 6 of Article XIII B of the California
Constitution.
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
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.

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

1. SECTION 1. Section 15658 of the Welfare and Institutions Code is amended to read:

   (a) (1) The written abuse reports required for the reporting of abuse, as defined in this chapter, shall be submitted on forms adopted by the State Department of Social Services after consultation with representatives of the various law enforcement agencies, the California Department of Aging, the State Department of Developmental Services, the State Department of Mental Health, the bureau, professional medical and nursing agencies, hospital
associations, and county welfare departments. These reporting forms shall be distributed by the county adult protective services agencies and the long-term care ombudsman programs. This reporting form may also be used for documenting the telephone report of a known or suspected instance of abuse of an elder or dependent adult by the county adult protective services agency, local ombudsman program, and local law enforcement agencies.

(2) The forms required by this section shall contain the following items:

(A) The name, address, telephone number, and occupation of the person reporting.
(B) The name and address of the victim.
(C) The date, time, and place of the incident.
(D) Other details, including the reporter’s observations and beliefs concerning the incident.
(E) Any statement relating to the incident made by the victim.
(F) The name of any individuals believed to have knowledge of the incident.
(G) The name of the individuals believed to be responsible for the incident and their connection to the victim.

(b) (1) Each county adult protective services agency shall report to the State Department of Social Services monthly on the reports received pursuant to this chapter. The reports shall be made on forms adopted by the department. The information reported shall include, but shall not be limited to, the number of incidents of abuse, the number of persons abused, the type of abuse sustained, and the actions taken on the reports. For purposes of these reports, sexual abuse shall be reported separately from physical abuse.

(2) The county’s report to the department shall not include reports it receives from the long-term care ombudsman program pursuant to subdivision (c).

(3) The department shall refer to the bureau monthly data summaries of the reports of elder and dependent adult abuse, neglect, abandonment, isolation, and financial abuse, and other abuse it receives from county adult protective services agencies.

(c) Each long-term care ombudsman program shall report to the office of the Long-Term Care Ombudsman of the California Department of Aging monthly on the reports it receives pursuant to this chapter **with and shall send** a copy sent to the county adult protective services agency. The office of the state ombudsman
shall submit a summarized quarterly report to the department based on the monthly reports submitted by local long-term care ombudsman programs. The reports shall be on forms adopted by the department and the office of the state ombudsman. The information reported shall include, but shall not be limited to, the number of incidents of abuse, the numbers of persons abused, the type of abuse, and the actions taken on the reports. For purposes of these reports, sexual abuse shall be reported separately from physical abuse.

(d) Reports required pursuant to this chapter may be submitted to a county adult protective services agency through a confidential Internet reporting tool, if the county chooses to implement such a system, so long as the information gathered meets the requirements of subdivision (a).
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.
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 include, but are 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

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

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 reiterates 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
SENATE BILL No. 747

Introduced by Senator Kehoe

February 18, 2011

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.


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

SECTION 1. Section 2190.1 of the Business and Professions Code is amended to read:

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2190.1. (a) The continuing medical education standards of Section 2190 may be met by educational activities that meet the standards of the Division of Licensing board and serve to maintain, develop, or increase the knowledge, skills, and professional performance that a physician and surgeon uses to provide care, or improve the quality of care provided for patients, including, but not limited to, educational activities that meet any of the following criteria:

1. Have a scientific or clinical content with a direct bearing on the quality or cost-effective provision of patient care, community or public health, or preventive medicine.
2. Concern quality assurance or improvement, risk management, health facility standards, or the legal aspects of clinical medicine.
3. Concern bioethics or professional ethics.
4. Are designed to improve the physician-patient relationship.

(b) (1) On and after July 1, 2006, all continuing medical education courses shall contain curriculum that includes cultural and linguistic competency in the practice of medicine.
(2) Notwithstanding the provisions of paragraph (1), a continuing medical education course dedicated solely to research or other issues that does not include a direct patient care component and a course offered by a continuing medical education provider that is not located in this state are not required to contain curriculum that includes cultural and linguistic competency in the practice of medicine.
(3) Associations that accredit continuing medical education courses shall develop standards before July 1, 2006, for compliance with the requirements of paragraph (1). The associations may develop these standards in conjunction with an advisory group that has expertise in cultural and linguistic competency issues.
(4) A physician and surgeon who completes a continuing education course meeting the standards developed pursuant to paragraph (3) satisfies the continuing education requirement for cultural and linguistic competency.

