



Board of Behavioral Sciences

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MEETING NOTICE

Policy and Advocacy Committee July 19, 2012

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

1:30 p.m.

- I. Introductions
- II. Review and Approval of the April 19, 2012 Policy and Advocacy Committee Meeting Minutes
- III. Discussion and Possible Action Regarding Possible Revisions to the Retired License Statute.
- IV. Discussion and Possible Action Regarding the Use of Electronic Means to Provide Psychotherapy.
- V. Discussion and Possible Rulemaking Action to Require All Applicants to Submit a National Data Bank Inquiry Result
- VI. Legislative Update
- VII. Rulemaking Update
- VIII. Public Comment for Items Not on the Agenda
- IX. Suggestions for Future Agenda Items
- X. Adjournment

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.



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Consumer Affairs

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Policy and Advocacy Committee Minutes - **DRAFT** April 19, 2012

Department of Consumer Affairs
El Dorado Room
1625 North Market Blvd, #N-220
Sacramento, CA 95834

Members Present

Renee Lonner, Chair, LCSW Member
Dr. Judy Johnson, LEP Member
Dr. Christine Wietlisbach, Public Member
Christina Wong, LCSW Member

Staff Present

Kim Madsen, Executive Officer
Marc Mason, Administrative Manager
Rosanne Helms, Legislative Analyst
Christina Kitamura, Administrative Analyst

Members Absent

None

Guest List

On file

I. **Introductions**

Renee Lonner, Policy and Advocacy Committee (Committee) Chair, called the meeting to order at approximately 9:37 a.m. Christina Kitamura called roll, and a quorum was established. Staff, Committee members, and guests introduced themselves.

II. **Review and Approval of the January 26, 2012 Policy and Advocacy Committee Meeting Minutes**

Renee Lonner moved to approve the January 26, 2012 Policy and Advocacy Committee meeting minutes. Dr. Christina Wietlisbach seconded. The Committee voted unanimously (4-0) to pass the motion.

III. **Discussion and Possible Action Regarding Pending Legislation**

a. **Assembly Bill 40 (Yamada)**

Rosanne Helms presented AB 40, Elder and Dependent Adult Abuse Reporting.

Existing Law:

- Specifies that certain individuals, including Licensed Marriage Family Therapists (LMFT), Licensed Clinical Social Workers (LCSW), Licensed Educational Psychologists (LEP), and Licensed Professional Clinical Counselors (LPCC) are “mandated reporters” of suspected instances of elder and dependent adult abuse and must report abuse that occurred in a long-term care facility by calling either the local ombudsperson or the local law enforcement agency immediately or as soon as possible.

- Restricts local ombudsman programs from sharing the identity of the complainant in 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.

This bill would require a report made via telephone by a mandated reporter to report suspected instances of elder or dependent adult physical abuse that occurred in a long-term care facility to be made to the local law enforcement agency. Furthermore, the written report must be made to both the local ombudsperson and the local law enforcement agency.

There is a concern that mandated reporters may not report suspected instances of abuse to local law enforcement for fear of losing the trust of the subject/client. However, current law ensures the confidentiality of the identity of the reporter except as disclosed to specified agencies and under specified circumstances. 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.

This is a 2-year bill that was introduced on December 6, 2010. At its meeting in May 2011, the Board took a support position on this bill. This bill has been amended since the Board took its last position. Some concern was raised in the Legislature about requiring a dual mandated report to both a local ombudsperson and the local law enforcement agency. Therefore, the bill has been amended so that such a dual report is only required in the case of suspected physical abuse to an elder or dependent adult.

Dr. Johnson asked why sexual abuse was not mandated to be reported to a law enforcement agency. Sexual abuse is typically specified for mandated reporters. Ms. Helms agreed, stating that the term "physical abuse" does not specify the types of physical abuse. Dr. Johnson recommended adding sexual abuse as a separate category to be consistent with all other mandated abuse reports.

Ben Caldwell, American Association for Marriage and Family Therapy California Division (AAMFT-CA), stated that AAMFT-CA opposes this bill. He explained that there is a problem that is caused by the inability of the ombudsman to communicate with law enforcement; the way to resolve that is not by adding a duplicative report on mandated reporters, but to allow the ombudsman to communicate with law enforcement as necessary.

Ms. Lonner asked why the ombudsman does not communicate with law enforcement. Mr. Caldwell responded that he was not familiar with the history; however, there is a restriction on the ability to communicate which can be resolved through legislation.

Jill Epstein, California Association of Marriage and Family Therapists (CAMFT), expressed that CAMFT also opposes this bill. Ms. Epstein explained that the state needs to figure out how to best accept these reports. It is not clear whether this is a matter that the ombudsman is not reporting or cannot report. There is a communication gap between the ombudsman and law enforcement, and it is not a problem for the practitioners to resolve.

Rebecca Gonzales, National Association of Social Workers California Chapter, (NASW-CA), stated that NASW-CA supports this bill. She stated that the protection given to elderly folks in these facilities is worth the dual reporting. Ms. Gonzales agreed, however, that the suggestion to broadening physical abuse to include sexual abuse is a good idea.

Renee Lonner moved to recommend to the Board a position of support if amended to include “sexual abuse.” Dr. Judy Johnson seconded. The Committee voted unanimously (4-0) to pass the motion.

b. Assembly Bill 154 (Beall)

This item was tabled.

c. Assembly Bill 171 (Beall)

Ms. Helms presented AB 171, Pervasive Development Disorder or Autism.

Existing law:

- 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.
- Defines “severe mental illness” and includes in its definition “pervasive developmental disorder or autism.”
- Requires the benefits provided to include outpatient services, inpatient hospital services, partial hospital services, and prescription drugs if the plan includes prescription drug coverage.
- Requires that every health care service plan or insurance policy that provides hospital, medical or surgical coverage must also provide coverage for behavioral health treatment for pervasive developmental disorder or autism, by no later than July 1, 2012.
- Defines “behavioral health treatment” as professional services and treatment programs and:
 - Is prescribed by a licensed physician and surgeon or is developed by a licensed psychologist;
 - Is provided under a treatment plan prescribed by a qualified autism service provider;
 - The treatment plan has measurable goals over a specific timeline and the plan is reviewed by the provider at least once every six months; and
 - Is not used for purposes of providing or for the reimbursement of respite, day care, or educational services.

This bill:

- 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, including pervasive developmental disorder or autism.
- Specifies that treatment for pervasive developmental disorder or autism does not include behavioral health treatment.
- Prohibits a health care service plan from terminating coverage or refusing to deliver, execute, issue, amend, adjust, or renew coverage to an enrollee or insured solely because that person is diagnosed with or has received treatment for pervasive developmental disorder or autism.

- Requires coverage to include all medically necessary services and prohibits any limitations based on age, number of visits, or dollar amounts.
- Prohibits coverage for pervasive developmental disorder or autism from being denied on the basis of the location of delivery of the treatment, or because the treatment is habilitative, nonrestorative, educational, academic, or custodial in nature.

Due to loopholes in current law, those with pervasive development disorder or autism (PDD/A) are frequently denied coverage for their disorder. When they are denied coverage, those with PDD/A 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 PDD/A 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 PDD/A by specifically requiring health plans and insurers to cover screening, diagnosis, and all medically necessary treatment related to the disorder.

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. This bill would make the law more explicit about what must be covered.

SB 946 was signed into law last fall. It requires, no later than July 1, 2012, that every health care service plan contract that provides hospital, medical, or surgical coverage shall also provide coverage for behavioral health treatment for PDD/A. This bill would expand upon SB 946 by requiring health care service plan contracts and health insurance policies to provide coverage for the screening, diagnosis, and treatment of PDD/A other than behavioral health treatment.

This is a two-year bill. At its meeting in May 2011, the Board took a “support if amended” position on this bill, recommending the bill be amended to define the term “screening of autism spectrum disorders.”

Ms. Lonner explained that PDD/A is already in the parity bill; it is one of the severe, persistent mental illnesses under the parity bill. Although AB 171 emphasizes PDD/A, she asked if it is necessary to outline it in this bill as well as the parity bill? Ms. Helms clarified that the current law requires treatment for severe mental illness including autism; however, it does not define coverage.

Marc Mason added further clarification stating that Senator Steinberg attempted to carve this out in SB 946. The author of AB 171 does not want to do away with the “carve out” of SB 946 by the passage of this bill. AB 171 will not affect the ability to treat for this or the ability to be reimbursed by the insurance companies.

Ms. Helms explained that SB 946 defines “behavioral health treatment” and specified that it must be covered by health insurance. AB 171 expands it by discussing additional conditions that must be covered. AB 171 does not specify behavioral health treatment because if the bill does not pass, then it will take behavioral health treatment down with it.

Dr. Johnson is in favor of this especially with all of the diminishing resources in the school districts, regional centers, social services, and government agencies.

Mr. Caldwell expressed AAMFT-CA’s support for this bill.

Dr. Judy Johnson moved to recommend to the Board a position of support for AB 171 and direct staff to contact the author's office to discuss technical details. Christina Wong seconded. The Committee voted unanimously (4-0) to pass the motion.

d. Assembly Bill 367 (Smyth)

Ms. Helms presented AB 367, Board of Behavioral Sciences (Board) Reporting.

Current law requires certain boards to report the name and license number of a person whose license has been revoked, suspended, surrendered, or made inactive to the State Department of Health Care Services within ten working days. The purpose of the reporting requirements is to prevent state reimbursement for Medi-Cal services that were provided after the cancellation of a license.

This bill would add the Board to the list of boards subject to the reporting requirements.

According to the author's office, the intent of this legislation is to prevent Medi-Cal fraud by Board licensees who may provide services that are eligible for Medi-Cal reimbursement, by requiring the Board to report to the Department of Health Care Services (DHCS) the name and license number of any license holder whose license is revoked.

The Department of Consumer Affairs (DCA) is in the process of implementing a new database system, called BreEZe, for its boards and bureaus. Implementation of the BreEZe system for this Board is scheduled for August 2012. However, any new program changes made between now and January 1, 2015 must be made by the BreEZe vendor at significant additional cost to the Board. Therefore, Board staff requests consideration of a delayed implementation date of January 1, 2015. At this point the department will retain control of the BreEZe system and will be able to make changes to the system internally.

Ms. Epstein stated that CAMFT sponsored this bill, and will work with the Board on the delayed implementation.

Mr. Caldwell expressed that AAMFT-CA supports AB 367.

Dr. Christine Wietlisbach moved to recommend to the Board a position of support for AB 367 if amended. Dr. Judy Johnson seconded. The Committee voted unanimously (4-0) to pass the motion.

e. Assembly Bill 1588 (Atkins)

Ms. Helms presented AB 1588, Reservists Licensees, Fees and Continuing Education.

Existing law:

- Allows a licensee or registrant of any board, commission, or bureau within the DCA to reinstate his or her license without examination or penalty if the license expired while he or she was on active duty with the California National Guard or the United States Armed Forces. The following conditions must be met:
 - The license or registration must have been valid at the time of entrance into the California National Guard or the United States Armed Forces;

- The application for reinstatement must be made while actively serving, or no later than one year from the date of discharge from active service or return to inactive military status; and
 - The applicant must submit an affidavit stating the date of entrance into the service, and must also submit the renewal fee for the current renewal period.
- Allows a licensee of the Board to submit a written request for a continuing education exemption if he or she was absent from the state of California due to military service for at least one year during the previous renewal period. The licensee must submit evidence of service and must submit the request for exemption at least 60 days prior to the license expiration date.

This bill is intended to prevent members of the military from being penalized if they allow their professional license to fall into delinquency during their service period.

This bill would require all boards, commissions, or bureaus within DCA to waive continuing education requirements and renewal fees for a licensee or registrant while called to active duty as a member of the United States Military Reserve or the California National Guard if the following requirements are met:

- The person's license or registration was in good standing at the time they were called to active duty;
- The renewal fees and continuing education requirements are only waived for the period that they are on active duty; and
- The licensee or registrant, or their spouse or domestic partner provides the Board with acceptable written notice of the active duty.

The Board does not currently waive renewal fees if a licensee is called to active military duty. A licensee called to active military duty may choose to renew their license to an inactive status. An inactive status is valid for two years and requires payment of an inactive license fee that is approximately one-half of the standard license renewal fee. There is no inactive status option for a registration.

The Board may waive a licensee's continuing education requirement if he or she was absent from the state of California due to active military service for at least one year during the previous renewal period. The licensee must request the exemption on a form prescribed by the Board at least 60 days before his or her license expires.

The Board does not currently track the number of licensees who are members of the military. However, for the past several years, the Board has tracked the number of licensees who have requested a continuing education exemption due to military service. This is typically a very small number.

Staff suggests an amendment setting a time limit by which the renewal fee must be paid once the licensee or registrant completes active service. The Medical Board currently has a renewal fee exemption for its licensees if they are engaging in active military status. This code states that a Medical Board licensee becomes liable for payment of the fee for the current renewal period upon discharge from full time active service, and has 60 days after discharge to pay the renewal fee before a delinquency fee is charged. However, any Medical Board licensee who is discharged within 60 days of the end of a renewal period is exempt from paying a fee for that renewal period.

Currently, this bill only requires the active duty reservist, or his or her spouse or domestic partner, to provide written notice to the Board substantiating the active duty service. Staff suggests an amendment specifying that the term “written notice” be replaced by the term “affidavit.”

Dr. Johnson asked if the Board of Psychology has something in place for their clinical psychologists who are serving in the armed forces. Ms. Helms responded that she will look into it. Dr. Johnson expressed that this bill is a good idea.

Ms. Madsen explained that the BreEZe project poses a problem with implementation. To make changes to the BreEZe programming at this time would cost the Board a substantial amount of money.

Ms. Helms stated that DCA is aware of the issue with BreEZe and implementation, and she expects that DCA would seek delayed implementation of January 2015.

Dr. Wietlisbach asked if we know for sure that this will cost the Board a substantial amount of money. Ms. Madsen responded that the system is not currently programmed to waive a renewal fee. This becomes a business process issue and requires a modification to the system. To achieve that, staff would be required to go through the BreEZe vendor. Ms. Madsen explained that a previous system change that staff was involved with cost \$15,000 just to have the conversation – that did not include design. After BreEZe is implemented, the costs will shift back to the DCA, and those costs will be significantly reduced. Ms. Madsen offered to do more research and provide the information at the May Board meeting regarding the cost of implementation.

Ms. Gonzales expressed that NASW-CA supports AB 1588.

Dr. Judy Johnson moved to recommend to the Board a position of support for AB 1588 if amended and direct staff to conduct further research regarding technical issues and the Board of Psychology’s policy. Renee Lonner seconded. The Committee voted unanimously (4-0) to pass the motion.

f. Assembly Bill 1764 (Hernandez, R.)

Ms. Helms began to present AB 1764 Private Adoption Agencies and Licensing, sponsored by CAMFT. Ms. Esptein stated that CAMFT is no longer pursuing this legislation. No discussion or action was taken.

g. Assembly Bill 1785 (Lowenthal, B.)

Ms. Helms presented AB 1785, Federally Qualified Health Centers and Rural Health Clinics and Medi-Cal.

Current law establishes that federally qualified health center services (FQHCs) and rural health clinic (RHC) services are covered Medi-Cal benefits that are reimbursed on a per-visit basis. The law defines a FQHC or RHC visit as a face-to-face encounter between an FQHC or RHC patient and one of the following:

- A physician;
- physician assistant;
- nurse practitioner;
- certified nurse-midwife;
- clinical psychologist;

- licensed clinical social worker;
- visiting nurse; or
- dental hygienist.

This bill would add a marriage and family therapist to the list of health care professionals included in the definition of a visit to a FQHC or RHC that is eligible for Medi-Cal reimbursement.

The intent of this legislation is to allow FQHCs and RHCs to be able to hire a marriage and family therapist and be reimbursed through Medi-Cal for covered mental health services. Under current law, only clinical psychologists or LCSWs may receive Medi-Cal reimbursement for covered services in such settings. According to the author's office, the inability to receive Medi-Cal reimbursement serves as a disincentive for a FQHC or a RHC to consider hiring a marriage and family therapist.

This amendment leaves out the Board's newest license type, LPCC. Because LPCCs also practice psychotherapy, the Board may want to recommend that LPCCs be included as well.

Staff suggests an amendment be made to include the word "licensed" in front of the term "marriage and family therapist."

Mr. Caldwell expressed that AAMFT-CA supports AB 1785.

Rebecca Gonzales expressed that NASW-CA opposes AB 1785. NASW-CA feels that the supply of LCSWs in these health centers is adequate, and the LCSW's experience is ideal for these types of centers for mental health services and any other services that are needed.

Ms. Epstein stated that CAMFT is receiving widespread support for this bill. The California Primary Care Association testified and sent letters of support, illustrating that physicians in these clinics do not have enough mental health professionals to refer out to. The cost increase is perceived to be a result of more visits, thus costing Medi-Cal more money.

Mr. Caldwell explained that there would be a short-term cost increase if LMFTs are added, because those who cannot access services would now be able to access services. Some analyses illustrate that there would be a long-term cost savings because mental health professionals are doing intervention as opposed to the client being hospitalized. This is an access to care issue, and a possible long term cost-savings.

Ms. Gonzales asked if there was another step to this process other than getting this bill passed. Ms. Epstein responded that this is a two-step process. If this legislation is passed, it does not mean that Medi-Cal will reimburse LMFTs. Legislative intent must be recorded, showing that the legislatures want LMFTs as providers to FQHCs. The state plan would then need to be amended by the Department of Health Care Services.

Dr. Christine Wietlisbach moved to recommend to the Board a position of support for AB 1785. Dr. Judy Johnson seconded. The Committee voted unanimously (4-0) to pass the motion.

h. Assembly Bill 1864 (Wagner)

Ms. Helms presented AB 1864, Immunity of Court-Appointed Professionals.

Existing law:

- Specifies that in the case of a court petition, application, or other pleading to obtain or modify child custody or visitation that is being contested, the court shall set the contested issues for mediation.
- States the purposes of a mediation proceeding are:
 - To reduce acrimony that may exist between the parties;
 - To develop an agreement assuring the child close and continuing contact with both parents that is in the best interest of the child;
 - To settle the issue of visitation rights of all parties in a manner that is in the best interest of the child.
- States that mediation of cases involving custody and visitation concerning children is governed by uniform standards of practice adopted by the judicial council.
- Allows a court to require parents or any other party involved in a custody or visitation dispute, and the minor child, to participate in outpatient counseling with a licensed mental health professional for not more than one year if the court finds:
 - The dispute between the parties seeking custody or visitation rights with the child poses a substantial danger to the best interest of the child;
 - The counseling is in the best interest of the child.
- States that a child custody evaluator must be an LMFT, LCSW, or other specified licensed professional or certified evaluator.
- States that a child custody evaluator licensed by the Board is subject to disciplinary action by the Board for unprofessional conduct.

This bill prohibits monetary liability or damages against a professional appointed by court order to provide services to the court in a child custody or visitation case or appointed by a court order to provide expert evidence. The prohibition extends to any act, opinion, report, or communication in the performance of the court ordered services as long it is in the scope of services and occurs during the provision of those service.

According to the author of this bill, California family courts regularly appoint lawyers, social workers, LMFTs, psychiatrists, or other professionals to serve as neutral fact-finders or expert witnesses. They provide the court with expert testimony or written reports to enable the court to make informed decisions.

While acting as a court appointed neutral professional for these purposes, these professionals are sometimes subject to attack in contentious family or custody disputes. Because they are working under a code of conduct as a court appointee that may be different from the code of conduct of their licensed profession, they risk facing duplicative but potentially inconsistent disciplinary proceedings. Additionally, because these professionals are licensed by different agencies, one type of professional may not be held to the exact same code of conduct as another professional, even if they are performing identical duties for the court. As a result of this situation, many qualified professionals are no longer willing to take appointments by family courts.

This bill states that no professional appointed by court order to provide services in a child custody case or appointed by the court to provide expert evidence is liable financially or liable for damages, as long as the act in question is within the scope of the appointed services and occurs during the provision of the appointed services.

However, a licensed mental health professional that is not acting in a mediator role may be acting under the jurisdiction of the Board. For example, certain Family Codes allow the court to require parties of a child custody or visitation dispute to participate in counseling with a licensed mental health professional. A Board licensee acting as a mental health professional may fall under the jurisdiction of the Board if psychotherapy is performed. In addition, the Family Code section 3110.5 specifies that a court-connected or private child custody evaluator that is licensed by the Board is subject to disciplinary action by the Board for unprofessional conduct.

This bill does not clearly address court-connected child custody evaluators or licensed mental health professionals who are providing certain court ordered services. Staff recommends an amendment to clearly define that the immunity from financial liability or damages only applies to an individual acting as a neutral party while performing specified defined services, and not when performing psychotherapeutic services.

Ms. Lonner commented that child custody evaluators need oversight; they have a powerful role over the most helpless people in society (children). The court usually accepts the evaluator's recommendations, and some evaluators are not neutral. This is a very specialized area, and it is very political. Ms. Lonner expressed that she does not agree with granting them immunity.

Dr. Wietlisbach added that the Board is charged with protecting the consumer.

Ms. Wong agreed with Dr. Wietlisbach, inquiring if the bill's intent is to protect the professional or the consumer.

Ms. Lonner pointed out that there are many professionals in very difficult roles; however, they are not given immunity.

Dr. Johnson pointed out that this is what they specialized in and this is their role. Family courts need to look internally to handle these issues, to better train these individuals, and find professionals that have integrity.

Ms. Lonner stated that, historically, this is a profession that is closed to new members and their problems are political.

There were no comments from the audience.

Renee Lonner moved to recommend to the Board a position of oppose AB 1864. Dr. Christine Wietlisbach seconded. The Committee voted unanimously (4-0) to pass the motion.

i. Assembly Bill 1904 (Block)

Ms. Helms presented AB 1904, Military Spouses and Temporary Licenses.

Existing law allows the Board to issue a license as an LMFT to a person who, at the time of application, holds a valid license issued by another state if that person has held that

license for at least two years if their education and experience is substantially equivalent to that required by the Board, passes specified Board-administered licensing examinations, and completes certain specified training or coursework.

The author's office notes that the process of obtaining a state license can cause re-employment delays for military spouses moving between states, and that because of these delays and the expense involved in re-licensure, many of these spouses decide not to practice their profession. They also note that this financial and career-related issue may impact military members' decisions to stay in the military.

This bill is part of a larger federal effort to improve the lives of military families. In February 2012, the U.S. Treasury and the U.S. Department of Defense issued a report titled "Supporting our Military Families: Best Practices for Streamlining Occupational Licensing across State Lines." This report noted that approximately 35 percent of military spouses work in professions that require state licensure or certification, and recommended the use of temporary licenses to be used to accommodate qualified military spouses while they work toward a permanent license.

This bill:

- Would allow a board within DCA to issue a temporary license to an applicant who can prove that he or she is married to or in a domestic partnership or other legal union with, an active duty member of the U.S. Armed Forces who is assigned to duty in California under official active duty military orders. The applicant must:
 - Hold a current license in another state whose requirements are determined by the Board to be substantially equivalent to the Board's licensure requirements;
 - Not have committed any act in any jurisdiction that would have constituted grounds for denial, suspension, or revocation of the license by the Board;
 - Not have been disciplined by another licensing entity and is not the subject of any unresolved complaint or disciplinary proceeding by another licensing entity;
 - Pay the fees required by the Board; and
 - Submit fingerprints and fingerprinting fee as required by the Board.
- Would require the Board to expedite this temporary licensing process
- States that a temporary license is valid for 180 days, but at the discretion of the Board, may be extended for an additional 180 days if the licensee holder applies for an extension.
- Would allow the Board to adopt regulations to administer the temporary license program.

The Board does not currently have a temporary license status. An applicant who has an out of state license can submit an application for examination eligibility. The Board will evaluate the application to ensure the applicant meets the Board's education and experience requirements. If the Board determines that they meet all of the requirements, the Board will deem the applicant eligible to take the required examinations. Upon passage of the Board-required examinations, the Board will issue a license.

Over the past year, due to furloughs and the State hiring freeze, the Board has experienced a significant increase in processing times. However, as of February 2012, the Board is now fully staffed for the first time since June 2010. The Board expects to be able to significantly reduce the delays in the evaluation of examination eligibility

applications, and hopes to be able to return to a processing time of two months or less for most license types, typical of previous years.

This bill states that a board *may* issue a temporary license to a military spouse under certain conditions. It later states that the board *shall* expedite the procedure for issuing a temporary license. It is unclear if the objective of this bill is to allow a board the discretion to consider issuing a temporary license on a case by case basis, or if the intent is to require it be done for all military spouses.

This bill requires that the military spouse hold a current license in another state that the Board determines has substantially equivalent licensing requirements. It says nothing about passage of required Board administered examinations. Each of the Board's four license types is currently required to pass at least one Board-administered examination. Passage of a Board-administered examination ensures that a candidate for licensure has competencies unique to the mental health environment in California. Allowing mental health professionals from other states that have not passed an examination tailored to address the unique mental health environment in California could jeopardize consumer protection.

This bill creates a temporary license that is valid for a six-month period, with the opportunity to extend the license for a one-year period. A consumer who seeks mental health services often seeks treatment for an extended period of time. Having a practitioner whose license is only valid for six months could disrupt the continuity of care for their patients.

If this bill becomes law, it will require the Board to modify its database system to accommodate a temporary license type. Due to the implementation of the BreEZe system, Board staff requests consideration of a delayed implementation date of January 1, 2015.

Mr. Mason stated that it is not necessary to request delayed implementation because this bill is permissive; therefore, that amendment is not necessary at this point.

Ms. Wong expressed concern over the continuity of care.

Ms. Madsen stated that this bill allows a temporary license to individuals without passing the examinations. This bill affords the opportunity to a group of individuals that is not afforded to the rest of the population.

Dr. Johnson pointed out that this affects a small number of people.

Mr. Caldwell expressed that AAMFT-CA does not have a position on this bill. Some of the specifics of the bill are problematic. He noted that a lot of folks in the universities are military spouses. Many of them leave the state because their spouse is being relocated. For this reason, the concept is worth considering.

Ms. Porter agrees with Mr. Caldwell, stating that she also receives a lot of inquiries of LPCCs moving to California because their spouses are moving. She expressed that CALPCC supports helping military families with these transitions.

Ms. Epstein asked how the Board will balance its resources when there are interns in California who are waiting to get their applications reviewed. Ms. Madsen responded that this would require additional staffing and additional work with BreEZe.

Dr. Johnson expressed that she supports the concept of this bill.

Renee Lonner moved to recommend to the Board a position of support for AB 1904. Christina Wong seconded. The Committee voted unanimously (4-0) pass the motion.

The Committee took a break at 11:10 a.m. and reconvened at 11:30 a.m.

j. Assembly Bill 1932 (Cook)

Ms. Helms presented AB 1932, United States Armed Forces and Healing Arts Boards. She noted that this bill was amended two days ago.

Current law:

- Requires healing arts boards under the DCA to provide methods of evaluating education, training, and experience obtained in military service if the training is applicable to the requirements of the profession.
- States that for persons who apply for marriage and family therapist licensure or registration on or after January 1, 2014, the Board shall accept education and experience gained while residing outside of California for purposes of satisfying licensure or registration requirements if the education and experience is substantially equivalent to the Board's requirements.

This bill:

- Beginning January 1, 2014, would require each healing arts board to annually issue a written report to the Department of Veterans Affairs and to the Legislature that details the board's method of evaluating education, training, and experience obtained in military service. The report must also state whether the military education, training, and experience can be applied toward the board's licensing requirements.
- Would require the report to include information about the number of military service members who have applied for and have used their military education, training and experience to fulfill the board's licensing requirements.

The author's office would like to require state agencies to identify which requirements are satisfied by military training and what additional training is required. The goal is to reduce the amount of time and money wasted forcing veterans to repeat their medical training from scratch.

The Board has very specific requirements for education and experience in its licensing laws. If an applicant for licensure or registration had military education and experience, the Board conducts a review to determine whether or not it was substantially equivalent to current licensing requirements.

The Board is not aware of specific circumstances in which an individual had military education or experience. This is not tracked by the Board and there is not a common provider of military education or experience that the Board sees cited on incoming applications. Occasionally, the Board sees supervised experience that was obtained out

of the country. This experience may be accepted by the Board if the Board can determine that the supervision was substantially equivalent and that the supervisor is an equivalently licensed acceptable professional who has been licensed at least two years.

The U.S. Army Medical Service Corps lists two types of behavioral health job descriptions on its website; one of those for a social worker. According to the website, appointment as a social worker requires a master's degree in social work with emphasis in clinical practice from a program accredited by the Council on Social Work Education. The social worker must also have a state license in social work that allows clinical independent practice.

Aside from utilizing social workers who are already state-licensed, it is unclear if the military offers any training programs to those seeking licensure as a psychotherapist. The military recently entered into a partnership with Fayetteville State University to establish a master of social work program at Fort Sam Houston military installation in Texas. This program is designed to allow soldiers to earn a master's degree in social work from an accredited university while in active duty military service in an effort to increase the number of social workers in military service.

Staff recommends an amendment to this bill which clarifies the Board's reporting requirement to the Department of Veterans Affairs. Currently, the report is required to "clearly detail the methods of evaluating the education, training, and experience obtained in military service and whether that education, training, and experience is applicable to the board's requirements for licensure." Military education and experience is evaluated by the Board on a case-by-case basis if a military applicant applies for licensure or registration. It is not possible for the Board to evaluate all possible scenarios of military education and experience if the Board is not aware of them.

Ms. Wong stated that if the new program at Fayetteville State University begins, it would be necessary for the program to go through the Council on Social Work Education in order to be accredited, which would be consistent with the Board's requirements. With that said, she does not understand how this bill would be applicable to the Board.

Mr. Mason stated that if the military is providing this training, it would seem that the burden of providing information on these programs would be on them. It would be unrealistic and burdensome to conduct a survey of each military branch's training. On another note, the Governor announced that he is working to stop unnecessary reports because there is a tremendous amount of reports within the state government that are using up staff resources and costing money.

Ms. Helms stated that she did not find any clear military education that was directed towards social workers. The military would have to provide information on its program so that the Board could evaluate it.

Ms. Lonner stated that it is not the Board's job to do that.

The Committee did not take a position on AB 1932. No action was taken.

k. Assembly Bill 2570 (Hill)

Ms. Helms presented AB 2570 regarding Licensees and Settlement Agreements.

Existing law subjects an attorney to suspension, disbarment, or other disciplinary action for seeking the following in a settlement agreement:

- A provision requiring that professional misconduct not be reported to the disciplinary agency;
- A provision requiring a plaintiff to withdraw a disciplinary complaint or refuse to cooperate with an investigation or prosecution being conducted by a disciplinary agency; and
- A provision requiring that a record of civil action for professional misconduct must be sealed from review by a disciplinary agency.

This bill:

- Would prohibit a licensee regulated by the DCA from including or allowing inclusion of the following provisions in a settlement agreement of a civil dispute:
 - A provision prohibiting the other party in the dispute from contacting, filing a complaint with, or cooperating with DCA or a board, bureau or program; and
 - A provision that requires the other party in the dispute to withdraw a complaint from DCA or a board, bureau or program.
- States that a licensee who includes or permits inclusion of such a provision is subject to disciplinary action by the board, bureau or program.
- States that a board, bureau or program under DCA that takes disciplinary action against a licensee based on a complaint that has also been the subject of a civil action that was settled for monetary damages may not require the disciplined licensee to pay any additional sums of money to the plaintiff.

The intent of this bill is to close a loophole in current law that allows a licensee or registrant regulated by DCA to prohibit a consumer that settles a civil suit with that licensee or registrant from filing a complaint or cooperating in an investigation.

Previous supporters of similar bills have argued that the increasing use of these “regulatory gag clauses” is problematic because they are often used to intimidate victims into refusing to cooperate with investigations. This may prevent a regulatory board from taking disciplinary action against a negligent licensee or registrant. These licensees or registrants may continue to practice and harm the public because the Board is not aware of a civil dispute settlement.

AB 320 (2004) and AB 446 (2005) were both very similar to this bill and would also have prohibited regulatory gag clauses. The Board took a position of support on AB 446. Both bills were vetoed by Governor Schwarzenegger.

SB 1111 (2010) and SB 544 (2011) were both part of an effort by DCA to provide healing arts boards with additional regulatory tools and with additional authority for investigating and prosecuting violations of the law. Both bills contained a provision similar to the one in this bill. The Board did not take a position on SB 1111, and took a “support if amended” position on SB 544. Both bills died in the Senate Business, Professions, and Economic Development Committee.

On March 2012, the Board filed a notice with the Office of Administrative Law to proceed with a regulation package that contained this provision as well.

There were no comments from the audience.

Dr. Christine Wietlisbach moved to recommend to the Board a position of support for AB 2570. Renee Lonner seconded. The Committee voted unanimously (4-0) to pass the motion.

I. Senate Bill 1134 (Yee)

Ms. Helms presented SB 1134, Persons of Unsound Mind and Psychotherapist Duty to Protect. This bill is sponsored by CAMFT.

