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**POLICY AND ADVOCACY COMMITTEE MEETING NOTICE**  
**April 23, 2015**  
**9:00 a.m.**

Department of Consumer Affairs  
Hearing Room  
1625 North Market Blvd., First Floor  
Sacramento, CA 95834

- I. Call to Order and Establishment of Quorum
- II. Introductions\*
- III. Approval of the January 30, 2015 Committee Meeting Minutes
- IV. Discussion and Recommendations for Possible Action Regarding Pending Legislation
  - a. Assembly Bill 85 (Wilk) – Open Meetings
  - b. Assembly Bill 250 (Oberholte) - Telehealth: Marriage and Family Therapist Interns and Trainees
  - c. Assembly Bill 333 (Melendez) – Healing Arts Continuing Education
  - d. Assembly Bill 690 (Wood) – Medi Cal: Federally Qualified Health Centers: Rural Health Clinics
  - e. Assembly Bill 796 (Nazarian) – Health Care Coverage: Autism and Pervasive Developmental Disorders
  - f. Assembly Bill 832 (Garcia) – Child Abuse: Reportable Conduct
  - g. Assembly Bill 1001 (Maienschein) – Child Abuse: Reporting
  - h. Assembly Bill 1279 (Holden) – Music Therapy
  - i. Senate Bill 479 (Bates) – Healing Arts: License and Regulate Applied Behavioral Analysis
  - j. Senate Bill 614 (Leno) – Medi Cal: Mental Health Services: Peer and Family Support Specialist Certification
  - k. Senate Bill 689 (Huff) – Veterans: Housing



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

- V. Update and Possible Action on Text of Proposed Legislation for 2015: Crime Victims: Compensation for Reimbursement of Violence Peer Counseling Expenses
- VI. Discussion and Recommendation for Possible Action Regarding Other Pending Legislation Affecting the Board
- VII. Discussion and Recommendation for Possible Action Regarding Proposed Regulations for Telehealth
- VIII. Legislation Update
- IX. Regulation Update
- X. Suggestions for Future Agenda Items
- XI. Public Comment for Items not on the Agenda
- XII. Adjournment

*\*Introductions are voluntary for members of the public.*

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

THIS AGENDA AS WELL AS BOARD MEETING MINUTES CAN BE FOUND ON THE BOARD OF BEHAVIORAL SCIENCES WEBSITE AT [www.bbs.ca.gov](http://www.bbs.ca.gov).

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

**Policy and Advocacy Committee Minutes - *DRAFT***  
**January 30, 2015**

Department of Consumer Affairs  
Hearing Room  
1625 N. Market Blvd.  
Sacramento, CA 95834

**Members Present**

Renee Lonner, Chair, LCSW Member  
Deborah Brown, Public Member  
Dr. Christine Wietlisbach, Public Member  
Christina Wong, LCSW Member

**Staff Present**

Kim Madsen, Executive Officer  
Steve Sodergren, Asst. Executive Officer  
Rosanne Helms, Legislative Analyst  
Christy Berger, Regulatory Analyst  
Dianne Dobbs, Legal Counsel  
Christina Kitamura, Administrative Analyst

**Members Absent**

None

**Guest List**

On file

**I. Call to Order and Establishment of Quorum**

Renee Lonner, Policy and Advocacy Committee (Committee) Chair, called the meeting to order at 9:07 a.m. Christina Kitamura took roll, and a quorum was established.

**II. Introductions**

The Committee, Board staff, and meeting attendees introduced themselves.

**III. Approval of the September 18, 2014 Committee Meeting Minutes**

The following edits were suggested:

- Page 3: omit line 28.
- Page 8, line 42: change "30 days" to "90 days."

***Renee Lonner moved to approve the Policy and Advocacy Committee meeting minutes as amended. Christina Wong seconded. The Committee voted to pass the motion.***

***Roll call vote:***

*Deborah Brown: Yay*  
*Renee Lonner: Yay*  
*Dr. Christine Wietlisbach: Yay*

1 Christina Wong: Yay

2

3

4 **IV. Discussion and Recommendations for Possible Action Regarding Telehealth**

5 **a. Other States' Telehealth Laws, Regulations, and Policies**

6 (This was a long discussion that ended at 10:20)

7

8 No action taken.

9

10 **b. Inclusion of Trainees in the Board's Proposed Telehealth Regulations**

11 Discussion ended 10:33.

12

13 The Committee took a break at 10:33 a.m. and reconvened 10:50 a.m.

14

15 Christina Wong moved to accept language presented and bring to board for discussion  
16 and continue ongoing discussions with camft. Renee Lonner seconded. The Committee  
17 voted to pass the motion.

18 **Roll call vote:**

19 Deborah Brown: Yay

20 Renee Lonner: Yay

21 Dr. Christine Wietlisbach: Yay

22 Christina Wong: Yay

23

24

25 **c. Security and Confidentiality Requirements for Telehealth**

26 Discussion ended at 11:13.

27

28 **Dr. Christine Wietlisbach moved to direct staff (see recording). ? seconded. The**  
29 **Committee voted to pass the motion.**

30 **Roll call vote:**

31 Deborah Brown: Yay

32 Renee Lonner: Yay

33 Dr. Christine Wietlisbach: Yay

34 Christina Wong: Yay

35

36 **d. Review of Proposed BBS Regulations for Telehealth**

37 Discussion ended at 12:11.

38

39 **Dr. Christine Wietlisbach moved to direct staff to make changes discussed and**  
40 **consult with legal on language and bring back to the Committee. Christina Wong**  
41 **seconded. The Committee voted to pass the motion.**

42

43 **Roll call vote:**

44 Deborah Brown: Yay

45 Renee Lonner: Yay

46 Dr. Christine Wietlisbach: Yay

47 Christina Wong: Yay

48

49 **e. Supervision Via Telehealth**

50

1 **Renee Lonner moved to refer this issue to the Supervision Committee. Dr. Christine**  
2 **Wietlisbach seconded. The Committee voted to pass the motion.**

3 **Roll call vote:**

4 Deborah Brown: Yay  
5 Renee Lonner: Yay  
6 Dr. Christine Wietlisbach: Yay  
7 Christina Wong: Yay  
8

9 **V. Update and Possible Action on Text of Proposed Legislation for 2015: Crime Victims:**  
10 **Compensation for Reimbursement of Violence Peer Counseling Expenses**

11  
12 **Renee Lonner moved to provide tech assistance to author's office. Dr. Christine**  
13 **Wietlisbach seconded. The Committee voted to pass the motion.**

14 **Roll call vote:**

15 Deborah Brown: Yay  
16 Renee Lonner: Yay  
17 Dr. Christine Wietlisbach: Yay  
18 Christina Wong: Yay  
19  
20

21 **VI. Update Regarding AB 2198: Suicide Prevention Training for Mental Health**  
22 **Professionals**

23  
24 Discussion ended 12:49  
25  
26

27 **VII. Legislative Update**

28  
29  
30

31 **VIII. Regulation Update**

32  
33  
34

35 **IX. Suggestions for Future Agenda Items**

36 No additional items. Items were mentioned in specific agenda item notes.  
37  
38

39 **X. Public Comment for Items not on the Agenda**

40 None  
41  
42

43 **XI. Adjournment**

44 The meeting was adjourned at 12:51 p.m.

# CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES

## BILL ANALYSIS

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**BILL NUMBER:** AB 85

**VERSION:** AMENDED APRIL 15, 2015

**AUTHOR:** WILK

**SPONSOR:** AUTHOR

**RECOMMENDED POSITION:** NONE

**SUBJECT:** OPEN MEETINGS

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### **Overview:**

This bill would make an advisory body consisting of less than three members subject to the Bagley-Keene Open Meeting Act if a member of the state body is serving on it in his or her official capacity, and if the advisory body is supported, wholly or partially, by funds from the state body.

### **Existing Law:**

- 1) Establishes the Bagley-Keene Open Meeting Act, which requires that actions and deliberations of state agencies be conducted openly. (Government Code (GC) §11120)
- 2) Defines a “state body” to mean any of the following (GC §11121):
  - A state board, commission, or multimember body of the state created by statute to conduct official meetings.
  - A board, commission or committee that exercises authority of a state body delegated by that state body.
  - An advisory board, commission, committee, or subcommittee that consists of three or more persons and is created by formal action by the state body or any of its members.
  - A board, commission, or committee on which a member of a state body serves in official capacity as a representative.
- 3) Requires that all meetings of a state body be open and all members of the public permitted to attend. (GC §11123)
- 4) Requires a state body to provide notice at least 10 days prior to a meeting, which includes an agenda for that meeting. (GC §11125)

### **This Bill:**

- 1) Revises the definition of a state body subject to the Bagley-Keene Open Meeting Act. Under the proposed change, an advisory body consisting of less than three members would be subject to Bagley-Keene if a member is serving in his or her official capacity and if the advisory body is supported, wholly or partially, by funds from the state body. (GC §11121)

**Comment:**

- 1) **Author's Intent.** Current law allows standing committees of a state entity to hold meetings that are not subject to the Bagley-Keene Open Meeting Act if they contain fewer than three members and do not vote to take action on items of discussion. The author's office is concerned that some state agencies are conducting meetings with two or fewer members specifically to avoid open meeting requirements. The author notes it is the intent of the Legislature and the public for government to conduct its business visibly and transparently.
- 2) **Brown Act for Local Governments.** Local government entities must abide by the Brown Act, which is an open meeting act similar to Bagley-Keene. In the early 1990s, the Brown Act contained a similar allowance as Bagley-Keene. This was corrected as soon as the Legislature discovered it; however, a conforming change was not made to the Bagley-Keene Act at that time.
- 3) **Current Board Process.** The Board commonly utilizes two-member standing committees to address issues requiring in-depth discussion and analysis. The intent is to create an environment that encourages discussion and sharing of ideas between Board members, staff, and interested stakeholders, which may eventually be used to generate a legislative or regulatory proposal. No votes are taken at these meetings; any action must be approved by the Board at a board meeting.

The Continuing Education Provider Review Committee and the Supervision Committee are examples of recent two-member standing committees. The Board still notices an agenda for these two-member meetings ten days prior, as Bagley-Keene requires.

If this bill were to become law, additional staff time would be required to complete meeting minutes, but otherwise the Board is already in compliance with Bagley-Keene in regards to these types of two-member committee meetings.

However, sometimes boards form two member executive committee meetings to handle matters such as personnel issues, or to review applications when hiring an executive officer. This bill would require these types of meetings to be noticed and subject to the requirements of Bagley-Keene.

- 4) **Board Members Serving on Other Multimember Bodies.** The amendments in this bill would mean that a board member acting in official capacity on any multimember body, whether a state body or corporate body, would subject that body to the Bagley-Keene Act if that board member receives state funds. In such a case, the Board must post notice of and an agenda for a meeting that it is not hosting. The

cost and compliance issues that this would create may act as a disincentive for Board members to represent the Board at other meetings and events.

- 5) Urgency Statute.** This bill is an urgency statute. Therefore, if signed by the Governor, it would become effective immediately.
- 6) Previous Legislation.** AB 2058 (Wilk, 2014) proposed making an advisory body consisting of less than three members subject to the Bagley-Keene Open Meeting Act if the body was a standing committee with a continuing subject matter jurisdiction or a had a meeting schedule fixed by formal action of a state body.

The Board took a “support” position on AB 2058.

However, AB 2058 was vetoed by the Governor, who stated the following in his veto message:

*“... Any meeting involving formal action by a state body should be open to the public. An advisory committee, however, does not have authority to act on its own and must present any findings and recommendations to a larger body in a public setting for formal action. That should be sufficient.”*

## **7) Support and Opposition.**

### Support

- California Association of Licensed Investigators

### Opposition

- California Board of Accountancy

## **8) History**

### **2015**

04/15/15 Read second time and amended.

04/14/15 From committee: Amend, and do pass as amended and re-refer to Com. on APPR. (Ayes 21. Noes 0.) (April 8).

01/26/15 Referred to Com. on G.O.

01/07/15 From printer. May be heard in committee February 6.

01/06/15 Read first time. To print.



AMENDED IN ASSEMBLY APRIL 15, 2015

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

**ASSEMBLY BILL**

**No. 85**

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**Introduced by Assembly Member Wilk**

January 6, 2015

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An act to amend Section 11121 of the Government Code, relating to state government, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 85, as amended, Wilk. Open meetings.

The Bagley-Keene Open Meeting Act requires that all meetings of a state body, as defined, be open and public and that all persons be permitted to attend and participate in a meeting of a state body, subject to certain conditions and exceptions.

This bill would specify that the definition of "state body" includes an advisory board, advisory commission, advisory committee, advisory subcommittee, or similar multimember advisory body of a state body that consists of 3 or more individuals, as prescribed, except a board, commission, committee, or similar multimember body on which a member of a body serves in his or her official capacity as a representative of that state body and that is supported, in whole or in part, by funds provided by the state body, whether the multimember body is organized and operated by the state body or by a private corporation.

~~This bill would make legislative findings and declarations, including, but not limited to, a statement of the Legislature's intent that this bill is declaratory of existing law.~~

This bill would declare that it is to take effect immediately as an urgency statute.

Vote:  $\frac{2}{3}$ . Appropriation: no. Fiscal committee: yes.  
 State-mandated local program: no.

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

1     ~~SECTION 1. The Legislature finds and declares all of the~~  
 2     ~~following:~~

3     ~~(a) The unpublished decision of the Third District Court of~~  
 4     ~~Appeals in Funeral Security Plans v. State Board of Funeral~~  
 5     ~~Directors (1994) 28 Cal. App.4th 1470 is an accurate reflection of~~  
 6     ~~legislative intent with respect to the applicability of the~~  
 7     ~~Bagley-Keene Open Meeting Act (Article 9 (commencing with~~  
 8     ~~Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of~~  
 9     ~~the Government Code) to a two-member standing advisory~~  
 10    ~~committee of a state body.~~

11    ~~(b) A two-member committee of a state body, even if operating~~  
 12    ~~solely in an advisory capacity, already is a “state body,” as defined~~  
 13    ~~in subdivision (d) of Section 11121 of the Government Code, if a~~  
 14    ~~member of the state body sits on the committee and the committee~~  
 15    ~~receives funds from the state body.~~

16    ~~(c) It is the intent of the Legislature that this bill is declaratory~~  
 17    ~~of existing law.~~

18    ~~SEC. 2.~~

19    ~~SECTION 1.~~ Section 11121 of the Government Code is  
 20    ~~amended to read:~~

21    11121. As used in this article, “state body” means each of the  
 22    ~~following:~~

23    ~~(a) Every state board, or commission, or similar multimember~~  
 24    ~~body of the state that is created by statute or required by law to~~  
 25    ~~conduct official meetings and every commission created by~~  
 26    ~~executive order.~~

27    ~~(b) A board, commission, committee, or similar multimember~~  
 28    ~~body that exercises any authority of a state body delegated to it by~~  
 29    ~~that state body.~~

30    ~~(c) An advisory board, advisory commission, advisory~~  
 31    ~~committee, advisory subcommittee, or similar multimember~~  
 32    ~~advisory body of a state body, if created by formal action of the~~  
 33    ~~state body or of any member of the state body, and if the advisory~~

1 body so created consists of three or more persons, except as in  
2 subdivision (d).

3 (d) A board, commission, committee, or similar multimember  
4 body on which a member of a body that is a state body pursuant  
5 to this section serves in his or her official capacity as a  
6 representative of that state body and that is supported, in whole or  
7 in part, by funds provided by the state body, whether the  
8 multimember body is organized and operated by the state body or  
9 by a private corporation.

10 ~~SEC. 3.~~

11 *SEC. 2.* This act is an urgency statute necessary for the  
12 immediate preservation of the public peace, health, or safety within  
13 the meaning of Article IV of the Constitution and shall go into  
14 immediate effect. The facts constituting the necessity are:

15 In order to avoid unnecessary litigation and ensure the people's  
16 right to access the meetings of public bodies pursuant to Section  
17 3 of Article 1 of the California Constitution, it is necessary that  
18 *this act take effect ~~immediately~~ immediately.*

# CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES

## BILL ANALYSIS

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**BILL NUMBER: AB 250**

**VERSION: AMENDED MARCH 26, 2015**

**AUTHOR: OLBERNOLTE**

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

**RECOMMENDED POSITION: NONE**

**SUBJECT: TELEHEALTH: MARRIAGE AND FAMILY THERAPIST INTERNS AND TRAINEES**

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### **Overview:**

Business and Professions Code (BPC) §2290.5 does not specify that MFT trainees may practice telehealth. This bill would clarify that MFT interns and trainees may do this.

### **Existing Law:**

- 1) Defines “telehealth” as a mode of delivering health care via information and communication technologies. The patient’s location is the originating site, and the health care provider’s location is the distant site. (BPC §2290.5)
- 2) Defines a “Health care provider” as a person who is licensed under Division 2 of the Business and Professions Code, which relates to healing arts. (BPC §2290.5)
- 3) Defines a “license” to mean a license, certificate, registration, or other means to engage in a business or profession regulated by the Business and Professions Code. (BPC §23.7)
- 4) Defines a marriage and family therapist trainee as an unlicensed person who is currently enrolled in a master’s or doctor’s degree program designed to qualify him or her for licensure, who has completed at least 12 semester units or 18 quarter units in that program. (BPC §4980.03(c))
- 5) Defines a marriage and family therapist intern as an unlicensed person who has earned his or her master’s or doctor’s degree qualifying him or her for licensure, and is registered with the board. (BPC §4980.03(b))
- 6) Permits MFT trainees to count some of their hours of supervised experience toward licensure. (BPC §§ 4980.43(a)(4), 4980.43(d)(1))
- 7) Requires hours of experience gained as a trainee to be coordinated between the school and the site where the hours are being approved. The school must approve each site and must have a written agreement with each site that details each party’s responsibilities, including supervision methods, progress reports, and performance evaluations. (BPC §4980.42(e))

- 8) Prohibits MFT trainees from providing services in a private practice (BPC §4980.43(d)(1)(C))
- 9) Allows applicants for licensure as an LMFT with the Board to count up to 375 hours of experience providing personal psychotherapy, crisis counseling, or other counseling services via telehealth, in accordance with BPC §2290.5. (BPC §4980.43(a)(11))

**This Bill:**

- 1) Clarifies that for purposes of the telehealth law (BPC §2290.5), MFT interns and trainees may provide services via telehealth. (BPC §4980.43(i))
- 2) Specifies that in order to provide telehealth services, MFT interns and trainees must be under licensed supervision as specified in BPC §4980.43(b), and must also comply with any telehealth regulations adopted by the Board. (BPC §4980.43(ii))

**Comments:**

- 1) **Background.** The sponsor of this bill has raised concern that BPC §2290.5 is written only for licensed individuals (a definition which includes interns, but not trainees, based on BPC §23.7.) However, at the same time, BPC §4980.43 allows MFT trainees to count some of their experience, gained as a trainee, toward licensure if working in an exempt setting, and allows some of this experience to be via telehealth.

There is concern that MFT trainees and their supervisors may be vulnerable to liability for providing telehealth services because BPC §2290.5 does not include trainees.

This same concern does not apply to ASW or PCC trainees, as they work in exempt settings and they may not count hours earned as a trainee toward licensure. Therefore, they are not under the jurisdiction of the Board in any way.

- 2) **Intent of This Bill.** The sponsor of this bill states that the proposed amendments would resolve the conflict in law so that pre-licensees could practice telehealth under supervision.
- 3) **Previous Board and Committee Consideration.** At its January 30, 2015 meeting, the Policy and Advocacy Committee discussed this issue, and staff proposed similar language to that used in this proposal.

At this meeting, the Committee learned that CAMFT was also pursuing a legislative proposal, and had found an author for the language. The Policy and Advocacy Committee directed staff to continue to work with CAMFT on the proposed language. The Board gave the same direction at its February 26, 2015 meeting.

- 4) **Inclusion of Interns.** This bill clarifies that both interns and trainees may provide services via telehealth. Interns are technically included in the definition of a “license”

in BPC §23.7, and therefore the law indicates that interns may provide telehealth. However, additional clarification in the law may be helpful.

## 5) Support and Opposition.

### Support

- California Association of Marriage and Family Therapists, (sponsor)
- California Primary Care Association

### Opposition

- None

## 6) History.

### **2015**

04/07/15 From committee: Do pass and re-refer to Com. on HEALTH. (Ayes 14. Noes 0.) (April 7). Re-referred to Com. on HEALTH.

04/06/15 Re-referred to Com. on B. & P.

03/26/15 From committee chair, with author's amendments: Amend, and re-refer to Com. on B. & P. Read second time and amended.

02/17/15 Referred to Coms. on B. & P. and HEALTH.

02/10/15 From printer. May be heard in committee March 12.

02/09/15 Read first time. To print.

## 7) Attachments.

**Attachment A:** Current Telehealth Law and Definition of a “License” (BPC §§ 2290.5 and 23.7)

AMENDED IN ASSEMBLY MARCH 26, 2015

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

**ASSEMBLY BILL**

**No. 250**

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**Introduced by Assembly Member Obernolte**

February 9, 2015

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An act to amend Section ~~2290.5~~ 4980.43 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 250, as amended, Obernolte. Telehealth: marriage and family therapist interns and trainees.