(c) In order to satisfy the requirements of subdivision (b), continuing medical education courses shall address at least one or a combination of the following:

1. Cultural competency. For the purposes of this section, “cultural competency” means a set of integrated attitudes,
knowledge, and skills that enables a health care professional or organization to care effectively for patients from diverse cultures, groups, and communities. At a minimum, cultural competency is recommended to include the following:

(A) Applying linguistic skills to communicate effectively with the target population.

(B) Utilizing cultural information to establish therapeutic relationships.

(C) Eliciting and incorporating pertinent cultural data in diagnosis and treatment.

(D) Understanding and applying cultural and ethnic data to the process of clinical care.

(2) Linguistic competency. For the purposes of this section, “linguistic competency” means the ability of a physician and surgeon to provide patients who do not speak English or who have limited ability to speak English, direct communication in the patient’s primary language.

(3) A review and explanation of relevant federal and state laws and regulations regarding linguistic access, including, but not limited to, the federal Civil Rights Act (42 U.S.C. Sec. 1981, et seq.), Executive Order 13166 of August 11, 2000, of the President of the United States, and the Dymally-Alatorre Bilingual Services Act (Chapter 17.5 (commencing with Section 7290) of Division 7 of Title 1 of the Government Code).

(d) On and after January 1, 2012, the board shall require all of its licensees to take at least one continuing education course that provides instruction on cultural competency, sensitivity, and best practices for providing adequate care to lesbian, gay, bisexual, and transgender persons. Persons licensed by the board before January 1, 2016, persons who are newly licensed by the board on and after January 1, 2012, shall complete the course within four years of their initial license issuance date or their second license renewal date, whichever occurs first. The course shall be between two and five hours in duration and shall contain content similar to the content described in the publication of the Gay and Lesbian Medical Association entitled “Guidelines for Care of Lesbian, Gay, Bisexual and Transgender Patients.” The board may specify the required contents of the course by regulation consistent with this subdivision. The board shall enforce this requirement in the
same manner as it enforces other required continuing education
requirements.

(d) Notwithstanding subdivision (a), educational activities that
are not directed toward the practice of medicine, or are directed
primarily toward the business aspects of medical practice,
including, but not limited to, medical office management, billing
and coding, and marketing shall not be deemed to meet the
continuing medical education standards for licensed physicians
and surgeons.

(e) Educational activities that meet the content standards set
forth in this section and are accredited by the California Medical
Association or the Accreditation Council for Continuing Medical
Education may be deemed by the Division of Licensing to meet
its continuing medical education standards.

SEC. 2. Section 2811.5 of the Business and Professions Code
is amended to read:

2811.5. (a) Each person renewing his or her license under
Section 2811 shall submit proof satisfactory to the board that,
during the preceding two-year period, he or she has been informed
of the developments in the registered nurse field or in any special
area of practice engaged in by the licensee, occurring since the
last renewal thereof, either by pursuing a course or courses of
continuing education in the registered nurse field or relevant to
the practice of the licensee, and approved by the board, or by other
means deemed equivalent by the board.

(b) For purposes of this section, the board shall, by regulation,
establish standards for continuing education. The standards shall
be established in a manner to assure that a variety of alternative
forms of continuing education are available to licensees, including,
but not limited to, academic studies, in-service education, institutes,
seminars, lectures, conferences, workshops, extension studies, and
home study programs. The standards shall take cognizance of
specialized areas of practice. The continuing education standards
established by the board shall not exceed 30 hours of direct
participation in a course or courses approved by the board, or its
equivalent in the units of measure adopted by the board.

(c) The board shall encourage continuing education in spousal
or partner abuse detection and treatment. In the event the board
establishes a requirement for continuing education coursework in spousal or partner abuse detection or treatment, that requirement shall be met by each licensee within no more than four years from the date the requirement is imposed.

(d) In establishing standards for continuing education, the board shall consider including a course in the special care needs of individuals and their families facing end-of-life issues, including, but not limited to, all of the following:

(1) Pain and symptom management.
(2) The psycho-social dynamics of death.
(3) Dying and bereavement.
(4) Hospice care.

(e) In establishing standards for continuing education, the board may include a course on pain management.

(f) This section shall not apply to licensees during the first two years immediately following their initial licensure in California or any other governmental jurisdiction.

(g) On and after January 1, 2012, the board shall require all of its licensees to take at least one continuing education course that provides instruction on cultural competency, sensitivity, and best practices for providing adequate care to lesbian, gay, bisexual, and transgender persons. Persons licensed by the board before January 1, 2012, shall complete the course no later January 1, 2016. Persons who are newly licensed by the board on and after January 1, 2012, shall complete the course within four years of their initial license issuance date or their second license renewal date, whichever occurs first. The course shall be between two and five hours in duration and shall contain content similar to the content described in the publication of the Gay and Lesbian Medical Association entitled “Guidelines for Care of Lesbian, Gay, Bisexual and Transgender Patients.” The board may specify the required contents of the course by regulation consistent with this subdivision. The board shall enforce this requirement in the same manner as it enforces other required continuing education requirements.