Existing law:

- Requires a therapist who determines, according to professional standards that a patient presents a serious danger of violence to another, to use reasonable care to protect the intended victim against such danger. This includes warning the intended victim, the police, or taking whatever other steps are reasonably necessary under the circumstances.
- Allows no monetary liability or cause of action to arise against a psychotherapist who fails to warn of and protect from a patient's threatened violent behavior, or who fails to predict and warn of and protect from a patient's violent behavior, except where the patient has communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims.
- Requires a therapist to warn a potential victim(s) if information communicated to the therapist leads the therapist to believe that the patient poses a serious risk of grave bodily injury to another.
- Defines a communication from a family member to the patient's therapist, made for the purpose of advancing a patient's therapy, as a "patient communication."
- Outlines instructions to a jury to determine if there is a cause of action for professional negligence against a psychotherapist for failure to protect a victim from a patient's act of violence.

This bill would remove a psychotherapist's duty to warn and provide that there can be no monetary liability or cause of action against a psychotherapist unless the psychotherapist fails to discharge his or her duty to protect by making reasonable efforts to communicate the threat to the victim or victims and to a law enforcement agency.

According to the author's office, this bill renames the duty of a psychotherapist from "duty to warn and protect" to "duty to protect." If this change is made, it will make the law consistent with changes made in 2007 to the Judicial Council of California Civil Jury Instructions, which renamed the therapist's duty a "duty to protect" and eliminated the reference of "duty to warn."

The author's office argues that the term "duty to warn" is no longer necessary, because steps needed for a therapist to avoid liability are spelled out in the Civil Code.

Ms. Epstein explained that this is to clean up language that was never intended by the court. This bill is not removing the duty to warn because there never really was a "duty to warn;" there is a "duty to protect." This bill is to give the psychotherapist the ability to determine the best way to protect without being subjected to lawsuits.

Ms. Lonner expressed concern about how this will be translated to licensees without it being too complicated.

Ms. Epstein stated that this bill does not change the way a therapist should behave now. Instead of making it a “duty to warn and protect,” which not what Tarasoff intended, it is making it a “duty to protect,” and it leaves it in the discretion of the therapist how to best protect.

Dr. Johnson agreed that this does clarify and it makes sense to her.

Ms. Lonner again expressed how this will get translated to the licensees. Currently, the duty is not all that well understood as it is now.

Ms. Wong expressed that this bill does not clarify the duty for her.

Ms. Epstein stated that there will be a hearing on May 8th; CAMFT’s expert witness will testify.

Ms. Lonner stated that she would like to see a more substantive change that would be well understood.

Mr. Mason stated that he would be interested to see if there is evidence of people who are warning when it’s inadvisable. The hearing may provide information on what is prompting this.

Dr. Johnson stated that she would like further clarification.

No action was taken.

m. Senate Bill 1183 (Lieu)

Ms. Helms presented SB 1183, Marriage and Family Therapists and Continuing Education. This bill was significantly amended. What this bill did before it was amended is more in line with SB 1172. SB 1172 will be analyzed in the May Board packet.

This bill:

- Would require continuing education (CE) providers other than accredited educational institutions to be approved by an accrediting organization such as a professional association, a licensed health facility, or a governmental entity.
- Stated that the Board will no longer approve CE providers.

According to the author’s office, this bill is an ongoing process and they are working on some of the details. As written, the version that was amended in April 2012, it only discusses CE for LMFTs and LCSWs. It leaves out LEPs and LPCCs. Ms. Helms expect another amended version of this bill to include LEPs and LPCCs.

Existing law:

- Requires the director of DCA 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.

- Requires licensees of the 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.

Over the past year, questions have been raised concerning the nature of the Board's continuing education course (CE) content requirements. Current law states that a CE course must be relevant to the profession, related to direct/indirect care and shall incorporate specific aspects of the discipline. By not requiring CE to meet standards usually utilized by accrediting bodies, such as requiring content to be derived from relevant peer-reviewed research literature, more innovative, and California specific CE may be presented. However, this approach also allows for CE providers to offer courses for Board credit that may include content not necessarily found to be best practices in the profession or scientifically based.

Over the past year, questions have been raised concerning the nature of the Board's CE course content requirements. Current law states that a CE course must be relevant to the profession, related to direct/indirect care, and shall incorporate specific aspects of the discipline. By not requiring CE to meet standards usually utilized by accrediting bodies, more innovative and California specific CE may be presented. However, this approach also allows for CE providers to offer courses for Board credit that may include content not necessarily found to be best practices in the profession or scientifically based.

In July 2011, the Board began receiving complaints from the public regarding the Board-approved CE Provider National Association of Research and Therapy of Homosexuality (NARTH). Hundreds of emails were received from individuals protesting the approval of an organization that proffers "reparative" or "conversion" therapy for individuals that have unwanted homosexual tendencies.

NARTH received approval from the Board to offer continuing education courses in 1998. Since then, that approval has been renewed on a biennial basis. Renewal requires payment of \$200, but no additional paperwork. NARTH's CE provider approval expired October 31, 2010, and it was not renewed.

The Board's ability to deny an application as a CE provider is governed by regulations which say the provider must ensure its coursework is relevant to a licensee's practice and is related to direct or indirect patient care. The Board can only deny an application if it does not meet those standards.

According to current law, after receiving Board approval, providers can add new courses without submitting additional paperwork. There is nothing in laws and regulations to compel a provider to notify the Board when it adds new courses.

At its November 2011 meeting, the Board voted to form a Continuing Education Provider Review Committee (Committee) in order to examine the above issues, as well as other issues that have been raised with the Board's CE regulations. The Committee's first public meeting was in April 2012.

Mr. Caldwell expressed that AAMFT-CA does not have a position on SB 1183. He suggested that the Board amend the language to allow a long implementation time frame so that the Committee has an opportunity to do its work and run legislation if necessary.

No action was taken.

n. Senate Bill 1238 (Price)

Ms. Helms reported on SB 1238, the Board's sunset bill. This bill would extend the operation of the Board until January 1, 2017.

The Sunset Hearing was held on March 19, 2012 before the Senate Committee on Business, Professions, and Economic Development. Based on the findings of the Committee it was recommended that the Board's sunset date be extended for four years, to January 1, 2017.

Renee Lonner moved to recommend to the Board a position of support for SB 1238. Dr. Judy Johnson seconded. The Committee voted unanimously (4-0) pass the motion.

IV. Discussion and Possible Action Regarding Other Legislation Affecting the Board

No further legislation was discussed.

V. Discussion and Possible Rulemaking Action Regarding Revision of Disciplinary Guidelines

Ms. Helms presented the proposed changes to enforcement regulations.

At its November 9, 2011 meeting, the Board approved several amendments to the Disciplinary Guidelines. The Disciplinary Guidelines are incorporated by reference into Board regulations. The proposed amendments were based on suggestions from the Board's enforcement unit. Staff is now in the process of preparing a regulatory package to make the proposed amendments.

The enforcement unit has proposed two additional amendments to the Disciplinary Guidelines. Because a regulatory proposal can take up to one year to obtain approval from the Office of Administrative Law (OAL), and because only one proposal affecting any particular regulatory code section can be run at a time, staff recommends that these additional proposals be considered for inclusion in the existing regulatory proposal to amend the Disciplinary Guidelines. The additional amendments are:

1. Recommended Language for Tolling of Probation, and
2. Recommended Language for Disciplinary Orders.

Tolling of Probation

The Board's Disciplinary Guidelines contain specific language for standard terms and conditions of probation, which are included in all disciplinary decisions.

Two of the standard terms and conditions, "Residing or Practicing Out of State" and "Failure to Practice – California Resident," allow a registrant or licensee to "toll" their probation if they are not practicing. Tolling probation stops the clock on a practitioner's probation term until they resume practice. The tolled period is then added to the end of the probation and extends the expiration date.

The "Residing or Practicing Out-of-State" condition includes language which allows the Board to cancel a license or registration after two years if the respondent does not return to California and resume practice.

The “Failure to Practice – California Resident” condition does not delineate a time limit on non-practice, as long as the licensee or registrant is residing in California. Therefore, probationers can continue in their toll status indefinitely or until their registration or license expires by operation of law.

Although the current disciplinary guidelines specify that time spent outside the state in an intensive training program is not to be considered non-practice, staff has never encountered a probationer who was in an intensive training program outside California. The current guidelines also state a respondent’s license must not be cancelled if he or she is residing and practicing in another state and is on active probation with the licensing authority of that state. Staff has also never encountered a probationer who was practicing in another state and on active probation with licensing authority in that state.

Board staff is experiencing an increased number of probationers who toll their probation as of the effective date of probation. Currently, there is no safeguard in place to ensure that these probationers are not practicing, other than their notification to the Board. Therefore, the amendments proposed combine “Residing or Practicing Out of State” and “Failure to Practice – California Resident,” standard conditions, deleting unnecessary language, and specifying the cancellation of a registration or license which has been tolled for a total of two years regardless of their in-state or out-of-state residency.

Disciplinary Orders

The “Board Policies and Guidelines” section of the current Disciplinary Guidelines contains recommended language for applicants and registrants to be used in the first paragraph of disciplinary orders. Staff proposes adding language to address the granting of other registrations or licenses by the Board and the application of probation for those other registrations and licenses.

Ms. Madsen stated that the intent of tolling was for short periods of time only.

No comments from the audience.

Christina Wong moved to direct staff to make any decided-upon changes and any non-substantive changes to the proposed language, and to recommend that the Board direct staff to include the proposed amendments in the rulemaking package to amend the Disciplinary Guidelines that were approved on November 9, 2011. Renee Lonner seconded. The Committee voted unanimously (4-0) to pass the motion.

VI. Discussion and Possible Action Regarding Complaints Against Licensees who Provide Confidential Child Custody Evaluations to the Courts

Ms. Madsen presented issues regarding licensees providing child custody evaluations.

For many years Board licensees have assisted California Family Courts in resolving issues or concerns related to matters of child custody. In this role a Board licensee may serve as a child custody recommending counselor (formerly known as mediators), as a court connected child custody evaluator or as a private child custody evaluator. Each role has specific qualifications and requirements established through the Rules of the Court and the California Family Code.

A child custody recommending counselor may be a member of the professional staff of the family court, probation department, or mental health services agency or any other person or agency designated by the court. The child custody recommending counselor is not required

to possess a license with the Board. However, they must meet specific educational and training requirements set forth in Family Code.

The role of the child custody recommending counselor is to assist parents in resolving their differences and to develop a plan agreeable to both parties. In situations in which the parties cannot agree, the child custody recommending counselor prepares a recommendation. The child custody recommending counselor submits either the plan or the recommendation to the court. The time appropriated for this service is not extensive.

A court connected child custody evaluator or a private child custody evaluator has a more extensive role and must be licensed as a LMFT, Clinical Social Worker, Psychologist, or a Physician that is either a Board certified Psychiatrist or has completed a residency in psychiatry. The evaluator has the task of conducting a comprehensive assessment (evaluation) to determine the best interest of the child in disputed custody or visitation rights.

Conducting an evaluation requires a significant amount of time. The Rules of the Court specify the content each evaluation must include as well as a description of the work completed by the evaluator. Upon the conclusion of the evaluator's work, the evaluator prepares a written report that is submitted to the court. The court will base their decision regarding custody and visitation on this report.

Pursuant to Family Code, this report is confidential. The report may only be disclosed to the following persons:

- A party to the proceeding and his or her attorney,
- A federal or state law enforcement officer, judicial officer, court employee, or family court facilitator for the county in which the action was filed, or an employee or agent of that facilitator,
- Counsel appointed for the child pursuant to Family Code Section 3150,
- Any other person upon order of the court for good cause.

An individual releasing this report may be subject to sanctions by the Court.

Family Code Section 3110.5(e) states a child custody evaluator who is licensed by the Medical Board of California, the Board of Psychology, or the Board of Behavioral Sciences shall be subject to disciplinary action by that board for unprofessional conduct, as defined in the licensing law applicable to that license.

The court advises individuals that if they have a complaint against a mediator or evaluator, to file a complaint with the court. Further, the individual may express their complaint to the judge at the time of their hearing.

The individuals are also advised that if their complaint is about ethical conduct or licensing issues, they may contact the appropriate state licensing board.

The Board receives numerous complaints against licensees who provide evaluations or recommendations to the courts. The Board does not investigate complaints that involve a mediator, due their limited role. The Board will investigate complaints involving evaluators.

In all complaints, the source of the complaint alleges the licensee's conduct/recommendation is unprofessional or is unethical. As in all complaint investigations, the Board must obtain the relevant information to determine if a violation of the Board's statutes and regulations has occurred.

Since the nature of the complaint directly references the evaluator's report to the court, to fully investigate the allegations, the report is a critical piece of information. Often the Board will receive this report from the source of the complaint. In cases where the Board has received this report, the Board has proceeded with an investigation. These investigations are time intensive and involve the use of a Subject Matter Expert and at times, assistance from the Division of Investigation.

Board staff observes significant challenges associated with these cases. The inability to obtain all of the relevant documentation requires the Board to close an investigation. This outcome increases the individual's frustration not only with the courts, but also the Board.

Moreover, the Board has learned that its investigation of these cases is a concern for the courts in that licensees were alarmed that their reports may be subject to a board investigation. Many licensees expressed an unwillingness to continue their role as an evaluator. Consequently, the courts became concerned about decreasing resources to perform this service.

Last year, Board staff initiated discussions with the Administrative Office of the Courts (AOC) to exchange information each entity's process, and to explore possible solutions to resolve the current issues. During the initial meeting, the Board was informed that current law did not allow the Board access to the evaluator's report. To obtain the report, the Board is required to file a petition or subpoena with the court.

The Board met with AOC to discuss the inability to fully investigate allegations of licensee misconduct if the Board cannot obtain the relevant documentation to use in an administrative hearing. Both the Board and the AOC agree that it is essential that the courts receive accurate information from the child custody evaluator in order to determine the best interest of the child. Further, the AOC and the Board agree that a solution to this issue requires a legislative proposal to revise existing law.

Ms. Madsen stated that yet it remains in law that complaints can be made to the Board. Without these reports, the Board cannot investigate. It takes a significant dedication of resources to investigate these complaints. If staff cannot gain access to these reports, the resources could be better spent. She expressed that the reports that the courts receive, need to be accurate and factual. If they're not, the courts need to be made aware of that. The AOC were supportive of the Board's efforts to have access to these reports.

Ms. Madsen referred to staff in the audience. Cassandra Kearney, Enforcement Analyst, provided that nearly 40% of the complaints received by the enforcement unit are involving child custody issues.

Mr. Caldwell referred to AB 1864 and the Deputy Attorney General opinion which states that when acting in the capacity of a court-appointed child custody mediator or evaluator, the Board does not have jurisdiction. Mr. Caldwell asked if there a piece about this jurisdictional issue that may need to be resolved?

Ms. Madsen responded affirmatively stating that it may need to be addressed. A strong argument can be made because the Board is the agency to go to for licensee violations.

Dr. Wietlisbach suggested combining the two issues together (access to reports and jurisdictional issue) and crafting legislation.

Ms. Epstein stated that the Attorney General (AG) can go to the judge and obtain the reports. It's not that the Board cannot get the document; the judge must approve that. However, the AG has the opportunity to argue to the judge the compelling reasons why the Board needs the document. CAMFT has concerns over giving the Board access to all confidential court documents without having the AG justify which confidential reports the Board can have access to.

Ms. Madsen stated that the report is needed at the beginning of the complaint investigation. She couldn't wait for the case to be referred to the AG in order to get the report. She added that Board staff is adept in determining those who are unhappy with their child custody decision versus those who have valid issues.

Ms. Wong stated that the child involved has no voice in the process. It is a disservice to the consumer if nothing is done regarding monitoring these professionals. The divorce rate is over 50%, and many of those divorces involve children. This population of children is already traumatized.

Dr. Judy Johnson moved to direct staff to draft a legislative proposal that allows the Board access to the confidential report for investigative purposes and, if needed, to address the jurisdictional issue, and to include LPCCs in the language. Christina Wong seconded. The Committee voted unanimously (4-0) to pass the motion.

VII. Discussion and Possible Action Regarding Research Related to the 90-Day Rule and Enforcement Actions

Ms. Helms reported.

Under current law, an applicant for marriage and family therapy intern or professional clinical counselor (PCC) intern registration must apply for intern registration within 90 days of the granting of his or her qualifying degree in order to be able to count supervised experience hours gained toward licensure while he or she is waiting for the Board to grant registration as an intern. This allowance in the law is commonly referred to as "the 90-day rule."

At its November 9, 2011 meeting, the Board approved amendments to eliminate the 90-day rule for MFT intern and PCC intern applicants, and directed staff to seek Board-sponsored legislation. The need for this bill was based on the following:

Need for Increased Consumer Protection

An applicant who has a previous conviction can submit an application for intern registration within 90 days of the degree being granted. They then have up to one year to submit their conviction records (considered a deficiency) to the Board for review. Although most submit the information quickly, an applicant with a serious conviction will occasionally try to delay, taking their one year period to submit the requested information. However, because they have followed the 90-day rule, they may then gain supervised experience during this one-year time period without any restrictions the Board might place on them due to their prior conviction. Once the Board's enforcement division obtains the conviction information and decides to deny or restrict the registration, they have already been gaining experience hours toward licensure.

If a consumer or the supervisor were to file a complaint against such a practitioner during this time, the Board would have no jurisdiction to investigate the complaint and take action, as they are not yet a registered intern.

Decreased Application Processing Times at the Board

The 90-day rule was put into place many years ago when applicants for licensure were required to submit fingerprints on paper cards (called “hard cards”) to the Board so that their criminal background could be checked. These hard cards were then processed by the Board and then physically sent to the Department of Justice (DOJ) and then to the FBI so that a background check could be performed by both of these agencies. This entire process could take up to three months before the Board received the results.

Today, the Board uses Livescan fingerprinting, which is an electronic fingerprinting system. The Board now receives the results of electronic fingerprints in approximately three to seven days.

The adoption of Livescan fingerprinting has significantly decreased the time it takes for the Board to process an application, therefore, potentially eliminating the need for the 90-day rule.

Due to concerns cited by stakeholders, the Board agreed to revisit the 90-day rule proposal at its February 2012 Board meeting. At this meeting, stakeholders noted that there are no statistics available to show how often an applicant who followed the 90-day rule and is gaining hours is referred to the Board’s Enforcement division and, upon further investigation, is denied the registration or issued a restricted registration.

Board staff approached several legislative offices in January and February about authoring the 90-day rule proposal. Although several offices were interested and stated that they may be interested in running this bill in 2013, this same concern about lack of statistics was cited by several legislative staff members.

The Board has not kept statistics on this particular scenario in the past. The amendments to eliminate the 90-day rule were proposed after the Board’s enforcement division raised concerns that they were noticing that sometimes applicants with a criminal history follow the 90-day rule, and then may gain hours while the enforcement division investigates their application.

Staff recommends that the enforcement division gather data over a one-year time period in order to allow the Board to determine the extent of the problem of applicants with a criminal history abusing the 90-day rule. Data on the following instances should be gathered:

1. Number of applicants with a criminal conviction who, while gaining hours, wait until the end of their one-year deficiency period (defined as the last two months) to submit any information requested by the Board’s enforcement division.
2. Number of instances in which an applicant follows the 90-day rule and begins gaining hours, only to have their registration denied due to the findings of the enforcement division.
3. Number of instances in which a denial of an application, due to enforcement division findings, is appealed and the applicant subsequently is granted a registration with restrictions.
4. In cases where a registration was denied or restricted due to enforcement division findings, the nature of the offenses that led to each particular denial or restriction should be tracked.

Mr. Caldwell stated that the hard card process is no longer required; however, people have been waiting several months for their applications to be processed. The timeline for folks getting their intern registrations have not gotten faster since the end of the hard card process.

Dr. Christine Wietlisbach moved to recommend to the Board to rescind the November 9, 20011 Board meeting motion to submit the proposed amendments as legislation to eliminate the 90-day rule; and direct staff to collect data on the four instances outlined, from May 2012 to May 2013, and to report this data to the Board at its May 2013 meeting. Renee Lonner seconded. The Committee voted unanimously (4-0) to pass the motion.

VIII. Legislative Update

Ms. Helms provided the legislative update.

SB 632 is the clean-up bill for SB 363 that allows a trainee to counsel clients while not enrolled in practicum only if the lapse in enrollment is less than 90 days and is immediately proceeded and followed by enrollment in practicum.

SB 1527 required social workers to take Law and Ethics in their coursework. The bill was amended to address accepting older exam scores. This bill passed committee and is on its way to the Appropriations Committee.

SB 1575, the omnibus bill, makes minor, technical, and non-substantive amendments to add clarity and consistency to current licensing law.

IX. Rulemaking Update

The rulemaking update was provided in the meeting materials.

X. Public Comments for Items Not on the Agenda

Ms. Porter referred to AB 1674, which requires DCA to provide a certification process through 24 hours of training for LMFTs, LCSWs, psychiatrists, psychologists to provide supervised visitation. She noted that LPCCs are not listed in that bill.

XI. Suggestions for Future Agenda Items

Mr. Caldwell stated that members have come to AAMFT-CA regarding concerns about child abuse neglect reporting act. Particularly, the concerns are that it is discriminatory against gay and lesbian adolescents by classifying that oral and anal sex is always abusive, and that vaginal sex is not always abusive. Additionally, it is inconsistent with what is considered to be normal sexual development. There are enough people who are concerned about this that AAMFT-CA would like this to be an issue of discussion.

Dean Porter suggested watching a bill AB 2007, which would license drug and alcohol counselors.

The meeting was adjourned at 1:41 p.m.

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To: Committee Members

Date: July 6, 2012

From: Rosanne Helms
Legislative Analyst

Telephone: (916) 574-7897

Subject: Restoring a Retired License to Active Status

AB 2190 (Chapter 548, Statutes of 2010) gave the Board the authority to issue retired licenses effective January 1, 2011.

As of June 2012, the Board has issued 561 retired licenses. The Board has received one request to reinstate a retired license back to active status.

Requirements for a Retired License

Licensees may request a retired license if they complete the required application, pay the required fee, if the license is current and active or capable of being renewed, and if the license is not under any type of disciplinary action by the Board.

The use of the term “current and active or capable of being renewed” has been a source of confusion for Board staff and licensees since the retired license law went into effect. For example, a suspended license is capable of being renewed; however, the disciplinary action would make the licensee ineligible for a retired license.

The intent of the phrase “capable of being renewed” was to allow a licensee on inactive status to apply for a retired license without having to first renew their license to active status. An inactive license is capable of being renewed. Furthermore, it would be burdensome to require an inactive licensee to complete continuing education and pay a renewal fee for an active license, simply in order to immediately request a retired license.

Due to this confusion, staff recommends consideration of the following amendment:

The board shall issue, upon application and payment of the fee fixed by this chapter, a retired license to a marriage and family therapist/licensed educational psychologist/licensed clinical social worker/professional clinical counselor who holds either a license that is current and active or ~~capable of being renewed~~ a license that is inactive, and whose license is not suspended, revoked, or otherwise punitively restricted by the board or subject to disciplinary action under this chapter. (Business and Professions Code (BPC) §§4984.41(a), 4989.45(a), 4997.1(a), 4999.113(a))

Timeline to Restore to Active Status

Current law allows a holder of a retired licensee to apply to restore his or her license to active status if he or she was issued the retired license less than five years ago.

This law is inconsistent with the law regarding renewal of an expired license. An expired license may only be renewed within three years of its expiration.

Staff recommends consideration of an amendment to reduce the timeline to restore a retired license from retired to active status from five years to three.

Recommendation

Conduct an open discussion to consider replacing the phrase “capable of being renewed,” and to consider narrowing the timeline to restore a retired license to active status.

Attachments

Attachment A: Retired License Statute

Attachment B: General Information about the Retired License

Attachment A Retired License Statute

LMFTs

Business and Professions Code (BPC) §4984.41

- (a) The board shall issue, upon application and payment of the fee fixed by this chapter, a retired license to a marriage and family therapist who holds a license that is current and active or capable of being renewed, and whose license is not suspended, revoked, or otherwise punitively restricted by the board or subject to disciplinary action under this chapter.
- (b) The holder of a retired license issued pursuant to this section shall not engage in any activity for which an active marriage and family therapist license is required.
- (c) The holder of a retired license shall not be required to renew that license.
- (d) The holder of a retired license may apply to restore to active status his or her license to practice marriage and family therapy if that retired license was issued less than five years prior to the application date, and the applicant meets all of the following requirements:
- (1) Has not committed an act or crime constituting grounds for denial of licensure.
 - (2) Pays the renewal fee required by this chapter.
 - (3) Completes the required continuing education as specified in Section 4980.54.
 - (4) Complies with the fingerprint submission requirements established by the board in regulation.
- (e) An applicant requesting to restore his or her license pursuant to subdivision (d), whose license was issued in accordance with this section less than one year from the date of the application, shall complete 18 hours of continuing education as specified in Section 4980.54.
- (f) An applicant requesting to restore his or her license pursuant to subdivision (d), whose license was issued in accordance with this section one or more years from the date of the application, shall complete 36 hours of continuing education as specified in Section 4980.54.
- (g) The holder of a retired license may apply to restore to active status his or her license to practice marriage and family therapy if that retired license was issued five or more years prior to the application date, and the applicant meets all of the following requirements:
- (1) Has not committed an act or crime constituting grounds for denial of licensure.
 - (2) Applies for licensure and pays the fee required by this chapter.
 - (3) Passes the examinations required for licensure.

(4) Complies with the fingerprint submission requirements established by the board in regulation.

LEPs

BPC §4989.45.

(a) The board shall issue, upon application and payment of the fee fixed by this chapter, a retired license to a licensed educational psychologist who holds a license that is current and active or capable of being renewed, and whose license is not suspended, revoked, or otherwise punitively restricted by the board or subject to disciplinary action under this chapter.

(b) The holder of a retired license issued pursuant to this section shall not engage in any activity for which an active educational psychologist license is required.

(c) The holder of a retired license shall not be required to renew that license.

(d) The holder of a retired license may apply to restore to active status his or her license to practice educational psychology if that retired license was issued less than five years prior to the application date, and the applicant meets all of the following requirements:

(1) Has not committed an act or crime constituting grounds for denial of licensure.

(2) Pays the renewal fee fixed by this chapter.

(3) Completes the required continuing education as specified in Section 4989.34.

(4) Complies with the fingerprint submission requirements established by the board in regulation.

(e) An applicant requesting to restore his or her license pursuant to subdivision (d), whose license was issued in accordance with this section less than one year from the date of the application, shall complete 18 hours of continuing education as specified in Section 4989.34.

(f) An applicant requesting to restore his or her license pursuant to subdivision (d), whose license was issued in accordance with this section one or more years from the date of application, shall complete 36 hours of continuing education as specified in Section 4989.34.

(g) The holder of a retired license may apply to restore to active status his or her license to practice educational psychology if that retired license was issued five or more years prior to the application date, and the applicant meets all of the following requirements:

(1) Has not committed an act or crime constituting grounds for denial of licensure.

(2) Applies for licensure and pays the required fee.

(3) Passes the examinations required for licensure.

(4) Complies with the fingerprint submission requirements established by the board in regulation.

LCSWs

BPC §4997.1

(a) The board shall issue, upon application and payment of the fee fixed by this chapter, a retired license to a licensed clinical social worker who holds a license that is current and active or capable of being renewed and whose license is not suspended, revoked, or otherwise punitively restricted by the board or subject to disciplinary action under this chapter.

(b) The holder of a retired license issued pursuant to this section shall not engage in any activity for which an active clinical social worker license is required.

(c) The holder of a retired license shall not be required to renew that license.

(d) The holder of a retired license may apply to restore to active status his or her license to practice clinical social work if that retired license was issued less than five years prior to the application date, and the applicant meets all of the following requirements:

(1) Has not committed an act or crime constituting grounds for denial of licensure.

(2) Pays the required renewal fee.

(3) Completes the required continuing education as specified in Section 4996.22.

(4) Complies with the fingerprint submission requirements established by the board in regulation.

(e) An applicant requesting to restore his or her license pursuant to subdivision (d), whose license was issued in accordance with this section less than one year from the date of the application, shall complete 18 hours of continuing education as specified in Section 4996.22.

(f) An applicant requesting to restore his or her license pursuant to subdivision (d), whose license was issued in accordance with this section one or more years from the date of application, shall complete 36 hours of continuing education as specified in Section 4996.22.

(g) The holder of a retired license may apply to restore to active status his or her license to practice clinical social work if that retired license was issued five or more years prior to the application date, and the applicant meets all of the following requirements:

(1) Has not committed an act or crime constituting grounds for denial of licensure.

(2) Applies for licensure and pays the required fees.

(3) Passes the examinations required for licensure.

(4) Complies with the fingerprint submission requirements established by the board in regulation.

LPCCs

BPC §4999.113

(a) The board shall issue, upon application and payment of the fee fixed by this chapter, a retired license to a professional clinical counselor who holds a license that is current and active or capable of being renewed and whose license is not suspended, revoked, or otherwise punitively restricted by the board or subject to disciplinary action under this chapter.

(b) The holder of a retired license issued pursuant to this section shall not engage in any activity for which an active professional clinical counselor license is required.

(c) The holder of a retired license shall not be required to renew that license.

(d) The holder of a retired license may apply to restore to active status his or her license to practice professional clinical counseling if that retired license was issued less than five years prior to the application date, and the applicant meets all of the following requirements:

(1) Has not committed an act or crime constituting grounds for denial of licensure.

(2) Pays the required renewal fee.

(3) Completes the required continuing education as specified in Section 4999.76.

(4) Complies with the fingerprint submission requirements established by the board in regulation.

(e) An applicant requesting to restore his or her license pursuant to subdivision (d), whose license was issued in accordance with this section less than one year from the date of the application, shall complete 18 hours of continuing education as specified in Section 4999.76.

(f) An applicant requesting to restore his or her license pursuant to subdivision (d), whose license was issued in accordance with this section one or more years from the date of application, shall complete 36 hours of continuing education as specified in Section 4999.76.

(g) The holder of a retired license may apply to restore to active status his or her license to practice professional clinical counseling if that retired license was issued five or more years prior to the application date, and the applicant meets all of the following requirements:

(1) Has not committed an act or crime constituting grounds for denial of licensure.

(2) Applies for licensure and pays the required fees.

(3) Passes the examinations required for licensure.

(4) Complies with the fingerprint submission requirements established by the board in regulation.

Attachment B

General Information about the Retired License

Who May Obtain a Retired License?

Effective January 1, 2011, a person who is a licensee of the Board of Behavioral Sciences (Board) may now obtain a retired license if the following conditions are met:

1. The license is current and active, or capable of being renewed;
2. The license is not suspended, revoked, or otherwise punitively restricted by the Board or subject to disciplinary action.

What are the Restrictions on a Retired Licensee?

A person holding a retired license may not engage in any activity for which an active license issued by the Board is required.

How do I apply for a Retired License?

You must submit an application form to the Board and pay a fee.

When can I apply for a Retired License?

The Board will begin accepting applications for a retired license on January 1, 2011.

What is the Fee for a Retired License?

The fee for issuance of a retired license is \$40.

Do I Need to Renew my Retired License?

A retired license does not need to be renewed.

How Will I Receive Proof of my Retired License Status?

If the application for a retired license is approved, a retired license certificate will be mailed to the retired licensee as proof of their status.

What if my License is Inactive?

Licensees with an inactive license may apply for retired license status if the license is eligible for renewal. If an individual's license is delinquent, all outstanding requirements for renewal must be met before application for retired status.

What are the Differences Between an Inactive License and a Retired License?

The main differences between an inactive license and a retired license are as follows:

1. An inactive licensee pays a biennial fee equal to one-half of the standard renewal fee. A retired licensee pays a one-time fee of \$40.
2. An inactive licensee may restore his or her license to active status upon request, including payment of the renewal fee and completion of continuing education as required by law.
3. A retired licensee may restore his or her license to active status if they meet specified requirements based on how long their license has been in retired status. These requirements are described below.
4. Neither an inactive licensee nor a retired licensee is permitted to engage in any activity for which an active license issued by the Board is required.

How do I Restore my Retired License to Active Status? (If Retired License was Issued Less than 5 Years Ago)

A person requesting to restore his or her retired license to active status whose retired license was issued less than 5 years ago must meet the following requirements:

1. No crime constituting grounds for license denial has been committed.
2. The prescribed renewal fee is paid.
3. All required continuing education is completed.
4. Fingerprints are submitted as required by the Board.

A person requesting to restore his or her retired license to active status whose retired license was issued less than 1 year ago must complete 18 hours of continuing education as required by their licensing law.

A person requesting to restore his or her retired license to active status whose retired license was issued 1 or more years ago must complete 36 hours of continuing education as required by their licensing law.

How do I Restore my Retired License to Active Status? (If Retired License Issued 5 or More Years Ago)

A person requesting to restore his or her retired license to active status whose retired license was issued less than 5 years ago must meet the following requirements:

1. No crime constituting grounds for license denial has been committed.
2. Licensure must be applied for and the prescribed renewal fee paid.
3. The required licensing examinations are passed.
4. Fingerprints are submitted as required by the Board.

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To: Committee Members

Date: July 6, 2012

From: Rosanne Helms
Legislative Analyst

Telephone: (916) 574-7897

Subject: Therapy via Electronic Means

Background

Board staff is receiving an increasing number of inquiries regarding laws and regulations pertaining to therapy via electronic means of communication (telehealth). Telehealth is performed over an electronic medium such as the internet, email, telephone, or teleconference (See **Attachment A** for a complete definition). Most frequently, licensees inquire about the license needed to perform therapy via Skype.