Under existing law, “telehealth” is defined as 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. Existing law requires a health care provider prior to the delivery of health care services via telehealth to inform the patient about the use of telehealth and obtain verbal or written consent from the patient for the use of telehealth. For these purposes, existing law defines a health care provider as a healing arts licensee. Existing law, the Licensed Marriage and Family Therapist Act, provides for the registration of marriage and family therapist interns and regulates marriage and family therapist trainees. Existing law requires applicants for a marriage and family therapist license to complete specified experience subject to certain limitations, including no more than a certain number of hours providing counseling services via telehealth. *Existing law requires all marriage and family therapist trainees and registrants to be supervised at all times by a supervisor,*

*as defined, responsible for ensuring that the extent, kind, and quality of counseling performed is consistent with the training and experience of the person being supervised. Existing law requires the supervisor to be responsible to the board for compliance with all laws, rules, and regulations governing the practice of marriage and family therapy.*

~~This bill, for purposes of the telehealth provisions, would expand the definition of “health care provider” to also include~~ *authorize a marriage and family therapist intern and trainee, as specified, to provide services via telehealth if he or she is supervised as required by the act, and is acting within the scope authorized by the act and in accordance with any regulations governing the use of telehealth promulgated by the Board of Behavioral Sciences.*

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

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

- 1     SECTION 1. Section 4980.43 of the Business and Professions
- 2     Code is amended to read:
- 3     4980.43. (a) Prior to applying for licensure examinations, each
- 4     applicant shall complete experience that shall comply with the
- 5     following:
- 6         (1) A minimum of 3,000 hours completed during a period of at
- 7         least 104 weeks.
- 8         (2) Not more than 40 hours in any seven consecutive days.
- 9         (3) Not less than 1,700 hours of supervised experience
- 10        completed subsequent to the granting of the qualifying master’s
- 11        or doctoral degree.
- 12        (4) Not more than 1,300 hours of supervised experience obtained
- 13        prior to completing a master’s or doctoral degree.
- 14        The applicant shall not be credited with more than 750 hours of
- 15        counseling and direct supervisor contact prior to completing the
- 16        master’s or doctoral degree.
- 17        (5) No hours of experience may be gained prior to completing
- 18        either 12 semester units or 18 quarter units of graduate instruction
- 19        and becoming a trainee except for personal psychotherapy.
- 20        (6) No hours of experience may be gained more than six years
- 21        prior to the date the application for examination eligibility was
- 22        filed, except that up to 500 hours of clinical experience gained in
- 23        the supervised practicum required by subdivision (c) of Section



1 4980.37 and subparagraph (B) of paragraph (1) of subdivision (d)  
2 of Section 4980.36 shall be exempt from this six-year requirement.

3 (7) Not more than a combined total of 1,000 hours of experience  
4 in the following:

5 (A) Direct supervisor contact.

6 (B) Professional enrichment activities. For purposes of this  
7 chapter, “professional enrichment activities” include the following:

8 (i) Workshops, seminars, training sessions, or conferences  
9 directly related to marriage and family therapy attended by the  
10 applicant that are approved by the applicant’s supervisor. An  
11 applicant shall have no more than 250 hours of verified attendance  
12 at these workshops, seminars, training sessions, or conferences.

13 (ii) Participation by the applicant in personal psychotherapy,  
14 which includes group, marital or conjoint, family, or individual  
15 psychotherapy by an appropriately licensed professional. An  
16 applicant shall have no more than 100 hours of participation in  
17 personal psychotherapy. The applicant shall be credited with three  
18 hours of experience for each hour of personal psychotherapy.

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

21 (9) For all hours gained on or after January 1, 2012, not more  
22 than 500 hours of experience in the following:

23 (A) Experience administering and evaluating psychological  
24 tests, writing clinical reports, writing progress notes, or writing  
25 process notes.

26 (B) Client centered advocacy.

27 (10) Not less than 500 total hours of experience in diagnosing  
28 and treating couples, families, and children. For up to 150 hours  
29 of treating couples and families in conjoint therapy, the applicant  
30 shall be credited with two hours of experience for each hour of  
31 therapy provided.

32 (11) Not more than 375 hours of experience providing personal  
33 psychotherapy, crisis counseling, or other counseling services via  
34 telehealth in accordance with Section 2290.5.

35 (12) It is anticipated and encouraged that hours of experience  
36 will include working with elders and dependent adults who have  
37 physical or mental limitations that restrict their ability to carry out  
38 normal activities or protect their rights.

39 This subdivision shall only apply to hours gained on and after  
40 January 1, 2010.

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

13 (1) If employed, an intern shall provide the board with copies  
14 of the corresponding W-2 tax forms for each year of experience  
15 claimed upon application for licensure.

16 (2) If volunteering, an intern shall provide the board with a letter  
17 from his or her employer verifying the intern’s employment as a  
18 volunteer upon application for licensure.

19 (c) Except for experience gained pursuant to subparagraph (B)  
20 of paragraph (7) of subdivision (a), supervision shall include at  
21 least one hour of direct supervisor contact in each week for which  
22 experience is credited in each work setting, as specified:

23 (1) A trainee shall receive an average of at least one hour of  
24 direct supervisor contact for every five hours of client contact in  
25 each setting. No more than six hours of supervision, whether  
26 individual or group, shall be credited during any single week.

27 (2) An individual supervised after being granted a qualifying  
28 degree shall receive at least one additional hour of direct supervisor  
29 contact for every week in which more than 10 hours of client  
30 contact is gained in each setting. No more than six hours of  
31 supervision, whether individual or group, shall be credited during  
32 any single week.

33 (3) For purposes of this section, “one hour of direct supervisor  
34 contact” means one hour per week of face-to-face contact on an  
35 individual basis or two hours per week of face-to-face contact in  
36 a group.

37 (4) Direct supervisor contact shall occur within the same week  
38 as the hours claimed.

1 (5) Direct supervisor contact provided in a group shall be  
2 provided in a group of not more than eight supervisees and in  
3 segments lasting no less than one continuous hour.

4 (6) Notwithstanding paragraph (3), an intern working in a  
5 governmental entity, a school, a college, or a university, or an  
6 institution that is both nonprofit and charitable may obtain the  
7 required weekly direct supervisor contact via two-way, real-time  
8 videoconferencing. The supervisor shall be responsible for ensuring  
9 that client confidentiality is upheld.

10 (7) All experience gained by a trainee shall be monitored by the  
11 supervisor as specified by regulation.

12 (8) The six hours of supervision that may be credited during  
13 any single week pursuant to paragraphs (1) and (2) shall apply to  
14 supervision hours gained on or after January 1, 2009.

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

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

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

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

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

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

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

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

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

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

4 (4) Except for periods of time during a supervisor's vacation or  
5 sick leave, an intern who is employed or volunteering in private  
6 practice shall be under the direct supervision of a licensee that has  
7 satisfied the requirements of subdivision (g) of Section 4980.03.  
8 The supervising licensee shall either be employed by and practice  
9 at the same site as the intern's employer, or shall be an owner or  
10 shareholder of the private practice. Alternative supervision may  
11 be arranged during a supervisor's vacation or sick leave if the  
12 supervision meets the requirements of this section.

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

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

18 (g) Except when employed in a private practice setting, all  
19 postdegree hours of experience shall be credited toward licensure  
20 so long as the applicant applies for the intern registration within  
21 90 days of the granting of the qualifying master's or doctoral  
22 degree and is thereafter granted the intern registration by the board.

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

26 (i) Trainees, interns, and applicants shall only perform services  
27 at the place where their employers regularly conduct business,  
28 which may include performing services at other locations, so long  
29 as the services are performed under the direction and control of  
30 their employer and supervisor, and in compliance with the laws  
31 and regulations pertaining to supervision. *For purposes of section*  
32 *2290.5, interns and trainees working under licensed supervision,*  
33 *consistent with subdivision (b), may provide services via telehealth*  
34 *within the scope authorized by this chapter and in accordance*  
35 *with any regulations governing the use of telehealth promulgated*  
36 *by the board.* Trainees and interns shall have no proprietary interest  
37 in their employers' businesses and shall not lease or rent space,  
38 pay for furnishings, equipment, or supplies, or in any other way  
39 pay for the obligations of their employers.

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

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

22 ~~SECTION 1. Section 2290.5 of the Business and Professions~~  
23 ~~Code is amended to read:~~

24 ~~2290.5. (a) For purposes of this division, the following~~  
25 ~~definitions shall apply:~~

26 (1) ~~“Asynchronous store and forward” means the transmission~~  
27 ~~of a patient’s medical information from an originating site to the~~  
28 ~~health care provider at a distant site without the presence of the~~  
29 ~~patient.~~

30 (2) ~~“Distant site” means a site where a health care provider who~~  
31 ~~provides health care services is located while providing these~~  
32 ~~services via a telecommunications system.~~

33 (3) ~~“Health care provider” means both of the following:~~

34 (A) ~~A person who is licensed under this division.~~

35 (B) ~~A marriage and family therapist intern and trainee, as~~  
36 ~~defined in Section 4980.03, completing supervised experience for~~  
37 ~~licensure pursuant to paragraph (11) of subdivision (a) of Section~~  
38 ~~4980.43.~~

39 (4) ~~“Originating site” means a site where a patient is located at~~  
40 ~~the time health care services are provided via a telecommunications~~

1 system or where the asynchronous store and forward service  
2 originates:

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

6 (6) “Telehealth” means the mode of delivering health care  
7 services and public health via information and communication  
8 technologies to facilitate the diagnosis, consultation, treatment,  
9 education, care management, and self-management of a patient’s  
10 health care while the patient is at the originating site and the health  
11 care provider is at a distant site. Telehealth facilitates patient  
12 self-management and caregiver support for patients and includes  
13 synchronous interactions and asynchronous store and forward  
14 transfers.

15 (b) Prior to the delivery of health care via telehealth, the health  
16 care provider initiating the use of telehealth shall inform the patient  
17 about the use of telehealth and obtain verbal or written consent  
18 from the patient for the use of telehealth as an acceptable mode of  
19 delivering health care services and public health. The consent shall  
20 be documented.

21 (c) Nothing in this section shall preclude a patient from receiving  
22 in-person health care delivery services during a specified course  
23 of health care and treatment after agreeing to receive services via  
24 telehealth.

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

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

32 (f) All laws regarding the confidentiality of health care  
33 information and a patient’s rights to his or her medical information  
34 shall apply to telehealth interactions.

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

38 (h) (1) Notwithstanding any other provision of law and for  
39 purposes of this section, the governing body of the hospital whose  
40 patients are receiving the telehealth services may grant privileges

1 to, and verify and approve credentials for, providers of telehealth  
2 services based on its medical staff recommendations that rely on  
3 information provided by the distant-site hospital or telehealth  
4 entity, as described in Sections 482.12, 482.22, and 485.616 of  
5 Title 42 of the Code of Federal Regulations.

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

10 (3) ~~For the purposes of this subdivision, “telehealth” shall~~  
11 ~~include “telemedicine” as the term is referenced in Sections 482.12,~~  
12 ~~482.22, and 485.616 of Title 42 of the Code of Federal Regulations.~~

**ATTACHMENT A**  
**CURRENT TELEHEALTH LAW AND DEFINITION OF A “LICENSE”**

**BPC § 23.7.**

Unless otherwise expressly provided, “license” means license, certificate, registration, or other means to engage in a business or profession regulated by this code or referred to in Section 1000 or 3600.

**BPC §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 initiating the use of telehealth shall inform the patient about the use of telehealth and obtain verbal or written consent from the patient for the use of telehealth as an acceptable mode of delivering health care services and public health. The consent shall be documented.

(c) Nothing in this section shall preclude a patient from receiving in-person health care delivery services during a specified course of health care and treatment after agreeing to receive services via telehealth.

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

(e) 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.

(f) 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.



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

(h) (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.

# CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES

## BILL ANALYSIS

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**BILL NUMBER:** AB 333                      **VERSION:** AMENDED MARCH 26, 2015

**AUTHOR:** MELENDEZ                      **SPONSOR:** AUTHOR

**RECOMMENDED POSITION:** NONE

**SUBJECT:** HEALING ARTS: CONTINUING EDUCATION

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### **Overview:**

This bill would allow a Board licensee who takes coursework toward, and becomes a certified instructor of, cardiopulmonary resuscitation (CPR) or automated external defibrillator (AED) use, to count one unit of credit toward his or her continuing education (CE) requirement.

### **Existing Law:**

- 1) Requires the director of the Department of Consumer Affairs to establish, by regulation, guidelines to prescribe components for mandatory continuing education programs administered by any board within the department. The guidelines shall be developed to ensure that mandatory continuing education is used as a means to create a more competent licensing population, thereby enhancing public protection. ((Business and Professions Code §166)
- 2) Requires licensees of the Board of Behavioral Sciences (Board), upon renewal of their license, to certify to the Board that he or she has completed at least 36 hours of approved continuing education in or relevant to their field of practice. (BPC §§4980.54(c), 4989.34(a), 4996.22(a), 4999.76(a)).
- 3) Specifies that continuing education training, education, and coursework must be from approved providers and must incorporate one or more of the following(BPC §§4980.54, 4989.34, 4996.22,4999.76 :
  - a) Aspects of the discipline that are fundamental to the practice of the profession for which licensed;
  - b) Aspects of the discipline for which licensed where significant recent developments have occurred; and
  - c) Aspects of other disciplines that enhance the understanding or practice of the profession for which licensed.
- 4) Defines the following continuing education credit equivalencies (California Code of Regulations (CCR) §1887.5):

- One hour of instruction equals one hour of continuing education credit;
- One academic quarter unit equals 10 hours of continuing education credit; and
- One academic semester unit equals 15 hours of continuing education credit.

**This Bill:**

- 1) Allows a Board licensee who attends a course which results in him or her becoming a certified CPR or AED instructor to count one unit of coursework toward the Board's continuing education requirement. (BPC §856(a))
- 2) Allows a Board licensee who conducts CPR or AED training sessions for employees of school districts or community colleges to count up to two units of coursework toward the Board's continuing education requirement. (BPC §856(b))
- 3) Defines a "unit" as any measurement for continuing education, such as hours or course credits. (BPC §856(c))

**Comments:**

- 1) **Author's Intent.** The author's office notes that AEDs are becoming more common on school campuses. However, pro bono instructors and training resources are rare, and paying for such training can be cost prohibitive.

Therefore, by allowing healing arts licensees to gain continuing education credit for becoming an instructor in CPR/AED use and for conducting training in schools, this bill creates an incentive that would benefit both licensees and schools.

- 2) **Current Continuing Education Requirements.** The Board has several one-time continuing educational requirements that must be completed by its LMFT, LCSW, and LPCC licensees. These additional courses must be completed prior to licensure or at the first renewal, depending on when the applicant began graduate study. These courses are as follows:

- Spousal/partner abuse (7 hours);
- Human sexuality (10 hours);
- Child abuse (7 hours);
- Substance abuse (15 hours);
- Aging/long term care (3 hours); and
- HIV/AIDS (7 hours).

All licensees must take a six-hour law and ethics course every renewal period. In total, a licensee must complete 36 hours of continuing education every renewal period.

- 3) **Relevance to the Practice.** Current law specifies that continuing education must incorporate either aspects of the discipline for which licensed that are fundamental to

the practice of the profession, aspects of the discipline where significant recent developments have occurred, or aspects of other disciplines that enhance the understanding or practice of the profession.

While CPR/AED training is important, it may be difficult to argue that it is fundamental to, or enhances the understanding of, the practice of psychotherapy.

- 4) Source of Coursework.** The Board's statutes and regulations require that continuing education be obtained from either an accredited or approved postsecondary institution, an entity approved by a board-recognized approval agency, or a board-recognized continuing education provider.

CPR and AED instructor certification programs appear to be commonly offered by nonprofits such as the American Red Cross and the American Heart Association. These entities would not meet the definition of an organization that would be approved by a board-recognized approval agency.

- 5) Bill's Definition of "Units" Unclear.** This bill states that a licensee may apply one unit of CE credit if he or she becomes a certified CPR or AED instructor, or up to two units of CE credit toward conducting CPR or AED training for employees of school districts or community colleges. The bill defines a "unit" of any measure of CE, such as hours or course credits.

The number of CE hours this bill intends to apply toward the CE requirements is unclear. Several nonprofit entities offer CPR and AED instructor courses, and while the programs vary, all programs appear to require many hours of training.

The Board's continuing education regulations state that one academic semester unit equals 15 hours of continuing education coursework. If the instructor training course was offered in academic units, this interpretation may apply. However, the board's regulations also define one hour of instruction as equaling one hour of continuing education credit. If the coursework is not offered in academic units, this interpretation may apply.

- 6) Support and Opposition.**

*None at this time.*

### **History.**

#### **2015**

04/06/15 Re-referred to Com. on B. & P.

03/26/15 From committee chair, with author's amendments: Amend, and re-refer to Com. on B. & P. Read second time and amended.

03/26/15 Referred to Com. on B. & P.

02/17/15 From printer. May be heard in committee March 19.

02/13/15 Read first time. To print.

AMENDED IN ASSEMBLY MARCH 26, 2015

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

**ASSEMBLY BILL**

**No. 333**

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**Introduced by Assembly Member Melendez**

February 13, 2015

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~~An act to amend Section 49417 of the Education Code, relating to pupil health.~~ *An act to add Section 856 to the Business and Professions Code, relating to healing arts.*

LEGISLATIVE COUNSEL'S DIGEST

AB 333, as amended, Melendez. ~~Pupil health: automated external defibrillators.~~ *Healing arts: continuing education.*

*Existing law provides for the licensure and regulation of various healing arts licensees by various boards, as defined, within the Department of Consumer Affairs and imposes various continuing education requirements for license renewal.*

*This bill would allow specified healing arts licensees to apply one unit, as defined, of continuing education credit towards any required continuing education units for attending a course that results in the licensee becoming a certified instructor of cardiopulmonary resuscitation (CPR) or the proper use of an automated external defibrillator (AED), and would allow specified healing arts licensees to apply up to 2 units of continuing education credit towards any required continuing education units for conducting CPR or AED training sessions for employees of school districts and community college districts in the state.*

~~Existing law authorizes a public school to solicit and receive nonstate funds to acquire and maintain an automated external defibrillator (AED). Existing law provides that the employees of the school district are not~~

liable for civil damages resulting from certain uses, attempted uses, or nonuses of an AED, except as provided. Existing law provides that a public school or school district that complies with certain requirements related to an AED is not liable for any civil damages resulting from any act or omission in the rendering of the emergency care or treatment, except as provided.

This bill would make a nonsubstantive change to these provisions.

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

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

1 SECTION 1. Section 856 is added to the Business and  
 2 Professions Code, to read:

3 856. (a) A person licensed pursuant to this division who is  
 4 required to complete continuing education units as a condition of  
 5 renewing his or her license may apply one unit of continuing  
 6 education credit towards that requirement for attending a course  
 7 that results in the licensee becoming a certified instructor of  
 8 cardiopulmonary resuscitation (CPR) or the proper use of an  
 9 automated external defibrillator (AED).

10 (b) A person licensed pursuant to this division who is required  
 11 to complete continuing education units as a condition of renewing  
 12 his or her license may apply up to two units of continuing education  
 13 credit towards that requirement for conducting CPR or AED  
 14 training sessions for employees of school districts and community  
 15 college districts in the state.

16 (c) For purposes of this section, “unit” means any measurement  
 17 for continuing education, such as hours or course credits.

18 SECTION 1. ~~Section 49417 of the Education Code is amended~~  
 19 ~~to read:~~

20 ~~49417. (a) A public school may solicit and receive nonstate~~  
 21 ~~funds to acquire and maintain an automated external defibrillator~~  
 22 ~~(AED). These funds shall only be used to acquire and maintain an~~  
 23 ~~AED and to provide training to school employees regarding the~~  
 24 ~~use of an AED.~~

25 ~~(b) Except as provided in subdivision (d), if an employee of a~~  
 26 ~~school district complies with Section 1714.21 of the Civil Code~~  
 27 ~~in rendering emergency care or treatment through the use,~~  
 28 ~~attempted use, or nonuse of an AED at the scene of an emergency,~~

1 ~~the employee shall not be liable for any civil damages resulting~~  
2 ~~from any act or omission in the rendering of the emergency care~~  
3 ~~or treatment.~~

4 ~~(e) Except as provided in subdivision (d), if a public school or~~  
5 ~~school district complies with the requirements of Section 1797.196~~  
6 ~~of the Health and Safety Code, the public school or school district~~  
7 ~~shall be covered by Section 1714.21 of the Civil Code and shall~~  
8 ~~not be liable for any civil damages resulting from any act or~~  
9 ~~omission in the rendering of the emergency care or treatment.~~

10 ~~(d) Subdivisions (b) and (e) do not apply in the case of personal~~  
11 ~~injury or wrongful death that results from gross negligence or~~  
12 ~~willful or wanton misconduct on the part of the person who uses,~~  
13 ~~attempts to use, or maliciously fails to use an AED to render~~  
14 ~~emergency care or treatment.~~

15 ~~(e) This section does not alter the requirements of Section~~  
16 ~~1797.196 of the Health and Safety Code.~~

# CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES

## BILL ANALYSIS

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**BILL NUMBER:** AB 690                      **VERSION:** INTRODUCED FEBRUARY 25, 2015

**AUTHOR:** WOOD                              **SPONSOR:**

- CALIFORNIA ASSOCIATION OF MARRIAGE AND FAMILY THERAPISTS (CAMFT)
- CALIFORNIA PRIMARY CARE ASSOCIATION

**RECOMMENDED POSITION:** NONE

**SUBJECT:** MEDI-CAL: FEDERALLY QUALIFIED HEALTH CENTERS: RURAL HEALTH CLINICS

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### **Overview:**

This bill would allow Medi-Cal reimbursement for covered mental health services provided by a marriage and family therapist employed by a federally qualified health center or a rural health clinic.

### **Existing Law:**

- 1) 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. (Welfare and Institutions Code (WIC) §14132.100(c))
- 2) Defines a FQHC or RHC “visit” as a face-to-face encounter between an FQHC or RHC patient and one of the following (WIC §14132.100(g))
  - A physician;
  - physician assistant;
  - nurse practitioner;
  - certified nurse-midwife;
  - clinical psychologist;
  - licensed clinical social worker;
  - visiting nurse; or
  - dental hygienist.

### **This Bill:**

- 1) 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. (WIC §14132.100(g)(1))



## **Comments:**

- 1) Author's Intent.** The intent of this legislation is to allow federally qualified health centers and rural health clinics to be able to hire a marriage and family therapist and be reimbursed through Medi-Cal for covered mental health services. Under current law, a clinic may hire a marriage and family therapist. However, only clinical psychologists or licensed clinical social workers 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. Allowing services provided by LMFTs to be reimbursed will maximize the availability of mental health services in rural areas.
- 2) Suggested Amendment.** Staff suggests an amendment be made to include the word "licensed" in front of the term "marriage and family therapist" in §14132.100(g)(1). This will clarify that the marriage and family therapist must be licensed by the Board, and it is consistent with the use of the term "licensed clinical social worker" in that code section. In addition, it is also consistent with the Board's August 18, 2011 decision that the title "Licensed Marriage and Family Therapist" be utilized in all new regulatory and legislative proposals.
- 3) Previous Legislation.** This bill was run as AB 1785 (B. Lowenthal) in 2012. The Board took a "support" position on AB 1785. However, the bill died in the Assembly Appropriations Committee.
- 4) Support and Opposition.**

### **Support:**

California Primary Care Association (Sponsor)  
Alameda Health Consortium  
American Association for Marriage and Family Therapy, California Division  
American Federation of State, County and Municipal Employees  
Ampla Health  
California Association of Marriage and Family Therapists  
California Association of Rural Health Centers  
California Council of Community Mental Health Agencies  
California Immigrant Policy Center  
California Medical Association  
California School-Based Health Alliance  
Central Valley Health Network  
Clinica Sierra Vista  
Community Clinic Consortium  
Community Health Partnership

County Behavioral Health Directors Association  
Family HealthCare Network  
Family Health Centers of San Diego  
Hill Country Community Clinic  
Livingston Community Health  
Mendocino Coast Clinics  
Mountain Valleys Health Centers  
North Coast Clinics Network  
Northeast Valley Health Corporation  
Ritter Health Center  
San Francisco Community Clinic Consortium  
San Ysidro Health Center  
SEIU California

Oppose:

National Association of Social Workers-California Chapter

**5) History**

**2015**

04/08/15 From committee: Do pass and re-refer to Com. on APPR. (Ayes 18. Noes 0.) (April 7). Re-referred to Com. on APPR.