(h) The board may, in accordance with the intent of this section, make exceptions from continuing education requirements for licensees residing in another state or country, or for reasons of health, military service, or other good cause.
SEC. 3. Section 2892.5 of the Business and Professions Code is amended to read:

2892.5. (a) Each person renewing his or her license under the provisions of this chapter shall submit proof satisfactory to the board that, during the preceding two-year period, he or she has informed himself or herself of developments in the vocational nurse field or in any special area of vocational nurse practice, occurring since the issuance of his or her certificate, or the last renewal thereof, whichever last occurred, either by pursuing a course or courses of continuing education approved by the board in the vocational nurse field or relevant to the practice of such licensee, and approved by the board; or by other means deemed equivalent by the board.

(b) For purposes of this section, the board shall, by regulation, establish standards for continuing education. The standards shall be established in a manner to assure that a variety of alternative forms of continuing education are available to licensees including, but not limited to, academic studies, in-service education, institutes, seminars, lectures, conferences, workshops, extension studies, and home study programs. The standards shall take cognizance of specialized areas of practice. The continuing education standards established by the board shall not exceed 30 hours of direct participation in a course or courses approved by the board, or its equivalent in the units of measure adopted by the board.

(c) This section shall not apply to the first license renewal following the initial issuance of a license.

(d) On and after January 1, 2012, the board shall require all of its licensees to take at least one continuing education course that provides instruction on cultural competency, sensitivity, and best practices for providing adequate care to lesbian, gay, bisexual, and transgender persons. Persons licensed by the board before January 1, 2012, shall complete the course no later January 1, 2016. Persons who are newly licensed by the board on and after January 1, 2012, shall complete the course within four years of their initial license issuance date or their second license renewal date, whichever occurs first. The course shall be between two and five hours in duration and shall contain content similar to the content described in the publication of the Gay and Lesbian Medical Association entitled “Guidelines for Care of Lesbian, Gay, Bisexual and Transgender Patients.” The board may specify...
the required contents of the course by regulation consistent with this subdivision. The board shall enforce this requirement in the same manner as it enforces other required continuing education requirements.

(d) The board may, in accordance with the intent of this section, make exceptions from continuing education for licensees residing in another state or country, or for reasons of health, military service, or other good cause.

This section shall become operative on July 1, 1980.

SEC. 4. Section 2915 of the Business and Professions Code is amended to read:

2915. (a) Except as provided in this section, on or after January 1, 1996, the board shall not issue any renewal license unless the applicant submits proof that he or she has completed no less than 18 hours of approved continuing education in the preceding year. On or after January 1, 1997, except as provided in this section, the board shall issue renewal licenses only to those applicants who have completed 36 hours of approved continuing education in the preceding two years.

(b) Each person renewing his or her license issued pursuant to this chapter shall submit proof of compliance with this section to the board. False statements submitted pursuant to this section shall be a violation of Section 2970.

(c) A person applying for relicensure or for reinstatement to an active license status shall certify under penalty of perjury that he or she is in compliance with this section.

(d) (1) The continuing education requirement shall include, but shall not be limited to, courses required pursuant to Sections 25 and 28. The requirement may include courses pursuant to Sections 32 and 2914.1.

(2) (A) The board shall require a licensed psychologist who began graduate study prior to January 1, 2004, to take a continuing education course during his or her first renewal period after the operative date of this section in spousal or partner abuse assessment, detection, and intervention strategies, including community resources, cultural factors, and same gender abuse dynamics. Equivalent courses in spousal or partner abuse assessment, detection, and intervention strategies taken prior to the operative date of this section or proof of equivalent teaching
or practice experience may be submitted to the board and at its discretion, may be accepted in satisfaction of this requirement.

(B) Continuing education courses taken pursuant to this paragraph shall be applied to the 36 hours of approved continuing education required under subdivision (a).

(C) A licensed psychologist whose practice does not include the direct provision of mental health services may apply to the board for an exemption from the requirements of this paragraph.

3) Continuing education instruction approved to meet the requirements of this section shall be completed within the State of California, or shall be approved for continuing education credit by the American Psychological Association or its equivalent as approved by the board.

(e) The board may establish a policy for exceptions from the continuing education requirement of this section.

(f) The board may recognize continuing education courses that have been approved by one or more private nonprofit organizations that have at least 10 years’ experience managing continuing education programs for psychologists on a statewide basis, including, but not limited to:

(1) Maintaining and managing related records and data.