Examples of questions staff receives on a weekly basis are as follows:

1. I am licensed as a marriage and family therapist in Florida. My long-term client is moving to California. Can I still counsel her via Skype?
2. I am licensed social worker in Minnesota. My client has accepted a temporary four month work assignment in California. Can I still have online therapy sessions with him while he is away? He will remain a permanent resident of the state in which I am licensed.
3. I am a licensed clinical counselor in California and I will be travelling overseas for a month. Can I continue to counsel my clients via Skype while I am away?
4. I am a licensed clinical counselor working in a rehabilitation facility in California. My clients live in our facility for several months and then return home. Can I continue to use telehealth to counsel my clients once they return to their homes in other states?
5. I am a licensed marriage and family therapist in the State of California. I frequently perform therapy via Skype for clients in rural areas of California. I recently began supervising a marriage and family therapist intern. Can she also perform therapy via Skype under my supervision?

6. I am a licensed clinical social worker in California and am supervising an associate social worker. My associate is travelling overseas to conduct charitable therapy for a year. Can he count these hours toward licensure if I continue to supervise him via Skype?

Current Law

Board licensing law requires a valid state license in marriage and family therapy, clinical social work, educational psychology, or clinical counseling, respectively, before a person can engage in the practice of any of these professions in this state. (See Business and Professions Code (BPC) §§4980, 4989.50, 4996, 4999.30 and 4999.82 in **Attachment B**).

This implies that a licensee in another state may not counsel an individual while located in the State of California, unless they hold a California license. If the client is not located in California, the state where the client is located would have jurisdiction.

However, as therapy via telehealth is becoming more common, the Board is receiving an increasing number of questions about this issue. Therefore, clarification in regulations may be helpful.

Laws, Regulations and Policies of Other Jurisdictions

Staff has conducted research to examine the laws, regulations, and policies of several other jurisdictions. The findings are summarized below:

California Board of Psychology

The California Board of Psychology, also under the Department of Consumer Affairs, is also considering clarifying telehealth guidelines in regulation.

This board is awaiting recommended guidelines from two national organizations currently examining the issue: the American Psychological Association (APA), and the Association of State and Provincial Psychology Boards (ASPPB).

Their goal is to have guidelines that are in line with the policies of other states. For example, if a national model is developed by one of these associations, the board may consider incorporating it by reference in regulations.

The Psychology Board expects completed models from these associations will be available for review in the fall. The board will consider these models once they become available.

Massachusetts

The Massachusetts Office of Consumer Affairs and Business Regulation licenses mental health professionals in that state. There is currently no language in statute or regulations that specifically discusses therapy performed via telehealth. However, their licensing board has adopted a policy guideline to address questions about the practice of telehealth. This policy guideline can be found in **Attachment C**.

The policy states that therapy via electronic means is considered to occur in both the location of the client and the location of the therapist. Therapy to clients located in

Massachusetts fall under the jurisdiction of the Board, regardless of the location of the therapist. If the therapist is not licensed in Massachusetts and the client is located there, it would be considered unlicensed practice.

The policy encourages Massachusetts licensees who would like to perform telehealth services to a client in another jurisdiction to check the practice requirements in the jurisdiction where the client is located.

Texas

The Texas Department of State Health Services licenses marriage and family therapists, social workers, and professional counselors in that state. A license is required to counsel any clients in Texas. Although this is not explicitly stated in marriage and family therapy or professional counselor law or regulation, there are regulations for social workers which define electronic practice and specify its use as follows:

Electronic practice may be used judiciously as part of the social work process and the supervision process. Social workers engaging in electronic practice must be licensed in Texas and adhere to provisions of this chapter. (Title 22, Texas Administrative Code, Chapter 781, §781.204(g)).

Washington State

The Washington State Department of Health licenses mental health counselors, marriage and family therapists, and social workers. The department indicates they currently do not have specific clarifying regulations, but are looking at the regulations of other states as a possible model.

At this time, when a licensee inquires about telehealth they tell them that they must meet all disclosure and confidentiality requirements. They would also recommend the licensee use an encrypted computer program for online therapy. If they were to receive a complaint about Skype therapy, they may investigate as Skype is not a secured network.

The provider must be credentialed in the state in which they are providing services, and if the client is located in another jurisdiction, they would advise the licensee to contact that jurisdiction for guidance.

Ohio

Mental health practitioners in Ohio are regulated by the Ohio Counselor, Social Worker, and Marriage and Family Therapist Board. The Ohio Administrative Code (OAC) requires practitioners providing services to citizens of Ohio to be licensed in Ohio. It also requires an Ohio licensee who is providing services to a client outside of Ohio to comply with the laws and rules of that jurisdiction.

The OAC also specifies a number of safeguards that its licensees providing services via telehealth must utilize:

- Licensees are required to use encrypted methods of service delivery;
- Licensees must have an initial face-to-face meeting with the client (which may be via electronic communications) to verify the client's identity;
- Licensees must identify an appropriately trained local professional to provide crisis intervention for the client, if needed; and

- Licensees must provide the client with the telephone numbers of the local crisis hotline and the local emergency mental health hotline.

The complete text of the OAC section covering telehealth services can be found in **Attachment D**.

Arizona

The Arizona Board of Behavioral Health Examiners licenses mental health professionals in that state.

According to the department, in Arizona, mental health services are assumed to take place in the jurisdiction where the client lives. Licensees are required to comply with the laws of that jurisdiction. Failure to do so is considered unprofessional conduct, as follows:

Failing to comply with the laws of the appropriate licensing or credentialing authority to provide behavioral health services by electronic means in all governmental jurisdictions where the client receiving these services resides (Arizona Revised Statutes (ARS) Title 32, Chapter 33, §3251(12)(dd)).

Arizona does have some exemptions to licensure that a behavioral health professional from another state who wants to perform services in Arizona may utilize. A non-resident is exempt from licensure if the following conditions are met (ARS Title 32, Chapter 33 §3271):

1. The person performs the behavioral health services for no more than 90 days in any year;
2. Is licensed to perform those services in the state or country where they reside; and
3. Informs the client of the limited nature of the services and that they are not licensed in Arizona.

A practitioner performing services under this law is considered under the jurisdiction of the board and bound by the laws of Arizona.

Under this law, a licensee from another state could counsel a client via telehealth without an Arizona license if the duration of the counseling was less than 90 calendar days and the conditions listed above are met. A licensee of another state whose client was temporarily travelling to Arizona could do the same.

The complete text of this law can be found in **Attachment E**.

Arkansas

The Arkansas Board of Examiners in Counseling requires a counselor or a marriage and family therapist licensed in Arkansas who wishes to perform counseling via electronic or technology-assisted mediums to obtain a "Technology-Assisted Distance Counseling or Marriage and Family Therapy Specialization License". This specialization requires specific training approved by the board.

Any telehealth counseling that occurs in Arkansas, whether by a Arkansas counselor or an out of state counselor, is considered to occur in Arkansas and the practitioner must hold the valid specialized license.

The Board has adopted the National Board of Certified Counselors (NBCC) document titled “The Practice of Internet Counseling” (2005) as part of its rules to clarify standards related to counseling via telehealth. This document defines various types of counseling, and outlines standards for ethical practice of internet counseling.

Rules related to technology-assisted distance counseling in the State of Arkansas can be found in **Attachment F**.

Discussion of Alternatives

Based on these findings, the Board has a number of options for clarifying the law for therapy via telehealth:

1. **Status Quo:** The Committee could decide to make no clarifying changes to current law or regulations. Current law requires a valid state license to practice marriage and family therapy, clinical social work, educational psychology, or clinical counseling in California. (Current law is shown in **Attachment B**). A therapist must have a valid California license to perform therapy on a client in California. A California licensed therapist would need to check licensing requirements with the other jurisdiction if performing therapy on a client in that jurisdiction.
2. **Incorporate National Model or Guidelines:** The Committee could direct staff to research models and guidelines of various national associations. The Board could then adopt the model or guideline it found most appropriate, and incorporate it either directly into regulations, or by reference.

This approach would be similar to the State of Arkansas’ adoption of the 2005 NBCC standards (**Attachment F**). This is also the approach being considered by the California Board of Psychology.

3. **Draft Regulations:** The Committee could direct staff to draft regulations clarifying its policy on telehealth. The draft regulations could be modeled after the Massachusetts policy guidelines (**Attachment C**), or the Ohio Administrative Code (**Attachment D**). The draft regulations could specify certain safeguards, if desired by the Board (for example, requiring encrypted methods of service delivery, providing telephone numbers for the local crisis hotline).

Recommendation

Conduct an open discussion of the alternatives discussed above, with specific focus on the following:

- Performance of telehealth while therapist is temporarily in another jurisdiction;
- Performance of telehealth while client is temporarily in another jurisdiction;

- Performance of telehealth by associates and interns; and
- Use of telehealth to supervise associates and interns who are travelling in another jurisdiction and performing services in that jurisdiction.

Direct staff to conduct research or draft clarifying regulations based on the Committee's discussion.

Attachments

Attachment A: California Business and Professions Code Section 2290.5: Definition of Telehealth

Attachment B: Current Law for Engaging in Practice in California

Attachment C: State of Massachusetts Policy on Distance, Online, and Other Electronic-Assisted Counseling

Attachment D: State of Ohio Administrative Code – Electronic Service Delivery Provisions

Attachment E: State of Arizona Revised Statutes – Exemptions to Licensure

Attachment F: State of Arkansas Code – Technology-Assisted Distance Counseling

Attachment G: Article: *“When Your Therapist is Only a Click Away,”* New York Times, September 23, 2011

Attachment H: Article: *“Effect of Telephone-Administered vs Face-to-Face Cognitive Behavioral Therapy on Adherence to Therapy and Depression Outcomes Among Primary Care Patients,”* Journal of American Medical Association, June 6, 2012.

Attachment A
California Business and Professions Code Section 2290.5
Definition of Telehealth

Business and Professions Code §2290.5

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

(1) "Asynchronous store and forward" means the transmission of a patient's medical information from an originating site to the health care provider at a distant site without the presence of the patient.

(2) "Distant site" means a site where a health care provider who provides health care services is located while providing these services via a telecommunications system.

(3) "Health care provider" means a person who is licensed under this division.

(4) "Originating site" means a site where a patient is located at the time health care services are provided via a telecommunications system or where the asynchronous store and forward service originates.

(5) "Synchronous interaction" means a real-time interaction between a patient and a health care provider located at a distant site.

(6) "Telehealth" means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

(b) Prior to the delivery of health care via telehealth, the health care provider at the originating site shall verbally inform the patient that telehealth may be used and obtain verbal consent from the patient for this use. The verbal consent shall be documented in the patient's medical record.

(c) The failure of a health care provider to comply with this section shall constitute unprofessional conduct. Section 2314 shall not apply to this section.

(d) This section shall not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law.

(e) All laws regarding the confidentiality of health care information and a patient's rights to his or her medical information shall apply to telehealth interactions.

(f) This section shall not apply to a patient under the jurisdiction of the Department of Corrections and Rehabilitation or any other correctional facility.

(g) (1) Notwithstanding any other provision of law and for purposes of this section, the governing body of the hospital whose patients are receiving the telehealth services may grant privileges to, and verify and approve credentials for, providers of telehealth services based on its medical staff recommendations that rely on information provided by the distant-site hospital or telehealth entity, as described in Sections 482.12, 482.22, and 485.616 of Title 42 of the Code of Federal Regulations.

(2) By enacting this subdivision, it is the intent of the Legislature to authorize a hospital to grant privileges to, and verify and approve credentials for, providers of telehealth services as described in paragraph (1).

(3) For the purposes of this subdivision, "telehealth" shall include "telemedicine" as the term is referenced in Sections 482.12, 482.22, and 485.616 of Title 42 of the Code of Federal Regulations.

Attachment B
California Business and Professions Code
Current Law for Engaging in Practice in California

LMFT Statute

Business and Professions Code (BPC) §4980

(a) Many California families and many individual Californians are experiencing difficulty and distress, and are in need of wise, competent, caring, compassionate, and effective counseling in order to enable them to improve and maintain healthy family relationships.

Healthy individuals and healthy families and healthy relationships are inherently beneficial and crucial to a healthy society, and are our most precious and valuable natural resource. Marriage and family therapists provide a crucial support for the well-being of the people and the State of California.

(b) No person may engage in the practice of marriage and family therapy as defined by Section 4980.02, unless he or she holds a valid license as a marriage and family therapist, or unless he or she is specifically exempted from that requirement, nor may any person advertise himself or herself as performing the services of a marriage, family, child, domestic, or marital consultant, or in any way use these or any similar titles, including the letters "M.F.T." or "M.F.C.C.," or other name, word initial, or symbol in connection with or following his or her name to imply that he or she performs these services without a license as provided by this chapter. Persons licensed under Article 4 (commencing with Section 4996) of Chapter 14 of Division 2, or under Chapter 6.6 (commencing with Section 2900) may engage in such practice or advertise that they practice marriage and family therapy but may not advertise that they hold the marriage and family therapist's license.

LEP Statute

BPC §4989.50

Except as authorized by this chapter, it is unlawful for any person to practice educational psychology or use any title or letters that imply that he or she is a licensed educational psychologist unless, at the time of so doing, he or she holds a valid, unexpired, and unrevoked license issued under this chapter.

LCSW Statute

BPC §4996

(a) Only individuals who have received a license under this article may style themselves as "Licensed Clinical Social Workers." Every individual who styles himself or herself or who holds himself or herself out to be a licensed clinical social worker, or who uses any words or symbols indicating or tending to indicate that he or she is a licensed clinical social worker, without holding his or her license in good standing under this article, is guilty of a misdemeanor.

(b) It is unlawful for any person to engage in the practice of clinical social work unless at the time of so doing such person holds a valid, unexpired, and unrevoked license under this article.

(c) A clinical social worker licensed under this chapter is a licentiate for purposes of paragraph (2) of subdivision (a) of Section 805, and thus is a health care practitioner subject to the provisions of Section 2290.5 pursuant to subdivision (b) of that section.

LPCC Statute

BPC §4999.30

Except as otherwise provided in this chapter, a person shall not practice or advertise the performance of professional clinical counseling services without a license issued by the board, and shall pay the license fee required by this chapter.

BPC §4999.82

It shall be unlawful for any person to engage in any of the following acts:

(a) Engage in the practice of professional clinical counseling, as defined in Section 4999.20, without first having complied with the provisions of this chapter and without holding a valid license as required by this chapter.

(b) Represent himself or herself by the title "licensed professional clinical counselor," "LPCC," "licensed clinical counselor," or "professional clinical counselor" without being duly licensed according to the provisions of this chapter.

(c) Make any use of any title, words, letters, or abbreviations, that may reasonably be confused with a designation provided by this chapter to denote a standard of professional or occupational competence without being duly licensed.

(d) Materially refuse to furnish the board information or records required or requested pursuant to this chapter.

Attachment C
State of Massachusetts
Policy on Distance, Online, and Other Electronic-Assisted Counseling

The Board of Registration of Allied Mental Health and Human Services Professionals ("the Board") voted at its meeting on November 16, 2007 to adopt the following Policy Guideline. This policy guideline is intended as a recommended protocol for the profession to follow. The guideline set forth below does not have the full force and effect of law, as would a Massachusetts General Law or a Board rule or regulation. However, the Board uses policy guidelines as an internal management tool in formulating decisions that relate to issues in the practice of allied mental health and human services.

Policy No. 07-03

Purpose:

The Board acknowledges that therapy and counseling are increasingly being provided at a distance, making use of the internet, telephone and other electronic means of communication. The emergence of new clinical procedures is necessarily accompanied by uncertainty about legal and ethical obligations. The purpose of this policy statement is to offer guidance to Licensees regarding the ethical obligations and standards of conduct in the use of distance, on-line, and other electronic assisted counseling.

Policy:

The Board's policy with regard to all distance or electronic-assisted provision of clinical services is as follows:

1. The services offered by licensees of this Board across a distance by electronic means, fall within the jurisdiction of the Board just as traditional, face-to-face services do. Therefore all Board policies and regulations will apply to these services.
2. Distance delivery of counseling and therapy is considered to occur in two locations: where the client is located and where the clinician is located.
3. Therefore, the provision of counseling and/or therapy to individuals located within Massachusetts at the time services are occurring, are considered to fall under the jurisdiction of the Board, regardless of the location of the provider.
4. Mental health professionals licensed by any jurisdiction other than Massachusetts, and not licensed by any Massachusetts Board or not eligible for an exception to Massachusetts licensure, are considered unlicensed by this Board for practice in Massachusetts.

5. Mental health professionals licensed by other jurisdictions who wish to provide services to clients within Massachusetts, are encouraged to apply for Massachusetts licensure. Some, licensees may find the following helpful:

a. Mental Health Counselors: 262CMR 2.03, (1) Licensure for CCMHC's in good standing with NBCC

b. MFT's: 262 CMR 3.04 Licensure by Reciprocity for MFT's.

6. Board licensees who wish to provide services via electronic means to clients located outside of Massachusetts are urged to ensure that they meet the requirements for practice within the jurisdiction where the client is located.

7. Licensees are encouraged to carefully review the way in which the structure of their relationships with clients will be impacted by distance-therapy or counseling to ensure **compliance with** Board regulations and standards of practice.

8. The following are some areas of practice that **licensees should carefully consider**:

- a. Informed consent
- b. Confidentiality
- c. Basis for making clinical judgments
- d. Areas of competence
- e. Avoiding harm
- f. Fees and financial arrangements
- g. Advertising
- h. Abandonment of clients
- i. Handling requests for obtaining clinical records

9. The Board expects licensees to understand and overcome the significant challenges inherent in providing counseling and therapy without face-to-face contact with the client.

10. Some of the challenges **that licensees are expected to manage include, but are not limited to**:

a. Full disclosure with regard to potential risks to confidentiality, including computer hacking and/or archiving of communications.

b. Full disclosure of the limits to confidentiality in the jurisdictions where the client, and where the clinician are located.

c. Full disclosure of mandated reporting requirements in the jurisdictions where the client, and where the clinician are located.

d. Full disclosure with regard to the potential disadvantages or limitations of electronic-assisted clinical services.

- e. Redirection and/or referral of clients for whom electronic services will not be adequate or appropriate.
 - f. Full disclosure with regard to fees and billing practices.
 - g. Full disclosure with regard to licensing, credentials and areas of expertise.
 - h. Screening and local referral for critical and urgent problems.
 - i. Verification of the identity and age of the client.
 - j. Obtaining consent to provide services by a guardian for minors or other vulnerable clients.
 - k. Management of any misunderstanding or compensation for any missing information, resulting from the lack of visual or auditory cues.
 - l. Managing the problem of incomplete or inaccurate diagnoses that may result from electronic-assisted services.
 - m. Managing the potential for technology failure
 - n. Procedures for contacting the clinician when he/she is offline
11. The Board expects that licensees providing any form of distance counseling will comply with all of the guidelines of ethical practice that apply to traditional, face-to-face counseling.
12. The Board expects that licensees will practice distance counseling in a manner that is consistent with any existing guidelines provided by their professional associations.
13. The Board expects that licensees providing any form of distance counseling will ensure that they are properly trained to manage the specific challenges of this form of counseling and will regularly participate in sufficient continuing education activities that maintain and update the required skills.
14. Unlicensed providers of electronic-assisted counseling will be **treated** by the Board in the same manner as providers of unlicensed counseling in traditional settings.

Authority:

M.G.L. Chapter 13, Section 90; and 262 CMR 8.00 et seq.

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Attachment D

Ohio Administrative Code (OAC)

Chapter 4757-3-01 (EE) “Electronic service delivery” (electronic therapy, cyber therapy, e-therapy, etc.) means counseling, social work or marriage and family therapy in any form offered or rendered primarily by electronic or technology-assisted approaches when the counselor, social worker or marriage and family therapist and the client are not located in the same place during delivery of services.

[4757-5-13 Standards of practice and professional conduct: electronic service delivery \(internet, email, teleconference, etc.\).](#)

Electronic service delivery is defined in paragraph (EE) of rule [4757-3-01](#) of the Administrative Code. Licensees are reminded that standards of ethical practice and professional conduct rules [4757-5-01](#) to [4757-5-12](#) of the Administrative Code apply to electronic service delivery.

(A) These standards govern the practice of electronic service delivery and address practices that are unique to electronic service delivery and electronic service delivery practitioners.

(1) All practitioners providing counseling, social work or marriage and family therapy via electronic service delivery to Ohio citizens shall be licensed in Ohio.

(2) All licensees of this board providing services to clients outside the state of Ohio shall comply with the laws and rules of that jurisdiction.

(3) Electronic service delivery shall require an initial face-to-face meeting, which may be via video/audio electronically, to verify the identity of the electronic service delivery client. At that meeting steps shall be taken to address impostor concerns, such as by using passwords to identify the client in future electronic contacts.

(4) Informed consent shall include information defining electronic service delivery as practiced by the licensee and the potential risks and ethical considerations per paragraph (B) of rule [4757-5-02](#) of the Administrative Code.

(a) Licensees shall obtain written informed consent.

(b) Licensees shall not provide services without client signed informed consent.

(5) Licensees shall provide links to websites for all of their certification bodies and licensure boards to facilitate consumer protection.

(6) Licensees shall identify an appropriately trained professional who can provide local assistance, including crisis intervention, if needed. Licensees shall provide electronic service delivery clients the local crisis hotline telephone number and the local emergency mental health telephone number.

(7) Licensees shall provide a link to the board's online license verification site on their web page. They shall also have a copy of the professional disclosure statement available on their web site per rule [4757-5-12](#) of the Administrative Code.

(B) Confidentiality in electronic service delivery shall be maintained by the licensee:

(1) Licensees shall use encryption methods for electronic service delivery; and

(2) Shall inform electronic service delivery clients details of data record storage.

Effective: 10/18/2009

R.C. [119.032](#) review dates: 09/20/2012

Promulgated Under: [119.03](#)

Statutory Authority: 4757.11

Rule Amplifies: 4757.11

Attachment E
State of Arizona
Board of Behavioral Health Examiners
Arizona Revised Statutes
Title 32, Chapter 33

32-3271. Exceptions to licensure; jurisdiction

A. This chapter does not apply to:

1. A person who is currently licensed, certified or regulated pursuant to another chapter of this title and who provides services within the person's scope of practice if the person does not claim to be licensed pursuant to this chapter.

2. A person who is not a resident of this state if the person:

(a) Performs behavioral health services in this state for not more than ninety days in any one

calendar year as prescribed by board rule.

(b) Is authorized to perform these services pursuant to the laws of the state or country in which

the person resides or pursuant to the laws of a federally recognized tribe.

(c) Informs the client of the limited nature of these services and that the person is not licensed in this state.

3. A rabbi, priest, minister or member of the clergy of any religious denomination or sect if the

activities and services that person performs are within the scope of the performance of the

regular or specialized ministerial duties of an established and legally recognizable church,

denomination or sect and the person performing the services remains accountable to the

established authority of the church, denomination or sect.

4. A member run self-help or self-growth group if no member of the group receives direct or

indirect financial compensation.

5. A behavioral health technician or behavioral health paraprofessional who is employed by an

agency licensed by the department of health services.

6. A person contracting with the supreme court or a person employed by or contracting with an

agency under contract with the supreme court who is otherwise ineligible to be licensed or who

is in the process of applying to be licensed under this chapter as long as that person is in

compliance with the supreme court contract conditions regarding professional counseling services and practices only under supervision.

7. A person who is employed by the department of economic security and who practices social work, marriage and family therapy, substance abuse counseling, counseling and case management within the scope of the person's job duties and under direct supervision by the department of economic security.

8. A student, intern or trainee who is pursuing a course of study in social work, counseling, marriage and family therapy, substance abuse counseling or case management in a regionally accredited institution of higher education or training institution if the person's activities are performed under qualified supervision and are part of the person's supervised course of study.

9. A person who is practicing social work, counseling and case management and who is employed by an agency licensed by the department of economic security.

10. A paraprofessional employed by the department of economic security or by an agency licensed by the department of economic security.

11. A christian science practitioner if all of the following are true:

(a) The person is not providing psychotherapy.

(b) The activities and services the person performs are within the scope of the performance of the regular or specialized duties of a christian science practitioner.

(c) The person remains accountable to the established authority of the practitioner's church.

12. A person who is not providing psychotherapy.

B. A person who provides services pursuant to subsection A, paragraph 2 is deemed to have agreed to the jurisdiction of the board and to be bound by the laws of this state.

Attachment F
Arkansas Board of Examiners in Counseling
Rules for Arkansas Code Anotated 17-27-101 Et Seq

Section 1.9 (t) “Technology-Assisted Distance Counseling” (Electronic Counseling, Cyber Counseling) for Counseling or Marriage and Family Therapy means any form of services offered or rendered by electronic or technology-assisted approaches when the Counselor or Marriage and Family Therapist and the client are not located in the same place. Technology-Assisted Distance Counseling may be synchronous or asynchronous. Only Counselors and Marriage and Family Therapists, licensed by the Arkansas Board of Examiners in Counseling, who also hold the Technology-assisted Distance Counseling or Marriage and Family Therapy Specialization License, may provide Technology Assisted Distance Counseling or Marriage and Family services.

Section 1.9 (w) “Technology” means electronically based hardware, software, video and related systems and telephone systems to deliver knowledge, skills, and tools for learning and communication processes. Technology for Counseling or Marriage and Family Therapy encompasses distance learning and distance counseling by any form of technology system /telephone system delivers of services. See section XII for the Technology-Assisted Distance Counseling definitions.

Section 3.5 (9) Technology-Assisted Distance Counseling or Marriage and Family Therapy Specialization license standards for issue for Counseling or Marriage and Family Therapy or Supervision being:

(A) A licensed LPC/LAC or LMFT/LAMFT in good standing with the Board must apply for the Technology-assisted Distance Counseling or Marriage Family Therapy specialization license and submit documentation of training for approval by the Board. As training sources are developed, the responsibility for seeking Board endorsement for the training rests with the provider of the training. The provider must submit a written request with materials documenting the training content for Board review and approval prior to endorsement of the training.

(B) The written submission of a detailed plan that delineates how the applicant will meet provisions of the 2005 American Counseling Association Code of Ethics and the Standards in Section XII regulating Technology-Assisted Distance Counseling or Marriage and Family Therapy for Board approval.

(C) Revised Statement of Intent (scope of practice) that includes a description of the Technology-Assisted Distance Counseling or Marriage and Family Therapy.

(D) The Board may require an oral examination if there are unresolved questions about requirements (9) (A-F).

(E) The submitted materials must be approved by the Board prior to the Technology-Assisted Distance Counseling or Marriage and Family Therapy Specialization license being issued.

(F) Any Technology-Assisted Distance Counseling or Marriage and Family Therapy that occurs within the State of Arkansas, whether by an Arkansas counselor or by an out of state Counselor or Marriage and Family Therapist, is deemed to have occurred in Arkansas. All providers of services whether traditional or Technology-Assisted who may offer or provide Counseling or Marriage and Family Therapy services to individuals or groups must hold a valid Arkansas license to provide such services.

(e) Specialization requests not already specified will be reviewed by the Board and standards established as needed.

(f) Licensed Counselors or Therapist who apply for a specialization license will be issued such license upon completion of the application for a specialization, documentation of a valid national or required credential (certificate, registry, or license), Pass on the oral examination (if required), payment of the specialization fee and approval by majority vote of the Board.+

SECTION XII. THE PRACTICE OF INTERNET OR TELEPHONE SERVICES

The Board adopts the National Board for Certified Counselors (NBCC) document titled The Practice of Internet Counseling, published in 2005. The NBCC document is adopted as part of Arkansas Rules to further extend and clarify Technology-Assisted Distance Counseling Ethics, Definitions and Standards for Counselors and Marriage and Family Therapist licensed in the state of Arkansas. The adoption of the document is to support and extend the American Counseling Code of Ethics, 2005 edition for the practice of Internet Counseling. *(Attachment Next Page)*

ARKANSAS BOARD OF EXAMIENRS IN COUNSELING
RULES FOR ARKANSAS CODE ANNOTATED 17-27-101 ET SEQ

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RULES

ARKANSAS CODE ANNOTATED § 17-27-101 et seq
Act 593 of 1979 and Act 244 of 1997

I. General Information

Section 1.1 ENABLING LEGISLATION

The Rules are adopted pursuant to Arkansas Code Annotated § 17-27-101-313 et seq.

Preface

The Arkansas Board of Examiners in Counseling interprets the intent of the Legislature, passed as Arkansas Code Annotated § 17-27-101 -104 et seq., to provide for the licensure and regulation of Counselors and Marriage and Family Therapists. The Act is both title and practice. The Governor, who signed it into law in 1979, and the Board interprets Act 593 of 1979, as amended by Act 244 of 1997, to be for the protection of the public welfare and in the public interest.

The Board of Examiners in Counseling shall, in all deliberations and in all adopted Rules, diligently pursue goals most consistent with the public interest and shall, at all times, apply the provisions of Arkansas Code Annotated § 17-27-101, et seq and the Rules adopted, from time to time, in a fair and impartial manner.

Section 1.2 DESCRIPTION OF ORGANIZATION

The Arkansas Board of Examiners in Counseling is composed of nine (9) members appointed by the Governor to staggered terms of three years. The composition of the Board shall include six (6) licensed or licensable counselors (three practicing counselors and three counselor educators or supervisors, one of which shall also be a licensed Marriage and Family Therapist, if available, and one (1) non-licensed individual who represents the general public. The seven are recommended to the governor by November 1 each year by the Executive Committee of the Arkansas Counseling Association (ArCA) or the Executive Committee of the Arkansas Mental Health Counseling Association (ArMHCA). One (1) licensed Marriage and Family Therapist shall be recommended to the governor by the Board of Directors of the Arkansas Association for Marriage and Family Therapists (ArAMFT). One (1) non-licensed member shall represent the over sixty populations and is selected by the governor from the general population. Section (c)(1)(e)(1)

The appointed replacement shall be eligible for reappointment to a full three year term upon completion of the partial term appointment created by the vacancy. Section (c) (1) (e) (1) (g)

Board members shall be ineligible for reappointment for a period of three (3) years following completion of each full, three (3) year term.

1.3 INFORMATION FOR PUBLIC GUIDANCE

Records of the Board shall be kept, maintained, and made available for inspection in accordance with the Arkansas Freedom of Information Act (Arkansas Code Annotated § 25-19-101 et seq).

In accordance with Arkansas Code Annotated §25-19-101 et seq, examination and copying of public records, client records “such as state income tax returns, medical records, scholastic records, adoption records, and other similar records which by law are required to be closed to the public shall not be deemed to be made open to the public.”

Individual files, not required to be kept for historical purposes (Act 918 of 2005- An Act Concerning the Retention of Public Records by State Agencies), will be destroyed after five years. Examples are: incomplete application files, non renewed licensee files, and files of deceased persons. If any form of disciplinary action was recorded for any licensee or applicant, the files will be kept permanently and never destroyed. If persons who no longer hold a license or failed to be granted a license have a file in the “DO NOT DESTROY” files and apply for a license, the old file will be combined with the new application for Board review.

Information for public guidance will follow Arkansas Code Annotated § 25-19-108 of the Arkansas Freedom of Information Act for public distribution.

The Board will periodically release names of new licensees and the names of those licensees whose licenses have been suspended or revoked, and those who are appealing a suspension or a revocation, to the Arkansas Counseling Association, to the Arkansas Association of Marriage and Family Therapy, and the Arkansas Mental Health Counselors Association for publication in their newsletters.

A periodic press release may be issued to state-wide newspapers listing licenses issued, suspended, and revoked. If the suspension or revocation is under appeal it will be so noted.

Final decisions arrived at through administrative hearings will be available to requesters [including third party payers]. These decisions will be available through the Board’s web site or by written request from the Board office.

Section 1.4

PURPOSE OF ORGANIZATION

Law charges the Board with the responsibility for the regulation of the titles and the practices of Counseling and Marriage and Family Therapy and Specialization Licenses related to Counseling and Marriage and Family Therapy in the State of Arkansas. This includes examining the qualifications of the applicants and approving each for licensing, as well as revoking, suspending, and renewing licenses.

Persons engaged in practices/activities of Counseling or Marriage and Family Therapy to individuals or groups in Arkansas must hold an Arkansas license for whatever method the services are offered, rendered or delivered. These regulations apply to all traditional approaches and to all technology-assisted distance approaches, including telephone approaches, to Counseling or Marriage and Family Therapy offered to individuals or groups in Arkansas. Telephone Crisis “Hot Lines”, telephone consultation between licensed mental health providers and emergency telephone calls are exempt. Counseling or Marriage and Family Therapy telephone services provided as a regular scope of practice, as a business, advertised to the public with hourly fees as mental health services by Counselors or Marriage and Family Therapists requires and Arkansas license. See Section XII for the ethics, definitions and standards.

In order to protect the citizens of Arkansas, obtaining a license as a Counselor/Psychotherapist or Marriage and Family Therapist is a prerequisite to offering, rendering or delivering counseling services in Arkansas to individuals or groups located in Arkansas. The license requirement applies to traditional face to face counseling as well as to Technology-Assisted distance (electronic, computer, telephone) counseling.