03/09/15 Referred to Com. on HEALTH.

02/26/15 From printer. May be heard in committee March 28.

02/25/15 Read first time. To print.

**ASSEMBLY BILL**

**No. 690**

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**Introduced by Assembly Member Wood**

February 25, 2015

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An act to amend Section 14132.100 of the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

AB 690, as introduced, Wood. Medi-Cal: federally qualified health centers: rural health clinics.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law provides that federally qualified health center services and rural health clinic services, as defined, are covered benefits under the Medi-Cal program, to be reimbursed, to the extent that federal financial participation is obtained, to providers on a per-visit basis. "Visit" is defined as a face-to-face encounter between a patient of a federally qualified health center or a rural health clinic and specified health care professionals.

This bill would include a marriage and family therapist within those health care professionals covered under that definition.

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

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

1 SECTION 1. Section 14132.100 of the Welfare and Institutions  
 2 Code is amended to read:  
 3 14132.100. (a) The federally qualified health center services  
 4 described in Section 1396d(a)(2)(C) of Title 42 of the United States  
 5 Code are covered benefits.  
 6 (b) The rural health clinic services described in Section  
 7 1396d(a)(2)(B) of Title 42 of the United States Code are covered  
 8 benefits.  
 9 (c) Federally qualified health center services and rural health  
 10 clinic services shall be reimbursed on a per-visit basis in  
 11 accordance with the definition of “visit” set forth in subdivision  
 12 (g).  
 13 (d) Effective October 1, 2004, and on each October 1, thereafter,  
 14 until no longer required by federal law, federally qualified health  
 15 center (FQHC) and rural health clinic (RHC) per-visit rates shall  
 16 be increased by the Medicare Economic Index applicable to  
 17 primary care services in the manner provided for in Section  
 18 1396a(bb)(3)(A) of Title 42 of the United States Code. Prior to  
 19 January 1, 2004, FQHC and RHC per-visit rates shall be adjusted  
 20 by the Medicare Economic Index in accordance with the  
 21 methodology set forth in the state plan in effect on October 1,  
 22 2001.  
 23 (e) (1) An FQHC or RHC may apply for an adjustment to its  
 24 per-visit rate based on a change in the scope of services provided  
 25 by the FQHC or RHC. Rate changes based on a change in the  
 26 scope of services provided by an FQHC or RHC shall be evaluated  
 27 in accordance with Medicare reasonable cost principles, as set  
 28 forth in Part 413 (commencing with Section 413.1) of Title 42 of  
 29 the Code of Federal Regulations, or its successor.  
 30 (2) Subject to the conditions set forth in subparagraphs (A) to  
 31 (D), inclusive, of paragraph (3), a change in scope of service means  
 32 any of the following:  
 33 (A) The addition of a new FQHC or RHC service that is not  
 34 incorporated in the baseline prospective payment system (PPS)  
 35 rate, or a deletion of an FQHC or RHC service that is incorporated  
 36 in the baseline PPS rate.  
 37 (B) A change in service due to amended regulatory requirements  
 38 or rules.

- 1 (C) A change in service resulting from relocating or remodeling  
2 an FQHC or RHC.
- 3 (D) A change in types of services due to a change in applicable  
4 technology and medical practice utilized by the center or clinic.
- 5 (E) An increase in service intensity attributable to changes in  
6 the types of patients served, including, but not limited to,  
7 populations with HIV or AIDS, or other chronic diseases, or  
8 homeless, elderly, migrant, or other special populations.
- 9 (F) Any changes in any of the services described in subdivision  
10 (a) or (b), or in the provider mix of an FQHC or RHC or one of  
11 its sites.
- 12 (G) Changes in operating costs attributable to capital  
13 expenditures associated with a modification of the scope of any  
14 of the services described in subdivision (a) or (b), including new  
15 or expanded service facilities, regulatory compliance, or changes  
16 in technology or medical practices at the center or clinic.
- 17 (H) Indirect medical education adjustments and a direct graduate  
18 medical education payment that reflects the costs of providing  
19 teaching services to interns and residents.
- 20 (I) Any changes in the scope of a project approved by the federal  
21 Health Resources and ~~Service~~ *Services* Administration (HRSA).
- 22 (3) No change in costs shall, in and of itself, be considered a  
23 scope-of-service change unless all of the following apply:
- 24 (A) The increase or decrease in cost is attributable to an increase  
25 or decrease in the scope of services defined in subdivisions (a) and  
26 (b), as applicable.
- 27 (B) The cost is allowable under Medicare reasonable cost  
28 principles set forth in Part 413 (commencing with Section 413) of  
29 Subchapter B of Chapter 4 of Title 42 of the Code of Federal  
30 Regulations, or its successor.
- 31 (C) The change in the scope of services is a change in the type,  
32 intensity, duration, or amount of services, or any combination  
33 thereof.
- 34 (D) The net change in the FQHC's or RHC's rate equals or  
35 exceeds 1.75 percent for the affected FQHC or RHC site. For  
36 FQHCs and RHCs that filed consolidated cost reports for multiple  
37 sites to establish the initial prospective payment reimbursement  
38 rate, the 1.75-percent threshold shall be applied to the average  
39 per-visit rate of all sites for the purposes of calculating the cost  
40 associated with a scope-of-service change. "Net change" means

1 the per-visit rate change attributable to the cumulative effect of all  
2 increases and decreases for a particular fiscal year.

3 (4) An FQHC or RHC may submit requests for scope-of-service  
4 changes once per fiscal year, only within 90 days following the  
5 beginning of the FQHC's or RHC's fiscal year. Any approved  
6 increase or decrease in the provider's rate shall be retroactive to  
7 the beginning of the FQHC's or RHC's fiscal year in which the  
8 request is submitted.

9 (5) An FQHC or RHC shall submit a scope-of-service rate  
10 change request within 90 days of the beginning of any FQHC or  
11 RHC fiscal year occurring after the effective date of this section,  
12 if, during the FQHC's or RHC's prior fiscal year, the FQHC or  
13 RHC experienced a decrease in the scope of services provided that  
14 the FQHC or RHC either knew or should have known would have  
15 resulted in a significantly lower per-visit rate. If an FQHC or RHC  
16 discontinues providing onsite pharmacy or dental services, it shall  
17 submit a scope-of-service rate change request within 90 days of  
18 the beginning of the following fiscal year. The rate change shall  
19 be effective as provided for in paragraph (4). As used in this  
20 paragraph, "significantly lower" means an average per-visit rate  
21 decrease in excess of 2.5 percent.

22 (6) Notwithstanding paragraph (4), if the approved  
23 scope-of-service change or changes were initially implemented  
24 on or after the first day of an FQHC's or RHC's fiscal year ending  
25 in calendar year 2001, but before the adoption and issuance of  
26 written instructions for applying for a scope-of-service change,  
27 the adjusted reimbursement rate for that scope-of-service change  
28 shall be made retroactive to the date the scope-of-service change  
29 was initially implemented. Scope-of-service changes under this  
30 paragraph shall be required to be submitted within the later of 150  
31 days after the adoption and issuance of the written instructions by  
32 the department, or 150 days after the end of the FQHC's or RHC's  
33 fiscal year ending in 2003.

34 (7) All references in this subdivision to "fiscal year" shall be  
35 construed to be references to the fiscal year of the individual FQHC  
36 or RHC, as the case may be.

37 (f) (1) An FQHC or RHC may request a supplemental payment  
38 if extraordinary circumstances beyond the control of the FQHC  
39 or RHC occur after December 31, 2001, and PPS payments are  
40 insufficient due to these extraordinary circumstances. Supplemental

1 payments arising from extraordinary circumstances under this  
2 subdivision shall be solely and exclusively within the discretion  
3 of the department and shall not be subject to subdivision (l). These  
4 supplemental payments shall be determined separately from the  
5 scope-of-service adjustments described in subdivision (e).  
6 Extraordinary circumstances include, but are not limited to, acts  
7 of nature, changes in applicable requirements in the Health and  
8 Safety Code, changes in applicable licensure requirements, and  
9 changes in applicable rules or regulations. Mere inflation of costs  
10 alone, absent extraordinary circumstances, shall not be grounds  
11 for supplemental payment. If an FQHC's or RHC's PPS rate is  
12 sufficient to cover its overall costs, including those associated with  
13 the extraordinary circumstances, then a supplemental payment is  
14 not warranted.

15 (2) The department shall accept requests for supplemental  
16 payment at any time throughout the prospective payment rate year.

17 (3) Requests for supplemental payments shall be submitted in  
18 writing to the department and shall set forth the reasons for the  
19 request. Each request shall be accompanied by sufficient  
20 documentation to enable the department to act upon the request.  
21 Documentation shall include the data necessary to demonstrate  
22 that the circumstances for which supplemental payment is requested  
23 meet the requirements set forth in this section. Documentation  
24 shall include all of the following:

25 (A) A presentation of data to demonstrate reasons for the  
26 FQHC's or RHC's request for a supplemental payment.

27 (B) Documentation showing the cost implications. The cost  
28 impact shall be material and significant, two hundred thousand  
29 dollars (\$200,000) or 1 percent of a facility's total costs, whichever  
30 is less.

31 (4) A request shall be submitted for each affected year.

32 (5) Amounts granted for supplemental payment requests shall  
33 be paid as lump-sum amounts for those years and not as revised  
34 PPS rates, and shall be repaid by the FQHC or RHC to the extent  
35 that it is not expended for the specified purposes.

36 (6) The department shall notify the provider of the department's  
37 discretionary decision in writing.

38 (g) (1) An FQHC or RHC "visit" means a face-to-face  
39 encounter between an FQHC or RHC patient and a physician,  
40 physician assistant, nurse practitioner, certified nurse-midwife,

1 clinical psychologist, licensed clinical social worker, *marriage*  
2 *and family therapist*, or a visiting nurse. For purposes of this  
3 section, “physician” shall be interpreted in a manner consistent  
4 with the Centers for Medicare and Medicaid Services’ Medicare  
5 Rural Health Clinic and Federally Qualified Health Center Manual  
6 (Publication 27), or its successor, only to the extent that it defines  
7 the professionals whose services are reimbursable on a per-visit  
8 basis and not as to the types of services that these professionals  
9 may render during these visits and shall include a physician and  
10 surgeon, podiatrist, dentist, optometrist, and chiropractor. A visit  
11 shall also include a face-to-face encounter between an FQHC or  
12 RHC patient and a comprehensive perinatal services practitioner,  
13 as defined in Section 51179.1 of Title 22 of the California Code  
14 of Regulations, providing comprehensive perinatal services, a  
15 four-hour day of attendance at an adult day health care center, and  
16 any other provider identified in the state plan’s definition of an  
17 FQHC or RHC visit.

18 (2) (A) A visit shall also include a face-to-face encounter  
19 between an FQHC or RHC patient and a dental hygienist or a  
20 dental hygienist in alternative practice.

21 (B) Notwithstanding subdivision (e), an FQHC or RHC that  
22 currently includes the cost of the services of a dental hygienist in  
23 alternative practice for the purposes of establishing its FQHC or  
24 RHC rate shall apply for an adjustment to its per-visit rate, and,  
25 after the rate adjustment has been approved by the department,  
26 shall bill these services as a separate visit. However, multiple  
27 encounters with dental professionals that take place on the same  
28 day shall constitute a single visit. The department shall develop  
29 the appropriate forms to determine which FQHC’s or RHC rates  
30 shall be adjusted and to facilitate the calculation of the adjusted  
31 rates. An FQHC’s or RHC’s application for, or the department’s  
32 approval of, a rate adjustment pursuant to this subparagraph shall  
33 not constitute a change in scope of service within the meaning of  
34 subdivision (e). An FQHC or RHC that applies for an adjustment  
35 to its rate pursuant to this subparagraph may continue to bill for  
36 all other FQHC or RHC visits at its existing per-visit rate, subject  
37 to reconciliation, until the rate adjustment for visits between an  
38 FQHC or RHC patient and a dental hygienist or a dental hygienist  
39 in alternative practice has been approved. Any approved increase  
40 or decrease in the provider’s rate shall be made within six months



1 after the date of receipt of the department's rate adjustment forms  
2 pursuant to this subparagraph and shall be retroactive to the  
3 beginning of the fiscal year in which the FQHC or RHC submits  
4 the request, but in no case shall the effective date be earlier than  
5 January 1, 2008.

6 (C) An FQHC or RHC that does not provide dental hygienist  
7 or dental hygienist in alternative practice services, and later elects  
8 to add these services, shall process the addition of these services  
9 as a change in scope of service pursuant to subdivision (e).

10 (h) If FQHC or RHC services are partially reimbursed by a  
11 third-party payer, such as a managed care entity (as defined in  
12 Section 1396u-2(a)(1)(B) of Title 42 of the United States Code),  
13 the Medicare Program, or the Child Health and Disability  
14 Prevention (CHDP) program, the department shall reimburse an  
15 FQHC or RHC for the difference between its per-visit PPS rate  
16 and receipts from other plans or programs on a contract-by-contract  
17 basis and not in the aggregate, and may not include managed care  
18 financial incentive payments that are required by federal law to  
19 be excluded from the calculation.

20 (i) (1) An entity that first qualifies as an FQHC or RHC in the  
21 year 2001 or later, a newly licensed facility at a new location added  
22 to an existing FQHC or RHC, and any entity that is an existing  
23 FQHC or RHC that is relocated to a new site shall each have its  
24 reimbursement rate established in accordance with one of the  
25 following methods, as selected by the FQHC or RHC:

26 (A) The rate may be calculated on a per-visit basis in an amount  
27 that is equal to the average of the per-visit rates of three comparable  
28 FQHCs or RHCs located in the same or adjacent area with a similar  
29 caseload.

30 (B) In the absence of three comparable FQHCs or RHCs with  
31 a similar caseload, the rate may be calculated on a per-visit basis  
32 in an amount that is equal to the average of the per-visit rates of  
33 three comparable FQHCs or RHCs located in the same or an  
34 adjacent service area, or in a reasonably similar geographic area  
35 with respect to relevant social, health care, and economic  
36 characteristics.

37 (C) At a new entity's one-time election, the department shall  
38 establish a reimbursement rate, calculated on a per-visit basis, that  
39 is equal to 100 percent of the projected allowable costs to the  
40 FQHC or RHC of furnishing FQHC or RHC services during the

1 first 12 months of operation as an FQHC or RHC. After the first  
2 12-month period, the projected per-visit rate shall be increased by  
3 the Medicare Economic Index then in effect. The projected  
4 allowable costs for the first 12 months shall be cost settled and the  
5 prospective payment reimbursement rate shall be adjusted based  
6 on actual and allowable cost per visit.

7 (D) The department may adopt any further and additional  
8 methods of setting reimbursement rates for newly qualified FQHCs  
9 or RHCs as are consistent with Section 1396a(bb)(4) of Title 42  
10 of the United States Code.

11 (2) In order for an FQHC or RHC to establish the comparability  
12 of its caseload for purposes of subparagraph (A) or (B) of paragraph  
13 (1), the department shall require that the FQHC or RHC submit  
14 its most recent annual utilization report as submitted to the Office  
15 of Statewide Health Planning and Development, unless the FQHC  
16 or RHC was not required to file an annual utilization report. FQHCs  
17 or RHCs that have experienced changes in their services or  
18 caseload subsequent to the filing of the annual utilization report  
19 may submit to the department a completed report in the format  
20 applicable to the prior calendar year. FQHCs or RHCs that have  
21 not previously submitted an annual utilization report shall submit  
22 to the department a completed report in the format applicable to  
23 the prior calendar year. The FQHC or RHC shall not be required  
24 to submit the annual utilization report for the comparable FQHCs  
25 or RHCs to the department, but shall be required to identify the  
26 comparable FQHCs or RHCs.

27 (3) The rate for any newly qualified entity set forth under this  
28 subdivision shall be effective retroactively to the later of the date  
29 that the entity was first qualified by the applicable federal agency  
30 as an FQHC or RHC, the date a new facility at a new location was  
31 added to an existing FQHC or RHC, or the date on which an  
32 existing FQHC or RHC was relocated to a new site. The FQHC  
33 or RHC shall be permitted to continue billing for Medi-Cal covered  
34 benefits on a fee-for-service basis until it is informed of its  
35 enrollment as an FQHC or RHC, and the department shall reconcile  
36 the difference between the fee-for-service payments and the  
37 FQHC's or RHC's prospective payment rate at that time.

38 (j) Visits occurring at an intermittent clinic site, as defined in  
39 subdivision (h) of Section 1206 of the Health and Safety Code, of  
40 an existing FQHC or RHC, or in a mobile unit as defined by

1 paragraph (2) of subdivision (b) of Section 1765.105 of the Health  
2 and Safety Code, shall be billed by and reimbursed at the same  
3 rate as the FQHC or RHC establishing the intermittent clinic site  
4 or the mobile unit, subject to the right of the FQHC or RHC to  
5 request a scope-of-service adjustment to the rate.

6 (k) An FQHC or RHC may elect to have pharmacy or dental  
7 services reimbursed on a fee-for-service basis, utilizing the current  
8 fee schedules established for those services. These costs shall be  
9 adjusted out of the FQHC's or RHC's clinic base rate as  
10 scope-of-service changes. An FQHC or RHC that reverses its  
11 election under this subdivision shall revert to its prior rate, subject  
12 to an increase to account for all MEI increases occurring during  
13 the intervening time period, and subject to any increase or decrease  
14 associated with applicable scope-of-services adjustments as  
15 provided in subdivision (e).

16 (l) FQHCs and RHCs may appeal a grievance or complaint  
17 concerning ratesetting, scope-of-service changes, and settlement  
18 of cost report audits, in the manner prescribed by Section 14171.  
19 The rights and remedies provided under this subdivision are  
20 cumulative to the rights and remedies available under all other  
21 provisions of law of this state.

22 (m) The department shall, by no later than March 30, 2008,  
23 promptly seek all necessary federal approvals in order to implement  
24 this section, including any amendments to the state plan. To the  
25 extent that any element or requirement of this section is not  
26 approved, the department shall submit a request to the federal  
27 Centers for Medicare and Medicaid Services for any waivers that  
28 would be necessary to implement this section.

29 (n) The department shall implement this section only to the  
30 extent that federal financial participation is obtained.

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# CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES

## BILL ANALYSIS

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**BILL NUMBER:** AB 796                      **VERSION:** INTRODUCED FEBRUARY 26, 2015

**AUTHOR:** NAZARIAN                      **SPONSOR:** DIR FLOOR TIME COALITION

**RECOMMENDED POSITION:** NONE

**SUBJECT:** HEALTH CARE COVERAGE: AUTISM AND PERVASIVE DEVELOPMENTAL DISORDERS

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**Overview:** This bill modifies the definition of “qualified autism service professional” and “qualified autism service paraprofessional” to allow insurance coverage for types of behavioral health treatment other than applied behavior analysis.

**Existing Law:**

- 1) 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 (PDD/A). (Health and Safety Code (HSC) §1374.73(a), Insurance Code (IC) §10144.51(a))
- 2) Requires these health care service plans and health insurers subject to this provision to maintain an adequate network of qualified autism service providers. (HSC §1374.73(b), IC §10144.51(b))
- 3) Defines “behavioral health treatment” as professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs which develop or restore the functioning of an individual with pervasive developmental disorder or autism, and meets the following criteria (HSC §1374.73(c), IC §10144.51(c):
  - a) Is prescribed by a licensed physician and surgeon or is developed by a licensed psychologist;
  - b) Is provided under a treatment plan prescribed by a qualified autism service provider and administered by such a provider or by a qualified autism service professional under supervision and employment of a qualified autism service provider;
  - c) 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
  - d) Is not used for purposes of providing or for the reimbursement of respite, day care, or educational services.

- 4) Defines a “qualified autism service provider” as either (HSC §1374.73(c), IC §10144.51(c)):
  - a) A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited and which designs, supervises, or provides treatment for pervasive developmental disorder or autism; or
  - b) A person who is licensed as a specified healing arts practitioner, including a psychologist, marriage and family therapist, educational psychologist, clinical social worker, or professional clinical counselor. The licensee must design, supervise, or provide treatment for pervasive developmental disorder or autism and be within his or her experience and competence.
- 5) Defines a “qualified autism service professional” as someone who meets all of the following (HSC §1374.73(c), IC §10144.51(c)):
  - a) Provides behavioral health treatment;
  - b) Is employed and supervised by a qualified autism service provider;
  - c) Provides treatment according to a treatment plan developed and approved by the qualified autism service provider.
  - d) Is a behavioral service provider approved by a regional center to provide services as an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program as defined in Section 54342 of Title 17 of the California Code of Regulations (CCR); and
  - e) Has training and experience providing services for pervasive developmental disorder or autism pursuant to the Lanterman Developmental Disabilities Services Act.
- 6) Defines a “qualified autism service paraprofessional” as an unlicensed and uncertified person who meets all of the following (HSC §1374.73(c), IC §10144.51(c)):
  - a) Is employed and supervised by a qualified autism service provider;
  - b) Provides treatment according to a treatment plan developed and approved by the qualified autism service provider;
  - c) Meets criteria set forth in regulations regarding use of paraprofessionals in group practice providing behavioral intervention services; and
  - d) Is certified by a qualified autism service provider as having adequate education, training, and experience.