(2) Monitoring and approving courses.

(g) The board shall adopt regulations as necessary for implementation of this section.

(h) A licensed psychologist shall choose continuing education instruction that is related to the assessment, diagnosis, and intervention for the client population being served or to the fields of psychology in which the psychologist intends to provide services, that may include new theoretical approaches, research, and applied techniques. Continuing education instruction shall include required courses specified in subdivision (d).

(i) A psychologist shall not practice outside his or her particular field or fields of competence as established by his or her education, training, continuing education, and experience.

(j) On and after January 1, 2012, the board shall require every person licensed under this chapter to take at least one continuing education course that provides instruction on cultural competency, sensitivity, and best practices for providing adequate care to lesbian, gay, bisexual, and transgender persons. Persons licensed by the board before January 1, 2012, shall complete the course
no later January 1, 2016. Persons who are newly licensed by the board under this chapter on and after January 1, 2012, shall complete the course within four years of their initial license issuance date or their second license renewal date, whichever occurs first. The course shall be between two and five hours in duration and shall contain content similar to the content described in the publication of the Gay and Lesbian Medical Association entitled “Guidelines for Care of Lesbian, Gay, Bisexual and Transgender Patients.” The board may specify the required contents of the course by regulation consistent with this subdivision. The board shall enforce this requirement in the same manner as it enforces other required continuing education requirements.

**(k)** The administration of this section may be funded through professional license fees and continuing education provider and course approval fees, or both. The fees related to the administration of this section shall not exceed the costs of administering the corresponding provisions of this section.

**(l)** Continuing education credit may be approved for those licensees who serve as commissioners on any examination pursuant to Section 2947, subject to limitations established by the board.

**(l)** This section shall become operative on January 1, 2004.

SEC. 5. Section 4517 of the Business and Professions Code is amended to read:

4517. (a) The board may, in its discretion, provide for a continuing education program in connection with the professional functions and courses described in this chapter. The number of course hours that the board may require in a continuing education program shall not exceed the number of course hours prescribed for licensed vocational nurses pursuant to Section 2892.5.

(b) On and after January 1, 2012, the board shall require all of its licensees to take at least one continuing education course that provides instruction on cultural competency, sensitivity, and best practices for providing adequate care to lesbian, gay, bisexual, and transgender persons. Persons licensed by the board before January 1, 2012, shall complete the course no later January 1, 2016. Persons who are newly licensed by the board on and after January 1, 2012, shall complete the course within four years of
their initial license issuance date or their second license renewal date, whichever occurs first. The course shall be between two and five hours in duration and shall contain content similar to the content described in the publication of the Gay and Lesbian Medical Association entitled “Guidelines for Care of Lesbian, Gay, Bisexual and Transgender Patients.” The board may specify the required contents of the course by regulation consistent with this subdivision. The board shall enforce this requirement in the same manner as it enforces other required continuing education requirements.

SEC. 6. Section 4980.54 of the Business and Professions Code is amended to read:

4980.54. (a) The Legislature recognizes that the education and experience requirements in this chapter constitute only minimal requirements to assure that an applicant is prepared and qualified to take the licensure examinations as specified in subdivision (d) of Section 4980.40 and, if he or she passes those examinations, to begin practice.

(b) In order to continuously improve the competence of licensed marriage and family therapists and as a model for all psychotherapeutic professions, the Legislature encourages all licensees to regularly engage in continuing education related to the profession or scope of practice as defined in this chapter.

(c) Except as provided in subdivision (e), the board shall not renew any license pursuant to this chapter unless the applicant certifies to the board, on a form prescribed by the board, that he or she has completed not less than 36 hours of approved continuing education in or relevant to the field of marriage and family therapy in the preceding two years, as determined by the board.

(d) The board shall have the right to audit the records of any applicant to verify the completion of the continuing education requirement. Applicants shall maintain records of completion of required continuing education coursework for a minimum of two years and shall make these records available to the board for auditing purposes upon request.

(e) The board may establish exceptions from the continuing education requirements of this section for good cause, as defined by the board.

(f) The continuing education shall be obtained from one of the following sources:
(1) An accredited school or state-approved school that meets the requirements set forth in Section 4980.36 or 4980.37. Nothing in this paragraph shall be construed as requiring coursework to be offered as part of a regular degree program.

(2) Other continuing education providers, including, but not limited to, a professional marriage and family therapist association, a licensed health facility, a governmental entity, a continuing education unit of an accredited four-year institution of higher learning, or a mental health professional association, approved by the board.