If the individual or group receiving mental health services is physically located in Arkansas, the Counselor/Psychotherapist or Marriage and Family Therapist providing the services must hold an Arkansas license regardless of the whether he or she is located in-state or out of state.

If the Counselor/Psychotherapist or Marriage and Family Therapist is physically located in Arkansas, he or she must have an Arkansas license to provide Counseling/Psychotherapy or Marriage and Family Therapy services to individuals or groups located in Arkansas. If the licensee offers services to clients in another state, the licensee is subject to the laws of that state.

Section 1.5

ORGANIZATION OF THE BOARD

The Board will meet to organize within 30 days following January 2 of each year. The Board shall elect a chair and a secretary and other such officers, as it deems

necessary, from its members to serve for terms of one year. Five (5) members shall at all times constitute a quorum. Additional meetings may be held at the discretion of the chair or upon written request of any three (3) members of the Board (Arkansas Code Annotated § 17-27-202 et seq).

Section 1.6 MEETINGS

Meetings of the Board, formal or informal, shall be open to the public. Dates, times, and places of meetings shall be furnished to anyone requesting the information and made available to the press in compliance with Arkansas Code Annotated § 25-19-101 et seq. (Freedom of Information Act).

Under the provisions of the Arkansas Freedom of information Act the Board may go into executive session for the purpose of giving oral licensure examinations or to develop examination questions to comply with Arkansas Code Annotated § 26-179-1059 (c) (5) (b). Executive session may be applied in accordance with Arkansas Code Annotated § 25-19-106 (a) (c) (1) and (5) (A) (B).

Section 1.7 FINANCES

The Board shall set licensing fees and no part of any fee shall be refundable under any conditions other than failure of the Board to hold examinations at the time originally announced. All fees collected shall be held in an Arkansas Bank, chosen by the Board, and deposited in the State Treasury to the credit of the Board via electronic transfer from the chosen financial institution. (A.C.A. Code 17-27-310 (C)(1) with funds being disbursed in accordance with current standard state accounting procedures. In addition to fees collected, the Board is empowered to accept grants from foundations and institutions to carry out its function. The Board may hire such personnel as necessary to carry out its activities. The Board Chairperson and the Executive Director shall be bonded to handle finances of the Board in compliance with state regulations.

All receipts for fees are numbered in triplicate and dated. Receipt numbers are to be certified by notarized letter from place of purchase.

Section 1.8 INTENT OF THE ACT

It is intended that the provisions of Arkansas Code Annotated § 17-27-101 et seq be in accordance and consistent with other licensing laws.

Section 1.9 DEFINITIONS

- (a) "Appraisal activities" means selecting, administering, scoring and interpreting instruments designed to assess an individual's aptitudes, attitudes, abilities, achievements, personal characteristics and interests, but shall not include the use of projective techniques for personality assessment unless specifically qualified to do so under another license. Documentation of all training for

appraisal activities and Board approval for those activities is required for protection of the public. Appraisal Specialization License [Rule Section 3.5 (C) (6)] is required if appraising/evaluating for placement of children or adults in special programs, in schools, institutions, etc. If appraisals are conducted under contracts with public schools or for the Arkansas Department of Human Services the Appraisal Specialization License must be verified prior to reimbursement to schools or individuals.

- (b) “Counseling/Psychotherapy” means assisting individuals or groups, through the counseling relationship, to develop understanding of personal problems, define goals, and plan action reflecting interests, abilities, aptitudes, and needs. Counseling/Psychotherapy is the application of mental health, psychological, or human development principles, through cognitive, affective, behavioral or systemic intervention strategies that address wellness, personal growth, or career development, as well as pathology. The terms Counseling/ Psychotherapy are used interchangeably in definitions of mental health activities in counseling textbooks
- (c) “Licensed Associate Counselor” means any person holding himself/herself out to the public by any title or description of services incorporating the words Licensed Associate Counselor, who meets the requirements set forth in Section 3.1 of these rules and regulations, and who offers to render counseling services to individuals, groups, organizations, corporations, institutions, government agencies, or the general public for monetary remuneration otherwise implying licensure, training, experience, and/or expertise in counseling, and who holds a current, valid license to practice counseling under the supervision of a duly Licensed Professional Counselor. Nothing in this definition shall be construed to include those professions excluded by Ark. Code Ann. § 17-27-103.
- (d) “Licensed Associate Marriage and Family Therapist” means any person who holds himself/herself out to the public by any title or description of services incorporating the words licensed associate marriage and family therapist, who meets the requirements set forth in Section 3.3 of these rules and regulations; offers to render marriage and family therapy services to individuals, couples and families, singularly or in groups for monetary remuneration; or holds a current, valid license to practice marriage and family therapy services under the supervision of a licensed Marriage and Family Therapist. Nothing in this definition shall be construed to include those professions excluded by Ark. Code Ann. § 17-27-103.
- (e) “Licensed Marriage and Family Therapist” means any person who: holds himself/herself out to the public by any title or description of services incorporating the words licensed marriage and family therapist, who meets the requirements set forth in Section 3.4 of the rules and regulations; offers to render marriage and family therapy services to individuals, groups, couples,

families, organizations, corporations, institutions, government agencies, or the general public for monetary remuneration or otherwise implying that he or she is licensed, trained, experienced, or an expert in marriage and family therapy; or holds a current, valid license to practice marriage and family therapy. Nothing in this definition shall be construed to include those professions excluded by Ark. Code Ann. § 17-27-103.

- (f) “Licensed Professional Counselor” shall mean any person holding himself/herself out to the public by any title or description of services incorporating the words Licensed Professional Counselor, who meets the requirements set forth in Section 3.2 of the rules and regulations, and who offers to render counseling services to individuals, groups, organizations, corporations, institutions, government agencies, or to the general public for monetary remuneration or who otherwise implies licensure, training, experience, and/or expertise in counseling and who holds a current valid license to practice counseling/psychotherapy. Nothing in this definition shall be construed to include those professions excluded by Ark. Code Ann. § 17-27-103.
- (g) “Marriage and Family Therapy” means the use of scientific and applied marriage and family theories, methods and procedures for the purpose of describing, evaluating and modifying marital, family and individual behavior within the context of marital and family systems, including the context of marital formation and dissolution. Marriage and family therapy is based on systems theories, marriage and family development, normal and dysfunctional behavior, human sexuality and psychotherapeutic, marital and family therapy theories, and techniques in the evaluation, assessment and treatment of interpersonal or intrapersonal dysfunction within the context of marriage and family systems. Marriage and family therapy may also include clinical research into more effective methods for the treatment and prevention of the above-named conditions. Nothing in this definition or in this chapter shall be construed as precluding licensed professional counselors or licensed associate counselors from rendering these services.
- (h) “Privileged Communication” shall mean any communication between client and counselor given in confidence and not intended to be disclosed to third persons other than those to whom disclosure is made in the furtherance of the rendition of professional services to the client.
- (i) “Referral activities” means the evaluating of data to identify problems and to determine the advisability of referral to other specialists.
- (j) “Relevant Professional” or “Continued Education Experience” means documented training, workshops, institutes, seminars, etc., primarily counseling in content. The Board accepts documented clock hours as described in Section 7.3.

- (k) “Research activities” means reporting, designing, conducting, or consulting on research in counseling with human subjects.
- (l) “Statement of Professional Intent” means a typed statement from the applicant , on file with the Board, describing the scope of practice for use under the requested license, the public with whom the applicant will work, and the counseling/psychotherapy and *appraisal approaches the applicant plans to use (including techniques and tools)*.
- (m) “Supervision” means professional monitoring and reporting (a) of a Licensed Associate Counselor (LAC) by an individual licensed as a LAC supervisor and (b) of a Licensed Associate Marriage and Family Therapist (LAMFT) by an individual licensed as a LMFT supervisor.
- (n) “Practicing Counselors” means individuals who apply mental health, psychological or human development principles, through cognitive, affective, behavioral or systemic intervention, strategies that address wellness, personal growth, or career development, as well as pathology.
- (o) “Counselor Educator” means Counselors who are responsible for developing, implementing, and supervising educational programs and are skilled as teachers and practitioners. They are knowledgeable regarding the ethical, legal, and regulatory aspects of the profession, are skilled in applying that knowledge, and make students and supervisees aware of their responsibilities. Counselor Educators conduct counselor education and training programs in an ethical manner and serve as role models for professional behavior. Individuals, who develop, implement/conduct and supervise comprehensive education and training programs for counseling trainees in a knowledgeable, skillful and ethical manner, and serve as culturally-aware role models for professional behavior. Counselor Educators are considered professionals at the degree level of Ed.D. or Ph.D. in counseling, psychology, or closely related field level of education who infuse material related to human diversity into all courses and/or workshops that are designed to promote the development of professional counselors. Counselor Educators are individuals whose primary profession is as a counselor educator, employed at least half time in an Arkansas institution of higher education or counselor educators retired from a higher education institution in Arkansas.
- (p) “Adjunct lecturer” means persons who teach counseling courses, part time for various reasons at universities in higher education. They are considered practicing counselors by profession, if licensed or licensable. They are eligible for board service under the practicing counselor category.
- (q) “Supervisor” means an individual who holds a state appointment as a supervisor in the State Department of Education for the purpose of promoting

the development of professional counselors in the public schools and holds the EdD or the PhD level of education in counseling or related field. The intent of Act 593 of 1979 was to recognize the State Supervisors of public school counselors as equal to Counselor Educators in Higher Education as persons responsible for programs and training. The amendments of Act 244 of 1997 did not address nor change the intent of the Act 593 of 1979. Arkansas individuals who hold the LPC or LMFT license and also hold the Supervision Specialization License are approved to supervise LAC and LAMFT licensed individuals.

- (r) “Licensed or Licensable” means a person who hold an Arkansas counseling or therapy license that is in good standing with the Board or persons who have filed an application and are in the process of becoming licensed by the Counseling Board. Individuals who have an application in process but fail the examinations or fingerprint check are not considered licensable.
- (s) “Distance Learning” means distance education; learning or distance learning, a formal education process, in which instruction occurs when the student and instructor are not located in the same place. Distance learning adds technology to the learning environment by a variety of means. Instruction may be synchronous or asynchronous. Courses taught via distance learning must be approved by the Board, as per the rules for distance course work, prior to acceptance of courses used in an application for an Arkansas license. Section 3.6 (1)(h)(i)(j) As this form of education has evolved with technology, it may be referred to as cyber learning, electronic learning, distance learning. For the purposes of these rules, the term distance learning refers to all none traditional methods of presentation.
- (t) “Technology-Assisted Distance Counseling” (Electronic Counseling, Cyber Counseling) for Counseling or Marriage and Family Therapy means any form of services offered or rendered by electronic or technology-assisted approaches when the Counselor or Marriage and Family Therapist and the client are not located in the same place. Technology-Assisted Distance Counseling may be synchronous or asynchronous. Only Counselors and Marriage and Family Therapists, licensed by the Arkansas Board of Examiners in Counseling, who also hold the Technology-assisted Distance Counseling or Marriage and Family Therapy Specialization License, may provide Technology Assisted Distance Counseling or Marriage and Family services.
- (u) “Traditional Counseling” means any form of Counseling or Marriage and Family Therapy offered or rendered in person, face to face, with the Counselor or Marriage and Family Therapist in the same physical location.
- (v) “Group Counseling or Group Marriage and Family Therapy” means two or more persons meeting with the Counselor or Marriage and Family Therapist.

- (w) “Technology” means electronically based hardware, software, video and related systems and telephone systems to deliver knowledge, skills, and tools for learning and communication processes. Technology for Counseling or Marriage and Family Therapy encompasses distance learning and distance counseling by any form of technology system /telephone system delivers of services. See section XII for the Technology-Assisted Distance Counseling definitions.
- (x) “Direct Service” means interaction with clients that includes the application of Counseling or Marriage and Family Therapy for human development skills and/or for mental health issues. In general, the term is used to refer to time spent by the Counselor or Marriage and Family Therapist working face to face or directly with individuals or groups.
- (y) “Indirect Service” means consultation, case management, paperwork, staffing, billing and test administration when the Counselor or Marriage and Family Therapist is not working directly with the individuals or groups , but the services are directly related to the individuals or groups employing the Counselor or Marriage and Family Therapist.
- (z) “Volunteer” means an individual offering volunteer services that is approved by the organization or agency for whom the service is rendered. See II. Exemptions, Section 2.2

II. EXEMPTIONS

Section 2.1 CLERGY

- (a) Clergy appointed and/or endorsed by their local congregation/church, synagogue, denominational institution or agency to practice pastoral counseling as parts of their responsibilities or duties of their ministry assignments are exempt from licensure requirements. The assignment must be authorized and/or endorsed by their local congregation/church, synagogue, denominational institution or agency. International and National licenses/certifications and/or assignments do not supersede state law. A.C.A.§17-27-101 et esq.
- (b) Any minister, clergy or pastoral counselor who has a private counseling or marriage and family therapist practice (full time or part time) outside of ministry assignment, accepts fees from any source, such as third party payments, clients, donations or the general public must be licensed by this Board.

Section 2.2 VOLUNTEERS

Individuals who offer volunteer pastoral, marriage and family therapy or counseling services are exempt from licensure requirements as long as their services are authorized and supervised by the local congregation/church, synagogue, denominational institution, agency, or organization for which the service is rendered. Volunteers must abide by the same requirements as the authorizing congregation/church, synagogue, denominational institution, agency or organization.

(a) Approval is documented by the organization or agency for which the service is rendered. Approval means a description of the assignment and designation of the person/persons responsible for supervising the volunteers (clergy, licensed professionals, etc). Documentation is by letter on the organization or agency letterhead, signed by the Arkansas organization or agency authority approving the service.

(b) Any fees to recover costs for materials and/or services rendered, whether assigned fees or donations, will be made payable and deposited to the agency, organization, church, or synagogue that has given the approval. Payment of any type, barter or cash, to the volunteer means the volunteer has entered the private sector and must be licensed according to A.C.A. §17-27-101 et esq.

(c) An organization or agency includes but is not limited to Arkansas churches, synagogues, military assignments, and The American Red Cross crisis assignments, etc.

(d) The titles of the volunteers must not be Counselor or Therapist. Acceptable volunteer title examples follow: volunteer, disciple, mentor, lay clergy, shepherd, American Red Cross Disaster Mental Health supervisor or technician.

III. LICENSING QUALIFICATIONS

Section 3.1 LICENSED ASSOCIATE COUNSELOR (LAC)

In order to be eligible as a Licensed Associate Counselor, an applicant:

(a) Must have received a graduate degree that is primarily professional counseling in content from a regionally accredited institution. The graduate semester hours must meet the national academic and training content standards adopted by the Board and the Council for the Accreditation of Counseling and Related Educational Programs (CACREP) or equivalent;

(b) Must demonstrate professional competencies by passing written, oral, and situational examinations as prescribed by the Board;

(c) Must arrange supervision with a Board-approved LAC supervisor and have the plan/agreement for the supervision approved by the Board prior to license issue;

(d) Must have met the criminal background check mandated by Act 1317 of 1997;

(e) Must be a citizen of the U.S. or have an immigration green card to document and verify legal alien work status in the U.S. The green card must be current and issued by the U.S. Immigration Bureau.

(f) The intent of the law is for the required three years of supervision as a Licensed Associate Counselor (LAC) to be training with the intent to become a Licensed Professional Counselor (LPC). The intent of the law is not for the LAC license to be a permanent license. If the three years of supervision, defined as Phases I, II, and III, are not completed in six calendar years from the date of the LAC license issue, the LAC license may not be renewed unless the individual holding the LAC license can document extenuating circumstances, acceptable to the Board, that would allow the Board to extend the six years. The Board, based on the documented circumstances, will determine the length of time, if any, that may be extended beyond the six years.

Section 3.2 LICENSURE PROFESSIONAL COUNSELOR (LPC)

In order to be eligible as a Licensed Professional Counselor, an applicant:

(a) Must meet the requirements of Section 3.1 with the exception of (c); and

(b) Must provide evidence of three years of supervised full-time experience in professional counseling beyond the Master's Degree acceptable to the Board. One year of experience may be gained for each 30-semester hours of graduate work beyond the Master's level, provided the hours are clearly counseling in nature and acceptable to the Board. Hours earned may be substituted for no more than two (2) years of supervised professional experience. The Board of Examiners in Counseling does not have the power to waive any required period of supervised experience.

Section 3.3 LICENSURE ASSOCIATE MARRIAGE AND FAMILY THERAPIST (LAMFT)

In order to be eligible as a Licensed Associate Marriage and Family Therapist, an applicant:

(a) Must have received a graduate degree in marriage and family therapy or related field from a regionally accredited institution. The graduate semester hours must meet the national academic and training content standards adopted by the Board from the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) or the Council for Accreditation Counselor Related Education Programs (CACREP) or equivalent;

- (b) Must demonstrate professional competencies by passing written, oral, and situational examinations prescribed by the Board;
- (c) Must arrange supervision with a Board-approved Licensed Associate Marriage and Family Therapist supervisor and have the plan/agreement for supervision approved by the Board prior to license issue;
- (d) Must have met the Criminal Background Check mandated by Act 1317 of 1997;
- (e) Must be a citizen of the U.S. or have an immigration green card to document and verify legal alien work status in the U.S. The green card must be current and issued by the U.S. Immigration Bureau.
- (f) The intent of the law is for the required three years of supervision as a Licensed Associate Marriage and Family Therapist (LAMFT) to be training with the intent to become a Licensed Marriage and Family Therapist (LMFT). The intent of the law is not for the LAMFT license to be a permanent license. If the three years of supervision, defined as Phases I, II, and III, are not completed in six calendar years from the date of the LAMFT license issue, the LAMFT license may not be renewed unless the individual holding the LAMFT license can document extenuating circumstances, acceptable to the Board, that would allow the Board to extend the six years. The Board, based on the documented circumstances, will determine the length of time, if any, that may be extended beyond the six years.

Section 3.4 LICENSED MARRIAGE AND FAMILY THERAPIST (LMFT)

In order to be eligible as a Licensed Marriage and Family Therapist, an applicant:

- (a) Must have received a graduate degree in Marriage and Family Therapy or related field from a regionally accredited institution. The graduate semester hours must meet the national academic and training content standards adopted by the Board from the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE version 10.1) or the Council for Accreditation of Counseling and Related Educational Programs (CACREP) 2001 Standards, pages 87-88;
- (b) Must demonstrate professional competencies by passing written, oral, and situational examinations prescribed by the Board;
- (c) Must have met the Criminal Background Check mandated by Act 1317 of 1997;

(d) Must be a citizen of the United States or have a green card to document and verify legal alien work status in the U.S. The green card must be current and issued by the United States Immigration Bureau; and

(e) Must provide evidence of three years of supervised full-time experience in marriage and family therapy beyond the Master's Degree acceptable to the Board. One year of experience may be gained for each 30 semester hours of graduate work beyond the Master's level, provided the hours are clearly marriage and family therapy in nature and acceptable to the Board. Hours earned may be substituted for no more than two years of supervised professional experience. The Board of Examiners in Counseling does not have the power to waive any required period of supervised experience.

Section 3.5 Specialization Areas

(a) The Board shall evaluate areas of specialization. The Board will use the national standards for the preparation of counselors, prepared by the specific professional association, as a guide in establishing the standards for counseling; i.e., Rehabilitation Counseling, Pastoral Counseling, Coaching, Career Counseling, School Counseling, Clinical Mental Health Counseling/Psychotherapy, Geriatric Counseling, Counseling Supervision, Drug & Alcohol, Addictions, Appraisal, Art, Music, Mediation, Technology-assisted Counseling or Marriage and Family Therapy, Technology-assisted Supervision, Traditional Supervision, Recreation Therapeutic Counseling, Applied Behavior Analysts or other specified counseling areas. If no national standards are available, the Board will adopt the highest Arkansas standards available.

(b) Specialization licenses will be granted to individuals who hold the LPC, LAC, LAMFT, or LMFT license and are in good standing with the Board. The applicant for the specialization license who holds certification, registry, or license issued by recognized and Board approved national associations or credentialing bodies will submit that documentation. All certifications received directly from the National Board for Certified Counselors (NBCC) or the American Association for Marriage and Family Therapist (AAMFT) will be accepted as evidence of specialization. If no national standards are available the Board will adopt the highest Arkansas state standards available for that specialization.

(c) Specialization approved national associations or credentialing bodies follow:

Appraisal and Supervision
(Request application materials from)
Arkansas Board of Examiners in Counseling
P.O. Box 70
Magnolia, AR71754-0070
Phone: (870) 901-7055

Hypnotherapy
(Request application materials from)
National Board for Certified Clinical Hypnotherapists (NBCCH)
8750 Georgia Ave., Suite 142-E
Silver Spring, Maryland 20910
Phone: (301) 608-0123 or (800) 449-8144

Rehabilitation

(Request application materials from)

Commission on Rehabilitation Counselor Certification (CRCC)
1835 Rohlwing Rd., Suite E
Rolling Meadows, Illinois 60008
Phone: (708) 394-2104

Pastoral

(Request application materials from)

American Association of Pastoral Counselors (AAPC)
9504 A Lee Highway
Fairfax, Virginia 22031-2303
Phone: (703) 385-6967

Association for Clinical Pastoral Education, Inc.
1549 Clairmont Road, Suite, 103
Decatur, GA 30033
Email: acpe@acpe.edu
www.acpe.edu

Art Therapy, Career, School Counseling,
Addictions, Gerontological, Coaching, Clinical
Mental Health Counseling/Psychotherapy
(Request applications from)

National Board for Certified Counselors (NBCC)
3 Terrace Way, Suite D
Greensboro, NC 27403-3660
Phone: (336) 547-0607

Recreation Therapeutic Counselor
(Request application materials from)

National Council for Therapeutic Recreation Certification (NCTRC)
7 Elmwood Drive
New City, New York 10956
Phone: (845) 639-1439
www.NCTRC.org

Drug & Alcohol

(Request application materials from)

Arkansas Substance Abuse Certification Board (ASACB)
UALR-Midsouth
2801 South University Ave.
Little Rock, AR 72204-1099
Phone: (501) 569-3073

Play Therapy

(Request application materials from)

Association for Play Therapy
2050 N. Winery Ave., #101
Fresno, CA 93703
Phone: (559) 252-2278
info@a4pt.org

Technology -assisted Specialization
Comply with Rule Section 3.5, (9), (A-F)
and Section XII

Dance Therapy

(Request application materials from)

American Dance Therapy Association (ADTA)
2000 Century Plaza, Suite 108
10632 Little Patuxent Parkway
Columbia, Maryland 21044

Mediation

Arkansas Alternative Dispute Resolution
Commission

(Request application materials from)

Arkansas Alternative Dispute Resolution
Commission
625 Marshall Street
Little Rock, AR 72201
Phone: (501) 682-9400

Applied Behavior Analysts

Request application materials from National Applied
Behavior Analyst

(d) Specialization license clarification for the following:

(4) Pastoral Counseling specialization license standard for issue for Clergy who are licensed by this Board and who are credentialed as member, fellow, or diplomat by the American Association of Pastoral Counselors (AAPC) or Association for Clinical Pastoral Education (ACPE).

(5) Rehabilitation Counselor specialization license standard for issue being for Counselors/Therapist who are licensed by this Board and who are credentialed by the Commission on Rehabilitation Counselor Certification (CRCC).

(6). Appraisal Specialization license standards for issue being (A) or (B) and (C)

(A) The curriculum and assessment experience standards acceptable for the School Psychology Specialist Specialization Certification/License issued by the Arkansas State Department of Education.

OR

(B) The standards for the School Psychologists from the National Association of School Psychologists (NASP).

(C) Documentation of a passing score on the School Psychologist Examination (Praxis II) Code 0400 from Educational Testing Service (ETS) required for (A) or (B).

(7) Supervision Specialization license standards for issue being:

(A) Three (3) years experience as a Licensed Professional Counselor and/or a Licensed Marriage and Family Therapist

(B) Good standing (as LPC and/or LMFT) in Arkansas

(C) Documentation of one of the following:

(i) A doctorate, primarily counseling/therapy in content, which included both course work in supervision (specific to the supervision license, LAC or LAMFT) and supervised experience in supervision; or

(ii) A completed, advanced three (3) hour graduate course in clinical supervision (specific to the supervision license, LAC or LAMFT) which included eighteen (18) hours of

supervised experience in supervision arranged as part of the graduate course

(D) Must submit and have Board approval of:

(i) A typed description of his/her theoretical orientation to supervision (specific to the supervision license, LAC or LAMFT), including model of supervision, and techniques of practice;

(ii) A signed code of ethics agreement and a group supervision plan and forms;

(iii) An Oral Examination with the Board

(8) Mediation Specialization license standard for issue being the Certification Standards established by the Arkansas Commission for Mediation.

(9) Technology-Assisted Distance Counseling or Marriage and Family Therapy Specialization license standards for issue for Counseling or Marriage and Family Therapy or Supervision being:

(A) A licensed LPC/LAC or LMFT/LAMFT in good standing with the Board must apply for the Technology-assisted Distance Counseling or Marriage Family Therapy specialization license and submit documentation of training for approval by the Board. As training sources are developed, the responsibility for seeking Board endorsement for the training rests with the provider of the training. The provider must submit a written request with materials documenting the training content for Board review and approval prior to endorsement of the training.

(B) The written submission of a detailed plan that delineates how the applicant will meet provisions of the 2005 American Counseling Association Code of Ethics and the Standards in Section XII regulating Technology-Assisted Distance Counseling or Marriage and Family Therapy for Board approval.

(C) Revised Statement of Intent (scope of practice) that includes a description of the Technology-Assisted Distance Counseling or Marriage and Family Therapy.

(D) The Board may require an oral examination if there are unresolved questions about requirements (9) (A-F).

(E) The submitted materials must be approved by the Board prior to the Technology-Assisted Distance Counseling or Marriage and Family Therapy Specialization license being issued.

(F) Any Technology-Assisted Distance Counseling or Marriage and Family Therapy that occurs within the State of Arkansas, whether by an Arkansas counselor or by an out of state Counselor or Marriage and Family Therapist, is deemed to have occurred in Arkansas. All providers of services whether traditional or Technology-Assisted who may offer or provide Counseling or Marriage and Family Therapy services to individuals or groups must hold a valid Arkansas license to provide such services.

(e) Specialization requests not already specified will be reviewed by the Board and standards established as needed.

(f) Licensed Counselors or Therapist who apply for a specialization license will be issued such license upon completion of the application for a specialization, documentation of a valid national or required credential (certificate, registry, or license), Pass on the oral examination (if required), payment of the specialization fee and approval by majority vote of the Board.

Section 3.6 GRADUATE COURSE REQUIREMENTS

(a) The applicant must have received a graduate degree from a regionally accredited institution of higher education that is primarily professional counseling or therapy in content **and** document completion of a minimum of 60 graduate semester hours in course work, counseling/therapy in content, that meet the academic and training standards established by the Board. The counseling programs, from which the degree/courses are earned, within the institution, shall meet the standards for the preparation of counselors by the specific national professional associations related to each license.

(b) The adopted standards of the national accrediting body, The Council for Accreditation of Counseling and Related Educational Programs (CACREP) for Licensed Associate Counselor (LAC) and for Licensed Professional Counselor (LPC). Endorsed and adopted as parallel are the standards of the following: The Council on Rehabilitation Education (CORE, Standards July 1, 2003), the United States Department of Education (USDE), and the Council for Higher Education Accreditation (CHEA). Other nationally recognized accrediting bodies will be reviewed for Board endorsement as needed.

(c) The adopted standards for Licensed Associate Marriage and Family Therapist (LAMFT) and Licensed Marriage and Family Therapist (LMFT) are the Commission on Accreditation for Marriage and Family Therapy Education Standards (COMFTE version 10.1) or CACREP Standards – 2001 Edition, pages 87-88, for Marriage and Family Therapy.

(d) Documentation from the institution issuing the credit may be required in addition to the Core Curriculum section of the application to verify that all course standards are met if the institution has not previously filed and gained approval for courses with the Arkansas Board.

(e) (1) Core Curriculum for LAC or LPC includes:

(A) Professional Identity, Pages 60-61 (3 Graduate Hour Minimum)

(B) Social and Cultural Diversity, Page 61 (3 Graduate Hour Minimum)

(C) Human Growth and Development, Pages 61-62 (3 Graduate Hour Minimum)

(D) Career Development, Page 62 (3 Graduate Hour Minimum)

(E) Helping Relations, Pages 62-63 (3 Hour Graduate Minimum)

(F) Group Work, Pages 63-64 (3 Graduate Hour Minimum)

(G) Assessment, Page 64 (3 Graduate Hour Minimum)

(H) Research and Program Evaluation, Pages 64-65 (3 Graduate Hour Minimum)

(I) Practicum and/or Internships, Pages 66-68 (9 Hour Minimum), Effective January 1, 2003

(f) January 1, 2005, courses (1-3), listed below became mandated core curriculum courses for any application processed for any license issued by the Board. The three courses are in addition to the requirements in (c) and (d) above.

(1) Psychopathology, including DSM and ICD training (3 Hour Minimum)

(2) Family and Relationship (3 Hour Minimum)

(3) Psychopharmacology (3 Hour Minimum)

(g) International degree(s) relied on in applying for a license of any kind from the Arkansas Board must be submitted with an English translation and certification from a credential evaluation service. These agencies must certify that the international degree is equivalent to a United States graduate degree. All cost for the certification is the responsibility of the applicant. The applicant may contact the Board office for information about approved agencies that provide the services.

(h) All graduate course hours used in the application for any license issued by the Arkansas Board must have a “B” grade or above. Grades of “C” or below will not be accepted for licensure purposes.

(i) (1) Distance/Cyber/Electronic education degrees will be treated the same as onsite education degrees if the degrees are primarily professional counseling or marriage and family therapy in content and are earned from a regionally accredited institution of higher education and the distance education degree programs are accredited as required, ((j) (A-H).

(2) Each course within the degree must meet the requirements in CACREP Standards-2001, pages 60-88. Courses must be graduate credit, meet the CACREP standards, and meet the American Counselor Educators and Supervisors (ACES) course guidelines. ACES Technology Interest Network 1999, course quality items 1-26, are adopted for distance learning courses.

(3) Cyber/Distance learning includes cyber/distance (electronic) learning/education. The definition of distance learning/education acceptable to the Board for licensure purposes is a formal education process in which instruction occurs when the student and instructor are not located in the same place. Distance learning adds technology to the learning environment by a variety of means, such as web sites, e-mail, video conferencing, and videotapes. Instruction may be synchronous or asynchronous. Video tapes may not comprise more than 20% of the instruction time in any one course.

(j) The responsibility for documenting that each course, content and presentation, meets the standards for Board endorsement and acceptance is the responsibility of the granting institution and the applicant. The Board review and acceptance/denial of each Cyber/Distance/Electronic course is mandated prior to the application being processed for any Arkansas license issued by the Board.

(k) Institutions of higher education that have graduate counselor education and related graduate programs that are not accredited by CACREP must seek endorsement from the Arkansas Board. The Board accepts certification/accreditation from the following, in addition to, CACREP: The

Council on Rehabilitation Education (CORE) the Council for Higher Education Accreditation, (CHEA). Institutions accredited by other nationally recognized accrediting bodies must seek and secure endorsement to the adopted standards from the Arkansas Board of Examiners in Counseling. Board endorsement must be completed prior to applications and course work of graduates from those programs being processed. The institution seeking endorsement must submit the following information for Board review:

- (1) Ten (10) graduate catalogs;
- (2) A completed Core Curriculum for the 60 hour requirements, effective January 1, 2003 with the course numbers and titles from the graduate program;
- (3) A copy of each syllabus listed on the Core Curriculum;
- (4) A letter from the university verifying that the content of the courses are equivalent to the CACREP Standards, 2001. The CACREP Course Standards-2001 are the standards used for a transcript to be processed for licensure purposes;
- (5) Documentation that the quality of each course meets the Course Quality Guidelines, 1- 26, of the ACES 1999 Guidelines;
- (6) A copy of the distance learning program or traditional program approval/accreditation from the accrediting/certifying agency that has accredited the university degree program/programs;
- (7) The software used for distance learning platform; and
- (8) Any other materials the university would like to submit to the Board to support the institution's endorsement request.

When the information (j) (k) (1-8) is received, reviewed, and approved by the Board, the administrative office staff may use the information to review current and future transcripts from graduates of the endorsed institution. The institution has the responsibility to keep the syllabi and other university materials current to expedite any applications received from graduates of the institution. The institution has the responsibility to ensure that all courses meet the requirements set forth in the Rules/Regulations.

IV. SUPERVISION

Section 4.1 SUPERVISION CONTENT

(a) Supervision for the Associate Counselor in Arkansas must be provided by a practitioner who is a Licensed Professional Counselor, holds approved supervisor status from the Arkansas Board and whose license is valid (i.e. not suspended due to delinquent renewal or disciplinary action). Supervision hours for applicants moving into the state must be approved by the Board. The Standards for Clinical Approved Supervisor (CAS) by the National Board for Certified Counselors are adopted by the Board as the standards to ensure the preparation in methods and techniques for practicing counselors who offer clinical supervision services to Associate Counselors for the protection of the client.