- 7) Defines vendor service codes and sets requirements for regional to classify the following professions (CCR 17 §54342):
  - a) Associate Behavior Analysts;
  - b) Behavior Analysts;
  - c) Behavior Management Assistants;
  - d) Behavior Management Consultants; and
  - e) Behavior Management Programs.

**This Bill:**

- 1) Modifies the qualifications of a “qualified autism service professional” to be either of the following (HSC §1374.73(c)(4)(D), IC §10144.51(c)(4)(D)):
  - a) A behavioral service provider approved by a regional center to provide services as an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program as defined in Section 54342 of Title 17 of the California Code of Regulations (CCR); or
  - b) Have a bachelor of arts or science degree and either:
    - i. Twelve semester units from an accredited institution in either applied behavioral analysis or clinical coursework in behavioral health, and one year of experience in designing or implementing behavioral health treatment; or
    - ii. Two years experience designing or implementing behavioral health treatment; or
    - iii. Is a registered psychological assistant or registered psychologist; or
    - iv. Is an associate clinical social worker registered with the Board.
- 2) Modifies the qualifications of a “qualified autism service paraprofessional” to be either of the following ((HSC §1374.73(c)(5)(C), IC §10144.51(c)(5)(C)):
  - a) Meets criteria set forth in regulations regarding use of paraprofessionals in group practice providing behavioral intervention services; or
  - b) Has all of the following:
    - i. A high school diploma or equivalent;
    - ii. Six months experience working with persons with developmental disabilities;

- iii. Thirty hours of training in evidence-based behavioral health treatment administered by a qualified autism service provider or professional
- iv. Passed a background check conducted by a state-approved agency.

**Comments:**

**1) Author's Intent.** SB 946 (Chapter 650, Statutes of 2011) required health service plan and insurance policies to provide coverage for behavioral health treatment for pervasive developmental disorder or autism (PDD/A). Furthermore, SB 946 defined behavioral health treatment as certain professional services and treatment programs that include applied behavior analysis under qualified autism service providers, professionals, and paraprofessionals.

The author's office notes that SB 946 went on to specifically define "qualified autism service professionals" and "qualified autism service paraprofessionals" as behavioral health treatment providers meeting the requirements of Section 54342 of Title 17 of the CCR. However, this section of the CCR only refers to behavioral health treatment providers as applied behavior analyst providers, leaving out other types of evidence-based behavioral health treatment.

Therefore, the author is attempting to have the behavioral health coverage mandated by SB 946 apply to all types of evidence-based behavioral health treatment, not just applied behavior analysis. This bill does this by codifying the educational and professional requirements listed in Title 17 of the CCR for applied behavior analysts, and applying them to all behavioral health providers.

The author's goal in doing this is to ensure that the qualified medical professional who knows the child best can prescribe the appropriate behavioral health treatment for that child, even if that behavioral health treatment is not applied behavior analysis.

**2) Inclusion of Board Registrants.** This bill allows an associate clinical social worker registered with the Board to be a qualified autism services professional if he or she provides behavioral health treatment, is employed and supervised by a qualified autism service provider and provides treatment pursuant to a treatment plan developed and approved by that provider, and has training and experience providing services for pervasive developmental disorder or autism pursuant to the Lanterman Developmental Disabilities Services Act.

It is unclear why associate clinical social workers are specified as being able to become qualified autism service professionals, but marriage and family therapist interns and professional clinical counselor interns are not.

**3) Proposed Licensure of Behavior Analysts.** The author's office writes that the definitions of applied behavioral analysis in Section 54342 of Title 17 of the CCR were written before newer forms of behavioral health treatment therapy had been developed and tested, and that is why current coverage requirements specify applied behavior analysis.

Applied behavior analysis has become a well-established standard of treatment for PDD/A, and the California Association for Behavior Analysis is currently sponsoring a bill proposal (SB 479, Bates), which would create a licensure category under the Board of Psychology.

The prospect of competing types of effective behavioral health treatment may raise questions about the implications of establishing a licensure category for one of the treatment types, but not the others.

**4) Previous Legislation.** SB 946 (Chapter 650, Statutes of 2011) requires every health care service plan contract and insurance policy that provides hospital, medical, or surgical coverage shall also provide coverage for behavioral health treatment for PDD/A.

AB 171 (Beall, 2012), would have required 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 bill died in the Senate Health Committee.

SB 126 (Chapter 680, Statutes of 2013) extended the provisions of SB 946 until January 1, 2017.

## **5) Support and Opposition.**

Support:

- DIR Floor Time Coalition (Sponsor)
- Numerous Individuals

Oppose:

- California Association of Behavior Analysts
- Center for Autism and Related Disorders
- Autism Research Group

## **6) History**

### **2015**

04/09/2015 Apr. 9 Re-referred to Coms. on B. & P. and HEALTH pursuant to Assembly Rule 96. (Ayes 51. Noes 26.)

03/12/2015 Mar. 12 Referred to Coms. on HEALTH and B. & P.

02/27/2015 Feb. 27 From printer. May be heard in committee March 29.

02/26/2015 Feb. 26 Read first time. To print.



**ASSEMBLY BILL**

**No. 796**

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**Introduced by Assembly Member Nazarian  
(Coauthor: Assembly Member Rendon)**

February 26, 2015

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

LEGISLATIVE COUNSEL'S DIGEST

AB 796, as introduced, Nazarian. Health care coverage: autism and pervasive developmental disorders.

Existing law provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. A violation of those provisions is a crime. Existing law provides for the licensure and regulation of health insurers by the Department of Insurance.

Existing law requires every health care service plan contract and health insurance policy to provide coverage for behavioral health treatment for pervasive developmental disorder or autism. Existing law requires every health care service plan and health insurance policy to maintain an adequate network that includes qualified autism service providers who supervise and employ qualified autism service professionals or paraprofessionals who provide and administer behavioral health treatment. Existing law defines "qualified autism service professional" and "qualified autism service paraprofessional" for this purpose to mean a person who meets specified educational and training requirements.

This bill would expand the eligibility for a person to be a qualified autism service professional to include a person who possesses a bachelor

of arts or science degree and meets other specified requirements, a registered psychological assistant, a registered psychologist, or an associate clinical social worker. The bill would also expand the eligibility for a person to be a qualified autism service paraprofessional to include a person with a high school diploma or equivalent and, among other things, 6 months experience working with persons with developmental disabilities.

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

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

- 1 SECTION 1. The Legislature finds and declares all of the  
2 following:
- 3 (a) Autism and other pervasive developmental disorders are  
4 complex neurobehavioral disorders that include impairments in  
5 social communication and social interaction combined with rigid,  
6 repetitive behaviors, interests, and activities.
- 7 (b) Autism covers a large spectrum of symptoms and levels of  
8 impairment ranging in severity from somewhat limiting to a severe  
9 disability that may require institutional care.
- 10 (c) One in 68 children born today will be diagnosed with autism  
11 or another pervasive developmental disorder.
- 12 (d) Research has demonstrated that children diagnosed with  
13 autism can often be helped with early administration of behavioral  
14 health treatment.
- 15 (e) There are several forms of evidence-based behavioral health  
16 treatment, including, but not limited to, applied behavioral analysis.
- 17 (f) Children diagnosed with autism respond differently to  
18 behavioral health treatment.
- 19 (g) It is critical that each child diagnosed with autism receives  
20 the specific type of evidence-based behavioral health treatment  
21 best suited to him or her, as prescribed by his or her physician or  
22 developed by a psychologist.
- 23 (h) The Legislature intends that all forms of evidence-based  
24 behavioral health treatment be covered by health care service plans,  
25 pursuant to Section 1374.73 of the Health and Safety Code, and  
26 health insurance policies, pursuant to Section 10144.51 of the  
27 Insurance Code.

1 (i) The Legislature intends that health care service plan provider  
2 networks include qualified professionals practicing all forms of  
3 evidence-based behavioral health treatment other than just applied  
4 behavioral analysis.

5 SEC. 2. Section 1374.73 of the Health and Safety Code is  
6 amended to read:

7 1374.73. (a) (1) Every health care service plan contract that  
8 provides hospital, medical, or surgical coverage shall also provide  
9 coverage for behavioral health treatment for pervasive  
10 developmental disorder or autism no later than July 1, 2012. The  
11 coverage shall be provided in the same manner and shall be subject  
12 to the same requirements as provided in Section 1374.72.

13 (2) Notwithstanding paragraph (1), as of the date that proposed  
14 final rulemaking for essential health benefits is issued, this section  
15 does not require ~~any~~ benefits to be provided that exceed the  
16 essential health benefits that all health plans will be required by  
17 federal regulations to provide under Section 1302(b) of the federal  
18 Patient Protection and Affordable Care Act (Public Law 111-148),  
19 as amended by the federal Health Care and Education  
20 Reconciliation Act of 2010 (Public Law 111-152).

21 (3) This section shall not affect services for which an individual  
22 is eligible pursuant to Division 4.5 (commencing with Section  
23 4500) of the Welfare and Institutions Code or Title 14  
24 (commencing with Section 95000) of the Government Code.

25 (4) This section shall not affect or reduce any obligation to  
26 provide services under an individualized education program, as  
27 defined in Section 56032 of the Education Code, or an individual  
28 service plan, as described in Section 5600.4 of the Welfare and  
29 Institutions Code, or under the federal Individuals with Disabilities  
30 Education Act (20 U.S.C. Sec. 1400 et seq.) and its implementing  
31 regulations.

32 (b) Every health care service plan subject to this section shall  
33 maintain an adequate network that includes qualified autism service  
34 providers who supervise and employ qualified autism service  
35 professionals or paraprofessionals who provide and administer  
36 behavioral health treatment. Nothing shall prevent a health care  
37 service plan from selectively contracting with providers within  
38 these requirements.

39 (c) For the purposes of this section, the following definitions  
40 shall apply:

1 (1) “Behavioral health treatment” means professional services  
2 and treatment programs, including applied behavior analysis and  
3 evidence-based behavior intervention programs, that develop or  
4 restore, to the maximum extent practicable, the functioning of an  
5 individual with pervasive developmental disorder or autism and  
6 that meet all of the following criteria:

7 (A) The treatment is prescribed by a physician and surgeon  
8 licensed pursuant to Chapter 5 (commencing with Section 2000)  
9 of, or is developed by a psychologist licensed pursuant to Chapter  
10 6.6 (commencing with Section 2900) of, Division 2 of the Business  
11 and Professions Code.

12 (B) The treatment is provided under a treatment plan prescribed  
13 by a qualified autism service provider and is administered by one  
14 of the following:

15 (i) A qualified autism service provider.

16 (ii) A qualified autism service professional supervised and  
17 employed by the qualified autism service provider.

18 (iii) A qualified autism service paraprofessional supervised and  
19 employed by a qualified autism service provider.

20 (C) The treatment plan has measurable goals over a specific  
21 timeline that is developed and approved by the qualified autism  
22 service provider for the specific patient being treated. The treatment  
23 plan shall be reviewed no less than once every six months by the  
24 qualified autism service provider and modified whenever  
25 appropriate, and shall be consistent with Section 4686.2 of the  
26 Welfare and Institutions Code pursuant to which the qualified  
27 autism service provider does all of the following:

28 (i) Describes the patient’s behavioral health impairments or  
29 developmental challenges that are to be treated.

30 (ii) Designs an intervention plan that includes the service type,  
31 number of hours, and parent participation needed to achieve the  
32 plan’s goal and objectives, and the frequency at which the patient’s  
33 progress is evaluated and reported.

34 (iii) Provides intervention plans that utilize evidence-based  
35 practices, with demonstrated clinical efficacy in treating pervasive  
36 developmental disorder or autism.

37 (iv) Discontinues intensive behavioral intervention services  
38 when the treatment goals and objectives are achieved or no longer  
39 appropriate.

1 (D) The treatment plan is not used for purposes of providing or  
2 for the reimbursement of respite, day care, or educational services  
3 and is not used to reimburse a parent for participating in the  
4 treatment program. The treatment plan shall be made available to  
5 the health care service plan upon request.

6 (2) “Pervasive developmental disorder or autism” shall have  
7 the same meaning and interpretation as used in Section 1374.72.

8 (3) “Qualified autism service provider” means either of the  
9 following:

10 (A) A person, entity, or group that is certified by a national  
11 entity, such as the Behavior Analyst Certification Board, that is  
12 accredited by the National Commission for Certifying Agencies,  
13 and who designs, supervises, or provides treatment for pervasive  
14 developmental disorder or autism, provided the services are within  
15 the experience and competence of the person, entity, or group that  
16 is nationally certified.

17 (B) A person licensed as a physician and surgeon, physical  
18 therapist, occupational therapist, psychologist, marriage and family  
19 therapist, educational psychologist, clinical social worker,  
20 professional clinical counselor, speech-language pathologist, or  
21 audiologist pursuant to Division 2 (commencing with Section 500)  
22 of the Business and Professions Code, who designs, supervises,  
23 or provides treatment for pervasive developmental disorder or  
24 autism, provided the services are within the experience and  
25 competence of the licensee.

26 (4) “Qualified autism service professional” means an individual  
27 who meets all of the following criteria:

28 (A) Provides behavioral health treatment.

29 (B) Is employed and supervised by a qualified autism service  
30 provider.

31 (C) Provides treatment pursuant to a treatment plan developed  
32 and approved by the qualified autism service provider.

33 (D) Is a behavioral service provider ~~approved~~ *who meets one*  
34 *of the following criteria:*

35 (i) *Is approved* as a vendor by a California regional center to  
36 provide services as an Associate Behavior Analyst, Behavior  
37 Analyst, Behavior Management Assistant, Behavior Management  
38 Consultant, or Behavior Management Program as defined in  
39 Section 54342 of Title 17 of the California Code of Regulations.

1 (ii) Possesses a bachelor of arts or science degree and has either  
2 of the following:

3 (I) Twelve semester units from an accredited institute of higher  
4 learning in either applied behavioral analysis or clinical  
5 coursework in behavioral health and one year of experience in  
6 designing or implementing behavioral health treatment.

7 (II) two years of experience in designing or implementing  
8 behavioral health treatment.

9 (iii) The person is a registered psychological assistant or  
10 registered psychologist pursuant to Chapter 6.6 (commencing with  
11 Section 2900) of Division 2 of the Business and Professions Code.

12 (iv) The person is an associate clinical social worker registered  
13 with the Board of Behavioral Sciences pursuant to Section 4996.18  
14 of the Business and Professions Code.

15 (E) Has training and experience in providing services for  
16 pervasive developmental disorder or autism pursuant to Division  
17 4.5 (commencing with Section 4500) of the Welfare and  
18 Institutions Code or Title 14 (commencing with Section 95000)  
19 of the Government Code.

20 (5) “Qualified autism service paraprofessional” means an  
21 unlicensed and uncertified individual who meets all of the  
22 following criteria:

23 (A) Is employed and supervised by a qualified autism service  
24 provider.

25 (B) Provides treatment and implements services pursuant to a  
26 treatment plan developed and approved by the qualified autism  
27 service provider.

28 (C) Meets the criteria set forth in the regulations adopted  
29 pursuant to Section 4686.3 of the Welfare and Institutions ~~Code~~  
30 *Code or meets all of the following:*

31 (i) Possesses a high school diploma or equivalent.

32 (ii) Has six months experience working with persons with a  
33 developmental disability.

34 (iii) Has 30 hours of training in the specific form of  
35 evidence-based behavioral health treatment administered by a  
36 qualified autism provider or qualified autism service professional.

37 (iv) Has successfully passed a background check conducted by  
38 a state-approved agency.

39 (D) Has adequate education, training, and experience, as  
40 certified by a qualified autism service provider.

- 1 (d) This section shall not apply to the following:
- 2 (1) A specialized health care service plan that does not deliver  
3 mental health or behavioral health services to enrollees.
- 4 (2) A health care service plan contract in the Medi-Cal program  
5 (Chapter 7 (commencing with Section 14000) of Part 3 of Division  
6 9 of the Welfare and Institutions Code).
- 7 (3) A health care service plan contract in the Healthy Families  
8 Program (Part 6.2 (commencing with Section 12693) of Division  
9 2 of the Insurance Code).
- 10 (4) A health care benefit plan or contract entered into with the  
11 Board of Administration of the Public Employees' Retirement  
12 System pursuant to the Public Employees' Medical and Hospital  
13 Care Act (Part 5 (commencing with Section 22750) of Division 5  
14 of Title 2 of the Government Code).
- 15 (e) Nothing in this section shall be construed to limit the  
16 obligation to provide services under Section 1374.72.
- 17 (f) As provided in Section 1374.72 and in paragraph (1) of  
18 subdivision (a), in the provision of benefits required by this section,  
19 a health care service plan may utilize case management, network  
20 providers, utilization review techniques, prior authorization,  
21 copayments, or other cost sharing.
- 22 (g) This section shall remain in effect only until January 1, 2017,  
23 and as of that date is repealed, unless a later enacted statute, that  
24 is enacted before January 1, 2017, deletes or extends that date.
- 25 SEC. 3. Section 10144.51 of the Insurance Code is amended  
26 to read:
- 27 10144.51. (a) (1) Every health insurance policy shall also  
28 provide coverage for behavioral health treatment for pervasive  
29 developmental disorder or autism no later than July 1, 2012. The  
30 coverage shall be provided in the same manner and shall be subject  
31 to the same requirements as provided in Section 10144.5.
- 32 (2) Notwithstanding paragraph (1), as of the date that proposed  
33 final rulemaking for essential health benefits is issued, this section  
34 does not require any benefits to be provided that exceed the  
35 essential health benefits that all health insurers will be required by  
36 federal regulations to provide under Section 1302(b) of the federal  
37 Patient Protection and Affordable Care Act (Public Law 111-148),  
38 as amended by the federal Health Care and Education  
39 Reconciliation Act of 2010 (Public Law 111-152).

1 (3) This section shall not affect services for which an individual  
2 is eligible pursuant to Division 4.5 (commencing with Section  
3 4500) of the Welfare and Institutions Code or Title 14  
4 (commencing with Section 95000) of the Government Code.

5 (4) This section shall not affect or reduce any obligation to  
6 provide services under an individualized education program, as  
7 defined in Section 56032 of the Education Code, or an individual  
8 service plan, as described in Section 5600.4 of the Welfare and  
9 Institutions Code, or under the federal Individuals with Disabilities  
10 Education Act (20 U.S.C. Sec. 1400 et seq.) and its implementing  
11 regulations.

12 (b) Pursuant to Article 6 (commencing with Section 2240) of  
13 Title 10 of the California Code of Regulations, every health insurer  
14 subject to this section shall maintain an adequate network that  
15 includes qualified autism service providers who supervise and  
16 employ qualified autism service professionals or paraprofessionals  
17 who provide and administer behavioral health treatment. Nothing  
18 shall prevent a health insurer from selectively contracting with  
19 providers within these requirements.

20 (c) For the purposes of this section, the following definitions  
21 shall apply:

22 (1) “Behavioral health treatment” means professional services  
23 and treatment programs, including applied behavior analysis and  
24 evidence-based behavior intervention programs, that develop or  
25 restore, to the maximum extent practicable, the functioning of an  
26 individual with pervasive developmental disorder or autism, and  
27 that meet all of the following criteria:

28 (A) The treatment is prescribed by a physician and surgeon  
29 licensed pursuant to Chapter 5 (commencing with Section 2000)  
30 of, or is developed by a psychologist licensed pursuant to Chapter  
31 6.6 (commencing with Section 2900) of, Division 2 of the Business  
32 and Professions Code.

33 (B) The treatment is provided under a treatment plan prescribed  
34 by a qualified autism service provider and is administered by one  
35 of the following:

- 36 (i) A qualified autism service provider.
- 37 (ii) A qualified autism service professional supervised and  
38 employed by the qualified autism service provider.
- 39 (iii) A qualified autism service paraprofessional supervised and  
40 employed by a qualified autism service provider.



1 (C) The treatment plan has measurable goals over a specific  
2 timeline that is developed and approved by the qualified autism  
3 service provider for the specific patient being treated. The treatment  
4 plan shall be reviewed no less than once every six months by the  
5 qualified autism service provider and modified whenever  
6 appropriate, and shall be consistent with Section 4686.2 of the  
7 Welfare and Institutions Code pursuant to which the qualified  
8 autism service provider does all of the following:

9 (i) Describes the patient’s behavioral health impairments or  
10 developmental challenges that are to be treated.

11 (ii) Designs an intervention plan that includes the service type,  
12 number of hours, and parent participation needed to achieve the  
13 plan’s goal and objectives, and the frequency at which the patient’s  
14 progress is evaluated and reported.

15 (iii) Provides intervention plans that utilize evidence-based  
16 practices, with demonstrated clinical efficacy in treating pervasive  
17 developmental disorder or autism.

18 (iv) Discontinues intensive behavioral intervention services  
19 when the treatment goals and objectives are achieved or no longer  
20 appropriate.

21 (D) The treatment plan is not used for purposes of providing or  
22 for the reimbursement of respite, day care, or educational services  
23 and is not used to reimburse a parent for participating in the  
24 treatment program. The treatment plan shall be made available to  
25 the insurer upon request.

26 (2) “Pervasive developmental disorder or autism” shall have  
27 the same meaning and interpretation as used in Section 10144.5.

28 (3) “Qualified autism service provider” means either of the  
29 following:

30 (A) A person, entity, or group that is certified by a national  
31 entity, such as the Behavior Analyst Certification Board, that is  
32 accredited by the National Commission for Certifying Agencies,  
33 and who designs, supervises, or provides treatment for pervasive  
34 developmental disorder or autism, provided the services are within  
35 the experience and competence of the person, entity, or group that  
36 is nationally certified.

37 (B) A person licensed as a physician and surgeon, physical  
38 therapist, occupational therapist, psychologist, marriage and family  
39 therapist, educational psychologist, clinical social worker,  
40 professional clinical counselor, speech-language pathologist, or

1 audiologist pursuant to Division 2 (commencing with Section 500)  
2 of the Business and Professions Code, who designs, supervises,  
3 or provides treatment for pervasive developmental disorder or  
4 autism, provided the services are within the experience and  
5 competence of the licensee.

6 (4) “Qualified autism service professional” means an individual  
7 who meets all of the following criteria:

8 (A) Provides behavioral health treatment.

9 (B) Is employed and supervised by a qualified autism service  
10 provider.

11 (C) Provides treatment pursuant to a treatment plan developed  
12 and approved by the qualified autism service provider.