(g) The board shall establish, by regulation, a procedure for approving providers of continuing education courses, and all providers of continuing education, as described in paragraphs (1) and (2) of subdivision (f), shall adhere to procedures established by the board. The board may revoke or deny the right of a provider to offer continuing education coursework pursuant to this section for failure to comply with the requirements of this section or any regulation adopted pursuant to this section.

(h) Training, education, and coursework by approved providers shall incorporate one or more of the following:

(1) Aspects of the discipline that are fundamental to the understanding or the practice of marriage and family therapy.

(2) Aspects of the discipline of marriage and family therapy in which significant recent developments have occurred.

(3) Aspects of other disciplines that enhance the understanding or the practice of marriage and family therapy.

(i) A system of continuing education for licensed marriage and family therapists shall include courses directly related to the diagnosis, assessment, and treatment of the client population being served.

(j) On and after January 1, 2012, the board shall require all of its licensees to take at least one continuing education course that provides instruction on cultural competency, sensitivity, and best practices for providing adequate care to lesbian, gay, bisexual, and transgender persons. Persons licensed by the board before January 1, 2012, shall complete the course no later January 1, 2016. Persons who are newly licensed by the board on and after January 1, 2012, shall complete the course within four years of their initial license issuance date or their second license renewal date, whichever occurs first. The course shall be between two and
five hours in duration and shall contain content similar to the content described in the publication of the Gay and Lesbian Medical Association entitled “Guidelines for Care of Lesbian, Gay, Bisexual and Transgender Patients.” The board may specify the required contents of the course by regulation consistent with this subdivision. The board shall enforce this requirement in the same manner as it enforces other required continuing education requirements.

(k) The board shall, by regulation, fund the administration of this section through continuing education provider fees to be deposited in the Behavioral Sciences Fund. The fees related to the administration of this section shall be sufficient to meet, but shall not exceed, the costs of administering the corresponding provisions of this section. For purposes of this subdivision, a provider of continuing education as described in paragraph (1) of subdivision (f) shall be deemed to be an approved provider.

(l) The continuing education requirements of this section shall comply fully with the guidelines for mandatory continuing education established by the Department of Consumer Affairs pursuant to Section 166.

SEC. 7. Section 4996.22 of the Business and Professions Code is amended to read:

4996.22. (a) (1) Except as provided in subdivision (c), the board shall not renew any license pursuant to this chapter unless the applicant certifies to the board, on a form prescribed by the board, that he or she has completed not less than 36 hours of approved continuing education in or relevant to the field of social work in the preceding two years, as determined by the board.

(2) The board shall not renew any license of an applicant who began graduate study prior to January 1, 2004, pursuant to this chapter unless the applicant certifies to the board that during the applicant’s first renewal period after the operative date of this section, he or she completed a continuing education course in spousal or partner abuse assessment, detection, and intervention strategies, including community resources, cultural factors, and same gender abuse dynamics. On and after January 1, 2005, the course shall consist of not less than seven hours of training. Equivalent courses in spousal or partner abuse assessment,
detection, and intervention strategies taken prior to the operative
date of this section or proof of equivalent teaching or practice
experience may be submitted to the board and at its discretion,
may be accepted in satisfaction of this requirement. Continuing
education courses taken pursuant to this paragraph shall be applied
to the 36 hours of approved continuing education required under
paragraph (1).
(b) The board shall have the right to audit the records of any
applicant to verify the completion of the continuing education
requirement. Applicants shall maintain records of completion of
required continuing education coursework for a minimum of two
years and shall make these records available to the board for
auditing purposes upon request.
(c) The board may establish exceptions from the continuing
education requirement of this section for good cause as defined
by the board.
(d) The continuing education shall be obtained from one of the
following sources:
(1) An accredited school of social work, as defined in Section
4991.2, or a school or department of social work that is a candidate
for accreditation by the Commission on Accreditation of the
Council on Social Work Education. Nothing in this paragraph shall
be construed as requiring coursework to be offered as part of a
regular degree program.
(2) Other continuing education providers, including, but not
limited to, a professional social work association, a licensed health
facility, a governmental entity, a continuing education unit of an
accredited four-year institution of higher learning, and a mental
health professional association, approved by the board.
(e) The board shall establish, by regulation, a procedure for
approving providers of continuing education courses, and all
providers of continuing education, as described in paragraphs (1)
and (2) of subdivision (d), shall adhere to the procedures
established by the board. The board may revoke or deny the right
of a provider to offer continuing education coursework pursuant
to this section for failure to comply with the requirements of this
section or any regulation adopted pursuant to this section.
(f) Training, education, and coursework by approved providers
shall incorporate one or more of the following:
(1) Aspects of the discipline that are fundamental to the understanding, or the practice, of social work.