(b) Supervision for the Associate Marriage and Family Therapist in Arkansas must be provided by a practitioner who is a Licensed Marriage and Family Therapist, holds approved supervisor status from the Arkansas Board, and whose license is current. (i.e. not suspended due to delinquent renewal or disciplinary actions). Supervision hours for applicants moving into the state must be approved by the Board. The Standards for Clinical Approved Supervisor (CAS) by the National Board for Certified Counselors are adopted by the Board as the standards to ensure the preparation in methods and techniques for practicing counselors who offer clinical supervision services to Associate Counselors for the protection of the client.

(c) Counselors or Marriage and Family Therapists licensed at the associate level must complete three years of Client Contact Hours (CCH) with supervision. One year is defined as 1000 supervised CCH. One year is referred to as Phase I for the first year, Phase II for the second year and Phase III for the third year. The supervision must be provided in the following manner:

(1) Year I (Phase I) is supervision of 1,000 CCH and the minimum of one hundred hours of supervision. The ratio of supervision is one hour of supervision for each 10 hours of client contact.

(2) Year II (Phase II) is supervision of 1,000 CCH and the minimum of fifty hours of supervision. The ratio of supervision is one hour of supervision for each 20 hours of client contact.

(3) Year III (Phase III) is supervision of 1,000 CCH and the minimum of 25 hours of supervision. The ratio of supervision is the minimum of one hour of supervision for each 40 hours of client contact. Two options are available for year III, see Section (e).

(e) All required supervision will begin with Phase I. All supervision in Phase I must be completed before beginning Phase II, and all in Phase II must be completed before beginning Phase III. All post-master's course work to be substituted for supervision will be applied to Phase III, then Phase II. No course work may be substituted for supervised practice in Phase I. All documented supervised work from other states, approved by the Board, will be applied to Phase III and then Phase II.

(f) Supervised experience in Phases I, II and III will be credited at the ratio specified by the Board for face to face (direct services) and indirect services as defined in Section I (1.9) and Section IX (3)(4)(5)(6).

LACs may not exceed fifty percent of the total 3000 client contact hours in family/group sessions. LAMFTs must have a minimum of fifty percent of the 3000 client contact hours in family/group sessions.

In sessions reported are the clock hours of the sessions, not the clock time multiplied by the number of persons in the group.

Indirect Service hours applied to supervised experience may not exceed 200 CCH in Phase I, 300 CCH in Phase II, and 300 CCH in Phase III.

Hours spent conducting Psycho-educational groups (whether inpatient/outpatient or at other locations) may not be credited as therapy/counseling for the required supervised work.

(g) LAC/LAMFT options for Phase III

A LAC/LAMFT may acquire the required 1000 CCH hours in direct and indirect services with the minimum of 25 hours of supervision in the required ratio of one hour of supervision for each 40 hours of CCH. The indirect service hours may not exceed 300 CCH of the total 1000 CCH.

OR

The LAC/LAMFT may choose to take the NCMHCE option:

The National Clinical Mental Health Counseling Examination (NCMHCE) option is available for the Licensed Associate Counselor (LAC) and the Licensed Associate Marriage and Family Therapist (LAMFT) who petitions for the Licensed Professional Counselor (LPC) or the Licensed Marriage and Family (LMFT) license upon completion of the required supervised Client Contact Hours (CCH) as a Licensed Associate Counselor (LAC) or Licensed Associate Marriage and Family Therapist (LAMFT).

(1) The LAC/LAMFT may petition the Board to take the NCMHCE with recommendation of the contracted supervisor upon the completion of Phase II. When approved, the applicant may apply to NBCC and take the NCMHCE. The passing score will be the national cut off score. A pass score on the NCMHCE will be equated to 500 Client Contact Hours (CCH) and applied to Phase III.

(2) When the passing score on the NCMHCE, all supervised CCH's are completed and documented, revised Statement of Intent and LPC/LAMFT

license fee are received, the LPC or LMFT license may be issued and supervision may cease.

(3) If the LAC/LAMFT has completed the NCMHCE option, has met the supervision and course requirements for the Arkansas Clinical Mental Health Counselor License, that specialization license may be issued.

(4) Test dates for the NCMHCE will be the same as the dates established for the NCE and all examinations will be administered by NBCC. The candidate will send test application and test fee directly to NBCC.

(h) Group supervision may not exceed half of the total Board specified supervision requirements. A supervision group is defined as consisting of two (2) to five (5) supervisees with the contracted supervisor.

(i) The contracted supervisor may not delegate supervision responsibility to any other individual. The contracted supervisor should have an emergency plan on file if he/she were to be unavailable.

(j) Post-master's course work necessary for application for an Arkansas license may not be applied to the required supervised work experience in accordance with the rules and regulations.

Post-master's course work may be applied toward supervised experience in accordance with the rules and regulations governing both Licensed Professional Counselors and Licensed Marriage and Family Therapists. The Board may accept thirty (30) hours of acceptable graduate coursework with the exception of Section 4.1 (j).

Section 4.2 SUPERVISEE REQUIREMENTS AND RESTRICTIONS

(a) All Licensed Associate Counselors must have a Board-approved supervision plan/agreement prior to providing any counseling services. The Licensed Associate Counselor must notify the Board immediately and in writing of any proposed change in supervisors. The Licensed Associate Counselor must obtain Board approval of any change in supervisors. Failure to maintain an approved current supervision agreement will result in license suspension or revocation.

(b) All Licensed Associate Marriage and Family Therapists must have a Board-approved supervision plan/agreement prior to providing any therapy services. The Licensed Associate Marriage and Family Therapists must notify the Board immediately and in writing of any proposed change in supervisors. The Licensed Associate Marriage and Family Therapists must obtain Board approval of any change in supervisors. Failure to maintain an approved current supervision agreement will result in license suspension or revocation.

(c) Counselors or Marriage and Family Therapists licensed at the associate level may offer professional counseling services beginning the date of approval on a valid and current supervision agreement filed with the Board and be under the supervision of a Board licensed supervisor. Not one client may be seen prior to that date. No clients may be seen by the associate licensee if the supervision agreement has expired and a new one has not been Board approved. There is no grace period for a supervision agreement that has expired; the associate licensee must cease and desist practice the expiration date of the agreement. Both supervisee and supervisor are responsible for being cognizant of the expiration date and for maintaining a current supervision agreement.

(d) The LAC or LAMFT is the responsible party for:

(1) Maintaining a current, valid, and approved supervision contract on file with the Board prior to providing any counseling services. The primary responsibility is with the LAC or LAMFT, but is a shared responsibility with the supervisor. Any practice or service rendered by the supervisee or any supervision by the supervisor becomes illegal at 12:01midnight the expiration date of the agreement.

(2) Maintaining an accurate Statement of Intent (Scope of Practice) and filing a copy of the current Board approved statement with the supervisor of record.

(3) Submission of supervision reports each six (6) months.

(e) Supervisees must carefully avoid multiple relationships with supervisors that interfere with the supervisory relationship; such as, having the ability to hire or dismiss the supervisee from employment.

Section 4.3 SUPERVISOR REQUIREMENTS AND RESTRICTIONS

(a) A Counselor or Therapist, holding a Supervision Specialization License, shall not sign new supervision plans/agreements if supervisor's license has not been renewed or if the supervisor is under investigation. If under investigation, no new contracts may be signed or submitted to the Board until all reviews, hearings, or disciplinary actions (if any in progress) are completed and resolved.

(b) Supervisors will be limited to ten (10) supervision contracts at any given time. Exceptions to the limitation of ten (10) may be made only at Board initiated request to a designated supervisor

(c) The Board office staff may not approve supervision contract/agreements to exceed ten supervisees (10) for any one supervisor.

Section 5.1 STATEMENT OF INTENT

The Statement of Intent (Scope of Practice) to practice must be machine produced, either by word processing or typing, signed and dated on each page. The statement must be consistent with the credentials documented in the application for licensure and include a satisfactory response to all items on the Statement of Intent (Scope of Practice) form.

Section 5.2 TRANSCRIPTS

(a) Applicants must submit official transcript documentation for Board review. The Board office staff will review applicants' transcripts to ensure:

- (1) That all academic coursework for licensure has been completed at institutions of higher education having accreditation duly recognized by the Board for degree programs and courses;
- (2) That applicants are minimally qualified to sit for the appropriate written examination (s) by having completed either the required CACREP or COAMFTE core curriculum courses; and
- (3) That core curriculum courses have been completed prior to admission to written examination/examinations unless exempt under section 6.2 (d).
- (4) That all course grades are B or above.

(b) If the transcript courses titles are ambiguous or do not adequately convey the pertinent content of the courses, the Board office staff is to request documentation of content from the applicant for clarification purposes.

Section 5.3 PROOF OF SUPERVISION

The applicant (licensed in another state or with an Arkansas state agency) will submit a record of post-master's supervised counseling work related experience and/or Marriage and Family Therapy work related experience for Board approval. The approved experience will determine the applicant's license (Associate or Professional) level.

Section 5.4 REFERENCES

- (a) The applicant will submit a minimum of three (3) references. Copies of references sent directly from other state boards or university placement centers will be accepted by endorsement if no more than five years old. Two of the three must be from mental health professionals. One may be from personal choice.
- (b) The Board will not accept evaluations recommendations, and documentation of supervised experience from persons related either by blood (both lineal and

collateral consanguinity) or marriage (affinity). Current members of the Board may not submit references for the applicants.

(c) If a Board member supervised an applicant in graduate courses, the supervision may be documented and verified by that Board member. A Board member will not lead the Oral Examination nor evaluate the application file of a former student.

(d) All forms and instructions included in the application process will be considered part of the rules and regulations of the Board. The forms may not be altered or changed by applicants.

Section 5.5 BOARD DECISIONS

An affirmative vote of a majority of those Board members present and voting will be held as evidence that the applicant:

- (a) Has passed the oral examination.
- (b) Has to pass a situational examination required because of unresolved questions.
- (c) Application is processed for the Associate or the Professional License as determined by the documented, approved post-master's work experience.
- (d) Has been denied the license. The applicant will be so notified by certified or signature confirmation mail. Specific reasons for the denial will be stated.
- (e) Has been granted the license based on satisfactory completion of the application process.

Section 5.6 APPLICANT STATUS WITH OTHER PROFESSIONAL ORGANIZATIONS AND BOARDS

Applications from individuals who are under investigation, sanction, probation, disciplinary supervision, revocation, or rehabilitation by counseling, psychology, social work, or other related Boards or credentialing bodies will not be considered for an Arkansas license until documentation from the issuing body is received that the sanctions are removed or completed. Applications from individuals who have violations of Arkansas Code Annotated § 17-27-313 and are pardoned by the Governor are not exempt from the requirements of Arkansas Code Annotated §17-27-313.

Section 5.7 DURATION OF APPLICATION

(a) Applications are active for twelve (12) calendar months from the date the application is received in the Board office.

(b) If the application process is not completed and the license issued in the twelve months, an applicant may request Board approval for an extension of the twelve month application window. If an extension is not requested, or is denied, the application becomes void and the individual must apply as any new applicant at any future date.

(c) If new requirements have been placed for applicants in the twelve-month window the Board may require that the new requirements be met within the extension period as part of the application extension approval.

(d) A second extension period is discouraged and will only be considered by the Board when very unusual, extenuating circumstances are documented.

VI. EXAMINATIONS

Section 6.1 GENERAL ADMINISTRATION

(a) An applicant, whose credentials meet the requirements of Ark. Code Ann. § 17-27-301 through 305, will be scheduled for written and oral examinations by the Board staff. Situational examinations may be required by the Board if deemed necessary.

(b) The Board administrative staff will compile lists of applicants who have met all requirements for admission to the NCE, AMFTRB, and/or NCMHCE examination(s). The list will be supplied to the national test administrators on the deadline date for the designated examination.

(c) Each year the Board will contract for the administration of:

(1) The National Counseling Examinations (NCE) with the National Board for Certifying Counselors (NBCC).

(2) The National Clinical Mental Health Counseling Examinations (NCMHCE) with NBCC.

(3) The Examinations in Marital and Family Therapy with the Association of Marital and Family Therapy Regulatory Boards (AMFTRB).

(d) National cut-off scores established by the national examination agencies for each examination date are the minimum scores accepted by the Arkansas Board for an applicant to meet respective written examination requirements for licensure.

(e) If the Board votes to deny the license, the applicant will be so notified by certified or signature confirmation mail. Specific reasons for denial will be stated.

(f) License will be granted to applicants who satisfactorily complete the application process and are approved by a majority vote of the Board.

(g) an applicant who fails required written examination the first time attempted may take it the second time at any date of his/her choice.

(h) If the applicant fails to pass written, oral, or situational examination(s) in two trials, the applicant's application file will be removed from active status. The applicant must wait two years from the date of the second examination and apply as a new applicant meeting any requirements in place the date the new application is received in the Board office.

(i) Prior to an application being processed when an examination has been failed two times, the Board requires:

(1) A new application for licensure and examination may not be submitted prior to two years following the date of the second failed examination; and

(2) Documentation of completed additional graduate study in Counseling or Marriage and Family Therapy or other remedial work that the Board may specify.

Section 6.2 WRITTEN EXAMINATIONS

(a) All applicants for licensure must complete one of the following written examinations.

(1) Counselor applicants must satisfactorily complete the National Counseling Examination (NCE) unless licensed in another state and required to take the NCMHCE (Section 9.(i)).

(2) Marriage and Family Therapist applicants must satisfactorily complete the American Marriage and Family Therapy Regulatory Board (AMFTRB) examination and meet the national pass score.

(b) The Board will adopt a prepared standardized test covering the specialized knowledge common to each license. The Board may contract with test design specialists to prepare and provide materials for such testing and to revise the examination as deemed necessary. Subtests in specialty skill areas may be a part of updating. The national pass score determined for each examination by the testing company is the acceptable score determined by the Board to be the pass level to qualify the applicant for the oral and situational examinations.

(c) Submission of application documentation and fees for national written examinations occurs in two (2) steps:

(1) Test application and associated fees must be made directly to the national examining organizations for admission to sit for the written examinations. The test applications and fees for written examinations must comply with the test company's deadlines.

(2) The licensure application, including transcripts, statements of intent, letters of recommendation and payment of the licensure application fee, must be received by the Board office 4 weeks prior to the test application deadline set by the national examining organization for the applicant's name to be added to the approved list for test admission.

(d) Persons who are enrolled in the final semester of graduate study in counseling or marriage and family therapy and have completed the core curriculum courses may be admitted to the written examination by submitting to the Board, with their application, a letter stating their projected graduation date from one of the following college or university officials:

- (1) Faculty Internship Coordinator
- (2) Master's Committee Chair
- (3) Graduate Coordinator

- (4) Department Chair
- (5) Registrar
- (6) Associate Dean
- (7) Dean

Section 6.3

(a) All individuals applying for licensure who have not previously had an oral examination with the Arkansas Board must complete an oral examination prior to being granted a license. If the applicant is seeking dual licensure, he or she must complete the Board required examinations, oral, written and/or situational.

Individuals applying for a supervision specialization license or a technology-assisted specialization license must have an oral examination with the full Board.

(b) An oral examination will be scheduled for applicants upon receipt by the Board office staff of a passing score on the written examination, their final official transcripts, reflecting degree completion, and all other application requirements completed.

(c) The oral examination will include a review of the applicant's Statement of Intent, questions from the Board relative to the profession of counseling/therapy, and questions about credentials submitted with the application.

(d) If there are unresolved questions, the Board may require an oral examination of any applicant.

Section 6.4 SITUATIONAL EXAMINATIONS

(a) Situational exam - A situational demonstration of counseling or marriage and family therapy skills may be requested by the Board in the form of a DVD/CD, other technology-assisted methods, (example Skype) or live demonstration. A consent and release statement signed by each participant must accompany such session. The Board may utilize Licensed Marriage and Family Therapists or Licensed Professional Counselors, who have specialized knowledge common to the license being sought, to review and advise regarding the session or demonstration. At least one reviewer will have specialized knowledge appropriate to the review.

(b) The Board does not routinely require a situational examination be passed prior to the oral examination. The Board may request a situational examination be administered and passed if the applicant does not successfully complete the oral examination or if the Board has unresolved questions about the competency and/or skills of the applicant.

(c) The situational examination may consist of a DVD/CD recording, technology assisted methods, to be determined by the Board, of the applicant engaged in a counseling interaction with an internship client or volunteer.

(d) Volunteer clients who participated in the the situational examination may not be persons related either by blood (both lineal and collateral consanguinity) or marriage (affinity) or from other inappropriate multiple relationships with the applicant.

(e) When the Board requires a situational examination, a signed and witnessed consent form signed by the client, even if a volunteer, must accompany the submitted videotape.

(f) Evaluation of the situational examination is based on demonstration of basic counseling skills on the part of the applicant appropriate to the content, effect, and behavior of the client/volunteer. The examination and the Board member reviews and evaluation forms signed by the Board members will be retained in the applicant's file for the minimum of two years.

Section 6.5 UNRESOLVED QUESTIONS

(a) Should the Board have unresolved questions of competence it may require any one or all of the following:

- (1) Additional academic work;
- (2) Additional supervised experience;
- (3) Additional training;
- (4) Additional references or recommendations;
- (5) Clarification of Statement of Intent;
- (6) Situational Examination, Oral Examination or both;
- (7) Training documentation
- (8) Other evidence deemed necessary to satisfy the Board as to the qualifications and/or fitness and competence of the applicant to practice as a counselor or marriage and family therapist.

Section 6.6 FEES

(a) Written examination fees are determined by the national testing company.

(b) An examination fee may be set by the Board for the processing and conducting situational examinations.

(c) An annual file maintenance fee, determined by the Board, will be charged when application materials are retained in an active status longer than twelve (12) months from application date.

(d) The schedule of service fees will be reviewed annually and will be set at the lowest possible level to meet the operational expenses of the Board as appropriated by the legislature. The fees established by the Board are published on the web (www.state.ar.us/abec) and are in each application packet and each license renewal packet. Application and Renewal fees are found in Section XIII of the Rules.

VII. LICENSE RENEWAL

Section 7.1 EXPIRATION

All licenses expire biennially on June 30 of the renewal year. Licensing dates and payment of fees will be set to conform to the State's fiscal year, July 1 through June 30.

Section 7.2 RENEWAL FEES

(a) The biennial license renewal fee is due and payable by June 30 of the renewal year. Checks should be made payable to the Arkansas Board of Examiners in

Counseling. The Board will establish and determine appropriate fees and adjust according to operational expenses.

(b) A late fee will be assessed if the envelope containing the renewal fee is postmarked after 12:01 midnight, June 30 of the renewal year.

(c) Failure to pay the biennial fee within the time stated shall automatically suspend the right of any licensee to practice while delinquent. {Arkansas Code Annotated §17-27-307 (2) (A)}. Such lapsed license may be renewed within a period of twelve (12) months, from the expiration date, by payment of all fees and Board requirements that are in arrears.

(d) Failure to renew a license within twelve (12) months from the date of expiration will necessitate applying for the license as a new applicant meeting all requirements in place the date the new application is received in the Board office. The Board may require an appearance before the Board to explain the failure to meet renewal deadlines prior to the application being processed.

Section 7.3 CONTINUING EDUCATION

(a) No license will be renewed without evidence of satisfactory completion of a minimum of twenty-four (24) clock hours of continued professional education and/or training in the twenty-four (24) months prior to renewal and evidence of same on file in the Board office. Twenty-two (22) of the twenty-four (24) clock hours must support the licensee's statement of intent. The minimum of two (2) clock hours must be in ethics relevant to the license being renewed.

(b) The continuing education policies for documentation and reporting for renewal purposes are adopted, as applicable, from those published by the National Board for Counselor Certification (NBCC).

(c) LAC's, LPC's, LAMFT's, and LMFT's are responsible for maintaining all appropriate documentation of their continuing education hours completed during the previous twenty-four (24) months should they be required for audit review.

(d) 90% of license renewals are not required to submit documentation for continuing education. 10% of all renewal notices will be audited and must submit documentation.

(e) If the licensee has not accumulated the required continuing education hours, the licensee may take the NCE, NCMHCE, or the AAMFT examination and meet the national pass score as a substitute for continuing education clock hours.

(f) Individuals holding both the Counseling and the Marriage and Family Therapy Licenses are required to obtain twenty-four (24) clock hours of CEU credit for each license with the minimum of two (2) of the required hours being in ethics for

each license. CEU credit must be applicable to each license per licensing period. The same hours may not be submitted for both licenses even if renewal year is the same; for example; if renewing both at the same time, the total of forty-eight (48) hours and four (4) clock hours of ethics will be required.

(g) American Association of Christian Counselors (AACC) continuing education documentation CEU'S related to Counseling or Marriage and Family Therapy is acceptable.

(h) The Arkansas Board of Examiners in Counseling does not screen programs offered by providers of continuing education. Providers are required to secure Approved Provider Status through NBCC, AAMFT, AACC, APA, etc., prior to advertising the programs as approved for license renewal purposes. With official documentation, the continuing education program hours related to counseling or therapy that are offered by Arkansas universities and Arkansas state departments will be accepted.

(i) The maximum number of continuing education clock hours to be approved for reading/reviewing journal articles or newsletter articles shall not exceed six (6) clock hours) in a two year renewal cycle.

(j) The maximum number of continuing education clock hours to be approved for renewal of the Supervision Specialization License for online shall not exceed three (3) clock hours. Three clock (3) hours must be from participation in a regional university continuing education program or from an ArCA, ArMHCA or ArMFT Conference program.

Section 7.4 STATEMENT OF INTENT

(a) A new Statement of Intent (Scope of Practice) must be received with the renewal fee and continuing education documentation for any license to be renewed. The Statement of Intent must be typed or word-processed in the format required by the Board.

(b) The approved Statement of Intent (Scope of Practice) will be in force for the valid license date.

(c) Each page of the Statement of Intent (Scope of Practice) must be signed and dated.

(d) The Statement of Intent (Scope of Practice) may be revised at any time the scope of practice changes. The revised Statement of Intent (Scope of Practice) must be submitted to the Board for approval.

Section 7.5 RENEWAL NOTICE

(a) Notices of renewal will be mailed by the Secretary of the Board, on or about, April 1 of the renewal year. Accompanying these notices will be forms for the licensee to use for the documentation of continued education, statement of intent, and other related professional activities. Completion of such documentation by the licensee is mandatory prior to license renewal.

(b) Notices of renewal will be mailed, on or about, March 1, of the renewal year for the 10% of the renewals, randomly selected for continuing education audit.

Section 7.6 RENEWAL REQUEST UNDER EXTENUATING CIRCUMSTANCES

Renewals from individuals who are under investigation, sanction, probation, disciplinary supervision, revocation, or rehabilitation by counseling, marriage and family therapy, psychology, social work, or other related Boards or credentialing bodies will not be considered for an Arkansas license renewal until documentation from the issuing body is received that the sanctions are removed or completed.

Applications from individuals who have violations of Arkansas Code Annotated § 17-27-313 and are pardoned by the Governor are not exempt from the requirements of Arkansas Code Annotated § 17-27-313.

VIII. DISCIPLINE

Section 8.1 COMPLAINTS

(a) When information/complaint that may affect the licensure of an applicant is presented to the Board, the informant is required to present the information to the Board in signed, written form unless this creates eminent danger to the informant.

(b) The complaint is investigated following the Arkansas Administrative Procedure Act, found at Arkansas Code Annotated § 25-15-201 et seq.

(c) Following the investigation the Board may by majority vote:

(1) Close the complaint with no further action.

(2) Process a Consent Order and Resolution Agreement with the licensee that specifies conditions to be met and maintained. If the licensee fails to keep all conditions of the agreement, an Administrative Hearing will be held for the purpose of disciplinary action.

(3) Hold an Administrative Hearing for the purpose of disciplinary action.

Section 8.2 HEARINGS

- (a) Any applicant or licensee who has been aggrieved by an action of the Board shall be entitled to judicial review under Ark. Code Ann § 25-15-201 et seq.
- (b) Informal hearing procedures may be held when needed for resolution of problems instead of/in addition to the formal Administrative Hearing.
- (c) Adjudicative Hearings to revoke a license or permit or to impose a civil penalty are adjudicative hearings. An agency acts in a quasi-judicial capacity when it conducts an adjudicative hearing.

The Arkansas Administrative Procedure Act (APA) provides the basic framework for the conducting of adjudicative hearings. Using the APA as a framework, these rules provide detailed procedures for hearings.

These rules apply in all administrative adjudications conducted by the Counseling Board. These procedures are developed to provide a process by which the agency formulates orders (for example, an order to suspend or revoke a license to practice or to impose civil penalties).

1. PRESIDING OFFICER

The Board Chairman shall preside at the hearing or may designate one or more members of the Counseling Board or one or more examiners, referees, or hearing officers to preside at a hearing.

2. APPEARANCES

- (i) Any party appearing in any agency proceeding has the right, at his or her own expense, to be represented by counsel.
- (ii) The respondent may appear on his or her behalf.
- (iii) Any attorney representing a party to an adjudicatory proceeding must file notice of appearance as soon as possible.
- (iv) Service on counsel of record is the equivalent of service on the party represented.
- (v) On written motion served on the party represented and all other parties of record, the presiding officer may grant counsel of record leave to withdraw for good cause shown.

3. CONSOLIDATION

If there are separate matters that involve similar issues of law or fact, or identical parties, the matters may be consolidated if it appears that consolidation would promote the just,

speedy, and inexpensive resolution of the proceedings, and would not unduly prejudice the rights of a party.

4. NOTICE TO INTERESTED PARTIES

If it appears that the determination of the rights of parties in a proceeding will necessarily involve a determination of the substantial interests of persons who are not parties, the presiding officer may enter an order requiring that an absent person be notified of the proceeding and be given an opportunity to be joined as a party of record.

5. SERVICE OF PAPERS

Unless the presiding officer otherwise orders, every pleading and every other paper filed for the proceeding, except applications for witness subpoenas and the subpoenas, shall be served on each party or the party's representative at the last address of record.

6. INITIATION & NOTICE OF HEARING

- (i) An administrative adjudication is initiated by the issuance by the Board of a notice of hearing.
- (ii) The notice of hearing will be sent to the respondent by U.S. Mail, return receipt requested, delivery restricted to the named recipient or his agent. Notice shall be sufficient when it is so mailed to the respondent's latest address on file with the agency.
- (iii) Notice will be mailed at least twenty one (21) days before the scheduled hearing unless an emergency is declared.
- (iv) The notice will include:
 - A statement of the time, place, and nature of the hearing;
 - A statement of the legal authority and jurisdiction under which the hearing is to be held; and
 - A short and plain statement of the matters of fact and law asserted.

7. MOTIONS

All requests for relief will be made by motion. Motions must be in writing or made on the record during a hearing. A motion must fully state the action requested and the grounds relied upon. The original written motion will be filed with the agency. When time allows, the other parties may, within seven (7) days of the service of the written motion, file a response in opposition. The presiding officer may conduct such proceedings and enter such orders as are deemed necessary to address issues raised by the motion. However, a presiding officer, other than the Counseling Board, will not enter a dispositive order unless expressly authorized in writing to do so.

8. ANSWER

A respondent may file an answer no later than ten (10) days before the scheduled hearing.

9. DISCOVERY

- (i) Upon written request, the agency will provide the information designated in A.C.A. § 25-15-208 (a) (3).
- (ii) Such requests should be received by the agency at least ten (10) days before the scheduled hearing.

10. CONTINUANCES

The Board Chairman may grant a continuance of hearing for good cause shown. Requests for continuances will be made in writing. The request must state the grounds to be considered and be made as soon as practicable and, except in cases of emergencies, no later than five (5) days prior to the date noticed for the hearing. In determining whether to grant a continuance, the Board Chairman may consider:

- (i) Prior continuances;
- (ii) The interests of all parties;
- (iii) The likelihood of informal settlements;
- (iv) The existence of an emergency;
- (v) Any objection;
- (vi) Any applicable time requirement;
- (vii) The existence of a conflict of the schedules of counsel, parties, or witnesses;
- (viii) The time limits of the request, and;
- (ix) Other relevant factors.

The Board Chairman may require documentation of any grounds for continuance.

11. HEARING PROCEDURES

- (i) The presiding officer presides at the hearing and may rule on motions, require briefs, and issue such orders as will ensure the orderly conduct of the proceedings; provided, however, any presiding officer other than the Counseling Board shall not enter a dispositive order or proposed decision unless expressly authorized in writing to do so.
- (ii) All objections must be made in a timely manner and stated on the record.
- (iii) Parties have the right to participate or to be represented by counsel in all hearings or pre-hearing conferences related to their case.
- (iv) Subject to terms and conditions prescribed by the Administrative Procedure Act, parties have the right to introduce evidence on issues of material fact, cross-examine witnesses as necessary for a full and true disclosure of the facts, present evidence in rebuttal,

and, upon request by the agency, may submit briefs and engage in oral argument.

- (v) The presiding officer is charged, with maintaining the decorum of the hearing and may refuse to admit, or may expel, anyone whose conduct is disorderly.

12. ORDER OF PROCEEDINGS

The presiding officer will conduct the hearing in the following manner:

- (i) The presiding officer will give an opening statement, briefly describing the nature of the proceedings.
- (ii) The parties are to be given the opportunity to present opening statements.
- (iii) The parties will be allowed to present their cases in the sequence determined by the presiding officer.
 - a. Each witness must be sworn or affirmed by the presiding officer, or the court reporter, and be subject to examination and cross-examination as well as questioning by the Counseling Board. The presiding officer may limit questioning in a manner consistent with the law.
 - b. When all parties and witnesses have been heard, parties may be given the opportunity to present final arguments.

13. EVIDENCE

- (i) The presiding officer shall rule on the admissibility of evidence and may, when appropriate, take official notice of facts in accordance with all applicable requirements of law.
- (ii) Stipulation of facts is encouraged. The agency may make a decision based on stipulated facts.
- (iii) Evidence in the proceeding must be confined to the issues set forth in the hearing notice, unless the parties waive their right to such notice or the presiding officer determines that good cause justifies expansion of the issues. If the presiding officer decides to admit evidence outside the scope of the notice, over the objection of a party who did not have actual notice of those issues, that party, upon timely request, will receive a continuance sufficient to prepare for the additional issue and to permit amendment of pleadings.
- (iv) A party seeking admission of an exhibit must provide twelve (12) copies of each exhibit at the hearing. The presiding officer must provide the opposing parties with an opportunity to examine the exhibit prior to the ruling on its admissibility. All exhibits admitted into evidence must be appropriately marked and be made part of the record.

- (v) Any party may object to specific evidence or any request limits on the scope of the examination or cross-examination. A brief statement of the grounds upon which it is based shall accompany such an objection. The objection, the ruling on the objection, and the reasons for the ruling will be noted in the record. The presiding officer may rule on the objection at the time it is made or may reserve the ruling until written decision.
- (vi) Whenever evidence is ruled inadmissible, the party offering that evidence may submit an offer of proof on the record. The party making the offer of proof for excluded oral testimony will briefly summarize the testimony or, with permission of the presiding officer, present the testimony. If the excluded evidence consists of a document or exhibit, it shall be marked as part of an offer of proof and inserted in the record.
- (vii) Irrelevant, immaterial, and unduly repetitive evidence will be excluded. Any other oral or documentary evidence, not privileged, may be received if it is of a type commonly relied upon by reasonably prudent men and women in the conduct of their affairs,
- (viii) Reasonable inferences. The finder of fact may base its findings of fact upon reasonable inferences derived from other evidence received.

14. DEFAULT

If a party fails to appear or participate in an administrative adjudication after proper service of notice, the agency may proceed with the hearing and render a decision in the absence of the party.

15. SUBPOENAS

- (i) At the request of any party, the agency shall issue subpoenas for the attendance of witnesses at the hearing. The requesting party shall specify whether the witness is also requested to bring documents and reasonably identify said documents.
- (ii) A subpoena may be served by any person specified by law to serve process or by any person who is not a party and who is eighteen (18) years of age or older. Delivering a copy to the person named in the subpoena shall make service. Proof of service may be made by affidavit of the person making service. The party seeking the subpoena shall have the burden of obtaining service of the process and shall be charged with the responsibility of tendering appropriate mileage fees and witness fees pursuant to Rule 45, Arkansas Rules of Civil Procedure. The witness must be served at least two days prior to the hearing. For good cause, the agency may

- authorize the subpoena to be served less than two days before the hearing.
- (iii) Any motion to quash or limit the subpoena shall be filed with the agency and shall state the grounds relied upon.

16. RECORDING THE PROCEEDINGS

The responsibility to record the testimony heard at a hearing is borne by the agency. Upon the filing of a petition for judicial review, the agency will provide a verbatim transcript of testimony taken before the agency. If requested under FOI, copies of the transcript will be provided at a cost per page.

17. FACTORS TO BE CONSIDERED IN IMPOSING SANCTIONS

In addition to any other considerations permitted by Arkansas Code Annotated § 17-27-101 et seq. if applicable, the agency in imposing any sanction may consider the following:

- (i) The nature and degree of the misconduct for which the licensee is being sanctioned.
- (ii) The seriousness and circumstances surrounding this misconduct.
- (iii) The loss or damage to clients or others.
- (iv) The assurance that those who seek similar professional services in the future will be protected from the type of misconduct found.
- (v) The profit to the licensee.
- (vi) The avoidance of repetition.
- (vii) Whether the conduct was deliberate, intentional, or negligent.
- (viii) The deterrent effect on others.
- (ix) The conduct of the individual during the course of the disciplinary proceeding.
- (x) The professional's prior disciplinary record, including warnings.
- (xi) Matters offered by the professional in mitigation or extenuation, except that a claim of disability or impairment resulting from the use of alcohol or drugs may not be considered unless the professional demonstrates that he or she is successfully pursuing in good faith a program of recovery.