13 (D) Is a behavioral service provider ~~approved~~ *who meets one*  
14 *of the following criteria:*

15 (i) *Is approved* as a vendor by a California regional center to  
16 provide services as an Associate Behavior Analyst, Behavior  
17 Analyst, Behavior Management Assistant, Behavior Management  
18 Consultant, or Behavior Management Program as defined in  
19 Section 54342 of Title 17 of the California Code of Regulations.

20 (ii) *Possesses a bachelor of arts or science degree and has either*  
21 *of the following:*

22 (I) *Twelve semester units from an accredited institute of higher*  
23 *learning in either applied behavioral analysis or clinical*  
24 *coursework in behavioral health and one year of experience in*  
25 *designing or implementing behavioral health treatment.*

26 (II) *Two years of experience in designing or implementing*  
27 *behavioral health treatment.*

28 (iii) *The person is a registered psychological assistant or*  
29 *registered psychologist pursuant to Chapter 6.6 (commencing with*  
30 *Section 2900) of Division 2 of the Business and Professions Code.*

31 (iv) *The person is an associate clinical social worker registered*  
32 *with the Board of Behavioral Sciences pursuant to Section 4996.18*  
33 *of the Business and Professions Code.*

34 (E) Has training and experience in providing services for  
35 pervasive developmental disorder or autism pursuant to Division  
36 4.5 (commencing with Section 4500) of the Welfare and  
37 Institutions Code or Title 14 (commencing with Section 95000)  
38 of the Government Code.

1 (5) “Qualified autism service paraprofessional” means an  
2 unlicensed and uncertified individual who meets all of the  
3 following criteria:

4 (A) Is employed and supervised by a qualified autism service  
5 provider.

6 (B) Provides treatment and implements services pursuant to a  
7 treatment plan developed and approved by the qualified autism  
8 service provider.

9 (C) Meets the criteria set forth in the regulations adopted  
10 pursuant to Section 4686.3 of the Welfare and Institutions Code.  
11 *Code or meets all of the following:*

12 (i) *Possesses a high school diploma or equivalent.*

13 (ii) *Has six months experience working with persons with a*  
14 *developmental disability.*

15 (iii) *Has 30 hours of training in the specific form of*  
16 *evidence-based behavioral health treatment administered by a*  
17 *qualified autism provider or qualified autism service professional.*

18 (iv) *Has successfully passed a background check conducted by*  
19 *a state-approved agency.*

20 (D) Has adequate education, training, and experience, as  
21 certified by a qualified autism service provider.

22 (d) This section shall not apply to the following:

23 (1) A specialized health insurance policy that does not cover  
24 mental health or behavioral health services or an accident only,  
25 specified disease, hospital indemnity, or Medicare supplement  
26 policy.

27 (2) A health insurance policy in the Medi-Cal program (Chapter  
28 7 (commencing with Section 14000) of Part 3 of Division 9 of the  
29 Welfare and Institutions Code).

30 (3) A health insurance policy in the Healthy Families Program  
31 (Part 6.2 (commencing with Section 12693)).

32 (4) A health care benefit plan or policy entered into with the  
33 Board of Administration of the Public Employees’ Retirement  
34 System pursuant to the Public Employees’ Medical and Hospital  
35 Care Act (Part 5 (commencing with Section 22750) of Division 5  
36 of Title 2 of the Government Code).

37 (e) Nothing in this section shall be construed to limit the  
38 obligation to provide services under Section 10144.5.

39 (f) As provided in Section 10144.5 and in paragraph (1) of  
40 subdivision (a), in the provision of benefits required by this section,

1 a health insurer may utilize case management, network providers,  
2 utilization review techniques, prior authorization, copayments, or  
3 other cost sharing.

4 (g) This section shall remain in effect only until January 1, 2017,  
5 and as of that date is repealed, unless a later enacted statute, that  
6 is enacted before January 1, 2017, deletes or extends that date.

# CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES

## BILL ANALYSIS

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**BILL NUMBER:** AB 832                      **VERSION:** AMENDED APRIL 16, 2015

**AUTHOR:** GARCIA                      **SPONSOR:** AUTHOR

**RECOMMENDED POSITION:** NONE

**SUBJECT:** CHILD ABUSE: REPORTABLE CONDUCT

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### **Overview:**

This bill would specify that voluntary acts of sodomy, oral copulation, and sexual penetration are not considered acts of sexual assault that must be reported by a mandated reporter, unless it is between a person age 21 or older and a minor under age 16.

### **Existing Law:**

- 1) Establishes the Child Abuse and Neglect Reporting Act (CANRA) which requires a mandated reporter to make a report in instances in which he or she knows or reasonably suspects that a child has been the victim of child abuse or neglect. (Penal Code (PC) 11164 et seq)
- 2) Defines "sexual abuse" for the purposes of CANRA as sexual assault or exploitation consisting of any of the following: rape, statutory rape, rape in concert, incest, sodomy, oral copulation, certain lewd or lascivious acts upon a child, sexual penetration, or child molestation. (PC §11165.1(a))
- 3) Except under certain specified circumstances, declares any person who participates in an act of sodomy or oral copulation with a person under age 18 shall be punished by up to one year in state prison or county jail. (PC §§ 286(b)(1), 288a(b)(1))
- 4) Except under certain specified circumstances, declares any person over age 21 who participates in an act of sodomy or oral copulation with someone under age 16 is guilty of a felony. (PC §§ 286(b)(2), 288a(b)(2))
- 5) States that a person who engages in unlawful sexual intercourse with a minor who is not more than three years older or three years younger, is guilty of a misdemeanor. (PC §261.5(b))
- 6) States that a person who engages in unlawful sexual intercourse with a minor who is not more than three years older or three years younger is guilty of a misdemeanor. (PC §261.5(b))

- 7) States that a person who engages in unlawful sexual intercourse with a minor who is more than three years younger is guilty of either a misdemeanor or a felony. (PC §261.5(c))
- 8) States that any person age 21 or older who engages in unlawful sexual intercourse with a minor under age 16 is guilty of either a misdemeanor or a felony. (PC §261.5(d))

**This Bill:**

- 1) Specifies that voluntary acts of sodomy, oral copulation, or sexual penetration are not considered to be mandated reports of sexual assault under CANRA, unless the conduct is between a person age 21 or older and a minor under age 16. (PC §11165.1(a))

**Comment:**

- 1) **Author's Intent.** The author's office states that the reporting requirements for mandated reporters of child abuse are confusing, inconsistent, and discriminatory.

They note that current law states that consensual sodomy and oral copulation is illegal with anyone under age 18, and that it requires a mandated report as sexual assault under CANRA. However, the same reporting standards do not apply to consensual heterosexual intercourse.

The author is attempting to make the law consistent by ensuring that all types of voluntary activities are treated equally for purposes of mandated reporting under CANRA.

- 2) **Background.** The Board examined this issue in 2013 when stakeholders expressed concern that consensual oral copulation and sodomy among minors were mandated reports under CANRA, while other types of consensual sexual activity were not.

However, at the same time, staffers at the Legislature contacted Board staff to caution that there had been past legal opinions stating that this interpretation of CANRA was incorrect, and that amendments could potentially have ramifications for family planning agencies.

The Board was concerned about a potential legal misinterpretation of CANRA, but at the same time saw this as a valid effort. Therefore, it directed staff to obtain a legal opinion from the DCA legal office.

- 3) **DCA Legal Opinion.** In its legal opinion, DCA found that CANRA does not require a mandated reporter to report incidents of consensual sex between minors of a similar age for any actions described in PC Section 11165.1, unless there is reasonable suspicion of force, exploitation, or other abuse. DCA also found the following, based on past court cases:

- Courts have found that the legislative intent of the reporting law is to leave the distinction between abusive and non-abusive sexual relations to the judgment of professionals who deal with children.
- Review of other legal cases has found that the law does not require reporting of consensual sexual activities between similarly-aged minors for any sexual acts unless there is evidence of abuse.

4) **Board of Psychology Action.** The Board of Psychology is seeking an opinion from the Attorney General’s Office on the laws regarding mandated reporting, specifically whether consensual sexual conduct between minors of a like age differs depending upon the type of sexual conduct described by the minor.

The Board of Psychology asked the AG to resolve the following legal questions:

1. The Child Abuse and Neglect Reporting Act (CANRA; Pen. Code, sec. 11164 et seq.) requires “mandated reporters” to report instances of child sexual abuse, assault, and exploitation to specified law enforcement and/or child protection agencies. Does this requirement include the mandatory reporting of voluntary acts of sexual intercourse, oral copulation, or sodomy between minors of a like age?
2. Under CANRA is the activity of mobile device “sexting,” between minors of a like age, a form of reportable sexual exploitation?
3. Does CANRA require a mandated reporter to relay third-party reports of downloading, streaming, or otherwise accessing child pornography through electronic or digital media?

The opinion was sent to the AG by Assemblywoman Garcia. A response is expected this summer.

5) **Possible Amendment Needed.** Board staff had a discussion with the author’s office to verify a question about how the amendments would affect the reportability of a situation of sexual activities between an adult under 21 and a significantly younger minor. For example, would an act of sodomy or oral copulation between a 20 year old and a 10 year old still be reportable under the law, even though it doesn’t fall under age range prescribed in the amendments?

Staff believes such an act would be reportable due to the provisions of Penal Code Section 288 (which addresses lewd and lascivious acts with someone under 14). However, the author’s office is in the process of consulting with Legislative Counsel on this issue, and will pursue further amendments if necessary.

6) **Previous Legislation.** AB 1505 (Garcia, 2014) would have specified that consensual acts of sodomy and oral copulation are not acts of sexual assault that must be reported by a mandated reporter, unless it involved either a person over age 21 or a minor under age 16.

At its April 2014 meeting, the Policy and Advocacy Committee recommended that the Board take a “support” position on this bill. However, AB 1505 died before the Board was able to take a position on it.

## 7) **Support and Opposition.**

### Support:

- American Association for Marriage and Family Therapy, California Division
- American Civil Liberties Union of California
- California Public Defenders Association
- Equality California
- Gerry Grossman Seminars
- National Center for Youth Law
- 144 private individuals

### Opposition

- California District Attorneys Association

## 8) **History**

### **2015**

04/16/2015 Apr. 16 Read second time and amended.

04/15/2015 Apr. 15 From committee: Amend, and do pass as amended and re-refer to Com. on APPR. (Ayes 5. Noes 2.) (April 7).

03/12/2015 Mar. 12 Referred to Com. on PUB. S.

02/27/2015 Feb. 27 From printer. May be heard in committee March 29.

02/26/2015 Feb. 26 Read first time. To print.

## 9) **Attachments**

**Attachment A:** DCA Legal Opinion: Evaluation of CANRA Reform Proposal Related to Reporting of Consensual Sex Between Minors

**Attachment B:** Relevant Code Sections: Penal Code Sections 261.5, 286, 288, 288a, and 289

**Attachment C:** CAMFT Article: “Reporting Consensual Activity Between Minors: The Confusion Unraveled,” by Cathy Atkins, Revised May 2013

**Attachment D:** Santa Clara County Child Abuse Council “Child Abuse Reporting Guidelines for Sexual Activity Between and with Minors”

**Attachment E:** Santa Clara County information sheet for mandated reporters: “Mandated Reporters: When Must you Report Consensual Sexual Activity Involving Minors?”



AMENDED IN ASSEMBLY APRIL 16, 2015

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

**ASSEMBLY BILL**

**No. 832**

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**Introduced by Assembly Member Cristina Garcia**  
*(Coauthor: Assembly Member Eggman)*

February 26, 2015

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An act to amend Section 11165.1 of the Penal Code, relating to child abuse.

LEGISLATIVE COUNSEL'S DIGEST

AB 832, as amended, Cristina Garcia. Child abuse: reportable conduct.

The Child Abuse and Neglect Reporting Act requires a mandated reporter, as defined, to make a report to a specified agency whenever the mandated reporter, in his or her professional capacity or within the scope of his or her employment, has knowledge of or observes a child whom the mandated reporter knows or reasonably suspects has been the victim of child abuse or neglect. Existing law provides that “child abuse or neglect” for these purposes includes “sexual assault,” that includes, among other things, the crimes of sodomy, oral copulation, and sexual penetration.

This bill would provide that “sexual assault” for these purposes does not include ~~consensual~~ *voluntary* sodomy, oral copulation, or sexual penetration, unless that conduct is between a person who is 21 years of age or older and a minor who is under 16 years of age.

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

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

1 SECTION 1. Section 11165.1 of the Penal Code is amended  
2 to read:

3 11165.1. As used in this article, “sexual abuse” means sexual  
4 assault or sexual exploitation as defined by the following:

5 (a) “Sexual assault” means conduct in violation of one or more  
6 of the following sections: Section 261 (rape), subdivision (d) of  
7 Section 261.5 (statutory rape), 264.1 (rape in concert), 285 (incest),  
8 286 (sodomy), subdivision (a) or ~~(b)~~; *(b) of*, or paragraph (1) of  
9 subdivision (c) ~~of~~ *of*, Section 288 (lewd or lascivious acts upon a  
10 child), 288a (oral copulation), 289 (sexual penetration), or 647.6  
11 (child molestation). “Sexual assault” for the purposes of this article  
12 does not include ~~consensual~~ *voluntary* conduct in violation of  
13 Section 286, 288a, or 289, unless the conduct is between a person  
14 21 years of age or older and a minor who is under 16 years of age.

15 (b) Conduct described as “sexual assault” includes, but is not  
16 limited to, all of the following:

17 (1) Penetration, however slight, of the vagina or anal opening  
18 of one person by the penis of another person, whether or not there  
19 is the emission of semen.

20 (2) Sexual contact between the genitals or anal opening of one  
21 person and the mouth or tongue of another person.

22 (3) Intrusion by one person into the genitals or anal opening of  
23 another person, including the use of an object for this purpose,  
24 except that, it does not include acts performed for a valid medical  
25 purpose.

26 (4) The intentional touching of the genitals or intimate parts,  
27 including the breasts, genital area, groin, inner thighs, and buttocks,  
28 or the clothing covering them, of a child, or of the perpetrator by  
29 a child, for purposes of sexual arousal or gratification, except that  
30 it does not include acts which may reasonably be construed to be  
31 normal caretaker responsibilities; interactions with, or  
32 demonstrations of affection for, the child; or acts performed for a  
33 valid medical purpose.

34 (5) The intentional masturbation of the perpetrator’s genitals in  
35 the presence of a child.

36 (c) “Sexual exploitation” refers to any of the following:

37 (1) Conduct involving matter depicting a minor engaged in  
38 obscene acts in violation of Section 311.2 (preparing, selling, or

1 distributing obscene matter) or subdivision (a) of Section 311.4  
2 (employment of a minor to perform obscene acts).

3 (2) A person who knowingly promotes, aids, or assists, employs,  
4 uses, persuades, induces, or coerces a child, or a person responsible  
5 for a child's welfare, who knowingly permits or encourages a child  
6 to engage in, or assist others to engage in, prostitution or a live  
7 performance involving obscene sexual conduct, or to either pose  
8 or model alone or with others for purposes of preparing a film,  
9 photograph, negative, slide, drawing, painting, or other pictorial  
10 depiction, involving obscene sexual conduct. For the purpose of  
11 this section, "person responsible for a child's welfare" means a  
12 parent, guardian, foster parent, or a licensed administrator or  
13 employee of a public or private residential home, residential school,  
14 or other residential institution.

15 (3) A person who depicts a child in, or who knowingly develops,  
16 duplicates, prints, downloads, streams, accesses through any  
17 electronic or digital media, or exchanges, a film, photograph,  
18 videotape, video recording, negative, or slide in which a child is  
19 engaged in an act of obscene sexual conduct, except for those  
20 activities by law enforcement and prosecution agencies and other  
21 persons described in subdivisions (c) and (e) of Section 311.3.



## MEMORANDUM

DATE	April 11, 2013
TO	Kim Madsen Members of the Board of Behavioral Sciences
FROM	DIANNE R. DOBBS Senior Staff Counsel, Legal Affairs
SUBJECT	<b>Evaluation of CANRA Reform Proposal Related to Reporting of Consensual Sex Between Minors</b>

Following presentation by Benjamin E. Caldwell, PsyD of a proposal to amend portions of the Child Abuse and Neglect Reporting Act ("CANRA") at the board meeting on February 28, 2013, the board requested a legal opinion on the proposal. The proposal seeks to amend CANRA to remove sodomy and oral copulation from the definition of sexual abuse, assault or exploitation. The purpose of the modification is to address concerns of mandated reporting in situations of consensual acts falling within these definitions when the actors are minors of like age under the law and the actions do not otherwise suggest other indications of abuse or neglect.

### QUESTIONS PRESENTED

1. As written does Penal Code section 11165.1 require practitioners to report all conduct by minors that fall under the definition of sodomy and oral copulation?
2. Does the legal interpretation of CANRA warrant support of the proposed amendments?

### SHORT ANSWERS

1. No. Court interpretation of CANRA dating back to 1986, and followed as recently as 2005 confirms that minors under and over age 14 can lawfully engage in consensual sexual activities with minors of a like age, and that not all sexual conduct involving a minor necessarily constitutes a violation of the law. That as such, a mandated reporter is required to report only those conditions and situations where the reporter has reason to know or suspects resulted from sexual conduct between the minor and an older adolescent or an adult and those contacts which resulted from undue influence, cohesion, use of force or other indicators of abuse.

2. No. Because practitioners are not required to report any non-abusive consensual sexual activities between minors of like age, amendment of the law is not necessary and should not be supported.

### STATEMENT OF FACTS/BACKGROUND

1. Benjamin Caldwell PhD, ("Dr. Caldwell") Legislative and Advocacy Committee Chair of the American Association of Marriage and Family Therapy – California Division seeks to amend CANRA and is seeking the support of the Board of Behavioral Sciences ("Board").
2. Dr. Caldwell claims that CANRA's inclusion of sodomy and oral copulation in the definition of sexual assault found in Penal Code section 11165.1<sup>1</sup> requires mandated reporters to report all homosexual activities meeting these definitions whether or not the acts are consensual and not otherwise suggestive of abuse.
3. The Senior Legislative Assistant of Assembly member Tom Ammiano believes that Dr. Caldwell and others are misinterpreting CANRA.

### ANALYSIS

CANRA does not require a mandated reporter to report incidents of consensual sex between minors of similar age, as provided in section 261.5, absent reasonable suspicion of force, exploitation or other indications of abuse. The California Court of Appeal decided this issue in its 1988 ruling in *Planned Parenthood v. Van De Kamp*. *Planned Parenthood v. Van De Kamp* (1988) 181 Cal.App.3e 245. In that case, Planned Parenthood sought to enjoin implementation of CANRA following an opinion of the Attorney General which provided that the inclusion of section 288 in the definition of sexual assault found in section 11165.1 (a) meant that all sexual activities between and with minors under age 14 was reportable. 67 Ops. Cal. Atty. Gen. 235 (1984).

In nullifying the AG's opinion, the court explored the legislative history and intent of CANRA and held that the legislative intent of the reporting law was to leave the distinction between abusive and non-abusive sexual relations to the judgment of those professionals who deal with children and who are by virtue of their training and experience particularly well suited to such judgment. The court reasoned that while the voluntary sexual conduct among minors under the age of 14 may be ill advised, it is not encompassed by section 288, and that the inclusion of that section in the reporting law does not mandate reporting of such activities. Id at 276.

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<sup>1</sup> All further citations are to the Penal Code unless otherwise specified.

After the court's ruling in *Planned Parenthood*, the Legislature amended CANRA and did nothing to nullify or change the effect of the court's decision. As such, the Legislature is deemed to have approved the interpretation because where a statute has been construed by judicial decision and that construction is not altered by subsequent legislation, it must be presumed that the Legislature is aware of the judicial construction and approved of it. See *People v. Stockton* (1988) 203 Cal.App.3d 225, citing *Wilkoff v. Superior Ct.*

Following *Planned Parenthood* several other Court of Appeal cases adopted the reasoning of the court including *People v. Stockton* later in 1988, and most recently with *People v. Davis* in 2005. All these cases discuss the CANRA reporting requirements in the context of section 288 which relates to lewd and lascivious conduct with minors under 14. Though none of the cases discuss any of the other acts which also constitute sexual assault under section 11165.1(a), the same reasoning applies to those acts in that absent other indications of abuse, the law does not require the reporting of consensual sexual activities between minors of similar age for any of these acts. This interpretation is consistent with the well settled legal principle that statutes are to be construed with reference to the entire system of law of which they are a part, including the various codes, and harmonized wherever possible to achieve a reasonable result. *Cossack v. City of Los Angeles* (1974) 11 Cal.3d 726, 732.

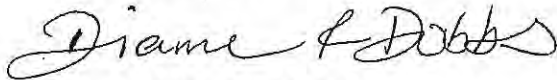
Dr. Caldwell claims that section 11165.1(a) requires mandated reporters to report all minors engaged in sodomy and oral copulation even where the conduct is consensual and is devoid of evidence of abuse is not supported by the law. All conduct enumerated in section 11165.1(a) must be treated the same for purposes of reporting. To interpret the law otherwise would be against the intent of the legislature to leave the distinction between abusive and non-abusive sexual relations to the judgment of the professionals. An interpretation that would require the reporting of all sodomy and oral copulation without reasonable suspicion of abuse would lead to an absurd result. The court in *Planned Parenthood* said it best when it stated, "...statutes must be construed in a reasonable and commonsense manner consistent with their apparent purpose and the legislative intent underlying them, practical rather than technical, and promoting a wise policy rather than mischief or absurdity. Even a statute's literal terms will not be given effect if to do so would yield an unreasonable or mischievous result." *Planned Parenthood* at 245. Therefore, sexual conduct of minors that meet the definition of sodomy and oral copulation must be treated as all other sexual conduct noted in section 11165.1(a) and is only reported if the acts are nonconsensual, abusive or involves minors of disparate ages, conduct between minors and adults, and situations where there is reasonable suspicion of undue influence, coercion, force or other indicators of abuse.

Section 11165.1(b) further outlines limited examples of conduct which qualifies as sexual assault. There is also no evidence that any of the examples in that section would lead to a discriminatory result to justify removal of sodomy or oral copulation from subsection (a).

CONCLUSION

It is our opinion that CANRA does not require mandated reporters to report consensual sex between minors of like age for any of the actions noted in section 11165.1 unless the practitioner reasonably suspects that the conduct resulted from force, undue influence, coercion, or other indicators of abuse. Accordingly, it is not necessary to amend the statute to remove sodomy and oral copulation, as those acts are not treated differently from other acts outlined in the code.