(2) Aspects of the social work discipline in which significant recent developments have occurred.

(3) Aspects of other related disciplines that enhance the understanding, or the practice, of social work.

(g) A system of continuing education for licensed clinical social workers shall include courses directly related to the diagnosis, assessment, and treatment of the client population being served.

(h) The continuing education requirements of this section shall comply fully with the guidelines for mandatory continuing education established by the Department of Consumer Affairs pursuant to Section 166.

(i) On and after January 1, 2012, the board shall require all of its licensees to take at least one continuing education course that provides instruction on cultural competency, sensitivity, and best practices for providing adequate care to lesbian, gay, bisexual, and transgender persons. Persons licensed by the board before January 1, 2012, shall complete the course no later January 1, 2016. Persons who are newly licensed by the board on and after January 1, 2012, shall complete the course within four years of their initial license issuance date or their second license renewal date, whichever occurs first. The course shall be between two and five hours in duration and shall contain content similar to the content described in the publication of the Gay and Lesbian Medical Association entitled “Guidelines for Care of Lesbian, Gay, Bisexual and Transgender Patients.” The board may specify the required contents of the course by regulation consistent with this subdivision. The board shall enforce this requirement in the same manner as it enforces other required continuing education requirements.

(j) The board may adopt regulations as necessary to implement this section.

(k) The board shall, by regulation, fund the administration of this section through continuing education provider fees to be deposited in the Behavioral Science Examiners Fund. The fees related to the administration of this section shall be sufficient to meet, but shall not exceed, the costs of administering the
corresponding provisions of this section. For purposes of this subdivision, a provider of continuing education as described in paragraph (1) of subdivision (d) shall be deemed to be an approved provider.
GUIDELINES
FOR CARE OF
LESBIAN, GAY,
BISEXUAL, AND
TRANSGENDER
PATIENTS
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CREATING A WELCOMING CLINICAL ENVIRONMENT
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.¹

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, 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

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 GBT men smoked 50% more than other men, and LBT 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.
**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)*

**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
2 Gay Men’s Health. Small Effort, Big Change. www.gmhp.demon.co.uk/guides/gp

Chapter 1 Resource Documents


See also Resources section, pages 53–59.
ARING 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.¹ 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.² 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 insurance¹-³ compared to 15% of the general population.⁴ 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, 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—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. 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. 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, and are the only demographic group whose smoking actually increases with age. A recent large study showed LBT women smoked almost 200% more than other women. 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


Chapter 2 Resource Documents
Mautner Project, the National Lesbian Health Organization. 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%5Findicator/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


See also Resources section, pages 53–59.
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.¹ 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.²

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. 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.

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. African-American gay and bisexual men are disproportionately affected by homelessness, substance abuse, and sexually transmitted diseases, all correlated with a lower socioeconomic status. Native American/Alaskan gay and bisexual men are at both economic and geographical disadvantages when considering access to prevention messages. 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.

◆ 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.9

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.10 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,11 and discussions of sexual health, including homosexuality, are not part of their cultural norms.12

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.14

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.15

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.16 In another study, only 35% of providers reported often or always taking a sexual history.17 One study documented physician awkwardness around issues of sexual health and HIV, leading to incomplete discussion of these topics.18 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, 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.20

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. 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. 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. 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. 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. 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. 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.

References and Resource Documents


Chapter 3 Resource Documents


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/

CDC National Prevention Information Network (NPIN): reference and referral service for information on HIV/AIDS, STDs, and TB. www.cdcnpin.org Helpline: 800-458-5231 (also Spanish)


See also Resources section, pages 53–59.
Resources

General Background: LGBT Health
Gay and Lesbian Medical Association
www.gfma.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
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

Seattle/King County GLBT Health Web Pages
www.metrokc.gov/health/glbtk

National Association of Gay and Lesbian Community Centers
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
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
General Information: National LGBT Rights

Human Rights Campaign
www.hrc.org
(national organization working for LGBT equal rights on federal government level)

Lambda Legal
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.ncrlrights.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.ngltf.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
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%5Findformation/lesbain%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

Mautner Project, the National Lesbian Health Organization
www.mautnerproject.org

Planned Parenthood Lesbian Health section

Verbena Health
www.verbenahealth.org

U.S. Department of Health and Human Services
womenshealth.org
Screening Schedule for Women:
www.4woman.gov/screeningcharts

General Gay Men’s Health

GayHealth.com@
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

General Bisexual Health

Bisexual Resource Center Health Resources
www.biresource.org/health

Bi Health Program, Fenway Community Health
www.biresource.org/health/bihealth.html