18. FINAL ORDER

The agency will serve on the respondent a written order that reflects the action taken by the agency. The order will include a recitation of facts found based on testimony and other evidence presented and reasonable inferences derived from the evidence pertinent to the issues of the case. It will also state conclusion of law and directives or other disposition entered against or in favor of the respondent.

SECTION 8.3 SUSPENSION, REVOCATION, DENIAL OF LICENSE ISSUE,
DENIAL OF RENEWAL, DENIAL OF APPLICATION FOR
PROCESSING

(a) In accordance with the Arkansas Code Annotated §17-26-309 and § 25-15-201 et seq (Arkansas Administration Procedure Act), the Board will suspend, revoke, or deny renewal of any license if the Board finds that holder thereof:

- (1) Has been found guilty of violating any ethical or professional standard under which the license holder practices; has failed to comply with mandated reporting as per state laws.
- (2) Has not paid biennial renewal fee within the time stated.
- (3) Has not satisfied the Board, by June 30 of the renewal year, with evidence of the completion of relevant professional or continued education experience.
- (4) Has been found to be incompetent, has misused the license, or has been negligent in the rendering of counseling services.
- (5) Has been convicted of a felony.
- (6) Has failed to follow any special directions of the Board.
- (7) Has had one's professional license/certificate revoked suspended, or under investigation by any other Arkansas Board or certifying/licensing agency or by any state Board of certifying/licensing agency.
- (8) Has failed to meet requirements of the Criminal Background Check. (Act 1317 of 1997).
- (9) Renewals from individuals who are under investigation, sanction, probation, disciplinary supervision, revocation, or rehabilitation by counseling, psychology, social work, or other related Boards or credentialing bodies will not be considered for an Arkansas license renewal until documentation from the issuing body is received that the sanctions are removed, or completed
- (10) ALTERNATIVE SANCTIONS

In addition, the Board may after a hearing, impose upon a person over whom the Board has jurisdiction the Alternative Sanctions provided by ACA 25-15-217 which include a civil penalty not to exceed \$500.00 per violation.

- (11) (a) Applications from individuals who have violations of Arkansas Code Annotated

§17-27- 313 and are pardoned by the governor are not exempt from the requirements of Arkansas Code Annotated §17-27-313.

(b) If the Board finds that it has erred in the granting of a license, the Board will give written notice by certified or signature confirmation mail of intent to annul the license. The notice will allow the applicant the opportunity to meet the requirements of licensure within 30 days.

(c) A period of suspension shall not exceed six (6) months. During the period of suspension, the licensee shall not practice counseling/therapy in the state of Arkansas, may petition for court proceedings to prohibit the unlawful practice of counseling/therapy and/or false representation as a licensed counselor or marriage and family therapist.

(d) The Board, or any member thereof, or any citizen of the state of Arkansas, may petition for court proceedings to prohibit the unlawful practice of counseling or marriage and family/therapy and/or false representation as a licensed counselor or marriage and family therapist.

REQUIREMENT TO KEEP CURRENT ADDRESSES ON FILE

(e) All persons holding a license issued by this Board are required to provide the Board with information so that the Board can remain in contact and provide notice of complaints and/or hearings. The licensee holder is required to provide written notice to the Board of any change in business and/or residence within ten (10) working days of the change. Service of notices of hearing sent by mail will be addressed to the latest address on file with the Board.

(f) The application and supporting documentation will be reviewed by Board staff. The Board administrative office will inform the applicant in writing if it determines that the application is incomplete and will specify why the application is incomplete. When a completed application, a supplemental application, or the requested information is returned, the Board office will reinstate action on the application for license. If all requirements are met, the applicant will be scheduled for the oral examination.

(f) DENIAL OF LICENSE

1. If a preliminary determination is made that the application should be denied, the agency will inform the applicant of the opportunity for a hearing on the application.

2. The grounds or basis for the proposed denial of a license will be set forth in writing by the agency. Any hearing on the denial of a license will be conducted in accordance with ACA § 25-15-208 and ACA § 25-15-213, and unless otherwise provided by law, the applicant has the burden of establishing entitlement to the license.

(g) SUSPENSION, REVOCATION, ANNULMENT OR WITHDRAWAL

1. Prior to the entry of a final order to suspend, revoke, annul or withdraw a license, or to impose other sanctions upon a licensee, the agency will serve the licensee a notice of hearing in the manner set out in Arkansas Code Annotated § 25-15-208 and Rule VII (G).
2. The agency has the burden of proving the alleged facts and violations of law stated in the notice.

(h) EMERGENCY ACTION

1. If the agency finds that the public health, safety, or welfare imperatively requires emergency action and incorporates that finding in its order, the agency can summarily suspend, limit, or restrict a license. The notice requirement in h (1) does not apply and must not be construed to prevent a hearing at the earliest time practicable.
2. Emergency Order: An emergency adjudicative order must contain findings that the public health, safety, and welfare imperatively require emergency action to be taken by the agency. The written order must include notification of the Written Notice. The written emergency adjudicative order will be immediately delivered to persons who are required to comply with the order. One or more of the following procedures will be used:

- (i) Personal Delivery; (ii) Certified mail, return receipt requested, to the last address on file with the agency;
- (iii) First class mail to the last address on file with the agency;
- (iv) Fax notice may be used as the sole method of delivery if the person required to comply with the order has filed a written request that the Board orders be sent by fax and has provided a fax number for that purpose;
- (v) Oral notice. Unless the written emergency order is served by personal delivery on the same day that the order issues, the Board shall make reasonable immediate efforts to contact by telephone the persons who are required to comply with the order.
- (vi) Unless otherwise provided by law, within ten (10) days after emergency action taken pursuant to paragraph 8.2 (4) of this rule, the agency must initiate a formal suspension or revocation proceeding.

(i) VOLUNTARY SUSPENSION OF LICENSE

The licensee, in lieu of formal disciplinary proceedings, may offer to surrender his or her license, subject to the agency's determination to accept the proffered surrender, rather than conducting a formal disciplinary proceeding.

(j) DUTY OF A SANCTIONED PROFESSIONAL

In every case in which a professional's license is revoked, suspended, or revocation, suspension, or surrender, do the following:

- (1) Return his or her license and any license pocket cards to the agency's office;
- (2) Notify all of his or her clients in writing that his or her license has been revoked, suspended, or surrendered;
- (3) Notify all clients to make arrangements for other professional services, calling attention to any urgency in seeking the substitution of another licensed professional;
- (4) Deliver to all clients any papers or property to which they are entitled, or notify the client of a suitable time and place where the papers and other property may be obtained, calling attention to any urgency for obtaining the papers or other property;
 - a. Refund any part of the fees paid in advance that have not been earned;
 - b. Keep and maintain a record of the steps necessary to accomplish the foregoing;
 - c. File with the agency a list of all other state, federal, and administrative jurisdictions by which he or she is licensed. Upon such filing, the agency will notify those entitled of the revocation, suspension, or surrender; and
 - d. The professional shall, within thirty (30) days of revocation, suspension, or surrender of the license, file an affidavit with the agency that he or she has fully complied with the provisions of the order and completely performed the foregoing or provide a full explanation of the reasons for his or her non-compliance. Such affidavit shall also set forth the address where communications may thereafter be directed to the respondent.

(k) REINSTATEMENT AFTER SUSPENSION

1. An order suspending a license may provide that a person desiring reinstatement may file with the Counseling Board a verified petition requesting reinstatement.
2. The petition for reinstatement must set out the following:
 - (i) That the individual has fully and promptly complied with the requirements of section VIII (K) of these rules pertaining to the duty of a sanctioned professional;
 - (ii) That the individual has refrained from practicing in this profession during the period of suspension;
 - (iii) That the individual's license fee is current or has been tendered to the agency;
 - (iv) That the individual has fully complied with any requirements imposed as conditions for reinstatement.

(v) Any knowing misstatement of fact may constitute grounds for denial or revocation of reinstatement.

3. Failure to comply with the provisions of Section 8.3 (K7 & K8) of the Rule precludes consideration for reinstatement.

4. No individual will be reinstated unless the Board of Examiners in Counseling approves reinstatement by majority vote.

(l) RE-LICENSURE FOR REVOKED OR SURRENDERED LICENSE

1. No individual who has had his or her license revoked or who has surrendered his or her license will be licensed, except on petition made to the agency. The application for re-licensure is not allowed until at least five years after the revocation or surrender of license took effect.
2. The applicant bears the burden of proof that he is rehabilitated following the revocation or the application for re-licensure is received.
3. The agency may impose any appropriate conditions or limitations on a license to protect the public health, safety, and welfare.
4. The agency may require that the person seeking re-licensure take licensing examination.
5. The agency may require that the person seeking re-licensure have supervision for a specified time and ratio.
6. surrender of his license, that he can engage in the conduct authorized by the license without undue risk to the public health, safety, and welfare, and that he is otherwise qualified for the license pursuant to Arkansas Code Annotated § 17-27-101 et seq and Rules in effect the date the application for re-licensure is received.
7. The agency may impose any appropriate conditions or limitations on a license to protect the public health, safety, and welfare.
8. The agency may require that the person seeking re-licensure take licensing examination.
9. The agency may require that the person seeking re-licensure have supervision for a specified time and ratio.

- (ii) Certified mail, return receipt requested, to the last address on file with the agency;
- (iii) First class mail to the last address on file with the agency;
- (vii) Fax notice may be used as the sole method of delivery if the person required to comply with the order has filed a written request that the Board orders be sent by fax and has provided a fax number for that purpose;
- (viii) Oral notice. Unless the written emergency order is served by personal delivery on the same day that the order issues, the Board shall make reasonable immediate efforts to contact by telephone the persons who are required to comply with the order.

- i. Unless otherwise provided by law, within ten (10) days after emergency action taken pursuant to paragraph 8.2 (4) of this rule, the agency must initiate a formal suspension or revocation proceeding.

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In every case in which a professional's license is revoked, suspended, or revocation, suspension, or surrender, do the following:

1. Return his or her license and any license pocket cards to the agency's office;
2. Notify all of his or her clients in writing that his or her license has been revoked, suspended, or surrendered;
3. Notify all clients to make arrangements for other professional services, calling attention to any urgency in seeking the substitution of another licensed professional;
4. 4. Deliver to all clients any papers or property to which they are entitled, or notify the client of a suitable time and place where the papers and other property may be obtained, calling attention to any urgency for obtaining the papers or other property;
5. Refund any part of the fees paid in advance that have not been earned;
6. Keep and maintain a record of the steps necessary to accomplish the foregoing;
7. File with the agency a list of all other state, federal, and administrative jurisdictions by which he or she is licensed. Upon such filing, the agency will notify those entitled of the revocation, suspension, or surrender; and
8. The professional shall, within thirty (30) days of revocation, suspension, or surrender of the license, file an affidavit with the agency that he or she has fully complied with the provisions of the order and completely performed the foregoing or provide a full explanation of the reasons for his or her non-compliance. Such affidavit shall also set forth the address where communications may thereafter be directed to the respondent.

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 - (i) That the individual has fully and promptly complied with the requirements of section VIII (K) of these rules pertaining to the duty of a sanctioned professional;
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 - (iii) That the individual's license fee is current or has been tendered to the agency;
 - (iv) That the individual has fully complied with any requirements imposed as conditions for reinstatement.
 - (v) Any knowing misstatement of fact may constitute grounds for denial or revocation of reinstatement.
 - (vi) Failure to comply with the provisions of Section 8.3 (K7 & K8) of the Rule precludes consideration for reinstatement.
 - (vii) No individual will be reinstated unless the Board of Examiners in Counseling approves reinstatement by majority vote.

(n) RE-LICENSURE FOR REVOKED OR SURRENDERED LICENSE

1. No individual who has had his or her license revoked or who has surrendered his or her license will be licensed, except on petition made to the agency. The application for re-licensure is not allowed until at least five years after the revocation or surrender of license took effect.
2. The applicant bears the burden of proof that he is rehabilitated following the revocation or the application for re-licensure is received.
3. The agency may impose any appropriate conditions or limitations on a license to protect the public health, safety, and welfare.
4. The agency may require that the person seeking re-licensure take licensing examination.
5. The agency may require that the person seeking re-licensure have supervision for a specified time and ratio.
6. Re-licensure after surrender of license, requires proof that he/she can engage in the conduct authorized by the license without undue risk to the public health, safety, and welfare, and that he is otherwise qualified for the license pursuant to Arkansas Code Annotated § 17-27-101 et seq and Rules in effect the date the application for re-licensure is received.

Section 8.4

UNAUTHORIZED COUNSELING

- (a) When the Board is made aware of a violation, or possible violation, of Ark. Code Ann. § 17-27-101 et seq., a certified or registered letter with return receipt, showing delivery to addressee only, shall be mailed to the last known address of the person in question. The letter will direct attention to pertinent aspects of the law and the rules and regulations of the law.
- (b) If (a) does not induce said person to cease violation and to desist from practicing, holding himself/herself out to practice, and/or from practicing, and/or use of title or activities, in violation, the information shall be forwarded to the appropriate law enforcement authorities.
- (c) Adjudicative Hearings will be conducted following the Arkansas Administrative Procedure Act (APA) framework. The Adjudicative Hearings format will follow Rules beginning Section 8.2

IX. LICENSING UNDER SPECIAL CONDITIONS

Section 9.1 RECIPROcity

No reciprocity agreement exists between other states or other Arkansas agencies. Applicants from other states or Arkansas agencies must apply and complete the formal application process prior to license issue. The following apply to the process:

- (a) An applicant who has been licensed as a counselor or mental health professional in other state/states or by other Arkansas agencies must submit a License Verification Form (LVF) from each state or agency prior to the oral examination.
- (b) Waiver of the NCE, NCMHCE, or the AMFTRB may be granted when the Board has determined that another examination is equivalent or an endorsement agreement has been reached with the other boards or agencies responsible for licensing Counselors/Therapists.
- (c) Applicants moving from another state, who hold their licenses from that state under grandfathering, and were not previously tested for licensure, will be required to satisfactorily complete the National Clinical Mental Health Counseling Self-Assessment Examination (NCMHCE) or the National Counseling Examination (NCE).
- (d) If requirements for full license (LPC or LMFT) in another state required 2000 Client Contact Hours (CCH), the applicant will need to document an additional 1000 CCH of supervision or the application will be processed for LAC or LAMFT. The 2000 CCH from another state will be applied first to year three, then year two. The 1000 CCH to be earned in Arkansas must be year one with 100 clock hours of supervision provided at the ratio of one (1) hour of supervision

for each ten (10) hours of client contact. If the applicant has been continuously licensed in another state for seven years, is in good standing in that state and has passed the NCMHCE within five years prior to the Arkansas application, the NCMHCE may substitute for 500 CCH hours of required supervision.

(e) Acceptability of supervision, gained prior to application, under other Licensing Boards or in exempt positions, will be judged according to:

(1) The ethical and professional standards of the Association for Counselor Education and Supervision or the Commission on Accreditation of Marriage and Family Therapy Education, the American Association for Pastoral Counselors, Council for Accreditation of Counseling and Related Educational Programs, National Board for Certifying Counselors, Commission on Rehabilitation Counselor Certification.

(2) The appropriateness of the supervisory relationship.

(3) The direct counseling hours performed while under supervision will be credited at the ratio specified by the Board and must consist of direct, face-to-face supervision in either individual and/or group format. Technology-Assisted Distance Supervision may be reported if the Supervisor holds the Specialization License. Technology-Assisted Distance Supervision may not exceed fifty percent in any one phase.

(4) Indirect service hours performed while under supervision may not exceed 200 Client Contact Hours (CCH) in Phase I, 300 CCH in Phase II, and 300 CCH in Phase III.

(5) Graduate school practicum or internship hours acquired in the Master's program are not credited to substitute for the required supervised professional work. Post Master's hours in practicum/internships not needed for the initial application for the Arkansas license may be applied as transcript credit to Phase III or Phase II (3 transcript semester hours equate 100 CCH).

(6) Hours spent conducting Psycho Educational groups (whether inpatient/outpatient or at other locations) may not be credited as Counseling or Marriage and Family Therapy to reduce the required direct or indirect post master's supervised work.

(f) Acceptable Post-Master's Supervision may include:

(1) A recognized post-master's internship training program

(2) Supervised CCH approved by another state's counseling Licensure Board or Marriage and Family Therapy Board

- (3) Supervision approved by NBCC, AAMFT, CRCC or AAPC
- (4) Supervised Counseling or Marriage and Family Therapy hours accrued during employment in private practice or in an agency or institution that meet Board adopted supervision criteria.

Section 9.2 CONSULTING

- (a) Non-resident persons who are licensed by Counseling or Marriage and Family Therapy regulatory boards in other states or countries may provide consulting or research services within Arkansas for not more than thirty (30) days (discontinuous or continuous) per calendar year.
- (b) Consultant is defined as a licensed LPC/LMFT who has practiced as a professional for a minimum of three (3) years in another state and contracts with an Arkansas agency or institution for research, workshops, training, or for providing advice and guidance on professional issues.
- (c) Consultant activities and services must be short-term and contractual and must be sponsored and supervised by a licensed Arkansas LPC or LMFT.
- (c) Prospective employees, moving to Arkansas from another state, who are applying for an Arkansas license are not to be considered consultants and are not exempt from licensure.
- (e) Licensed Counselors or Marriage and Family Therapist who consult with other licensed professionals and/or develop relationships with Colleagues, Employers and Employees must follow the ACA Code Section D1.a through D.2.d.

Section 9.3 OTHER PROFESSIONALS AND AGENCIES

- (a) Neither the National Counselor Examination nor the Association of Marital and Family Therapy Regulatory Board Examination will be waived for licensed Psychologists who apply for a license from the Counseling Board.
- (b) Licensed Psychological Examiners (LPE) who apply for a counseling or a marriage and family therapy license must complete the supervision requirements in Phase I (1000 Client Contact Hours at the ratio of one (1) hour of supervision for each ten (10) hours of direct client contact). The maximum of two (2) years of supervised professional experience may be submitted for approval by the Board if the applicant documents supervised experience consistent with his/her Statement of Intent by submitting:
 - (1) Documentation from the Arkansas Board of Examiners in Psychology (ABEP)

- (2) Statement from the ABEP or LPE supervisor verifying the ratio of supervision to CCH and that the scope of the practice supervised was not related to assessment, appraisal, or testing as part of their practice
- (c) Any person holding a license from the Arkansas Board of Examiners in Psychology (ABEP) will not be approved for any appraisal, assessment, or testing under any license issued by this Board. All appraisal activities will be regulated by the ABEP for any persons licensed by both the Board of Examiners in Counseling and Board of Examiners in Psychology.
- (d)(1) Clergy who are credentialed as member, fellow, or diplomat by the American Association of Pastoral Counselors (AAPC), Association for Clinical Pastoral Education (ACPE) or other Board-approved credentialing organizations will be accepted as meeting the Board definition of equivalent training for Licensed Associate or Professional Counselor or Marriage and Family Therapist
- (2) Upon completion of the application process, providing a passing score on one of the written examinations (National Counseling Examination, Marriage and Family Therapy Examination, Pastoral Counselor Examination or equivalent), passing the situational and oral exams, clergy applicants with appropriate documented experience will be granted the Licensed Counselor or Marriage and Family Therapist license with the specialty license as pastoral counselor or pastoral marriage and family therapist.
- (e) Applicants for the Licensed Professional Counselor license who hold a master's degree and who are credentialed as CRC by the Commission on Rehabilitation Counselor Certification (CRCC) standards adopted by CRCC July 1, 2003 will be accepted as meeting the Board definition of equivalent/parallel training for licensed Associate or Professional Counselor or Marriage and Family Therapist provided the core curriculum courses are included in the degree or in post-master's course work. The Certified Rehabilitation Counselor Examination (CRC Examination) has not been determined equivalent to the National Counseling Examination (NCE) and will not be substituted for the NCE for the LPC license. The CRC Examination will be accepted for the Rehabilitation Counselor Specialization License.
- (f) If a candidate is licensed or certified to practice Counseling and/or Marriage and Family Therapy by a similar Board in another state, the Arkansas Board may at its discretion, waive the written examination requirements of a candidate if the candidate had an equivalent written examination in the process of obtaining the license in another state and has been continuously licensed. If the previous license has expired or lapsed the examination may not be waived. If the applicant had written the examination, but did not complete the licensure process, the

written examination of record may not be more than five (5) years old to be accepted for Arkansas license application purposes.

(g) Persons who apply for an Arkansas license, have been continuously licensed seven years in another state and in good standing but lack no more than nine hours of the required graduate course work may have a one time license issued with the provision that the graduate course requirements must be met prior to the first license renewal.

(h) Documents relevant to an application from a person licensed in another state will be accepted as official if sent directly from the state licensing board, from NBCC, or from the American Association of State Counseling Boards National Credential Registry.

X. Ethics

Section 11.1

PROFESSIONAL ETHICS

(a) The Arkansas Board of Examiners in Counseling (ARBOEC) adopts the 2005 revision of the American Counseling Association (ACA) Code of Ethics, to comply with Arkansas Code Annotated 17-27-203 (c). Effective 10 days following the Legislative Council approval date of these Rules.

(b) The American Association of Marriage and Family Therapist (AAMFT) Ethical Code, 2001, is adopted for all persons holding a Licensed Associate Marriage and Family Therapist (LAMFT) or the Licensed Marriage and Family Therapist (LMFT) license.

(c) Licensees holding multiple licenses must adhere to the codes of ethics of all professional certificates/licenses held and to the more stringent of the codes of ethics where there may be any appearance of conflict between codes.

(d) The Anti-Fraud and Code of Ethics Policy dated September 10, 2005 is adopted to comply with the Department of Finance and Administration to meet Auditing Standards #90 as issued by the auditing Standards Board of the American Institute of Certified Public Accountants.

XI. COUNSELOR/PSYCHOTHERAPIST AND MARRIAGE AND FAMILY THERAPIST – CLIENT COMMUNICATIONS AND MEDICAL RECORDS

The client of persons licensed by this Board has a privilege to refuse to disclose and to prevent any other person from disclosing his medical records or confidential communications made for the purpose of diagnosis or treatment of his physical, mental or

emotional condition, including alcohol or drug addiction, among himself, the licensee, and persons who are participating in the diagnosis or treatment under the direction of the licensee, including members of the client's family. See Rules 501, 502 and 503, Arkansas Rules of Evidence. The licensee is presumed to have authority to claim the privilege on behalf of the patient. The privilege is subject to the exceptions listed in Rule 503(d). The following communications are not protected by the privilege:

- a. Communications relevant to an issue in proceedings to hospitalize the client are not privileged.
- b. Communications made in the course of a court ordered examination of the client are not privileged unless the court orders otherwise.
- c. Medical records or communications relevant to an issue of the physical, mental, or emotional condition of the patient in any proceeding in which he or she relies upon the condition as an element of his or her claim or defense, or, after the patient's death, in any proceeding in which any party relies upon the condition as an element of his or her claim or defense.
- d. The licensee may be required to furnish medical records, and communications in the context of formal discovery procedures.

SECTION XII. THE PRACTICE OF INTERNET OR TELEPHONE SERVICES

The Board adopts the National Board for Certified Counselors (NBCC) document titled *The Practice of Internet Counseling*, published in 2005. The NBCC document is adopted as part of Arkansas Rules to further extend and clarify Technology-Assisted Distance Counseling Ethics, Definitions and Standards for Counselors and Marriage and Family Therapist licensed in the state of Arkansas. The adoption of the document is to support and extend the American Counseling Code of Ethics, 2005 edition for the practice of Internet Counseling.

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THE PRACTICE OF INTERNET COUNSELING

This document contains a statement of principles for guiding the evolving practice of Internet counseling. In order to provide a context for these principles, the following definition of Internet counseling, which is one element of technology-assisted distance counseling, is provided. The Internet counseling standards follow the definitions presented below.

A Taxonomy for Defining Face-To-Face and Technology-Assisted Distance Counseling

The delivery of technology-assisted distance counseling continues to grow and evolve. Technology assistance in the form of computer-assisted assessment, computer-assisted information systems, and telephone counseling has been available and widely used for some time. The rapid development and use of the Internet to deliver information and foster communication has resulted in the creation of new forms of counseling. Developments have occurred so rapidly that it is difficult to communicate a common understanding of these new forms of counseling practice.

The purpose of this document is to create standard definitions of technology-assisted distance counseling that can be easily updated in response to evolutions in technology and practice. A definition of traditional face-to-face counseling is also presented to show similarities and differences with respect to various applications of technology in counseling. A taxonomy of forms of counseling is also presented to further clarify how technology relates to counseling practice.

Nature of Counseling

Counseling is the application of mental health, psychological, or human development principles, through cognitive, affective, behavioral or systemic intervention strategies, that address wellness, personal growth, or career development, as well as pathology.

Depending on the needs of the client and the availability of services, counseling may range from a few brief interactions in a short period of time, to numerous interactions over an extended period of time. Brief interventions, such as classroom discussions, workshop presentations, or assistance in using assessment, information, or instructional resources, may be sufficient to meet individual needs. Or, these brief interventions may lead to longer-term counseling interventions for individuals with more substantial needs. Counseling may be delivered by a single counselor, two counselors working collaboratively, or a single counselor with brief assistance from another counselor who has specialized expertise that is needed by the client.

Forms of Counseling

Counseling can be delivered in a variety of forms that share the definition presented above. Forms of counseling differ with respect to participants, delivery location, communication medium, and interaction process. Counseling *participants* can be individuals, couples, or groups. The *location* for counseling delivery can be face-to-face or at a distance with the assistance of technology. The *communication medium* for counseling can be what is read from text, what is heard from audio, or what is seen and heard in person or from video. The *interaction process* for counseling can be synchronous or asynchronous. Synchronous interaction occurs with little or no gap in time between the responses of the counselor and the client. Asynchronous interaction occurs with a gap in time between the responses of the counselor and the client.

The selection of a specific form of counseling is based on the needs and preferences of the client within the range of services available. Distance counseling supplements face-to-face counseling by providing increased access to counseling on the basis of necessity or convenience. Barriers, such as being a long distance from counseling services, geographic separation of a couple, or limited physical mobility as a result of having a disability, can make it necessary to provide counseling at a distance. Options, such as scheduling counseling sessions outside of traditional service delivery hours or delivering counseling services at a place of residence or employment, can make it more convenient to provide counseling at a distance.

A Taxonomy of Forms of Counseling Practice. Table 1 presents a taxonomy of currently available forms of counseling practice. This schema is intended to show the relationships among counseling forms.

Table 1

A Taxonomy of Face-To-Face and Technology-Assisted Distance Counseling

Counseling

- Face-To-Face Counseling
 - Individual Counseling
 - Couple Counseling
 - Group Counseling
- Technology-Assisted Distance Counseling
 - Telecounseling
 - Telephone-Based Individual Counseling
 - Telephone-Based Couple Counseling
 - Telephone-Based Group Counseling
 - Internet Counseling
 - E-Mail-Based Individual Counseling
 - Chat-Based Individual Counseling
 - Chat-Based Couple Counseling
 - Chat-Based Group Counseling
 - Video-Based Individual Counseling
 - Video-Based Couple Counseling
 - Video-Based Group Counseling

Definitions

Counseling is the application of mental health, psychological, or human development principles, through cognitive, affective, behavioral or systemic intervention strategies, that address wellness, personal growth, or

career development, as well as pathology.

Face-to-face counseling for individuals, couples, and groups involves synchronous interaction between and among counselors and clients using what is seen and heard in person to communicate.

Technology-assisted distance counseling for individuals, couples, and groups involves the use of the telephone or the computer to enable counselors and clients to communicate at a distance when circumstances make this approach necessary or convenient.

Telecounseling involves synchronous distance interaction among counselors and clients using one-to-one or conferencing features of the telephone to communicate.

Telephone-based individual counseling involves synchronous distance interaction between a counselor and a client using what is heard via audio to communicate.

Telephone-based couple counseling involves synchronous distance interaction among a counselor or counselors and a couple using what is heard via audio to communicate.

Telephone-based group counseling involves synchronous distance interaction among counselors and clients using what is heard via audio to communicate.

Internet counseling involves asynchronous and synchronous distance interaction among counselors and clients using e-mail, chat, and videoconferencing features of the Internet to communicate.

E-mail-based individual Internet counseling involves asynchronous distance interaction between counselor and client using what is read via text to communicate.

Chat-based individual Internet counseling involves synchronous distance interaction between counselor and client using what is read via text to communicate.

Chat-based couple Internet counseling involves synchronous distance interaction among a counselor or counselors and a couple using what is read via text to communicate.

Chat-based group Internet counseling involves synchronous distance interaction among counselors and clients using what is read via text to communicate.

Video-based individual Internet counseling involves synchronous distance interaction between counselor and client using what is seen and heard via video to communicate.

Video-based couple Internet counseling involves synchronous distance interaction among a counselor or counselors and a couple using what is seen and heard via video to communicate.

Video-based group Internet counseling involves synchronous distance interaction among counselors and clients using what is seen and heard via video to communicate.

Standards for the Ethical Practice of Internet Counseling

These standards govern the practice of Internet counseling and are intended for use by counselors, clients, the public, counselor educators, and organizations that examine and deliver Internet counseling. These standards are intended to address practices that are unique to Internet counseling and Internet counselors and do not duplicate principles found in traditional codes of ethics.

These Internet counseling standards of practice are based upon the principles of ethical practice embodied in the

NBCC Code of Ethics. Therefore, these standards should be used in conjunction with the most recent version of the NBCC ethical code. Related content in the NBCC Code are indicated in parentheses after each standard.

Recognizing that significant new technology emerges continuously, these standards should be reviewed frequently. It is also recognized that Internet counseling ethics cases should be reviewed in light of delivery systems existing at the moment rather than at the time the standards were adopted.

Internet Counseling Relationship

1. In situations where it is difficult to verify the identity of the Internet client, steps are taken to address impostor concerns, such as by using code words or numbers.
2. Internet counselors determine if a client is a minor and therefore in need of parental/guardian consent. When parent/guardian consent is required to provide Internet counseling to minors, the identity of the consenting person is verified.
3. As part of the counseling orientation process, the Internet counselor explains to clients the procedures for contacting the Internet counselor when he or she is off-line and, in the case of asynchronous counseling, how often e-mail messages will be checked by the Internet counselor.
4. As part of the counseling orientation process, the Internet counselor explains to clients the possibility of technology failure and discusses alternative modes of communication, if that failure occurs.
5. As part of the counseling orientation process, the Internet counselor explains to clients how to cope with potential misunderstandings when visual cues do not exist.
6. As a part of the counseling orientation process, the Internet counselor collaborates with the Internet client to identify an appropriately trained professional who can provide local assistance, including crisis intervention, if needed. The Internet counselor and Internet client should also collaborate to determine the local crisis hotline telephone number and the local emergency telephone number.
7. The Internet counselor has an obligation, when appropriate, to make clients aware of free public access points to the Internet within the community for accessing Internet counseling or Web-based assessment, information, and instructional resources.
8. Within the limits of readily available technology, Internet counselors have an obligation to make their Web site a barrier-free environment to clients with disabilities.
9. Internet counselors are aware that some clients may communicate in different languages, live in different time zones, and have unique cultural perspectives. Internet counselors are also aware that local conditions and events may impact the client.

Confidentiality in Internet Counseling

10. The Internet counselor informs Internet clients of encryption methods being used to help insure the security of client/counselor/supervisor communications.

Encryption methods should be used whenever possible. If encryption is not made available to clients, clients must be informed of the potential hazards of unsecured communication on the Internet. Hazards may include unauthorized monitoring of transmissions and/or records of

Internet counseling sessions.

11. The Internet counselor informs Internet clients if, how, and how long session data are being preserved.

Session data may include Internet counselor/Internet client e-mail, test results, audio/video session recordings, session notes, and counselor/supervisor communications. The likelihood of electronic sessions being preserved is greater because of the ease and decreased costs involved in recording. Thus, its potential use in supervision, research, and legal proceedings increases.

12. Internet counselors follow appropriate procedures regarding the release of information for sharing Internet client information with other electronic sources.

Because of the relative ease with which e-mail messages can be forwarded to formal and casual referral sources, Internet counselors must work to insure the confidentiality of the Internet counseling relationship.

Legal Considerations, Licensure, and Certification

13. Internet counselors review pertinent legal and ethical codes for guidance on the practice of Internet counseling and supervision.

Local, state, provincial, and national statutes as well as codes of professional membership organizations, professional certifying bodies, and state or provincial licensing boards need to be reviewed. Also, as varying state rules and opinions exist on questions pertaining to whether Internet counseling takes place in the Internet counselor's location or the Internet client's location, it is important to review codes in the counselor's home jurisdiction as well as the client's. Internet counselors also consider carefully local customs regarding age of consent and child abuse reporting, and liability insurance policies need to be reviewed to determine if the practice of Internet counseling is a covered activity.

14. The Internet counselor's Web site provides links to websites of all appropriate certification bodies and licensure boards to facilitate consumer protection.