DOREATHEA JOHNSON  
Deputy Director, Legal Affairs



By: DIANNE R. DOBBS  
Senior Staff Counsel  
Legal Affairs

**Attachment B**  
**Relevant Code Sections**

**Penal Code (PC)**

**PC §261.5.**

(a) Unlawful sexual intercourse is an act of sexual intercourse accomplished with a person who is not the spouse of the perpetrator, if the person is a minor. For the purposes of this section, a “minor” is a person under the age of 18 years and an “adult” is a person who is at least 18 years of age.

(b) Any person who engages in an act of unlawful sexual intercourse with a minor who is not more than three years older or three years younger than the perpetrator, is guilty of a misdemeanor.

(c) Any person who engages in an act of unlawful sexual intercourse with a minor who is more than three years younger than the perpetrator is guilty of either a misdemeanor or a felony, and shall be punished by imprisonment in a county jail not exceeding one year, or by imprisonment pursuant to subdivision (h) of Section 1170.

(d) Any person 21 years of age or older who engages in an act of unlawful sexual intercourse with a minor who is under 16 years of age is guilty of either a misdemeanor or a felony, and shall be punished by imprisonment in a county jail not exceeding one year, or by imprisonment pursuant to subdivision (h) of Section 1170 for two, three, or four years.

(e) (1) Notwithstanding any other provision of this section, an adult who engages in an act of sexual intercourse with a minor in violation of this section may be liable for civil penalties in the following amounts:

(A) An adult who engages in an act of unlawful sexual intercourse with a minor less than two years younger than the adult is liable for a civil penalty not to exceed two thousand dollars (\$2,000).

(B) An adult who engages in an act of unlawful sexual intercourse with a minor at least two years younger than the adult is liable for a civil penalty not to exceed five thousand dollars (\$5,000).

(C) An adult who engages in an act of unlawful sexual intercourse with a minor at least three years younger than the adult is liable for a civil penalty not to exceed ten thousand dollars (\$10,000).

(D) An adult over the age of 21 years who engages in an act of unlawful sexual intercourse with a minor under 16 years of age is liable for a civil penalty not to exceed twenty-five thousand dollars (\$25,000).



(2) The district attorney may bring actions to recover civil penalties pursuant to this subdivision. From the amounts collected for each case, an amount equal to the costs of pursuing the action shall be deposited with the treasurer of the county in which the judgment was entered, and the remainder shall be deposited in the Underage Pregnancy Prevention Fund, which is hereby created in the State Treasury. Amounts deposited in the Underage Pregnancy Prevention Fund may be used only for the purpose of preventing underage pregnancy upon appropriation by the Legislature.

(3) In addition to any punishment imposed under this section, the judge may assess a fine not to exceed seventy dollars (\$70) against any person who violates this section with the proceeds of this fine to be used in accordance with Section 1463.23. The court shall, however, take into consideration the defendant's ability to pay, and no defendant shall be denied probation because of his or her inability to pay the fine permitted under this subdivision.

### **PC §286.**

(a) Sodomy is sexual conduct consisting of contact between the penis of one person and the anus of another person. Any sexual penetration, however slight, is sufficient to complete the crime of sodomy.

(b) (1) Except as provided in Section 288, any person who participates in an act of sodomy with another person who is under 18 years of age shall be punished by imprisonment in the state prison, or in a county jail for not more than one year.

(2) Except as provided in Section 288, any person over 21 years of age who participates in an act of sodomy with another person who is under 16 years of age shall be guilty of a felony.

(c) (1) Any person who participates in an act of sodomy with another person who is under 14 years of age and more than 10 years younger than he or she shall be punished by imprisonment in the state prison for three, six, or eight years.

(2) (A) Any person who commits an act of sodomy when the act is accomplished against the victim's will by means of force, violence, duress, menace, or fear of immediate and unlawful bodily injury on the victim or another person shall be punished by imprisonment in the state prison for three, six, or eight years.

(B) Any person who commits an act of sodomy with another person who is under 14 years of age when the act is accomplished against the victim's will by means of force, violence, duress, menace, or fear of immediate and unlawful bodily injury on the victim or another person shall be punished by imprisonment in the state prison for 9, 11, or 13 years.

(C) Any person who commits an act of sodomy with another person who is a minor 14 years of age or older when the act is accomplished against the victim's will by means of force, violence, duress, menace, or fear of immediate and unlawful bodily injury on the victim or another person shall be punished by imprisonment in the state prison for 7, 9, or 11 years.

(D) This paragraph does not preclude prosecution under Section 269, Section 288.7, or any other provision of law.

(3) Any person who commits an act of sodomy where the act is accomplished against the victim's will by threatening to retaliate in the future against the victim or any other person, and there is a reasonable possibility that the perpetrator will execute the threat, shall be punished by imprisonment in the state prison for three, six, or eight years.

(d) (1) Any person who, while voluntarily acting in concert with another person, either personally or aiding and abetting that other person, commits an act of sodomy when the act is accomplished against the victim's will by means of force or fear of immediate and unlawful bodily injury on the victim or another person or where the act is accomplished against the victim's will by threatening to retaliate in the future against the victim or any other person, and there is a reasonable possibility that the perpetrator will execute the threat, shall be punished by imprisonment in the state prison for five, seven, or nine years.

(2) Any person who, while voluntarily acting in concert with another person, either personally or aiding and abetting that other person, commits an act of sodomy upon a victim who is under 14 years of age, when the act is accomplished against the victim's will by means of force or fear of immediate and unlawful bodily injury on the victim or another person, shall be punished by imprisonment in the state prison for 10, 12, or 14 years.

(3) Any person who, while voluntarily acting in concert with another person, either personally or aiding and abetting that other person, commits an act of sodomy upon a victim who is a minor 14 years of age or older, when the act is accomplished against the victim's will by means of force or fear of immediate and unlawful bodily injury on the victim or another person, shall be punished by imprisonment in the state prison for 7, 9, or 11 years.

(4) This subdivision does not preclude prosecution under Section 269, Section 288.7, or any other provision of law.

(e) Any person who participates in an act of sodomy with any person of any age while confined in any state prison, as defined in Section 4504, or in any local detention facility, as defined in Section 6031.4, shall be punished by imprisonment in the state prison, or in a county jail for not more than one year.

(f) Any person who commits an act of sodomy, and the victim is at the time unconscious of the nature of the act and this is known to the person committing the act, shall be punished by imprisonment in the state prison for three, six, or eight years. As used in this subdivision, "unconscious of the nature of the act" means incapable of resisting because the victim meets one of the following conditions:

(1) Was unconscious or asleep.

(2) Was not aware, knowing, perceiving, or cognizant that the act occurred.

(3) Was not aware, knowing, perceiving, or cognizant of the essential characteristics of the act due to the perpetrator's fraud in fact.

(4) Was not aware, knowing, perceiving, or cognizant of the essential characteristics of the act due to the perpetrator's fraudulent representation that the sexual penetration served a professional purpose when it served no professional purpose.

(g) Except as provided in subdivision (h), a person who commits an act of sodomy, and the victim is at the time incapable, because of a mental disorder or developmental or physical disability, of giving legal consent, and this is known or reasonably should be known to the person committing the act, shall be punished by imprisonment in the state prison for three, six, or eight years. Notwithstanding the existence of a conservatorship pursuant to the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code), the prosecuting attorney shall prove, as an element of the crime, that a mental disorder or developmental or physical disability rendered the alleged victim incapable of giving consent.

(h) Any person who commits an act of sodomy, and the victim is at the time incapable, because of a mental disorder or developmental or physical disability, of giving legal consent, and this is known or reasonably should be known to the person committing the act, and both the defendant and the victim are at the time confined in a state hospital for the care and treatment of the mentally disordered or in any other public or private facility for the care and treatment of the mentally disordered approved by a county mental health director, shall be punished by imprisonment in the state prison, or in a county jail for not more than one year. Notwithstanding the existence of a conservatorship pursuant to the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code), the prosecuting attorney shall prove, as an element of the crime, that a mental disorder or developmental or physical disability rendered the alleged victim incapable of giving legal consent.

(i) Any person who commits an act of sodomy, where the victim is prevented from resisting by an intoxicating or anesthetic substance, or any controlled substance, and this condition was known, or reasonably should have been known by the accused, shall be punished by imprisonment in the state prison for three, six, or eight years.

(j) Any person who commits an act of sodomy, where the victim submits under the belief that the person committing the act is someone known to the victim other than the accused, and this belief is induced by any artifice, pretense, or concealment practiced by the accused, with intent to induce the belief, shall be punished by imprisonment in the state prison for three, six, or eight years.

(k) Any person who commits an act of sodomy, where the act is accomplished against the victim's will by threatening to use the authority of a public official to incarcerate, arrest, or deport the victim or another, and the victim has a reasonable belief that the perpetrator is a public official, shall be punished by imprisonment in the state prison for three, six, or eight years.

As used in this subdivision, "public official" means a person employed by a governmental agency who has the authority, as part of that position, to incarcerate, arrest, or deport another. The perpetrator does not actually have to be a public official.

(l) As used in subdivisions (c) and (d), "threatening to retaliate" means a threat to kidnap or falsely imprison, or inflict extreme pain, serious bodily injury, or death.

(m) In addition to any punishment imposed under this section, the judge may assess a fine not to exceed seventy dollars (\$70) against any person who violates this section, with the proceeds of this fine to be used in accordance with Section 1463.23. The court, however, shall take into consideration the defendant's ability to pay, and no defendant shall be denied probation because of his or her inability to pay the fine permitted under this subdivision.

### **PC §288.**

(a) Except as provided in subdivision (i), any person who willfully and lewdly commits any lewd or lascivious act, including any of the acts constituting other crimes provided for in Part 1, upon or with the body, or any part or member thereof, of a child who is under the age of 14 years, with the intent of arousing, appealing to, or gratifying the lust, passions, or sexual desires of that person or the child, is guilty of a felony and shall be punished by imprisonment in the state prison for three, six, or eight years.

(b) (1) Any person who commits an act described in subdivision (a) by use of force, violence, duress, menace, or fear of immediate and unlawful bodily injury on the victim or another person, is guilty of a felony and shall be punished by imprisonment in the state prison for 5, 8, or 10 years.

(2) Any person who is a caretaker and commits an act described in subdivision (a) upon a dependent person by use of force, violence, duress, menace, or fear of immediate and unlawful bodily injury on the victim or another person, with the intent described in subdivision (a), is guilty of a felony and shall be punished by imprisonment in the state prison for 5, 8, or 10 years.

(c) (1) Any person who commits an act described in subdivision (a) with the intent described in that subdivision, and the victim is a child of 14 or 15 years, and that person is at least 10 years older than the child, is guilty of a public offense and shall be punished by imprisonment in the state prison for one, two, or three years, or by imprisonment in a county jail for not more than one year. In determining whether the person is at least 10 years older than the child, the difference in age shall be measured from the birth date of the person to the birth date of the child.

(2) Any person who is a caretaker and commits an act described in subdivision (a) upon a dependent person, with the intent described in subdivision (a), is guilty of a public offense and shall be punished by imprisonment in the state prison for one, two, or three years, or by imprisonment in a county jail for not more than one year.

(d) In any arrest or prosecution under this section or Section 288.5, the peace officer, district attorney, and the court shall consider the needs of the child victim or dependent person and

shall do whatever is necessary, within existing budgetary resources, and constitutionally permissible to prevent psychological harm to the child victim or to prevent psychological harm to the dependent person victim resulting from participation in the court process.

(e) Upon the conviction of any person for a violation of subdivision (a) or (b), the court may, in addition to any other penalty or fine imposed, order the defendant to pay an additional fine not to exceed ten thousand dollars (\$10,000). In setting the amount of the fine, the court shall consider any relevant factors, including, but not limited to, the seriousness and gravity of the offense, the circumstances of its commission, whether the defendant derived any economic gain as a result of the crime, and the extent to which the victim suffered economic losses as a result of the crime. Every fine imposed and collected under this section shall be deposited in the Victim-Witness Assistance Fund to be available for appropriation to fund child sexual exploitation and child sexual abuse victim counseling centers and prevention programs pursuant to Section 13837.

If the court orders a fine imposed pursuant to this subdivision, the actual administrative cost of collecting that fine, not to exceed 2 percent of the total amount paid, may be paid into the general fund of the county treasury for the use and benefit of the county.

(f) For purposes of paragraph (2) of subdivision (b) and paragraph (2) of subdivision (c), the following definitions apply:

(1) "Caretaker" means an owner, operator, administrator, employee, independent contractor, agent, or volunteer of any of the following public or private facilities when the facilities provide care for elder or dependent persons:

(A) Twenty-four hour health facilities, as defined in Sections 1250, 1250.2, and 1250.3 of the Health and Safety Code.

(B) Clinics.

(C) Home health agencies.

(D) Adult day health care centers.

(E) Secondary schools that serve dependent persons and postsecondary educational institutions that serve dependent persons or elders.

(F) Sheltered workshops.

(G) Camps.

(H) Community care facilities, as defined by Section 1402 of the Health and Safety Code, and residential care facilities for the elderly, as defined in Section 1569.2 of the Health and Safety Code.

(I) Respite care facilities.

(J) Foster homes.

(K) Regional centers for persons with developmental disabilities.

(L) A home health agency licensed in accordance with Chapter 8 (commencing with Section 1725) of Division 2 of the Health and Safety Code.

(M) An agency that supplies in-home supportive services.

(N) Board and care facilities.

(O) Any other protective or public assistance agency that provides health services or social services to elder or dependent persons, including, but not limited to, in-home supportive services, as defined in Section 14005.14 of the Welfare and Institutions Code.

(P) Private residences.

(2) "Board and care facilities" means licensed or unlicensed facilities that provide assistance with one or more of the following activities:

(A) Bathing.

(B) Dressing.

(C) Grooming.

(D) Medication storage.

(E) Medical dispensation.

(F) Money management.

(3) "Dependent person" means any person who has a physical or mental impairment that substantially restricts his or her ability to carry out normal activities or to protect his or her rights, including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have significantly diminished because of age. "Dependent person" includes any person who is admitted as an inpatient to a 24-hour health facility, as defined in Sections 1250, 1250.2, and 1250.3 of the Health and Safety Code.

(g) Paragraph (2) of subdivision (b) and paragraph (2) of subdivision (c) apply to the owners, operators, administrators, employees, independent contractors, agents, or volunteers working at these public or private facilities and only to the extent that the individuals personally commit, conspire, aid, abet, or facilitate any act prohibited by paragraph (2) of subdivision (b) and paragraph (2) of subdivision (c).

(h) Paragraph (2) of subdivision (b) and paragraph (2) of subdivision (c) do not apply to a caretaker who is a spouse of, or who is in an equivalent domestic relationship with, the dependent person under care.

(i) (1) Any person convicted of a violation of subdivision (a) shall be imprisoned in the state prison for life with the possibility of parole if the defendant personally inflicted bodily harm upon the victim.

(2) The penalty provided in this subdivision shall only apply if the fact that the defendant personally inflicted bodily harm upon the victim is pled and proved.

(3) As used in this subdivision, "bodily harm" means any substantial physical injury resulting from the use of force that is more than the force necessary to commit the offense.

**PC §288a.**

(a) Oral copulation is the act of copulating the mouth of one person with the sexual organ or anus of another person.

(b) (1) Except as provided in Section 288, any person who participates in an act of oral copulation with another person who is under 18 years of age shall be punished by imprisonment in the state prison, or in a county jail for a period of not more than one year.

(2) Except as provided in Section 288, any person over 21 years of age who participates in an act of oral copulation with another person who is under 16 years of age is guilty of a felony.

(c) (1) Any person who participates in an act of oral copulation with another person who is under 14 years of age and more than 10 years younger than he or she shall be punished by imprisonment in the state prison for three, six, or eight years.

(2) (A) Any person who commits an act of oral copulation when the act is accomplished against the victim's will by means of force, violence, duress, menace, or fear of immediate and unlawful bodily injury on the victim or another person shall be punished by imprisonment in the state prison for three, six, or eight years.

(B) Any person who commits an act of oral copulation upon a person who is under 14 years of age, when the act is accomplished against the victim's will by means of force, violence, duress, menace, or fear of immediate and unlawful bodily injury on the victim or another person, shall be punished by imprisonment in the state prison for 8, 10, or 12 years.

(C) Any person who commits an act of oral copulation upon a minor who is 14 years of age or older, when the act is accomplished against the victim's will by means of force, violence, duress, menace, or fear of immediate and unlawful bodily injury on the victim or another person, shall be punished by imprisonment in the state prison for 6, 8, or 10 years.

(D) This paragraph does not preclude prosecution under Section 269, Section 288.7, or any other provision of law.

(3) Any person who commits an act of oral copulation where the act is accomplished against the victim's will by threatening to retaliate in the future against the victim or any other person, and there is a reasonable possibility that the perpetrator will execute the threat, shall be punished by imprisonment in the state prison for three, six, or eight years.

(d) (1) Any person who, while voluntarily acting in concert with another person, either personally or by aiding and abetting that other person, commits an act of oral copulation (A) when the act is accomplished against the victim's will by means of force or fear of immediate and unlawful bodily injury on the victim or another person, or (B) where the act is accomplished against the victim's will by threatening to retaliate in the future against the victim or any other person, and there is a reasonable possibility that the perpetrator will execute the threat, or (C) where the victim is at the time incapable, because of a mental disorder or developmental or physical disability, of giving legal consent, and this is known or reasonably should be known to the person committing the act, shall be punished by imprisonment in the state prison for five, seven, or nine years. Notwithstanding the appointment of a conservator with respect to the victim pursuant to the provisions of the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code), the prosecuting attorney shall prove, as an element of the crime described under paragraph (3), that a mental disorder or developmental or physical disability rendered the alleged victim incapable of giving legal consent.

(2) Any person who, while voluntarily acting in concert with another person, either personally or aiding and abetting that other person, commits an act of oral copulation upon a victim who is under 14 years of age, when the act is accomplished against the victim's will by means of force or fear of immediate and unlawful bodily injury on the victim or another person, shall be punished by imprisonment in the state prison for 10, 12, or 14 years.

(3) Any person who, while voluntarily acting in concert with another person, either personally or aiding and abetting that other person, commits an act of oral copulation upon a victim who is a minor 14 years of age or older, when the act is accomplished against the victim's will by means of force or fear of immediate and unlawful bodily injury on the victim or another person, shall be punished by imprisonment in the state prison for 8, 10, or 12 years.

(4) This paragraph does not preclude prosecution under Section 269, Section 288.7, or any other provision of law.

(e) Any person who participates in an act of oral copulation while confined in any state prison, as defined in Section 4504 or in any local detention facility as defined in Section 6031.4, shall be punished by imprisonment in the state prison, or in a county jail for a period of not more than one year.

(f) Any person who commits an act of oral copulation, and the victim is at the time unconscious of the nature of the act and this is known to the person committing the act, shall be punished by imprisonment in the state prison for a period of three, six, or eight years. As used in this subdivision, "unconscious of the nature of the act" means incapable of resisting because the victim meets one of the following conditions:

(1) Was unconscious or asleep.

(2) Was not aware, knowing, perceiving, or cognizant that the act occurred.



(3) Was not aware, knowing, perceiving, or cognizant of the essential characteristics of the act due to the perpetrator's fraud in fact.

(4) Was not aware, knowing, perceiving, or cognizant of the essential characteristics of the act due to the perpetrator's fraudulent representation that the oral copulation served a professional purpose when it served no professional purpose.

(g) Except as provided in subdivision (h), any person who commits an act of oral copulation, and the victim is at the time incapable, because of a mental disorder or developmental or physical disability, of giving legal consent, and this is known or reasonably should be known to the person committing the act, shall be punished by imprisonment in the state prison, for three, six, or eight years. Notwithstanding the existence of a conservatorship pursuant to the provisions of the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code), the prosecuting attorney shall prove, as an element of the crime, that a mental disorder or developmental or physical disability rendered the alleged victim incapable of giving consent.

(h) Any person who commits an act of oral copulation, and the victim is at the time incapable, because of a mental disorder or developmental or physical disability, of giving legal consent, and this is known or reasonably should be known to the person committing the act, and both the defendant and the victim are at the time confined in a state hospital for the care and treatment of the mentally disordered or in any other public or private facility for the care and treatment of the mentally disordered approved by a county mental health director, shall be punished by imprisonment in the state prison, or in a county jail for a period of not more than one year. Notwithstanding the existence of a conservatorship pursuant to the provisions of the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code), the prosecuting attorney shall prove, as an element of the crime, that a mental disorder or developmental or physical disability rendered the alleged victim incapable of giving legal consent.

(i) Any person who commits an act of oral copulation, where the victim is prevented from resisting by any intoxicating or anesthetic substance, or any controlled substance, and this condition was known, or reasonably should have been known by the accused, shall be punished by imprisonment in the state prison for a period of three, six, or eight years.

(j) Any person who commits an act of oral copulation, where the victim submits under the belief that the person committing the act is someone known to the victim other than the accused, and this belief is induced by any artifice, pretense, or concealment practiced by the accused, with intent to induce the belief, shall be punished by imprisonment in the state prison for a period of three, six, or eight years.

(k) Any person who commits an act of oral copulation, where the act is accomplished against the victim's will by threatening to use the authority of a public official to incarcerate, arrest, or deport the victim or another, and the victim has a reasonable belief that the perpetrator is a public official, shall be punished by imprisonment in the state prison for a period of three, six, or eight years.

As used in this subdivision, "public official" means a person employed by a governmental agency who has the authority, as part of that position, to incarcerate, arrest, or deport another. The perpetrator does not actually have to be a public official.

(l) As used in subdivisions (c) and (d), "threatening to retaliate" means a threat to kidnap or falsely imprison, or to inflict extreme pain, serious bodily injury, or death.

(m) In addition to any punishment imposed under this section, the judge may assess a fine not to exceed seventy dollars (\$70) against any person who violates this section, with the proceeds of this fine to be used in accordance with Section 1463.23. The court shall, however, take into consideration the defendant's ability to pay, and no defendant shall be denied probation because of his or her inability to pay the fine permitted under this subdivision.

### **PC §289.**

(a) (1) (A) Any person who commits an act of sexual penetration when the act is accomplished against the victim's will by means of force, violence, duress, menace, or fear of immediate and unlawful bodily injury on the victim or another person shall be punished by imprisonment in the state prison for three, six, or eight years.