“Safer Sex For Bisexuals and Their Partners” pamphlet
contact: bihealth@fenwayhealth.org
Transgender Health
FTM International
www.ftmi.org
International Foundation for Gender Education
www.ifge.org
TransGenderCare
www.transgendercare.com
Transgender Forum’s Community Center
www.transgender.org
Transgender Law Center
Recommendations for Transgender Health Care
www.transgenderlaw.org/resources/tlchealth.htm
Transgender Resource and Neighborhood Space (TRANS)
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
Transsexual Road Map
www.tsroadmap.com
Transsexual Women’s Resources
www.annelawrence.com/twr/

Intersex Health
Intersex Society of North America
www.isna.org

Sexually Transmitted Diseases (STDs)
STDs AND LESBIANS AND BISEXUAL WOMEN
LesbianSTD
www.lesbianstd.com
Planned Parenthood
www.plannedparenthood.org/sti/lesbian.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/
Gay City
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@gima.org
Free and low-cost hepatitis clinics:
www.hepclinics.com

Centers for Disease Control and Prevention Division of Viral Hepatitis
www.cdc.gov/ncidod/diseases/hepatitis/msm/
Model programs for MSM and hepatitis A, B, and C prevention:
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
American Foundation for AIDS Research (amfAR)
www.amfar.org
The Body: an AIDS and HIV information resource
www.thebody.com
Center for AIDS Prevention Studies
www.caps.ucsf.edu
Centers for Disease Control and Prevention
www.cdc.gov/hiv/dhap.htm
HIVandHepatitis.com
www.hivandhepatitis.com
National AIDS Treatment Advocacy Project
www.natap.org
New Mexico AIDSNet
(online fact sheets in English and Spanish regarding various aspects of HIV/AIDS)
www.aidsinfonet.org
Project Inform
(HIV/AIDS health information and treatment options) Hotline: 800-822-7422
www.projectinform.org
Youth HIV: a project of Advocates for Youth
www.youthhiv.org
National Association on HIV over 50 (NAHOF)
www.hivoverfifty.org

HIV AND PEOPLE OF COLOR
Asian and Pacific Islander Wellness Center
www.apiwellness.org
Black AIDS Institute
www.blackaids.org
Latino Coalition on AIDS
www.latinoads.com
National Minority AIDS Coalition
www.nmac.org
National Native American AIDS Prevention Center
www.nnaapc.org
HIV AND LESBIANS
TheBody.com
www.thebody.com/whatis/lesbians.html
Lesbian AIDS Project, Gay Men’s Health Crisis
www.gmhc.org/programs/wfs.html#lap

HIV AND TRANSGENDER POPULATIONS
AEGIS
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
U.S. DHHS HIV/AIDS Education and Resource Center
www.aidsinfo.nih.gov
Helpline: 800-448-0440 (also Spanish); 888-480-3739 (TTY)
AEGIS: HIV news from around the world
www.aegis.com
Infectious Diseases Society of America
www.idsociety.org

Substance Abuse
Sober Dykes
www.soberdykes.org
Stonewall Project
www.tweaker.org
Substance Abuse Mental Health Services
Administration/National Clearinghouse for Alcohol and Drug
Information—LGBT site
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
Youth Resource: a project of Advocates for Youth
www.youthresource.com
National Youth Advocacy Coalition
www.nyacyouth.org
Seattle and King County Public Health
www.metrokc.gov/health/glbt/youth.htm

Intimate Partner Violence
Community United Against Violence
www.cuav.org
Family Violence Prevention Fund Health Care Program
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
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/

Elders
SAGE: Services and Advocacy for Gay, Lesbian, Bisexual,
and Transgender Elders
www.sageusa.org
National Gay and Lesbian Task Force
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

See also HIV/AIDS and General Bisexual Health sections

See also References and Other Resource Documents.
Acknowledgments

Staci Bush, PA-C
Howard Brown Health Center

Lisabeth Castro-Smyth, B.A.
Lesbian Health Research Center at University of California
San Francisco (UCSF)

Pete Chvany, Ph.D.
Bisexual Resource Center

Ryan Clary
Project Inform

Suzanne Dibble, D.NSc., R.N.
Lesbian Health Research Center at University of California
San Francisco (UCSF)

Tri Do, M.D., M.P.H.
UCSF Department of Medicine
Center for AIDS Prevention Studies
SFGH Positive Health Program
Board Member, Gay and Lesbian Medical Association

Patricia Dunn, J.D., M.S.W.
Amphora Consulting
Lead Author and Editor

Jessica Halem
Lesbian Community Cancer Project (LCCP)

Lynn Hunt, M.D.
Lesbian Health Fund
Board Member, Gay and Lesbian Medical Association
Department of Pediatrics, University of California, Irvine

Marion (Mhel) H. E. Kavanaugh-Lynch, M.D., M.P.H.
California Breast Cancer Research Program
University of California, Office of the President
Lesbian Health Fund

Anne Lawrence, M.D., Ph.D.
Private practice, clinical sexology

Harold S. Levine
Levine & Partners, Inc.