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XIII. FEES

License Application Fees

*Application Fee Initial LAC/LPC/LAMFT/LMFT license	\$200.00
Application LAC to LPC or LAMFT to LMFT License	\$100.00
*Application for Specialization License/Licenses	\$ 50.00

First license fee for LAC/LAMFT is prorated based on the biennial \$250.00 license fee, according to the number of months licensed, one time only, beginning July 1 of the fiscal year of license issue.

First license fee for LPC/LMFT is prorated based on the biennial \$300.00 license fee, according to the number of months licensed, one time only, beginning July 1 of the fiscal year of license issue.

License Renewal Fees

Biennial license renewal-Associates (LAC/LAMFT)	\$250.00
Biennial license renewal-Professionals (LPC/LMFT)	\$300.00
Late renewal fee July 1 to December 1	\$100.00
Late renewal fee December 2 to June 30	\$200.00

Specialization renewal fee \$0.00 (renewal based on generic license renewal) if required continuing education submitted with renewal. If late, the late renewal fee will apply to specialization license renewal.

*If Specialization License applied for with initial application for the LAC/LPC , LAMFT/LMFT license the Specialization License fee of \$50.00 does not apply.

License Examination Fees

NCE Examination – pay to	NBCC
NCMHCE Examination – pay to	NBCC
AMFTRB Examination –pay to	AMFTRB

XIV. FOOTNOTES

Rules shall be in effect ten (10) days following the Legislative Council approval date for individuals who hold a current Arkansas License, have an Arkansas application in process or for applications filed thereafter.

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September 23, 2011

When Your Therapist Is Only a Click Away

By JAN HOFFMAN

THE event reminder on Melissa Weinblatt's [iPhone](#) buzzed: 15 minutes till her shrink appointment.

She mixed herself a mojito, added a sprig of mint, put on her sunglasses and headed outside to her friend's pool. Settling into a lounge chair, she tapped the [Skype](#) app on her phone. Hundreds of miles away, her face popped up on her therapist's computer monitor; he smiled back on her phone's screen.

She took a sip of her cocktail. The session began.

Ms. Weinblatt, a 30-year-old high school teacher in Oregon, used to be in treatment the conventional way — with face-to-face office appointments. Now, with her new doctor, she said: "I can have a Skype therapy session with my morning coffee or before a night on the town with the girls. I can take a break from shopping for a session. I took my doctor with me through three states this summer!"

And, she added, "I even e-mailed him that I was panicked about a first date, and he wrote back and said we could do a 20-minute mini-session."

Since telepsychiatry was introduced decades ago, video conferencing has been an increasingly accepted way to reach patients in hospitals, prisons, veterans' health care facilities and rural clinics — all supervised sites.

But today Skype, and encrypted digital software through third-party sites like [CaliforniaLiveVisit.com](#), have made online private practice accessible for a broader swath of patients, including those who shun office treatment or who simply like the convenience of therapy on the fly.

One third-party online therapy site, [Breakthrough.com](#), said it has signed up 900 [psychiatrists](#), [psychologists](#), counselors and coaches in just two years. Another indication that online treatment is migrating into mainstream sensibility: "Web Therapy," the Lisa Kudrow comedy that started online and pokes fun at three-minute webcam therapy sessions, moved to cable (Showtime) this summer.

“In three years, this will take off like a rocket,” said Eric A. Harris, a lawyer and psychologist who consults with the American Psychological Association Insurance Trust. “Everyone will have real-time audiovisual availability. There will be a group of true believers who will think that being in a room with a client is special and you can’t replicate that by remote involvement. But a lot of people, especially younger clinicians, will feel there is no basis for thinking this. Still, appropriate professional standards will have to be followed.”

The pragmatic benefits are obvious. “No parking necessary!” touts one online therapist. Some therapists charge less for sessions since they, too, can do it from home, saving on gas and office rent. Blizzards, broken legs and business trips no longer cancel appointments. The anxiety of shrink-less August could be, dare one say ... curable?

Ms. Weinblatt came to the approach through geographical necessity. When her therapist moved, she was apprehensive about transferring to the other psychologist in her small town, who would certainly know her prominent ex-boyfriend. So her therapist referred her to another doctor, whose practice was a day’s drive away. But he was willing to use Skype with long-distance patients. She was game.

Now she prefers these sessions to the old-fashioned kind.

But does knowing that your therapist is just a phone tap or mouse click away create a 21st-century version of shrink-neediness?

“There’s that comfort of carrying your doctor around with you like a security blanket,” Ms. Weinblatt acknowledged. “But,” she added, “because he’s more accessible, I feel like I need him less.”

The technology does have its speed bumps. Online treatment upends a basic element of therapeutic connection: eye contact.

Patient and therapist typically look at each other’s faces on a computer screen. But in many setups, the camera is perched atop a monitor. Their gazes are then off-kilter.

“So patients can think you’re not looking them in the eye,” said Lynn Bufka, a staff psychologist with the [American Psychological Association](#). “You need to acknowledge that upfront to the patient, or the provider has to be trained to look at the camera instead of the screen.”

The quiriness of Internet connections can also be an impediment. “You have to prepare vulnerable people for the possibility that just when they are saying something that’s difficult, the screen can go blank,” said [DeeAnna Merz Nagel](#), a psychotherapist licensed in New Jersey and New York. “So I always say, ‘I will never disconnect from you online on purpose.’ You make arrangements ahead of time to call each other if that happens.”

Still, opportunities for exploitation, especially by those with sketchy credentials, are rife. Solo providers who hang out virtual [shingles](#) are a growing phenomenon. In the Wild Web West, one site sponsored a contest asking readers to post why they would seek therapy; the person with the most popular answer would receive six months of free treatment. When the blogosphere erupted with outrage from patients and professionals alike, the site quickly made the applications private.

Other questions abound. How should insurance reimburse online therapy? Is the therapist complying with licensing laws that govern practice in different states? Are videoconferencing sessions recorded? Hack-proof?

Another draw and danger of online therapy: anonymity. Many people avoid treatment for reasons of shame or privacy. Some online therapists do not require patients to fully identify themselves. What if those patients have breakdowns? How can the therapist get emergency help to an anonymous patient? "A lot of patients start therapy and feel worse before they feel better," noted Marlene M. Maheu, founder of the [TeleMental Health Institute](#), which trains providers and who has served on task forces to address these questions. "It's more complex than people imagine. A provider's Web site may say, 'I won't deal with patients who are feeling suicidal.' But it's our job to assess patients, not to ask them to self-diagnose." She practices online therapy, but advocates consumer protections and rigorous training of therapists.

Psychologists say certain conditions might be well-suited for treatment online, including [agoraphobia](#), anxiety, [depression](#) and [obsessive-compulsive disorder](#). Some doctors suggest that Internet addiction or other addictive behaviors could be treated through videoconferencing.

Others disagree. As one doctor said, "If I'm treating an alcoholic, I can't smell his breath over Skype."

Cognitive behavioral therapy, which can require homework rather than tunneling into the patient's past, seems another candidate. Tech-savvy teenagers resistant to office visits might brighten at seeing a therapist through a computer monitor in their bedroom. Home court advantage.

Therapists who have tried online therapy range from evangelizing standard-bearers, planting their stake in the new future, to those who, after a few sessions, have backed away. Elaine Ducharme, a psychologist in Glastonbury, Conn., uses Skype with patients from her former Florida practice, but finds it disconcerting when a patient's face becomes pixilated. Dr. Ducharme, who is licensed in both states, will not videoconference with a patient she has not met in person. She flies to Florida every three months for office visits with her Skype patients.

"There is definitely something important about bearing witness," she said. "There is so much that happens in a room that I can't see on Skype."

Dr. Heath Canfield, a psychiatrist in Colorado Springs, also uses Skype to continue therapy with

some patients from his former West Coast practice. He is licensed in both locations. "If you're doing therapy, pauses are important and telling, and Skype isn't fast enough to keep up in real time," Dr. Canfield said. He wears a headset. "I want patients to know that their sound isn't going through walls but into my ears. I speak into a microphone so they don't feel like I'm shouting at the computer. It's not the same as being there, but it's better than nothing. And I wouldn't treat people this way who are severely mentally ill."

Indeed, the pitfalls of videoconferencing with the severely mentally ill became apparent to Michael Terry, a psychiatric [nurse practitioner](#), when he did psychological evaluations for patients throughout Alaska's Eastern Aleutian Islands. "Once I was wearing a white jacket and the wall behind me was white," recalled Dr. Terry, an associate clinical professor at the University of San Diego. "My face looked very dark because of the contrast, and the patient thought he was talking to the devil."

Another time, lighting caused a halo effect. "An adolescent thought he was talking to the Holy Spirit, that he had God on the line. It fit right into his delusions."

Johanna Herwitz, a Manhattan psychologist, tried Skype to augment face-to-face therapy. "It creates this perverse lower version of intimacy," she said. "Skype doesn't therapeutically disinhibit patients so that they let down their guard and take emotional risks. I've decided not to do it anymore."

Several [studies](#) have concluded that patient satisfaction with face-to-face interaction and online therapy (often preceded by in-person contact) was statistically similar. Lynn, a patient who prefers not to reveal her full identity, had been seeing her therapist for years. Their work deepened into psychoanalysis. Then her psychotherapist retired, moving out of state.

Now, four times a week, Lynn carries her laptop to an analyst's unoccupied office (her insurance requires that a local provider have some oversight). She logs on to an encrypted program at [Breakthrough.com](#) and clicks through until she reads an alert: "Talk now!"

Hundreds of miles away, so does her analyst. Their faces loom, side by side on each other's monitors. They say hello. Then Lynn puts her laptop on a chair and lies down on the couch. Just the top of her head is visible to her analyst.

Fifty minutes later the session ends. "The screen is asleep so I wake it up and see her face," Lynn said. "I say goodbye and she says goodbye. Then we lean in to press a button and exit."

As attenuated as this all may seem, Lynn said, "I'm just grateful we can continue to do this."

This article has been revised to reflect the following correction:

Correction: October 2, 2011

A picture caption last Sunday with an article about psychotherapy conducted via online technology misstated the method used by Marlene M. Maheu, a therapist. It is videoconferencing, not Skype.

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Scan for Author
Video Interview

Effect of Telephone-Administered vs Face-to-face Cognitive Behavioral Therapy on Adherence to Therapy and Depression Outcomes Among Primary Care Patients

A Randomized Trial

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DEPRESSION IS COMMON, WITH the 1-year prevalence rate of major depressive disorder estimated at between 6.6% and 10.3% in the general population^{1,2} and roughly 25% of all primary care visits involving patients with clinically significant levels of depression.³ Psychotherapy is effective at treating depression,⁴ and most primary care patients prefer psychotherapy to antidepressant medication.⁵ When referred for psychotherapy, however, only a small percentage of patients follow through.⁶ Attrition from psychotherapy in randomized controlled trials is often 30% or greater⁷ and can exceed 50% in clinical practice.⁸

The discrepancy between patients' preference for psychotherapy and the low rates of initiation and adherence is likely due to access barriers. Approximately 75% of depressed primary care patients report barriers that make it extremely difficult or impossible to attend regular psychotherapy sessions.^{9,10} These barriers are largely

Author Video Interview available at www.jama.com.

Context Primary care is the most common site for the treatment of depression. Most depressed patients prefer psychotherapy over antidepressant medications, but access barriers are believed to prevent engagement in and completion of treatment. The telephone has been investigated as a treatment delivery medium to overcome access barriers, but little is known about its efficacy compared with face-to-face treatment delivery.

Objective To examine whether telephone-administered cognitive behavioral therapy (T-CBT) reduces attrition and is not inferior to face-to-face CBT in treating depression among primary care patients.

Design, Setting, and Participants A randomized controlled trial of 325 Chicago-area primary care patients with major depressive disorder, recruited from November 2007 to December 2010.

Interventions Eighteen sessions of T-CBT or face-to-face CBT.

Main Outcome Measures The primary outcome was attrition (completion vs non-completion) at posttreatment (week 18). Secondary outcomes included masked interviewer-rated depression with the Hamilton Depression Rating Scale (Ham-D) and self-reported depression with the Patient Health Questionnaire-9 (PHQ-9).

Results Significantly fewer participants discontinued T-CBT ($n=34$; 20.9%) compared with face-to-face CBT ($n=53$; 32.7%; $P=.02$). Patients showed significant improvement in depression across both treatments ($P<.001$). There were no significant treatment differences at posttreatment between T-CBT and face-to-face CBT on the Ham-D ($P=.22$) or the PHQ-9 ($P=.89$). The intention-to-treat posttreatment effect size on the Ham-D was $d=0.14$ (90% CI, -0.05 to 0.33), and for the PHQ-9 it was $d=-0.02$ (90% CI, -0.20 to 0.17). Both results were within the inferiority margin of $d=0.41$, indicating that T-CBT was not inferior to face-to-face CBT. Although participants remained significantly less depressed at 6-month follow-up relative to baseline ($P<.001$), participants receiving face-to-face CBT were significantly less depressed than those receiving T-CBT on the Ham-D (difference, 2.91; 95% CI, 1.20-4.63; $P<.001$) and the PHQ-9 (difference, 2.12; 95% CI, 0.68-3.56; $P=.004$).

Conclusions Among primary care patients with depression, providing CBT over the telephone compared with face-to-face resulted in lower attrition and close to equivalent improvement in depression at posttreatment. At 6-month follow-up, patients remained less depressed relative to baseline; however, those receiving face-to-face CBT were less depressed than those receiving T-CBT. These results indicate that T-CBT improves adherence compared with face-to-face delivery, but at the cost of some increased risk of poorer maintenance of gains after treatment cessation.

Trial Registration clinicaltrials.gov Identifier: NCT00498706

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www.jama.com

structural and include time constraints, lack of available and accessible services, transportation problems, and cost.

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A meta-analysis of trials of telephone-administered psychotherapy found a mean attrition rate of 7.6%, suggesting that telephone delivery may reduce attrition.⁷ Telephone care has also been incorporated into aspects of collaborative care models that integrate mental health specialists into primary care settings.¹¹ Although telephone-administered psychotherapy for depression has been tested as a tool to deliver care and overcome access barriers within primary care, the underlying assumptions that it is as effective as face-to-face care and that it reduces attrition have not been examined.

We describe a randomized trial comparing standard face-to-face cognitive behavioral therapy (CBT) vs a telephone-administered cognitive behavioral therapy (T-CBT) for the treatment of depression in primary care. It was hypothesized that T-CBT would produce lower levels of attrition and secondarily that it would not be inferior in efficacy to face-to-face CBT.

METHODS

Participants

Participants were recruited from November 2007 to December 2010 from general internal medicine clinics in the Northwestern Medical Faculty Foundation and Northwestern Memorial Physician's Group and from 4 primary care clinic members of Northwestern's Practice-Based Research Network in the Chicago area.

Participants were included if they met criteria for major depressive disorder, had a Hamilton Depression Rating Scale (Ham-D) score greater than or equal to 16, were aged 18 years or older, could speak and read English, and were able to participate in face-to-face or telephone therapy. Participants were excluded if they had visual or hearing impairments that would prevent participation; met diagnostic criteria for a severe psychiatric disorder (eg, bipolar disorder, psychotic disorders) or depression of organic etiology (eg, hypothyroidism) for which psychotherapy would be inappropriate; reported alcohol or substance abuse severe enough that 2 psychologists (D.C.M. and J.H.)

agreed psychotherapy would be inappropriate; met criteria for dementia by scoring less than 25 on the Telephone Interview for Cognitive Status¹²; exhibited severe suicidality, including a plan and intent or a suicide attempt in the past 5 years; were receiving or planning to receive individual psychotherapy; or had initiated antidepressant pharmacotherapy in the previous 10 days. Race and ethnicity were measured by self-report to characterize the sample.

This trial was approved by the Northwestern University institutional review board and was monitored by an independent data and safety monitoring board. In accordance with the Northwestern IRB-approved protocol, participants were sent a consent form, which was reviewed over the telephone with research staff prior to the eligibility interview. Patients signed and returned the consent form prior to randomization.

Randomization and Masking

An independent statistician used computer-generated randomization with a 1:1 ratio, stratified by antidepressant status and therapist, with block size of 4 within each stratum. To prevent allocation bias, randomization was conducted after entry criteria were confirmed. Clinical evaluators, who were masked to treatment assignment, enrolled and evaluated participants; if they became unmasked, participants were reassigned to another masked evaluator.

Treatments

Face-to-face CBT and T-CBT used the same CBT protocol,¹³ with treatment delivery medium being the only factor that varied between conditions. This treatment model has been adapted and validated for telephone administration.^{14,15} Participants received 18 45-minute sessions: 2 sessions weekly for the first 2 weeks, followed by 12 weekly sessions, with 2 final booster sessions during 4 weeks. All participants received a patient workbook that included 8 chapters covering CBT concepts, including behavioral activation, cognitive restruc-

turing, and social support, along with 5 optional modules that covered common comorbidities and treatment content, including anxiety and worry, relaxation training, communication and assertiveness training, anger management, and insomnia.^{14,15}

T-CBT telephone calls were initiated by the therapist. Nine therapists, all PhD-level psychologists, provided both face-to-face CBT and T-CBT to eliminate therapist effects. Face-to-face CBT was provided in the Preventive Medicine clinic at Northwestern University, located in the same medical center as the primary recruitment clinics. T-CBT was provided entirely over the telephone. Specific rules to ensure privacy and safety were discussed in the first session, such as being in a private place during telephone calls and not engaging in therapy while driving. Protocols were in place to ensure safety, which could include calling local emergency personnel to conduct a health and safety check in the event of severe suicidality.

All therapists received 2 days of initial training, followed by weekly supervised training from the Beck Institute Director of Education (L.S.) until the therapists reached the competence criterion defined as consistent scores of greater than or equal to 40 on the Cognitive Therapy Scale,¹⁶ at which point they began treating study participants. Once trained, therapists received weekly supervision by the Beck Education Director or a Beck-certified psychologist for at least 6 months, which could then be reduced to once every 2 to 3 weeks, as determined by the supervisor. All sessions were audiorecorded and 8% were rated on the Cognitive Therapy Scale for fidelity. Fidelity ratings were used in the supervision of the therapists.

This trial is focused on the treatment delivery medium. To prevent confounding through differences in the management of nonadherent patients across treatment arms, the therapist protocol included specific instructions for handling missed sessions and cancellations. A session was considered missed

if less than 24 hours' notice was given. If patients missed a session, they received 2 therapist telephone calls followed by a letter, after which, if still non-responsive, the patients were determined to have discontinued treatment. Participants did not pay for treatment.

Outcome Assessment

The primary outcome was adherence to treatment, defined as attending therapy sessions. Participants were permitted to reschedule sessions if they notified their therapist 24 hours before a cancellation. The primary outcome was dichotomized as completion vs noncompletion of 18 sessions. Secondly, we examined failure to engage in treatment (completion of ≤ 4 sessions), failure to complete (> 4 sessions but < 18 sessions), and number of sessions completed.

The secondary outcome, depression severity, was measured with the interviewer-rated 17-item Ham-D¹⁷ and the self-reported Patient Health Questionnaire-9 (PHQ-9).¹⁸ Psychiatric diagnoses, including major depressive disorder, were evaluated with the Mini International Neuropsychiatric Interview.¹⁹ Remission used the Ham-D abbreviated 7-item scale criterion, whereas response was a 50% decrease in Ham-D symptoms.²⁰ To eliminate potential loss to follow-up because of access barriers, all interview assessments were conducted by telephone, and self-reports were administered online or by mail. Antidepressant use was assessed by interview. Before randomization, participants reported their treatment preference (face-to-face, telephone, or no preference). To identify any potential effects of systematic therapist expectation bias that might occur as a result of crossing therapist by treatment arm, therapists rated their expectations for patient outcome on a 7-point Likert scale after the second session.

Clinical evaluators, who had at least a bachelor's degree, received no fewer than 16 hours of training on the Mini International Neuropsychiatric Interview and Ham-D, including receiving didactic instruction, role playing, and performing ratings on a library of ex-

isting taped interviews. All study interviews were audiotaped and were supervised by a psychologist until reliable proficiency was established. Supervision continued thereafter every 1 to 2 weeks. One audiotape was randomly selected every 1 to 2 weeks for calibration ratings to ensure interrater reliability. The mean interclass correlations were 0.96. All training and supervision were performed by a licensed PhD-level psychologist (J.H.).

Statistical Analysis

The study was designed to enroll 322 participants, resulting in 90% power for a 2-sided test at $\alpha = .05$ to detect a difference in nonadherence rates of 15% vs 30%.²¹ Although a meta-analysis found an attrition rate of 7.4% in telephone psychotherapy, 15% was used because heterogeneity was high and many trials were small.⁷ Attrition of 30% and greater is commonly observed in trials of face-to-face psychotherapy.⁷ Differences in baseline characteristics by treatment group, nonadherence rates, treatment preference, and post-treatment major depressive disorder were analyzed with *t* tests for continuous variables and χ^2 tests for categorical variables.

Although the rate of missing depression outcomes was low at each post-baseline point, ranging from 9% to 22%, we multiply imputed missing depression scores and generated 20 imputations for each missing value, using the R package MICE,²² in which incomplete variables are imputed one at a time according to a set of conditional densities.²³ Imputations were conducted separately by treatment group, and every imputation model was conditioned on a large number of relevant variables, including depression scores, demographics, and total number of CBT sessions attended. Using an imputation model that includes many auxiliary variables preserves relationships among variables and provides more precise and accurate imputations.²⁴ In particular, by including the number of CBT sessions attended, we were able to preserve the relationship between amount

of treatment received and depression symptoms among patients with missing depression scores.

Longitudinal depression scores were modeled with repeated-measures linear regression models as implemented in the SAS procedure PROC MIXED (version 9.02). Time was treated as a categorical variable to account for nonlinear effects of time, and an unstructured covariance matrix was assumed. Differences by treatment group in major depressive disorder and remission at 3- and 6-month follow-up were assessed with logistic regression, as was treatment response. These analyses were performed on each of the 20 imputed data sets and results were combined by using the rules of Rubin.²⁵

During the trial, the data and safety monitoring board recommended changes in the planned analyses to replace the originally proposed analyses with a noninferiority analysis for depression outcomes. The noninferiority margin was not determined before the initiation of the trial, but it was determined before any analyses of outcome data and with the full knowledge and approval of oversight bodies. Noninferiority is established by showing that the true difference between 2 treatment arms is likely to be smaller than a prespecified noninferiority margin that separates clinically important from clinically negligible (acceptable) differences.^{26,27}

The clinical community has generally accepted 30% to 50% of the difference between treatment and control conditions as an acceptable definition for the noninferiority margin,^{27,28} and noninferiority trials of pharmacologic treatments have used the 50% criterion.²⁹⁻³¹ A recent meta-analysis of CBT found an overall effect size of $d = 0.82$.³² Accordingly, we used $d = 0.41$ as the noninferiority criterion. A 1-sided test at $\alpha = .05$ of whether the difference in treatment groups is less than the noninferiority margin is equivalent to testing whether a 2-sided 90% CI around the treatment difference falls within the noninferiority margin. Accordingly, we calculated 90% CIs and rejected the null hypothesis of inferiority (in favor of

noninferiority) if the upper bound of the CI was less than $d=0.41$.

To assess variable antidepressant use across treatment arms, a repeated-measures analysis of the binary antidepressant use outcomes over time³³ was performed. To evaluate whether antidepressant use had differential effects by treatment group, antidepressant use and its interaction with treatment was included in our repeated-measures regression models for Ham-D and PHQ-9.

RESULTS

The flow of patients through the study is depicted in the FIGURE. TABLE 1 summarizes the baseline demographics and psychiatric characteristics of the participants. There were no significant differences in these baseline variables across treatment arms. There was no significant difference in therapist expectations of participant outcomes across treatments ($P=.83$).

Attrition

Significantly fewer participants discontinued T-CBT ($n=34$; 20.9%) before session 18 compared with face-to-face CBT ($n=53$; 32.7%; $P=.02$). Attrition before week 5 was significantly lower in T-CBT ($n=7$; 4.3%) than in face-to-face CBT ($n=21$; 13.0%; $P=.006$), but there was no significant difference in attrition between sessions 5 and 18 ($P=.31$). T-CBT patients attended significantly more sessions (mean, 15.5; median, 17; SD, 4.4; interquartile range, 16-18) than those receiving face-to-face CBT (mean [SD], 13.7 [6.1]; median [IQR], 17 [11-18]; $P=.003$).

Depression Outcomes

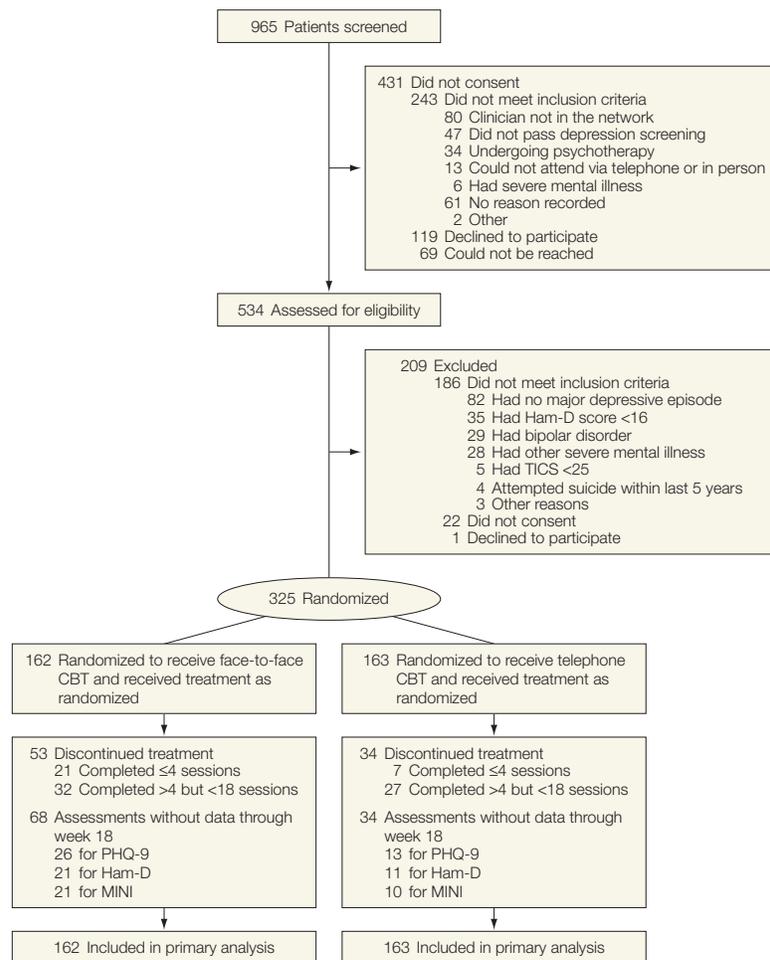
TABLE 2 shows the intention-to-treat depression outcomes on the Ham-D and the PHQ-9 according to multiply imputed values. In terms of changes from baseline, patients demonstrated significant improvements at posttreatment in both face-to-face (Ham-D $\Delta=-10.32$; PHQ-9 $\Delta=-10.03$; $P<.001$) and T-CBT (Ham-D $\Delta=-9.25$; PHQ-9

$\Delta=-10.12$; $P<.001$). At 6-month follow-up, changes from baseline remained significant in face-to-face CBT (Ham-D $\Delta=-10.69$; PHQ-9 $\Delta=-10.46$; $P<.001$) and T-CBT (Ham-D $\Delta=-7.78$; PHQ-9 $\Delta=-8.35$; $P<.001$). There were no significant posttreatment differences between T-CBT and face-to-face CBT on the Ham-D (difference=1.07; $P=.22$) or PHQ-9 (difference=-0.09; $P=.89$), although this difference was significant at 6-month follow-up on both the Ham-D (difference=2.91; $P<.001$) and PHQ-9 (difference=2.12; $P=.004$).

Among T-CBT patients, 23% met criteria for major depressive disorder at

posttreatment compared with 25% in face-to-face CBT ($P=.69$). At 6-month follow-up, major depressive disorder rates were 29% and 26% in the T-CBT and face-to-face CBT groups, respectively ($P=.57$). At posttreatment, 27% of both T-CBT and face-to-face CBT participants met the Ham-D abbreviated 7-item scale criterion for full remission ($P=.95$). By 6-month follow-up, 19% of T-CBT vs 32% of face-to-face CBT participants were fully remitted ($P=.009$). At posttreatment, 44% of T-CBT and 49% of face-to-face CBT participants met the response to treatment criterion of a 50% decrease on the HAM-D ($P=.40$).

Figure. Flow of Participants Through the Trial



Ham-D indicates Hamilton Depression Rating Scale; TICS, Telephone Interview for Cognitive Status; PHQ-9, Patient Health Questionnaire-9; MINI, Mini International Neuropsychiatric Interview.

Table 1. Baseline Demographics and Psychiatric Characteristics

Characteristic	No. (%)		P Value
	Face-to-face CBT (n = 162)	T-CBT (n = 163)	
Age, mean (SD), y	47.5 (13.5)	47.8 (12.6)	.87
Female	127 (78.4)	125 (76.7)	.71
Ethnicity ^a			
Hispanic or Latino	21 (13.0)	23 (14.1)	.76
Race ^b			
African American	36 (24.0)	36 (24.3)	.63
White	98 (65.3)	89 (60.1)	
>1 Race	12 (8.0)	18 (12.2)	
Other ^c	4 (2.7)	5 (3.4)	
Married/cohabitating	51 (31.7)	56 (34.4)	.61
Education			
High school	14 (8.6)	20 (12.3)	.57
Some college	41 (25.3)	40 (24.5)	
Bachelor's degree	64 (39.5)	55 (33.7)	
Advanced degree	43 (26.5)	48 (29.4)	
PHQ-9, mean (SD) ^d	16.4 (4.8)	17.2 (4.7)	.12
Ham-D, mean (SD) ^e	22.8 (4.6)	22.9 (4.6)	.77
Receiving active dose of antidepressant medication	56 (34.6)	54 (33.1)	.78

Abbreviations: CBT, cognitive behavioral therapy; Ham-D, Hamilton Depression Rating Scale; PHQ-9, Patient Health Questionnaire-9; T-CBT, telephone cognitive behavioral therapy.

^aTwo missing values because of patients who elected not to answer.

^bTwelve missing values in the face-to-face CBT and 15 missing values in the T-CBT.

^cOther includes American Indian or Alaska Native, Asian, and Native Hawaiian or Pacific Islander.

^dThree patients in each group did not complete the PHQ-9 at baseline. The PHQ-9 scale range is 0-27 and higher scores indicate more severe depression.

^eThe Ham-D range is 0 to 52 and higher scores indicate more severe depression.

The posttreatment effect size was $d=0.14$ (90% CI -0.05 to 0.33) on the Ham-D and -0.02 (90% CI -0.20 to 0.17) on the PHQ-9. Both of these values were within the inferiority margin of $d=0.41$, indicating that T-CBT was not inferior to face-to-face CBT at the end of treatment. The 6-month follow-up effect size was $d=0.37$ (90% CI 0.19 - 0.55) on the Ham-D and 0.33 (90% CI, 0.14 - 0.52) on the PHQ-9. Both of these CIs were outside the inferiority margin, indicating that T-CBT was inferior to face-to-face CBT at 6-month follow-up.

Antidepressant Effects

At baseline, 52 (32%) face-to-face CBT patients and 54 (33%) T-CBT patients were receiving antidepressants. During the course of the study, antidepressant use did not change significantly ($P=.41$), was not different across treatment arms ($P=.70$), and was not associated with depression outcomes in

either the face-to-face CBT ($P=.92$) or T-CBT ($P=.83$) patients. Baseline antidepressant use was also not associated with discontinuation of treatment in either face-to-face CBT ($P=.29$) or T-CBT ($P=.91$).

Patient Preferences

Before randomization, 117 (36.6%) participants indicated they would prefer face-to-face CBT, 89 (27.8%) preferred T-CBT, 114 (35.6%) indicated no preference, and 5 did not answer ($P=.60$). Receiving or not receiving one's preferred treatment was not statistically associated with adherence ($P=.39$) or depression outcomes ($P=.76$ for Ham-D; $P=.18$ for PHQ-9).

Demographic Predictors of Clinical Outcomes and Attrition

There were no significant 2-way (demographic \times treatment) or 3-way (demographic \times treatment \times time) effects for age, sex, race, education, or

marital status on depression. Age, sex, race, marital status, and antidepressant status at baseline were unrelated to attrition. Education was significantly related to attrition ($P=.02$); participants with advanced degrees were more likely to complete treatment than those with some college education ($P<.05$), but there were no other significant differences across education groups.

Safety

There were no adverse events (eg, suicide, suicide attempt, psychiatric hospitalization) for either treatment condition.

COMMENT

This study confirmed that T-CBT produces significantly lower attrition rates compared with face-to-face CBT among depressed primary care patients, suggesting that telephone delivery can overcome barriers to adhering to face-to-face treatment. The effect of telephone administration on adherence appears to occur during the initial engagement period. These effects may be due to the capacity of telephone delivery to overcome barriers and patient ambivalence toward treatment. Access barriers likely exert their effects early in treatment, and thus the effect of the telephone on overcoming those barriers is most prominent in the first sessions. Patients who continue in face-to-face treatment for 5 or more sessions likely have fewer access barriers or are more motivated, and thus use of the telephone likely reduces attrition less during that period.