(B) Any person who commits an act of sexual penetration upon a child who is under 14 years of age, when the act is accomplished against the victim's will by means of force, violence, duress, menace, or fear of immediate and unlawful bodily injury on the victim or another person, shall be punished by imprisonment in the state prison for 8, 10, or 12 years.

(C) Any person who commits an act of sexual penetration upon a minor who is 14 years of age or older, when the act is accomplished against the victim's will by means of force, violence, duress, menace, or fear of immediate and unlawful bodily injury on the victim or another person, shall be punished by imprisonment in the state prison for 6, 8, or 10 years.

(D) This paragraph does not preclude prosecution under Section 269, Section 288.7, or any other provision of law.

(2) Any person who commits an act of sexual penetration when the act is accomplished against the victim's will by threatening to retaliate in the future against the victim or any other person, and there is a reasonable possibility that the perpetrator will execute the threat, shall be punished by imprisonment in the state prison for three, six, or eight years.

(b) Except as provided in subdivision (c), any person who commits an act of sexual penetration, and the victim is at the time incapable, because of a mental disorder or developmental or physical disability, of giving legal consent, and this is known or reasonably should be known to the person committing the act or causing the act to be committed, shall be punished by imprisonment in the state prison for three, six, or eight years. Notwithstanding the appointment of a conservator with respect to the victim pursuant to the provisions of the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code), the prosecuting attorney shall prove, as an element of the crime, that a mental disorder

or developmental or physical disability rendered the alleged victim incapable of giving legal consent.

(c) Any person who commits an act of sexual penetration, and the victim is at the time incapable, because of a mental disorder or developmental or physical disability, of giving legal consent, and this is known or reasonably should be known to the person committing the act or causing the act to be committed and both the defendant and the victim are at the time confined in a state hospital for the care and treatment of the mentally disordered or in any other public or private facility for the care and treatment of the mentally disordered approved by a county mental health director, shall be punished by imprisonment in the state prison, or in a county jail for a period of not more than one year. Notwithstanding the existence of a conservatorship pursuant to the provisions of the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code), the prosecuting attorney shall prove, as an element of the crime, that a mental disorder or developmental or physical disability rendered the alleged victim incapable of giving legal consent.

(d) Any person who commits an act of sexual penetration, and the victim is at the time unconscious of the nature of the act and this is known to the person committing the act or causing the act to be committed, shall be punished by imprisonment in the state prison for three, six, or eight years. As used in this subdivision, "unconscious of the nature of the act" means incapable of resisting because the victim meets one of the following conditions:

(1) Was unconscious or asleep.

(2) Was not aware, knowing, perceiving, or cognizant that the act occurred.

(3) Was not aware, knowing, perceiving, or cognizant of the essential characteristics of the act due to the perpetrator's fraud in fact.

(4) Was not aware, knowing, perceiving, or cognizant of the essential characteristics of the act due to the perpetrator's fraudulent representation that the sexual penetration served a professional purpose when it served no professional purpose.

(e) Any person who commits an act of sexual penetration when the victim is prevented from resisting by any intoxicating or anesthetic substance, or any controlled substance, and this condition was known, or reasonably should have been known by the accused, shall be punished by imprisonment in the state prison for a period of three, six, or eight years.

(f) Any person who commits an act of sexual penetration when the victim submits under the belief that the person committing the act or causing the act to be committed is someone known to the victim other than the accused, and this belief is induced by any artifice, pretense, or concealment practiced by the accused, with intent to induce the belief, shall be punished by imprisonment in the state prison for a period of three, six, or eight years.

(g) Any person who commits an act of sexual penetration when the act is accomplished against the victim's will by threatening to use the authority of a public official to incarcerate, arrest, or deport the victim or another, and the victim has a reasonable belief that the perpetrator is a

public official, shall be punished by imprisonment in the state prison for a period of three, six, or eight years.

As used in this subdivision, "public official" means a person employed by a governmental agency who has the authority, as part of that position, to incarcerate, arrest, or deport another. The perpetrator does not actually have to be a public official.

(h) Except as provided in Section 288, any person who participates in an act of sexual penetration with another person who is under 18 years of age shall be punished by imprisonment in the state prison or in a county jail for a period of not more than one year.

(i) Except as provided in Section 288, any person over 21 years of age who participates in an act of sexual penetration with another person who is under 16 years of age shall be guilty of a felony.

(j) Any person who participates in an act of sexual penetration with another person who is under 14 years of age and who is more than 10 years younger than he or she shall be punished by imprisonment in the state prison for three, six, or eight years.

(k) As used in this section:

(1) "Sexual penetration" is the act of causing the penetration, however slight, of the genital or anal opening of any person or causing another person to so penetrate the defendant's or another person's genital or anal opening for the purpose of sexual arousal, gratification, or abuse by any foreign object, substance, instrument, or device, or by any unknown object.

(2) "Foreign object, substance, instrument, or device" shall include any part of the body, except a sexual organ.

(3) "Unknown object" shall include any foreign object, substance, instrument, or device, or any part of the body, including a penis, when it is not known whether penetration was by a penis or by a foreign object, substance, instrument, or device, or by any other part of the body.

(l) As used in subdivision (a), "threatening to retaliate" means a threat to kidnap or falsely imprison, or inflict extreme pain, serious bodily injury or death.

(m) As used in this section, "victim" includes any person who the defendant causes to penetrate the genital or anal opening of the defendant or another person or whose genital or anal opening is caused to be penetrated by the defendant or another person and who otherwise qualifies as a victim under the requirements of this section.



# Reporting Consensual Activity Between Minors:

## The Confusion Unraveled

CATHERINE ATKINS, STAFF ATTORNEY  
(Revised May 2013)

Time and time again, there seems to be much confusion with regard to whether an MFT must, or is even permitted to, report consensual sexual activity involving minors. The information below applies only to consensual sexual activity-not incest, date rape or any situation in which the minor did not fully consent to the sexual activity. Involuntary sexual activity involving minors, and incest involving a minor (even when voluntary), is always a mandatory report.

Below is a chart which identifies the various ages of children and consensual sexual activity at issue<sup>1</sup>:

"Child" refers to the person that the mandated child abuse reporter is involved with.	Definitions and Comments	Mandatory Report	Not Mandatory Report
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### A. Child younger than 14 years old

1. Partner is younger than 14 years old and of similar chronological or maturational age. Sexual behavior is voluntary & consensual. There are no indications of intimidation, coercion, bribery or other indications of an exploitive relationship.	See, <i>Planned Parenthood Affiliates of California v. John K. Van De Kamp</i> (1986) 181 Cal. App. 3d 245 (1986); See also, <i>In re Jerry M.</i> 59 Cal. App. 4th 289.		X
2. Partner is younger than 14 years old, but there is disparity in chronological or maturational age or indications of intimidation, coercion or bribery or other indications of an exploitive relationship.		X	

<i>"Child" refers to the person that the mandated child abuse reporter is involved with.</i>	<b>Definitions and Comments</b>	<b>Mandatory Report</b>	<b>Not Mandatory Report</b>
3. Partner is 14 years or older.		X	
4. Lewd & Lascivious acts committed by a partner of any age.	The perpetrator has the intent of "Arousing, appealing to or gratifying the lust, passions, or sexual desires of the perpetrator or the child". This behavior is generally of an exploitative nature; for instance, 'flashing' a minor-exposing one's genitals to a minor.	X	
5. Partner is alleged spouse and over 14 years of age.	The appropriate authority will determine the legality of the marriage.	X	

**B. Child 14 or 15 years old**

1. Partner is less than 14		X	
2. Unlawful Sexual Intercourse with a partner older than 14 and less than 21 years of age & there is no indication of abuse or evidence of an exploitive relationship.			X
3. Unlawful Sexual Intercourse with a partner older than 21 years of age.		X	

<i>"Child" refers to the person that the mandated child abuse reporter is involved with.</i>	<b>Definitions and Comments</b>	<b>Mandatory Report</b>	<b>Not Mandatory Report</b>
4. Lewd & Lascivious acts committed by a partner more than 10 years older than the child.	The perpetrator has the intent of "Arousing, appealing to or gratifying the lust, passions, or gratifying the lust, passions, or sexual desires of the perpetrator or the child". This behavior is generally of an exploitative nature; for instance, 'flashing' a minor-exposing one's genitals to a minor.	X	
5. Partner is alleged spouse and over 21 years of age.	The appropriate authority will determine the legality of the marriage.	X	

### **C. Child 16 or 17 years old**

1. Partner is less than 14		X	
2. Unlawful Sexual Intercourse with a partner older than 14 & there is no indication of an exploitive relationship.			X
3. Unlawful Sexual Intercourse with a partner older than 14 & there is evidence of an exploitive relationship.		X	
4. Partner is alleged spouse and there is evidence of an exploitive relationship.	The appropriate authority will determine the legality of the marriage.	X	

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## D. Oral Copulation and Sodomy of Child under the age of 18

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Historically most county agencies and professional associations stated that under Penal Code section 11165.1, all sodomy, oral copulation, penetration of a genital or anal opening by a foreign object, even if consensual, with a partner of any age, was a mandatory report.

However, on April 11, 2013, the Board of Behavioral Sciences (BBS) released an evaluation of the Child Abuse and Neglect Reporting Act (CANRA), specifically answering the question: "Did Penal Code 11165.1 require practitioners to report all conduct by minors that fall under the definition of sodomy and oral copulation?"

Counsel to the BBS stated, in summary, that court interpretations throughout the years confirmed that minors can lawfully engage in consensual sex with other minors *of like age*, without the necessity of a mandatory report. Counsel further stated that while the cases cited in her analysis did not directly discuss oral copulation and sodomy between minors, the same reasoning applied and as such, practitioners were not required to report all conduct by minors that fell under the definition of sodomy and oral copulation.

So what does this mean? When a provider learns of consensual, non-abusive sexual activity between two minors, the provider would:

1. Utilize the chart above to determine if the ages are "of like ages."
2. If there is a mandatory report, based on the ages above, for intercourse, certainly there would be a mandatory report for oral copulation or sodomy.
3. However, if there is no mandatory report, based on the ages above, according to the BBS, there would be no mandatory report necessary in the case of oral copulation or sodomy either.
4. Forced, coerced, and/or non-consensual sexual activity is always a mandatory report.

**NOTE: It is important to note that the recent BBS evaluation is the BBS' interpretation of law. While the BBS evaluation would be a good evidentiary resource in defense of a provider who is challenged in court for not making a mandatory report for consensual oral copulation or sodomy, the laws regarding mandatory reporting have not changed. Since state law regarding reporting of consensual oral copulation and sodomy has not changed and this exact issue has not been examined by the courts, the conservative approach, in order to gain immunity from suit under CANRA, would be to continue to report those types of consensual acts between minors.**

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*This information is intended to provide guidelines for addressing difficult legal dilemmas. It is not intended to address every situation that could potentially arise, nor is it intended to be a substitute for independent legal advice or consultation. When using such information as a guide, be aware that laws, regulations and technical standards change over time, and thus one should verify and update any references or information contained herein. Ⓞ*

### REFERENCES

- 1 This chart was adapted from the Child Abuse Council of Santa Clara County found at [www.cacsc.org](http://www.cacsc.org).



*Catherine L. Atkins, JD, is a Staff Attorney and the Deputy Executive Director at CAMFT. Cathy is available to answer members' questions regarding legal, ethical, and licensure issues.*



Placeholder box for reporting information.

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# Child Abuse Reporting Guidelines for Sexual Activity Between and with Minors

## Santa Clara County Child Abuse Council

This is a guide for mandated reporters and the information contained in this document is designed to assist those mandated by California Child Abuse Reporting Laws to determine their reporting responsibilities. It is not intended to be and should not be considered legal advice. In the event there are questions regarding reporting responsibilities in a specific case, the advice of legal counsel should be sought. This guide incorporates changes in the Child Abuse Reporting Law, effective January, 1998. For more detailed information refer to Penal Code Section 11164 & 11165.1 et al.

**I. INVOLUNTARY SEXUAL ACTIVITY** is always reportable.

**II. INCEST**, even if voluntary is always reportable. Incest is a marriage or act of intercourse between parents and children; ancestors and descendants of every degree; brothers and sisters of half and whole blood and uncles and nieces or aunts and nephews. (Family Code, § 2200.)

**III. VOLUNTARY SEXUAL ACTIVITY** may or may not be reportable. Even if the behavior is voluntary, there are circumstances where the behavior is abusive, either by Penal Code definition or because of an exploitive relationship and this behavior must be reported. Review **either** section A, B or C **and** section D. In addition, if there is reasonable suspicion of sexual abuse prior to the consensual activity, the abuse must be reported.

"Child" refers to the person that the mandated child abuse reporter is involved with.	Definitions and Comments	Mandatory Report	Not Mandatory Report
<b>A. Child younger than 14 years old</b>			
1. Partner is younger than 14 years old and of similar chronological or maturational age. Sexual behavior is voluntary &	See, <i>Planned Parenthood Affiliates of California v. John K. Van De Kamp</i> (1986) 181 Cal. App. 3d 245		X

consensual. There are no indications of intimidation, coercion, bribery or other indications of an exploitive relationship.	(1986) & <i>In re Jerry M.</i> 59 Cal. App. 4th 289		
2. Partner is younger than 14 years old, but there is disparity in chronological or maturational age or indications of intimidation, coercion or bribery or other indications of an exploitive relationship.		X	
3. Partner is 14 years or older.		X	
4. Lewd & Lascivious acts committed by a partner of any age.	The perpetrator has the intent of "Arousing, appealing to or gratifying the lust, passions, or sexual desires of the perpetrator or the child".?	X	
5. Partner is alleged spouse and over 14 years of age.	The appropriate authority will determine the legality of the marriage.	X	
<b>B. Child 14 or 15 years old</b>			
1. Partner is less than 14		X	
2. Unlawful Sexual Intercourse with a partner older than 14 and less than 21 years of age & there is no indication of abuse or evidence of an exploitive relationship.			X
3. Unlawful Sexual Intercourse with a partner older than 21 years of age.		X	
4. Lewd & Lascivious acts	The perpetrator has the	X	

committed by a partner more than 10 years older than the child.	intent of "Arousing, appealing to or gratifying the lust, passions, or gratifying the lust, passions, or sexual desires of the perpetrator or the child".		
5. Partner is alleged spouse and over 21 years of age.	The appropriate authority will determine the legality of the marriage.	X	
<b>C. Child 16 or 17 years old</b>			
1. Partner is less than 14		X	
2. Unlawful Sexual Intercourse with a partner older than 14 & there is no indication of an exploitive relationship.			X
3. Unlawful Sexual Intercourse with a partner older than 14 & there is evidence of an exploitive relationship.		X	
4. Partner is alleged spouse and there is evidence of an exploitive relationship.	The appropriate authority will determine the legality of the marriage.	X	
<b>D. Child under the age of 18</b>			
1. Sodomy, oral copulation, penetration of a genital or anal opening by a foreign object, even if consensual, with a partner of any age.		X	

Mandated reports of sexual activity must be reported to either The Department of Family & Children's Services (DFCS) or to the appropriate police jurisdiction. This information will then be cross-reported to the other agency. Reporting does not necessarily mean that a civil or criminal proceeding will be initiated against the suspected abuser.

Failure to report known or reasonable suspicion of child abuse, including sexual abuse, is a misdemeanor. Mandated reporters are provided immunity from civil or criminal liability as a result of making a mandated report of child abuse.

Child Abuse Council, Interagency Collaboration Committee (3/12/98). Reviewed February 2008..  
Adapted from Orange County Reporting Guidelines

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## MANDATED REPORTERS: WHEN MUST YOU REPORT *CONSENSUAL* SEXUAL ACTIVITY INVOLVING MINORS?

The question of whether the Child Abuse and Neglect Reporting Act (CANRA) (Penal Code §§ 11165 - 11174) requires designated professionals to report consensual sexual activity involving minors remains a “hopelessly blurred” area of the law. On the one hand, *Planned Parenthood v. Van de Kamp* (1986) 181 Cal.App.3d 245 holds that laws which require the reporting of voluntary, nonabusive sexual behavior between minors of a similar age violate a minor’s right to sexual privacy. On the other hand, *People v. Stockton Pregnancy Control Medical Clinic, Inc.* (1988) 203 Cal.App.3d 225, as well as legislative changes in 1997, affirm that certain types of sexual conduct involving minors still must be reported even if consensual. (See AB 327, Stats. 1997, c. 83.) The following guidelines are designed to synthesize conflicting legal authority and provide mandated reporters with reasonable guidance.

- ☞ **Both children are under age 14? No report is required** unless there is disparate age, intimidation, coercion, exploitation or bribery.
  
- ☞ **One child is under age 14, the other child is age 14 - 17? Yes, a report is required.** Penal Code sections 11165.1(a) and 288(a) afford special protection to children under age 14.
  
- ☞ **Both children are ages 14 - 17? No report is required**, unless the sexual activity involves incest (see Penal Code § 285, Family Code 2200) or there is evidence of abuse or an exploitative relationship.
  
- ☞ **The child is age 14 - 17, the other person 18 or older? No report is required**, unless the sexual activity involves one of the following: 1. Incest (see Penal Code § 285, Family Code 2200); 2. Unlawful Sexual Intercourse (also known as “Statutory Rape”) involving a person over age 21 with a child age 14 or 15 (see Penal Code § 261.5(d)); and 3. Lewd and Lascivious Acts involving a child age 14 or 15 and a person who is at least ten years older than the child (see Penal Code § 288(c)(1)).

While consensual sexual intercourse between a child (a person under age 18) and an adult (a person age 18 or older) is still a crime and thus subject to prosecution, California law only requires that it be reported if the child is under age 16 and the adult is over age 21. (See Penal Code § 261.5(a).)

**Note:** Sodomy (Penal Code § 286); Oral Copulation (Penal Code § 288a) and Penetration by Foreign Object (Penal Code § 289) (which includes a penetration by a finger) are still listed as reportable offenses under Penal Code § 11165.1, but recent cases such as *People v. Hofsheier* (2006) 37 Cal. 4th 1185 and *Lawrence v. Texas* (2003) 539 U.S. 558 cast doubt on the constitutionality of treating these types of consensual sexual activity different from sexual intercourse.

# CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES

## BILL ANALYSIS

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**BILL NUMBER:** AB 1001                      **VERSION:** INTRODUCED FEBRUARY 26, 2015

**AUTHOR:** MAIENSCHIN                      **SPONSOR:** CHILDREN'S ADVOCACY INSTITUTE  
AT UNIVERSITY OF SAN DIEGO  
SCHOOL OF LAW

**RECOMMENDED POSITION:** NONE

**SUBJECT:** CHILD ABUSE: REPORTING

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### **Overview:**

This bill clarifies that it is illegal for anyone, including a supervisor, to impede or interfere with the making of a mandated report of suspected child abuse or neglect.

### **Existing Law:**

- 1) Specifies that licensees of the Board of Behavioral Sciences (Board) are mandated reporters under the Child Abuse and Neglect Reporting Act and as such, he or she must submit a report whenever in their professional capacity, they have knowledge of, or observe a child who is known, or reasonably suspected to have been, a victim of child abuse or neglect. (Penal Code (PC) §§11165.7(a)(21) – (25) and 11166(a))
- 2) Requires mandated reports of suspected child abuse or neglect be made to any police or sheriff's department, the county probation department, or the county welfare department. (PC §11165.9)
- 3) Makes mandated reporting duties individual. This means that supervisors or administrators may not impede reporting duties, and mandated reporters shall not be subject to sanctions for making a report. (PC §11166(i)(1))
- 4) States that reporting a case of possible child abuse or neglect to an employer or supervisor is not a substitute for making a mandated report to a designated agency. (PC §11166(i)(3))
- 5) States that a supervisor or administrator who impedes reporting duties shall be punished by a fine up to \$1,000 and/or up to six months in county jail. (PC §11166.01)

### **This Bill:**

- 1) Prohibits a person from impeding or interfering with the making of a mandated report of suspected child abuse or neglect. (PC §11166(l))

- 2) States that a person who impedes or interferes with a mandated report is guilty of a misdemeanor and may be liable for actual damages to the victim. (PC §11166(l))

**Comment:**

- 1) **Author's Intent.** The author's office believes that mandated reporters should have a clear path to reporting and eliminating child abuse and neglect without interference. However, they have learned that social workers who work for private, non-profit foster family agencies, as well as one teacher, have confidentially reported to the Children's Advocacy Institute at the University of San Diego School of Law that supervisors at foster family agencies sometimes override mandated reporting.

They believe that this bill will clarify the law and provide consequences, in the form of a misdemeanor and liability, for those who interfere with a mandated report.

- 2) **Support and Opposition.**

Support

- Children's Advocacy Institute (Sponsor)
- California Association of Private School Organizations
- California District Attorneys Association
- California State Sheriffs' Association
- Crime Victims United
- Junior Leagues of California

Opposition

- California Attorneys for Criminal Justice California Public Defenders Association

- 3) **History**

**2015**

04/07/15 In committee: Set, first hearing. Hearing canceled at the request of author.

03/19/15 Referred to Com. on PUB. S.

02/27/15 From printer. May be heard in committee March 29.

02/26/15 Read first time. To print.

**ASSEMBLY BILL**

**No. 1001**

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**Introduced by Assembly Member Maienschein**

(Principal coauthor: Senator Vidak)

**(Coauthors: Assembly Members Chávez, Olsen, and Waldron)**

(Coauthor: Senator Bates)

February 26, 2015

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An act to amend Section 11166 of the Penal Code, relating to child abuse.

LEGISLATIVE COUNSEL'S DIGEST

AB 1001, as introduced, Maienschein. Child abuse: reporting.

The Child Abuse and Neglect Reporting Act requires a mandated reporter, as defined, to make a report to a specified agency whenever the mandated reporter, in his or her professional capacity or within the scope of his or her employment, has knowledge of or observes a child whom the mandated reporter knows or reasonably suspects has been the victim of child abuse or neglect. Under existing law, the failure to make this report is a crime.

This bill would prohibit a person from impeding or interfering with the making of a report of suspected child abuse or neglect by a mandated reporter. The bill would provide that an intentional violation of these provisions is a misdemeanor and may subject the offender to liability for actual damages sustained by a victim of child abuse or neglect for any abuse or neglect that occurs after the person impeded or interfered with the report being made.

By creating a new crime, this bill would impose a state-mandated local program.