Ana Maldonado PA-C/MPH
Fenway Community Health

Amari Sokoya Pearson-Fields, M.P.H.
Doctoral Candidate
Mautner Project, the National Lesbian Health Organization

Leigh Roberts, M.D.
Howard Brown Health Center

Laurie Safford, M.S.W.
Survey and Evaluation Research Laboratory
Virginia Commonwealth University

Jason Schneider, M.D.
Division of General Medicine
Department of Medicine
Emory University School of Medicine
Policy Chair, Gay and Lesbian Medical Association
Lead Author, Caring for Gay and Bisexual Men: Additional
Considerations for Clinicians

Scout, Ph.D.
Health Consultant
Associate Author and Editor

Shane Snowdon
University of California San Francisco
Edgework Consulting

Jodi Sperber, M.S.W., M.P.H.
Health Dialog

Jennifer S. Taylor, M.P.P., M.P.H.
Associate Author and Editor

Bianca Wilson, Ph.D.
Lesbian Health Research Center at University of California
San Francisco (UCSF)

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.

Gay and Lesbian
Medical Association (GLMA)
459 Fulton Street, Suite 107
San Francisco, CA 94102
Phone: 415-255-4547
Fax: 415-255-4784
Info@glma.org
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 speech1 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\(^2\). 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\(^3\).

**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\(^4\) 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\(^2\).

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\(^5\). 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.

**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.

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 and other expert research, 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**


# BOARD OF BEHAVIORAL SCIENCES
## Continuing Education Requirement

<table>
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<th>MFT</th>
<th>LCSW</th>
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| **36 CE hours required to renew** | Business and Professions Code: 4980.54(c)(1)  
California Code of Regulations: 1887.3(a) | Business and Professions Code: 4996.22(a)(1)  
California Code of Regulations: 1887.3(a) |
| **Spousal/Partner Abuse** | If course is taken **before** January 1, 2005  
there is not hour length specified  
If the course is taken **after** January 1, 2005  
It must be seven hours in length  
B&P Code: 4980.57(a) | If course is taken **before** January 1, 2005  
there is not hour length specified  
If the course is taken **after** January 1, 2005  
It must be seven hours in length  
B&P Code: 4996.22(a)(3) |
| **Aging and Long Term Care** | Three hour requirement  
B&P Code: 4980.395(a) | Three hour requirement  
B&P Code: 4996.26(a) |
| **HIV/AIDS** | Seven hour requirement  
California Code of Regulations 1887.3(c) | Seven hour requirement  
California Code of Regulations 1887.3(c) |
| **Law and Ethics** | Six hours for every renewal period  
California Code of Regulations 1887.3(d) | Six hours for every renewal period  
California Code of Regulations 1887.3(d) |

Mandated courses are one-time only courses, and once taken, need not be taken again. The only exception is the Law and Ethics course. Law and Ethics must be taken for each renewal.

18 hours of CE are required for your first renewal, but that is a MINIMUM, not a maximum. All mandated courses are required for your first renewal. If you have taken any of the mandated courses in the past, you are not required to repeat it. The only exception is the Law and Ethics course. Law and Ethics must be taken for each renewal.

Supervisors of Associate Clinical Social Workers and Marriage and Family Therapist Interns may apply their supervisor course training hours to their continuing education requirement as long as the training has been taken by an approved continuing education provider.

(chart updated: 10/06)
To: Policy and Advocacy Committee

From: Christina Kitamura
Administrative Analyst

Date: March 23, 2011

Telephone: (916) 574-7835

Subject: Discussion and Possible Action Regarding Other Legislation Affecting the Board

This page serves as a placeholder for other legislation that may need to be discussed.
To: Policy and Advocacy Committee
From: Rosanne Helms
Legislative Analyst

Subject: Legislative Update

To: Policy and Advocacy Committee
Date: March 23, 2011
From: Rosanne Helms
Legislative Analyst

Subject: Legislative Update

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.
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.
To: Policy and Advocacy Committee

From: Rosanne Helms
Legislative/Regulatory Analyst

Date: March 22, 2011

Telephone: (916) 574-7897

Subject: Rulemaking Update

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**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.