This trial found that T-CBT was as effective in reducing depressive symptoms as traditional face-to-face CBT at posttreatment, supporting our hypothesis. However, face-to-face treatment was significantly superior to T-CBT during the 6-month follow-up period. The size of these differences in group analyses did not reach the PHQ-9 criterion of 5 or more points for clinical significance³⁵ but was close to the Ham-D criterion of 3 points.³⁴ However, it is likely that these effects are driven by subgroups who show greater risk of failure to maintain

therapeutic gains. This effect may be an artifact of T-CBT's capacity to differentially retain patients with characteristics that leave them at greater risk for posttreatment deterioration.

If the finding that face-to-face treatment produces better maintenance of gains after treatment cessation is not an artifact, it suggests that longer-term follow-up is critical in research examining the effects of tele-mental health interventions, and telemedicine more broadly. There are at least 2 possible reasons that some patients may have poorer post-treatment outcomes in T-CBT. One is that the requirement that patients in face-to-face therapy physically attend sessions may serve as a form of behavioral activation. That is, that act of physically attending treatment may be therapeutic in a manner that promotes maintenance of gains in some patients. The other possibility is that the physical presence of the therapist, although not having an effect during treatment, contributes to the maintenance of gains, which suggests that human contact may have

unique qualities that exert their effects and contribute to resilience after contact has ceased.

The patient-clinician interaction can be conceptualized as a variety of cues and information transmitted through different verbal and nonverbal channels, each of which carries some unique information. Various telemedicine media (eg, telephone, videoconference, e-mail) limit the effectiveness of specific cues,³⁶ which may have both disadvantages and benefits. For example, in the context of a positive relationship, individuals are likely to make positive attributions in the absence of cues (for example in the absence of visual cues, patients would likely imagine a provider as being more like themselves and more sympathetic than the provider actually is).³⁷ However, if difficulties or suspicions arise, attributions regarding missing cues can become overly negative (eg, imagining the clinician to be more uncaring than a complete set of cues would suggest), which may reduce the patient's com-

mitment to treatment. Thus, future research should not only examine overall effects of the use of treatment delivery media on patient-clinician relationships and clinical outcomes but also identify the circumstances and patients for which specific media are most advantageous.

The findings of this study suggest that telephone-delivered care has both advantages and disadvantages. The acceptability of delivering care over the telephone is growing, increasing the potential for individuals to continue with treatment. A survey of primary care patients found that nearly 19% of patients who desired behavioral and psychological care wanted telephone treatment, and an additional 44% would consider it.³⁸ The data from this trial suggest that preferences for delivery medium do not affect adherence or outcome. The telephone offers the opportunity to extend care to populations that are difficult to reach, such as rural populations, patients with chronic illnesses and disabilities, and individu-

Table 2. Intention-to-Treat Depression Outcomes

Instrument	Face-to-face CBT		T-CBT		Between-Group Difference (95% CI)	P Value
	No. Observed	Model-Based Mean (95% CI) ^a	No. Observed	Model-Based Mean (95% CI) ^a		
Ham-D ^b						
Baseline	162	22.83 (22.34 to 23.33)	163	22.83 (22.34 to 23.33)		
Week 4	149	17.86 (16.96 to 18.77)	155	18.07 (17.16 to 18.98)		
Week 9	147	16.45 (15.40 to 17.51)	154	15.62 (14.60 to 16.65)		
Week 14	143	14.18 (12.97 to 15.39)	151	14.94 (13.77 to 16.12)		
End of treatment (week 18)	141	12.51 (11.22 to 13.81)	152	13.58 (12.42 to 14.74)	1.07 (−0.63 to 2.76)	.22
Δ Baseline to week 18		−10.32 (−11.62 to −9.02)		−9.25 (−10.42 to −8.09)		
3-mo follow-up	136	12.33 (11.01 to 13.64)	146	14.58 (13.45 to 15.71)	2.25 (0.52 to 3.99)	.01
6-mo follow-up	133	12.14 (10.84 to 13.45)	134	15.06 (13.84 to 16.27)	2.91 (1.20 to 4.63)	<.001
Δ Baseline to 6 mo		−10.69 (−11.99 to −9.39)		−7.78 (−8.98 to −6.57)		
PHQ-9 ^c						
Baseline	159	16.76 (16.24 to 17.29)	160	16.76 (16.24 to 17.29)		
Week 4	142	10.09 (9.21 to 10.97)	152	10.78 (9.92 to 11.64)		
Week 9	144	8.62 (7.64 to 9.59)	151	9.05 (8.13 to 9.96)		
Week 14	138	7.77 (6.73 to 8.82)	144	8.55 (7.53 to 9.56)		
End of treatment (week 18)	136	6.74 (5.74 to 7.73)	150	6.65 (5.72 to 7.58)	−0.09 (−1.35 to 1.17)	.89
Δ Baseline to week 18		−10.03 (−11.05 to −9.00)		−10.12 (11.08 to −9.15)		
3-mo follow-up	134	6.60 (5.56 to 7.64)	144	7.59 (6.60 to 8.58)	0.99 (−0.40 to 2.38)	.16
6-mo follow-up	126	6.30 (5.24 to 7.37)	128	8.42 (7.38 to 9.46)	2.12 (0.68 to 3.56)	.004
Δ Baseline to 6-mo follow-up		−10.46 (−11.53 to −9.39)		−8.35 (−9.40 to −7.29)		

Abbreviations: CBT, cognitive behavioral therapy; Ham-D, Hamilton Depression Rating Scale; PHQ-9, Patient Health Questionnaire-9; T-CBT, telephone cognitive behavioral therapy.

^aThese are values based on parameter estimates from the mixed-effects models and use multiply imputed data from all time points to predict means at each point.

^bThe Ham-D range is 0 to 52. A difference of 3 points on the Hamilton scale has been identified as clinically significant.³⁴

^cThe PHQ-9 range is 0-27. A difference of 5 or more points on the PHQ-9 is considered a clinically meaningful response to treatment.³⁵

als who otherwise have barriers to treatment.^{14,39} Telephone psychotherapy would also meet at least 1 of the key attributes of the advanced medical home, namely, to “provide enhanced and convenient access to care not only through face-to-face visits but also via telephone, e-mail, and other modes of communication.”⁴⁰ However, the increased risk of posttreatment deterioration in telephone-delivered treatment relative to face-to-face treatment underscores the importance of continued monitoring of depressive symptoms even after successful treatment.

Several limitations and caveats exist in interpreting these data. First, this efficacy trial used CBT for depression. Although we are unaware of reasons why these results cannot be generalized to other forms of psychotherapy and other common mental health problems such as anxiety disorders, we cannot rule out the possibility that these findings are treatment or disorder specific. Second, this sample was fairly well educated, potentially limiting generalizability to lower socioeconomic groups. Third, it was not possible to mask patients to treatment arm.

Our findings demonstrate that T-CBT can reduce attrition and is as effective as face-to-face CBT at posttreatment for depression among primary care patients. However, the increased adherence associated with T-CBT may come at the cost of some increased risk of poorer outcomes after treatment cessation.

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Author Contributions: Dr Mohr had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis. **Study concept and design:** Mohr, Duffecy, Sokol. **Acquisition of data:** Mohr, Ho, Duffecy, Reifler, Burns. **Analysis and interpretation of data:** Mohr, Ho, Duffecy, Jin, Siddique.

Drafting of the manuscript: Mohr, Ho, Duffecy, Jin, Siddique.

Critical revision of the manuscript for important intellectual content: Mohr, Ho, Duffecy, Reifler, Sokol, Burns, Siddique.

Statistical analysis: Ho, Jin, Siddique.

Obtained funding: Mohr.

Administrative, technical, or material support: Mohr, Ho, Duffecy, Reifler, Burns.

Study supervision: Mohr, Ho, Duffecy, Reifler, Sokol.

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If you would hit the mark, you must aim a little above it.

—Henry Wadsworth Longfellow (1807-1882)

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To: Committee Members

Date: July 9, 2012

From: Steve Sodergren
Assistant Executive Officer

Telephone: (916) 574-7847

Subject: Discussion and Possible Rulemaking Action to Require All Applicants to Submit a National Data Bank Inquiry Result

Background

The Board has a statutory mandate to enforce laws designed to protect the public from incompetent, unethical, or unprofessional practitioners. In order to comply with this mandate the Board requires both a Department of Justice (DOJ) and Federal Bureau of Investigation (FBI) criminal history background check on all applicants for licensure. Currently, the Board does not conduct a review of the applicant's employment background and disciplinary history. During the 2012 Sunset Review process, the Senate Business, Professions and Economic Development Committee, requested an explanation from the Board as to why the Board was not currently using the National Data Bank to conduct background checks on applicants. The Board indicated that it has an interest in using this resource as another tool to conduct background checks and was exploring options to best incorporate its use.

One option for the Board would be to require applicants to submit a Self Query Report. The requirement for applicants to submit a Self Query Report would further assist the Board in determining if an applicant has been the subject of discipline in another state prior to making a license decision to grant or deny a license. This would give the Board an additional tool to assist in meeting its mandate to protect the public.

Analysis

The Data Bank, consisting of the National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB), is a confidential information clearinghouse created by Congress to improve health care quality. This clearinghouse was established to receive and disclose certain final adverse actions against health care practitioners, providers, and suppliers.

The HIPDB and NPDB statutes require State licensing authorities to submit, generally within 30 days, adverse licensing and certification actions, as well as negative actions and findings, taken against health care entities, providers, suppliers, and practitioners. These reportable actions or findings include both final actions and those taken as a result of formal proceedings. The Health Resources and Services

Administration (HRSA) has developed a list of current State Agencies and Licensing Boards responsible for licensing or certifying health care professionals and is actively monitoring those agencies and boards reporting compliance. The Data Bank will add the status of Behavioral Health professions to the Reporting Compliance Status review on July 1, 2012.

While the Board has the ability to query individuals, this may not be feasible because (1) it would increase the time it would take the board to process an application for licensure and (2) licensure could be delayed and additional deficiencies could be generated if the applicant did not provide the board with the exact name under which any discipline had been reported to the NPDB-HIPDB. Also, the current fee for each query is \$4.75 per practitioner for each Data Bank: the NPDB or the HIPDB. This fee is assessed even if the query is improperly submitted or lacks information.

The NPDB-HIPDB Web site guides a practitioner on how to request a Self-Query. According to the NPDB-HIPDB main Web page, a person would select services for a "Practitioner" or for an "Organization." The practitioner must print the self-query request, sign and date it in the presence of a notary public, and mail the notarized self-query to the address specified by the NPDB-HIPDB. Upon receipt of the notarized self-query request, the NPDB-HIPDB would then process, in approximately two business days, the self-query and electronically alert the practitioner via e-mail that the self-query is available for on-line viewing. Also, if so elected, the NPDB-HIPDB would issue a paper copy of the self-query to the practitioner. The current fee for each Self-Query is \$8.00 per practitioner for each Data Bank: the NPDB or the HIPDB.

Because the NPDB and HIPDB retain different information (see attached "Data Bank at a Glance") the Board would require the applicant to submit both Self-Queries. It is not expected that this process would extend the application processing time unless the applicant is deficient in submitting the form with their application paperwork.

Recommendation

The Committee should conduct an open discussion concerning the adoption of a regulation to require all applicants for licensure to submit a National Data Bank Self Query to the Board.

The Data Bank at a Glance	
NPDB	HIPDB
Background	
<p>The National Practitioner Data Bank was established under Title IV of Public Law 99-660, the <i>Health Care Quality Improvement Act of 1986</i>, and is expanded by Section 1921, as amended by section 5(b) of the <i>Medicare and Medicaid Patient and Program Protection Act of 1987</i>, and as amended by the <i>Omnibus Budget Reconciliation Act of 1990</i>. NPDB is an information clearinghouse to collect and release all licensure actions taken against all health care practitioners and health care entities, as well as any negative actions or findings taken against health care practitioners or organizations by Peer Review Organizations and Private Accreditation Organizations.</p>	<p>The Healthcare Integrity and Protection Data Bank was established under section 1128E of the <i>Social Security Act</i> as added by Section 221(A) of the <i>Health Insurance Portability and Accountability Act of 1996</i>. HIPDB was implemented to combat fraud and abuse in health insurance and health care delivery and to promote quality care. HIPDB alerts users that a more comprehensive review of past actions by a practitioner, provider or supplier may be prudent.</p>
Who Reports?	
<ul style="list-style-type: none"> • Medical malpractice payers • State health care practitioner licensing and certification authorities (including medical and dental boards) • Hospitals • Other health care entities with formal peer review (HMOs, group practices, managed care organizations) • Professional societies with formal peer review • State entity licensing and certification authorities • Peer review organizations • Private accreditation organizations 	<ul style="list-style-type: none"> • Federal and State Government agencies • Health plans
What Information is Available?	
<ul style="list-style-type: none"> • Medical malpractice payments (all health care practitioners) • Any adverse licensure actions (all practitioners or entities) <ul style="list-style-type: none"> • revocation, reprimand, censure, suspension, probation • any dismissal or closure of the proceedings by reason of the practitioner or entity surrendering the license or leaving the State or jurisdiction • any other loss of license • Adverse clinical privileging actions • Adverse professional society membership actions • Any negative action or finding by a State licensing or certification authority • Peer review organization negative actions or finding against a health care practitioner or entity • Private accreditation organization negative actions or findings against a health care practitioner or entity 	<ul style="list-style-type: none"> • Licensure and certification actions <ul style="list-style-type: none"> • Revocation, suspension, censure, reprimand, probation • Any other loss of license - or right to apply for or renew - a license of the provider, supplier, or practitioner, whether by voluntary surrender, non-renewal, or otherwise • Any negative action or finding by a Federal or State licensing and certification agency that is publicly available information • Civil judgments (health care-related) • Criminal convictions (health care-related) • Exclusions from Federal or State health care programs • Other adjudicated actions or decisions (formal or official actions, availability of due process mechanism and based on acts or omissions that affect or could affect the payment, provision, or delivery of a health care item or service)

Who Can Query?

- Hospitals
- Other health care entities, with formal peer review
- Professional societies with formal peer review
- State health care practitioner licensing and certification authorities (including medical and dental boards)
- State entity licensing and certification authorities*
- Agencies or contractors administering Federal health care programs*
- State agencies administering State health care programs*
- State Medicaid Fraud Units*
- U.S. Comptroller General*
- U.S. Attorney General and other law enforcement*
- Health care practitioners (self query)
- Plaintiff's attorney/pro se plaintiffs (under limited circumstances)**
- Quality Improvement Organizations*
- Researchers (statistical data only)

- Federal and State Government agencies
- Health plans
- Health care practitioners/providers/suppliers (self-query)
- Researchers (statistical data only)

* eligible to receive only those reports authorized by Section 1921.

** eligible to receive only those reports authorized by HCQIA.

Who Cannot Query?

The Data Bank is prohibited by law from disclosing information on a specific practitioner, provider, or supplier to a member of the general public. However, persons or organizations can request information in a form that does not identify any particular organization or practitioner.

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To: Board Members **Date:** July 6, 2012
From: Rosanne Helms **Telephone:** (916) 574-7897
Legislative Analyst
Subject: Review of Board Sponsored and Monitored Legislation

BOARD-SPONSORED LEGISLATION

SB 632 (Emmerson) Marriage and Family Therapist Trainee Practicum

Board-sponsored SB 363 (Chapter 384, Statutes of 2011) became law on January 1, 2012. It allows a trainee to counsel clients while not enrolled in practicum only if the lapse in enrollment is less than 90 days and is immediately preceded and immediately followed by enrollment in practicum.

Because the requirement to be enrolled in practicum to counsel clients only applies to specified MFT trainees, (individuals that begin graduate study after August 1, 2012; individuals that begin graduate study before August 1, 2012 but do not complete that study before December 31, 2018; and, individuals that attend a graduate program that meets the enhanced requirements required by Business and Professions Code Section 4980.36) an exception from the requirement should have only applied to those specific MFT trainees. However, the effect of the language signed into law with SB 363 instead requires all trainees to be enrolled in practicum to counsel clients regardless of when the trainee began graduate study.

This bill is an urgency measure which will amend this section of licensing law and restore the original intent of requiring only specified MFT trainees to enroll in practicum to counsel clients.

Status: This bill is currently enrolled and awaiting the Governor's signature.

SB 1527 (Negrete McLeod) Social Workers: Licensing

As part of the Board's examination restructure, each associate social worker (ASW) will be required to take and pass a California law and ethics examination. This bill adds a requirement, similar to the ones in the LMFT and LPCC licensing laws, that an individual seeking ASW registration or LCSW licensure complete coursework in California law and ethics.

This bill would also clarify the acceptability of older licensing exam scores. Under the examination restructure, the Board may use national examinations as the clinical examinations, if the Board determines that they meet California standards. However, SB 704 did not place a limit on when a

passing score on the clinical exam must have been obtained. In order to address the question about the acceptability of older exam scores, this bill does the following:

- For applicants who do not hold an out of state license, it allows a passing score on the clinical exam to be accepted by the Board for seven years.
- For applicants who already hold a valid license in good standing in another state, who had passed the exam this Board is requiring as part of their requirements for licensure in that other state, this Board may accept that exam score regardless of age.

Status: This bill is currently in the Assembly Appropriations Committee.

SB 1575 (Senate Business, Professions, and Economic Development Committee) Omnibus Legislation

This bill makes minor, technical, and non-substantive amendments to add clarity and consistency to current licensing law. It would also extend the effective date of the examination restructure from January 1, 2013 to January 1, 2014.

Status: This bill is currently in the Assembly Appropriations Committee.

BOARD-SUPPORTED LEGISLATION

AB 40 (Yamada) Elder and Dependent Adult Abuse: Reporting

This bill would require mandated reporters to report suspected instances of elder or dependent adult physical abuse that occurred in a long-term care facility via telephone to local law enforcement and a written report be made to both the local ombudsman and the local law enforcement agency.

By requiring mandated reporters to report physical abuse to both entities, this bill protects victims by ensuring that both the local ombudsman and local law enforcement are aware of all reports of this type of criminal activity.

The Board has one suggested amendment that could increase the clarity of the reporting requirements for mandated reporters. The Board suggests that the proposed reporting requirement in the case of elder or dependent adult “physical abuse” be changed to reference “physical abuse and/or sexual abuse.”

The Board is aware that the bill references a definition of physical abuse in Welfare and Institutions code section 15610.63, and that the referenced definition includes types of sexual abuse. However, the Board is concerned that a mandated reporter in the field will not have access to this definition, and that the term “physical and/or sexual abuse” will eliminate any confusion whether sexual abuse is to be included. This suggested amendment is consistent with other areas of law which reference physical and/or sexual abuse.

The Board adopted a “Support” position on this legislation at its May 16, 2012 meeting.

Update: This bill was amended on June 18, 2012, to specify that if suspected abuse in a long term care facility results in serious bodily injury, a mandated reporter must make a telephone report to the local law enforcement agency within 2 hours. A written report must then be made to the local ombudsman, the corresponding licensing agency, and the local law enforcement agency within 24 hours.

Status: This bill is currently in the Senate Appropriations Committee.

AB 154 (Beall) Health Care Coverage: Mental Health Services

This bill would require a health care services plan to provide coverage for the diagnosis and medically necessary treatment of a mental illness under the same terms and conditions applied to other medical conditions. Current mental health parity laws only require coverage for severe mental illness and a child's severe emotional disturbance.

The Board adopted a "support" position on this legislation at its meeting on May 18, 2011.

Status: This bill failed passage in the Senate Health Committee, but has been granted re-consideration.

AB 171 (Beall) Pervasive Development Disorder or Autism

This bill would require a health care service plan that provides hospital, medical, or surgical coverage to provide coverage for the screening, diagnosis, and treatment of pervasive developmental disorder or autism. The Board believes this bill would help to close several loopholes that insurers currently use in order to deny coverage to those with pervasive developmental disorder or autism.

The Board adopted a "support" position on this legislation at its meeting on May 16, 2012.

Status: This bill is currently in the Senate Health Committee.

AB 367 (Smyth) Board of Behavioral Sciences: Reporting

This bill would add the Board of Behavioral Sciences to the list of boards that are required to report the name and license number of a person whose license has been revoked, suspended, surrendered, or made inactive, to the State Department of Health Care Services within ten working days.

The Board supports the intent of this legislation to prevent providers who are no longer licensed from submitting for and receiving Medi-Cal reimbursement. However, the Department of Consumer Affairs (DCA) is in the process of implementing a new database system. As this change will require a costly change to the Board's database system, the Board requests a delayed implementation date to January 1, 2015. At this time, the new system will be fully implemented, and DCA staff will be able to make the required changes at a substantially reduced cost to the Board.

At its May 16, 2012 meeting, the Board adopted a "support if amended" position on this bill, requesting that it be amended to have a January 1, 2015 implementation date.

Update: The requested amendment to change the implementation date to January 1, 2015 was made on May 21, 2012. Therefore, the Board now has a "support" position on this bill.

Status: This bill is currently on the Senate Special Consent Calendar.

AB 1785 (B. Lowenthal) Medi-Cal Reimbursement for Federally Qualified Health Centers and Rural Health Clinics

This bill would add licensed marriage and family therapists to the list of health care professionals whose services are reimbursed through Medi-Cal on a per visit basis to federally qualified health centers and rural health clinics. The Board agrees that its licensed marriage and family therapists have the qualifications to be included in this group of professionals.

The Board adopted a “support” position on this legislation at its meeting on May 16, 2012.

Status: This bill died in the Assembly Appropriations Committee.

AB 1904 (Block, Butler & Cook) Military Spouses: Temporary Licenses

This bill would allow the Board to issue a temporary license to an applicant who can prove that he or she is married to or in a domestic partnership or other legal union with an active duty member of the U.S. Armed Forces who is assigned to active military duty in California. This bill would also allow the Board to adopt regulations to administer this temporary license program. The Board is supportive of this bill because it allows the Board, through regulations, to maintain consumer protection by specifying standards that a temporary licensee must meet, while at the same time assisting military families by allowing them to obtain a professional license in this state more quickly.

The Board adopted a “support” position on this legislation at its meeting on May 16, 2012.

Update: This bill was amended on June 12, 2012 to require the Board to expedite the licensing process of an applicant who is a spouse of a military member assigned to active duty in California, if they hold a current license for the same profession in another state. The Board will re-consider this bill at its meeting on July 19, 2012.

Status: This bill is currently in the Senate Business, Professions, and Economic Development Committee.

AB 2570 (Hill) Licensees: Settlement Agreements

This bill would close a loophole in current law that allows a Board licensee or registrant to prohibit a consumer who settles a civil suit with that licensee or registrant from filing a complaint with or cooperating in an investigation of the Board. This bill protects consumers by disallowing “gag clauses” that hamper the ability of a regulatory board to take disciplinary action against a negligent practitioner.

The Board adopted a “support” position on this legislation at its meeting on May 16, 2012.

Status: This bill is currently in the Senate Judiciary Committee.

SB 1238 (Price) Professions: Board of Psychology: Board of Behavioral Sciences

This bill will extend the Board's sunset date until January 1, 2017.

The Board adopted a "support" position on this legislation at its meeting on May 16, 2012.

Status: This bill is currently in the Assembly Appropriations Committee.

THE BOARD IS MONITORING THE FOLLOWING LEGISLATION:

AB 1588 (Atkins) Reservist Licensees: Fees and Continuing Education

This bill would require the Board to waive continuing education requirements and renewal fees for a licensee or registrant while he or she is called to active duty as a member of the United States Military Reserve or the California National Guard if he or she meets certain requirements.

The Board supports the intent of this bill to assist military members while they are actively serving. At its meeting on May 16, 2012, the Board took a "support if amended" position on this bill, requesting the following amendments:

- 1) **Time Limit To Pay Renewal Fee After Active Status Complete.** The Board requests an amendment setting a time limit to clarify when the renewal fee must be paid once the licensee or registrant completes active service.
- 2) **Affidavit Substantiating Active Duty Service.** Currently, this bill only requires the active duty reservist, or his or her spouse or domestic partner, to provide written notice to the Board substantiating the active duty service. The Board requests an amendment specifying that the term "written notice" be replaced by the term "affidavit."

Status: This bill is currently in the Senate Business, Professions and Economic Development Committee.

AB 1932 (Gorell) United States Armed Services: Healing Arts Boards

AB 1932 would require the Board to annually issue a written report to the Department of Veterans Affairs and to the Legislature that details the Board's method of evaluating education, training, and experience obtained in military service. The report must also state whether the military education, training, and experience can be applied to the Board's licensing requirements.

The Board is supportive of allowing military education, training, and experience to be used toward licensing requirements if it is equivalent to the Board's current licensing requirements. The Board has very specific requirements for evaluating education and experience in its licensing laws. Currently, if an applicant for licensure or registration had military education and experience, the Board would conduct a review to determine if that experience is substantially equivalent to current licensing requirements.

The Board already has a procedure in place to evaluate an applicant's education, training and experience, and would perform such an evaluation and maintain records of such a military program if

this type of application were received. In addition, it would be very time consuming for the Board's already limited staff to be required to seek out and evaluate scenarios where someone might gain military education or experience toward licensure, before the Board receives an application from such an individual. Therefore, at its May 16, 2012 meeting, the Board adopted an "oppose" position on this bill.

Status: This bill is currently in the Senate Rules Committee.

AB 1976 (Logue) Acceptance of Military Education and Experience Toward Licensing Requirements

AB 1976 would require the Board to accept education, training, and experience gained in the military toward licensing requirements unless the Board determines that this education, training, and experience is not substantially equivalent to licensing requirements. It would also require the Board, if it accredits or approves schools offering education course credits toward licensing requirements, to require schools seeking accreditation or approval to have procedures in place to fully accept an applicant's military education, training and experience toward an educational program which leads to licensure.

The Board believes it should be excluded from this bill, as it does not accredit or approve schools and it already has a procedure in place to evaluate an applicant's education, training and experience. Such an evaluation would be performed, and records of such a military program maintained for future use, if this type of application were received.

At its meeting on May 16, 2012, the Board took an "oppose" position on this legislation.

Status: This bill died in the Assembly Appropriations Committee.

AB 1134 (Yee) Persons of Unsound Mind: Psychotherapist Duty to Protect

Current law allows no monetary liability or cause of action to arise against a psychotherapist who fails to warn of and protect from a patient's threatened violent behavior, or who fails to predict and warn of and protect from a patient's violent behavior, except where the patient has communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims.

This bill would rename the duty of a psychotherapist, defined in Section 43.92 of the Civil Code, from "duty to warn and protect" to "duty to protect."

At its meeting on May 16, 2012, the Board opted to take no position on this bill.

Status: This bill is on the Assembly consent calendar.

SB 1172 (Lieu) Sexual Orientation Change Efforts

This bill would prohibit a psychotherapist from engaging in sexual orientation change efforts without first obtaining the patient's signed informed consent. It would also prohibit a patient under 18 from undergoing sexual orientation change efforts.

The Board shares the author's concerns about the use of sexual orientation change efforts in psychotherapy. At its meeting on May 16, 2012, the Board took an "oppose unless amended" position on this legislation, requesting that the bill be amended to more precisely define the term "sexual orientation change efforts." A more precise definition will help avoid the perception among therapists that any discussion of sexual orientation raised by a patient during psychotherapy may be considered a sexual orientation change effort, therefore opening the therapist up to liability.

Update: This bill is being amended to more precisely define the term "sexual orientation change efforts". The Board will re-consider this bill at its July 19, 2012 meeting.

Status: This bill is on third reading in the Assembly.

SB 1183 (Lieu) Board of Behavioral Sciences: Continuing Education

SB 1183 would remove the Board's authority to approve continuing education (CE) providers, and instead require that Board licensees obtain their required CE from an accredited educational institution, or a CE provider that is approved by an accrediting organization, such as a professional association, a licensed health facility, a governmental entity, or a continuing education unit of an accredited educational institution.

The Board is concerned that this bill removes its authority to set CE standards and requirements. The Board is the sole regulating entity for licensed marriage and family therapists, licensed educational psychologists, licensed clinical social workers, and licensed professional clinical counselors. Therefore, it possesses the experience and knowledge necessary to best set CE standards.

In addition, this bill does not specifically define "accrediting organizations". If standards for an accrediting organization remain unspecified, licensees may be permitted to obtain CE credit from any provider approved by an entity that calls itself an "accrediting organization."

The Board has identified a number of issues regarding its CE program, and has formed a CE committee to address these issues. The committee is in the process of working with stakeholders and interested parties to develop regulatory changes to address specified areas of concern. The first public meeting of the CE committee was held April 18, 2012. Additional public meetings of the CE committee are set for May 31, 2012, and July 19, 2012.

For these reasons, at its meeting on May 16, 2012, the Board took an "oppose" position on this legislation.

Status: This bill is currently in the Assembly Appropriations Committee.

Updated: July 2, 2012

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To: Committee Members

Date: June 29, 2012

From: Rosanne Helms
Legislative Analyst

Telephone: (916) 574-7897

Subject: Rulemaking Update

SUBMITTED REGULATORY PROPOSALS

Title 16, CCR Sections 1803, 1845, 1858, 1881; Add Sections 1823, 1888.1, SB 1111 Enforcement Regulations

This proposal is part of an effort by DCA for healing arts boards to individually seek regulations to implement those provisions of SB 1111 and SB 544 (part of DCA's Consumer Protection Enforcement Initiative) that do not require statutory authority.

The intent of SB 1111, which failed passage in 2010, and SB 544, which failed passage in 2011, was to provide healing arts boards under DCA with additional authority and resources to make the enforcement process more efficient. These regulations propose delegation of certain functions to the executive officer, required actions against registered sex offenders, and additional unprofessional conduct provisions to aid in the enforcement streamlining effort.

This proposal was approved by the Board at its meeting on August 18, 2011. This rulemaking was submitted to the Office of Administrative Law (OAL), and published in its California Regulatory Notice Register on March 16, 2012. The proposal is now through the 45-day public comment period, and the public hearing was held on May 1, 2012. Board staff is now reviewing comments that were received at the public hearing.

Title 16, CCR Sections 1811, 1870, 1887.3 – Revision of Advertising Regulations, Two-Year Practice Requirement for Supervisors of Associate Social Workers (ASWs), and HIV/AIDS Continuing Education Course for LPCCs

This proposal makes three types of revisions to current Board regulations:

1. Revises the regulatory provisions related to advertising by Board licensees. The Board approved the originally proposed text at its meeting on November 18, 2008. Due to changes in regulations from the LPCC regulation package as well as other changes to the proposed text, staff obtained approval for a revised version of this rulemaking proposal at the August 18, 2011 Board meeting.

2. 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.
3. This proposed change, approved by the Board in June 2007, requires supervisors of ASWs to be licensed for two years prior to commencing any supervision.

This rulemaking proposal was submitted to OAL and published in its California Regulatory Notice Register on June 29, 2012. The proposal is now in the 45-day public comment period, and the public hearing will be held on August 14, 2012.

Title 16, CCR Section 1833, Regulations to Implement SB 363 (Marriage and Family Therapist Intern Experience)

SB 363 (Chapter 384, Statutes of 2011) limited the number of client-centered advocacy hours for a marriage and family therapist intern to 500 hours.

This proposal deletes a provision of Board regulations which conflicts with SB 363 and that is no longer needed due to the new legislative provisions enacted by SB 363. This amendment was approved by Board at its meeting on November 9, 2011. This proposal also deletes an outdated provision in Section 1833 regarding crisis counseling on the telephone, which directly conflicts with telehealth provisions in LMFT licensing law. This amendment was approved by the Board at its meeting on February 29, 2012.

This rulemaking proposal was submitted to OAL and published in its California Regulatory Notice Register on June 29, 2012. The proposal is now in the 45-day public comment period, and the public hearing will be held on August 14, 2012.

PENDING REGULATORY PROPOSALS

Title 16, CCR Sections 1806, 1816, 1816.2, 1816.3, 1816.4, 1816.5, 1816.6, 1816.7, 1829, 1877; Add Section 1825, Regulations to Implement SB 704 (Examination Restructure)

This proposal revises current Board regulations in order to be consistent with the statutory changes made by SB 704 (Chapter 387, Statutes of 2011), which restructures the examination process for LMFT, LCSW, and LPCC applicants. This proposal was approved by the Board at its meeting on November 9, 2011. It is currently on hold, as the Board is pursuing legislation to extend the implementation date of the exam restructure from January 1, 2013 to January 1, 2014.

Title 16, CCR Section 1888 and Disciplinary Guidelines, Enforcement Regulations

This proposal makes several revisions to the Disciplinary Guidelines, which are incorporated by reference into Board regulations. This proposal was approved by the Board at its meeting on November 9, 2011, and additional changes were approved by the Board at its meeting on May 16, 2012. The proposal will be submitted to OAL for initial notice in Fall 2012.

Title 16, CCR Sections 1820, 1820.1, 1820.2, 1820.3, Exemptions for Sponsored Free Health Care Events

As a result of AB 2699 (Chapter 270, Statutes of 2010), beginning January 1, 2011, health care practitioners licensed or certified in good standing in another state may be temporarily exempted from California licensing requirements under certain conditions. However, before this law can be implemented, regulations must be approved by each healing arts board under DCA which specify the methods of implementation. This proposal was approved by the Board at its meeting on November 9, 2011 and will be submitted to OAL for initial notice in Fall 2012.

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