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

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

Vote: majority. Appropriation: no. Fiscal committee: yes.

State-mandated local program: yes.

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

1 SECTION 1. Section 11166 of the Penal Code is amended to  
2 read:

3 11166. (a) Except as provided in subdivision (d), and in  
4 Section 11166.05, a mandated reporter shall make a report to an  
5 agency specified in Section 11165.9 whenever the mandated  
6 reporter, in his or her professional capacity or within the scope of  
7 his or her employment, has knowledge of or observes a child whom  
8 the mandated reporter knows or reasonably suspects has been the  
9 victim of child abuse or neglect. The mandated reporter shall make  
10 an initial report by telephone to the agency immediately or as soon  
11 as is practicably possible, and shall prepare and send, fax, or  
12 electronically transmit a written followup report within 36 hours  
13 of receiving the information concerning the incident. The mandated  
14 reporter may include with the report any nonprivileged  
15 documentary evidence the mandated reporter possesses relating  
16 to the incident.

17 (1) For purposes of this article, “reasonable suspicion” means  
18 that it is objectively reasonable for a person to entertain a suspicion,  
19 based upon facts that could cause a reasonable person in a like  
20 position, drawing, when appropriate, on his or her training and  
21 experience, to suspect child abuse or neglect. “Reasonable  
22 suspicion” does not require certainty that child abuse or neglect  
23 has occurred nor does it require a specific medical indication of  
24 child abuse or neglect; any “reasonable suspicion” is sufficient.  
25 For purposes of this article, the pregnancy of a minor does not, in  
26 and of itself, constitute a basis for a reasonable suspicion of sexual  
27 abuse.

28 (2) The agency shall be notified and a report shall be prepared  
29 and sent, faxed, or electronically transmitted even if the child has  
30 expired, regardless of whether or not the possible abuse was a

1 factor contributing to the death, and even if suspected child abuse  
2 was discovered during an autopsy.

3 (3) A report made by a mandated reporter pursuant to this  
4 section shall be known as a mandated report.

5 (b) If, after reasonable efforts, a mandated reporter is unable  
6 to submit an initial report by telephone, he or she shall immediately  
7 or as soon as is practicably possible, by fax or electronic  
8 transmission, make a one-time automated written report on the  
9 form prescribed by the Department of Justice, and shall also be  
10 available to respond to a telephone followup call by the agency  
11 with which he or she filed the report. A mandated reporter who  
12 files a one-time automated written report because he or she was  
13 unable to submit an initial report by telephone is not required to  
14 submit a written followup report.

15 (1) The one-time automated written report form prescribed by  
16 the Department of Justice shall be clearly identifiable so that it is  
17 not mistaken for a standard written followup report. In addition,  
18 the automated one-time report shall contain a section that allows  
19 the mandated reporter to state the reason the initial telephone call  
20 was not able to be completed. The reason for the submission of  
21 the one-time automated written report in lieu of the procedure  
22 prescribed in subdivision (a) shall be captured in the Child Welfare  
23 Services/Case Management System (CWS/CMS). The department  
24 shall work with stakeholders to modify reporting forms and the  
25 CWS/CMS as is necessary to accommodate the changes enacted  
26 by these provisions.

27 (2) This subdivision shall not become operative until the  
28 CWS/CMS is updated to capture the information prescribed in this  
29 subdivision.

30 (3) This subdivision shall become inoperative three years after  
31 this subdivision becomes operative or on January 1, 2009,  
32 whichever occurs first.

33 (4) On the inoperative date of these provisions, a report shall  
34 be submitted to the counties and the Legislature by the State  
35 Department of Social Services that reflects the data collected from  
36 automated one-time reports indicating the reasons stated as to why  
37 the automated one-time report was filed in lieu of the initial  
38 telephone report.

39 (5) Nothing in this section shall supersede the requirement that  
40 a mandated reporter first attempt to make a report via telephone,

1 or that agencies specified in Section 11165.9 accept reports from  
2 mandated reporters and other persons as required.

3 (c) A mandated reporter who fails to report an incident of  
4 known or reasonably suspected child abuse or neglect as required  
5 by this section is guilty of a misdemeanor punishable by up to six  
6 months confinement in a county jail or by a fine of one thousand  
7 dollars (\$1,000) or by both that imprisonment and fine. If a  
8 mandated reporter intentionally conceals his or her failure to report  
9 an incident known by the mandated reporter to be abuse or severe  
10 neglect under this section, the failure to report is a continuing  
11 offense until an agency specified in Section 11165.9 discovers the  
12 offense.

13 (d) (1) A clergy member who acquires knowledge or a  
14 reasonable suspicion of child abuse or neglect during a penitential  
15 communication is not subject to subdivision (a). For the purposes  
16 of this subdivision, “penitential communication” means a  
17 communication, intended to be in confidence, including, but not  
18 limited to, a sacramental confession, made to a clergy member  
19 who, in the course of the discipline or practice of his or her church,  
20 denomination, or organization, is authorized or accustomed to hear  
21 those communications, and under the discipline, tenets, customs,  
22 or practices of his or her church, denomination, or organization,  
23 has a duty to keep those communications secret.

24 (2) Nothing in this subdivision shall be construed to modify or  
25 limit a clergy member’s duty to report known or suspected child  
26 abuse or neglect when the clergy member is acting in some other  
27 capacity that would otherwise make the clergy member a mandated  
28 reporter.

29 (3) (A) On or before January 1, 2004, a clergy member or any  
30 custodian of records for the clergy member may report to an agency  
31 specified in Section 11165.9 that the clergy member or any  
32 custodian of records for the clergy member, prior to January 1,  
33 1997, in his or her professional capacity or within the scope of his  
34 or her employment, other than during a penitential communication,  
35 acquired knowledge or had a reasonable suspicion that a child had  
36 been the victim of sexual abuse and that the clergy member or any  
37 custodian of records for the clergy member did not previously  
38 report the abuse to an agency specified in Section 11165.9. The  
39 provisions of Section 11172 shall apply to all reports made pursuant  
40 to this paragraph.

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

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

8 (e) (1) A commercial film, photographic print, or image  
9 processor who has knowledge of or observes, within the scope of  
10 his or her professional capacity or employment, any film,  
11 photograph, videotape, negative, slide, or any representation of  
12 information, data, or an image, including, but not limited to, any  
13 film, filmstrip, photograph, negative, slide, photocopy, videotape,  
14 video laser disc, computer hardware, computer software, computer  
15 floppy disk, data storage medium, CD-ROM, computer-generated  
16 equipment, or computer-generated image depicting a child under  
17 16 years of age engaged in an act of sexual conduct, shall,  
18 immediately or as soon as practicably possible, telephonically  
19 report the instance of suspected abuse to the law enforcement  
20 agency located in the county in which the images are seen. Within  
21 36 hours of receiving the information concerning the incident, the  
22 reporter shall prepare and send, fax, or electronically transmit a  
23 written followup report of the incident with a copy of the image  
24 or material attached.

25 (2) A commercial computer technician who has knowledge of  
26 or observes, within the scope of his or her professional capacity  
27 or employment, any representation of information, data, or an  
28 image, including, but not limited to, any computer hardware,  
29 computer software, computer file, computer floppy disk, data  
30 storage medium, CD-ROM, computer-generated equipment, or  
31 computer-generated image that is retrievable in perceivable form  
32 and that is intentionally saved, transmitted, or organized on an  
33 electronic medium, depicting a child under 16 years of age engaged  
34 in an act of sexual conduct, shall immediately, or as soon as  
35 practicably possible, telephonically report the instance of suspected  
36 abuse to the law enforcement agency located in the county in which  
37 the images or material are seen. As soon as practicably possible  
38 after receiving the information concerning the incident, the reporter  
39 shall prepare and send, fax, or electronically transmit a written

1 followup report of the incident with a brief description of the  
2 images or materials.

3 (3) For purposes of this article, “commercial computer  
4 technician” includes an employee designated by an employer to  
5 receive reports pursuant to an established reporting process  
6 authorized by subparagraph (B) of paragraph (43) of subdivision  
7 (a) of Section 11165.7.

8 (4) As used in this subdivision, “electronic medium” includes,  
9 but is not limited to, a recording, CD-ROM, magnetic disk memory,  
10 magnetic tape memory, CD, DVD, thumbdrive, or any other  
11 computer hardware or media.

12 (5) As used in this subdivision, “sexual conduct” means any of  
13 the following:

14 (A) Sexual intercourse, including genital-genital, oral-genital,  
15 anal-genital, or oral-anal, whether between persons of the same or  
16 opposite sex or between humans and animals.

17 (B) Penetration of the vagina or rectum by any object.

18 (C) Masturbation for the purpose of sexual stimulation of the  
19 viewer.

20 (D) Sadoomasochistic abuse for the purpose of sexual stimulation  
21 of the viewer.

22 (E) Exhibition of the genitals, pubic, or rectal areas of a person  
23 for the purpose of sexual stimulation of the viewer.

24 (f) Any mandated reporter who knows or reasonably suspects  
25 that the home or institution in which a child resides is unsuitable  
26 for the child because of abuse or neglect of the child shall bring  
27 the condition to the attention of the agency to which, and at the  
28 same time as, he or she makes a report of the abuse or neglect  
29 pursuant to subdivision (a).

30 (g) Any other person who has knowledge of or observes a child  
31 whom he or she knows or reasonably suspects has been a victim  
32 of child abuse or neglect may report the known or suspected  
33 instance of child abuse or neglect to an agency specified in Section  
34 11165.9. For purposes of this section, “any other person” includes  
35 a mandated reporter who acts in his or her private capacity and  
36 not in his or her professional capacity or within the scope of his  
37 or her employment.

38 (h) When two or more persons, who are required to report,  
39 jointly have knowledge of a known or suspected instance of child  
40 abuse or neglect, and when there is agreement among them, the

1 telephone report may be made by a member of the team selected  
2 by mutual agreement and a single report may be made and signed  
3 by the selected member of the reporting team. Any member who  
4 has knowledge that the member designated to report has failed to  
5 do so shall thereafter make the report.

6 (i) (1) The reporting duties under this section are individual,  
7 and no supervisor or administrator may impede or inhibit the  
8 reporting duties, and no person making a report shall be subject  
9 to any sanction for making the report. However, internal procedures  
10 to facilitate reporting and apprise supervisors and administrators  
11 of reports may be established provided that they are not inconsistent  
12 with this article.

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

16 (3) Reporting the information regarding a case of possible child  
17 abuse or neglect to an employer, supervisor, school principal,  
18 school counselor, coworker, or other person shall not be a substitute  
19 for making a mandated report to an agency specified in Section  
20 11165.9.

21 (j) A county probation or welfare department shall immediately,  
22 or as soon as practicably possible, report by telephone, fax, or  
23 electronic transmission to the law enforcement agency having  
24 jurisdiction over the case, to the agency given the responsibility  
25 for investigation of cases under Section 300 of the Welfare and  
26 Institutions Code, and to the district attorney's office every known  
27 or suspected instance of child abuse or neglect, as defined in  
28 Section 11165.6, except acts or omissions coming within  
29 subdivision (b) of Section 11165.2, or reports made pursuant to  
30 Section 11165.13 based on risk to a child which relates solely to  
31 the inability of the parent to provide the child with regular care  
32 due to the parent's substance abuse, which shall be reported only  
33 to the county welfare or probation department. A county probation  
34 or welfare department also shall send, fax, or electronically transmit  
35 a written report thereof within 36 hours of receiving the information  
36 concerning the incident to any agency to which it makes a  
37 telephone report under this subdivision.

38 (k) A law enforcement agency shall immediately, or as soon  
39 as practicably possible, report by telephone, fax, or electronic  
40 transmission to the agency given responsibility for investigation

1 of cases under Section 300 of the Welfare and Institutions Code  
 2 and to the district attorney’s office every known or suspected  
 3 instance of child abuse or neglect reported to it, except acts or  
 4 omissions coming within subdivision (b) of Section 11165.2, which  
 5 shall be reported only to the county welfare or probation  
 6 department. A law enforcement agency shall report to the county  
 7 welfare or probation department every known or suspected instance  
 8 of child abuse or neglect reported to it which is alleged to have  
 9 occurred as a result of the action of a person responsible for the  
 10 child’s welfare, or as the result of the failure of a person responsible  
 11 for the child’s welfare to adequately protect the minor from abuse  
 12 when the person responsible for the child’s welfare knew or  
 13 reasonably should have known that the minor was in danger of  
 14 abuse. A law enforcement agency also shall send, fax, or  
 15 electronically transmit a written report thereof within 36 hours of  
 16 receiving the information concerning the incident to any agency  
 17 to which it makes a telephone report under this subdivision.

18 *(l) A person shall not impede or interfere with the making of a*  
 19 *report of suspected child abuse or neglect required under this*  
 20 *section. A person who intentionally impedes or interferes with a*  
 21 *report of suspected child abuse or neglect being made is guilty of*  
 22 *a misdemeanor, and may be liable for actual damages sustained*  
 23 *by a victim of child abuse or neglect for any abuse or neglect that*  
 24 *occurs after the person impeded or interfered with the report being*  
 25 *made.*

26 SEC. 2. No reimbursement is required by this act pursuant to  
 27 Section 6 of Article XIII B of the California Constitution because  
 28 the only costs that may be incurred by a local agency or school  
 29 district will be incurred because this act creates a new crime or  
 30 infraction, eliminates a crime or infraction, or changes the penalty  
 31 for a crime or infraction, within the meaning of Section 17556 of  
 32 the Government Code, or changes the definition of a crime within  
 33 the meaning of Section 6 of Article XIII B of the California  
 34 Constitution.

# CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES

## BILL ANALYSIS

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**BILL NUMBER:** AB 1279

**VERSION:** AMENDED MARCH 26, 2015

**AUTHOR:** HOLDEN

**SPONSOR:** THE CERTIFICATION BOARD FOR  
MUSIC THERAPISTS

**RECOMMENDED POSITION:** NONE

**SUBJECT:** MUSIC THERAPY

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### **Overview:**

This bill seeks to define music therapy in statute and to provide guidance to consumers and agencies regarding the education and training requirements of a qualified music therapist.

### **Existing Law:**

- 1) Several state agencies define music therapy in their regulations.
  - The California Department of Education was the most recent agency to do this, adopting a definition for music therapy as it relates to special education in July 2014. (5 CCR (California Code of Regulations) §3051.21)
  - The CCR also defines music therapy under its regulations on Licensing and Certification of Health Facilities, when discussing skilled nursing facilities, immediate care facilities, adult day health centers, and general acute care hospitals. (22 CCR §§ 70055, 72069, 73065, 76105, 78065)
  - The Department of Mental Health regulations include a definition when discussing mental health rehabilitation centers. (9 CCR §782.36)
  - The Public Health title of the CCR defines music therapy when describing vender number codes. (17 CCR 54342)

There is some variance in the definitions of music therapy across these regulations.

### **This Bill:**

- 1) Establishes the Music Therapy Act. (BPC Chapter 10.7, §§ 4650-4654)
- 2) States that it is the intent of the Legislature to provide statutory definitions related to the practice of music therapy and to enable consumers and agencies to more easily identify qualified music therapists. (BPC §4652)



- 3) Defines “music therapy” as the clinical and evidence-based use of music therapy interventions in developmental, rehabilitative, habilitative, medical, mental health, preventive, wellness care, or educational settings to accomplish individualized goals for people of all ages within a therapeutic relationship by a qualified individual. (BPC §4653)
- 4) Includes the following in the scope of music therapy (BPC §4653):
  - a) Development of music therapy treatment plans specific to the needs and strengths of the client;
  - b) Individualized treatment plans for each client; and
  - c) Establishment of goals, objectives, and strategies of music therapy services appropriate for the client and setting.
- 5) Defines music therapy interventions as including the following: music improvisation, receptive music listening, song writing, lyric discussion, music and imagery, singing, music performance, learning through music, music combined with other arts, music-assisted relaxation, music-based patient education, electronic music technology, adapted music intervention, and movement to music. (BPC §4653)
- 6) Defines a “qualified individual” as one who has completed the education and clinical training requirements established by the American Music Therapy Association. The individual must also hold a current board certification from the Certification Board for Music Therapists. (BPC §4653)
- 7) Allows only qualified persons, as defined, to perform music therapy interventions in this state. (BPC §4654)
- 8) Prohibits use of the term “Board Certified Music Therapist” unless the person meets the definition of “qualified individual” and has obtained the “Music Therapist – Board Certified” (MT-BC) credential from the Certification Board of Music Therapists.

**Comments:**

- 1) **Author’s Intent.** The author is seeking to create a uniform definition for music therapy in statute. They note that several agencies have established definitions of music therapy in regulation, however the definitions are inconsistent and sometimes refer to obsolete entities. The goal of this bill is to protect consumers from harm and misrepresentation from practitioners who are not board certified music therapists and who are not practicing under the Certified Board for Music Therapists’ Code of Professional Practice.
- 2) **Existing Certification Process.** Two organizations are jointly involved in the certification process for music therapists. They are the American Music Therapy Association and the Certification Board for Music Therapists.

American Music Therapy Association (AMTA): The AMTA approves music therapy college and university programs. Once a bachelor's degree is completed from an approved program and the 1,200 hours of clinical training requirements are met, an applicant is eligible to take the national board certification exam. The AMTA has also developed standards of clinical practice and a code of ethics.

Certification Board for Music Therapists (CBMT): This agency is fully accredited and certifies music therapists to practice nationally. It offers a credential title of Music Therapist – Board Certified (MT-BC). It states its purpose is to provide an objective national standard that can be used as a measure of professionalism.

The certification board administers its own board certification examination. Once passed, the certification is valid for five years. To recertify after this time, the exam must either be passed again, or continuing education must be completed. The certification board has a code of professional practice that all its certified music therapists must follow, and it includes disciplinary measures.

- 3) Scope of Practice.** The AMTA and the CBMT have jointly developed a definition of the scope of music therapy practice. This document, "Scope of Music Therapy Practice (2015)" can be found in **Attachment A**.

The document defines music therapy practice as the clinical and evidence-based use of music interventions to accomplish individualized goals for people of all ages and ability levels within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program. It states that music therapy clinical practice may be in developmental, rehabilitative, habilitative, medical, mental health, preventive, wellness care, or educational areas.

- 4) Single Specialty Recognition.** Music therapy is one of several sub-types of specialty therapies. Many of these specialty therapies have an independent certification board that will issue a certification or credential if specified requirements are met. Examples of other specialties are dance and movement therapy (certified by the Dance/Movement Therapy Certification Board), and art therapy (certified by the Art Therapy Credentials Board).
- 5) May Prohibit BBS Licensees from Practicing Music Therapy.** This bill states that only a qualified person is permitted to perform music therapy interventions in this state. It defines a "qualified individual" as one who has completed the American Music Therapy Association education and training requirements, and who is certified by the CMBT.

Therefore, as written, a Board licensee who currently practices music therapy would not be able to do so unless certified by the CMBT.

An amendment similar to the following would ensure that Board licensees could continue to practice music therapy:

*"This chapter shall not be construed to constrict, limit, or withdraw the Psychology Licensing Law (Chapter 6.6 (commencing with Section 2900)), the Licensed Marriage and Family Therapist Act (Chapter 13 (commencing with Section 4980)),*

*the Educational Psychologist Practice Act (Chapter 13.5 (commencing with Section 4989.10), the Clinical Social Worker Practice Act (Chapter 14 (commencing with Section 4991)), or the Licensed Professional Clinical Counselor Act (Chapter 16 (commencing with Section 4999.10)).”*

**6) Support and Opposition.**

Support

- The Certification Board for Music Therapists (Sponsor)
- McConnell Music Therapy Services

Oppose

- None at this time.

**7) History.**

**2015**

04/06/15 Re-referred to Com. on B. & P.

03/26/15 From committee chair, with author's amendments: Amend, and re-refer to Com. on B. & P. Read second time and amended.

03/26/15 Referred to Com. on B. & P.

03/02/15 Read first time.

03/01/15 From printer. May be heard in committee March 31.

02/27/15 Introduced. To print.

**8) Attachments.**

**Attachment A:** Scope of Music Therapy Practice, 2015 (American Music Therapy Association, Certification Board for Music Therapists)

AMENDED IN ASSEMBLY MARCH 26, 2015

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

**ASSEMBLY BILL**

**No. 1279**

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**Introduced by Assembly Member Holden**

February 27, 2015

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An act to add Chapter 10.7 (commencing with Section 4650) to Division 2 of the Business and Professions Code, relating to music therapy.

LEGISLATIVE COUNSEL'S DIGEST

AB 1279, as amended, Holden. Music therapy.

Existing law provides for the licensure and regulation of various healing arts practitioners by boards within the Department of Consumer Affairs. *Existing law does not provide for the licensure of music therapists.*

~~This bill would enact the Music Therapy Act and would state the intent of the Legislature to provide statutory definitions relating to the practice of music therapy and enable consumers and state and local agencies to more easily identify qualified music therapists. The bill would define terms for the purposes of the act. provide that only a qualified person, defined as an individual who has completed the education and clinical training requirements established by a specified music therapy association and who holds current board certification from a specified certification organization, shall be permitted to perform music therapy interventions. The bill would further provide that an individual providing music therapy interventions shall not refer to himself or herself using the title of "Board Certified Music Therapist" unless the individual meets certain criteria and has been awarded a credential from the specified certification organization.~~

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

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

1 SECTION 1. Chapter 10.7 (commencing with Section 4650)  
2 is added to Division 2 of the Business and Professions Code, to  
3 read:

4  
5 CHAPTER 10.7. MUSIC THERAPY  
6

7 4650. This chapter shall be known, and may be cited, as the  
8 Music Therapy Act.

9 4651. The Legislature finds and declares the following:

10 (a) Existing national certification of music therapist requires  
11 the therapist to have graduated with a bachelor’s degree or its  
12 equivalent, or higher, from a music therapy degree program  
13 approved by the American Music Therapy Association (AMTA),  
14 successful completion of a minimum of 1,200 hours of supervised  
15 clinical work through preinternship training at an approved degree  
16 program, and internship training through approved national roster  
17 or university affiliated internship programs, or an equivalent.

18 (b) Upon successful completion of the AMTA academic and  
19 clinical training requirements or its international equivalent, an  
20 individual is eligible to sit for the national board certification exam  
21 administered by the Certification Board for Music Therapists  
22 (CBMT), an independent, nonprofit corporation fully accredited  
23 by the National Commission for Certifying Agencies.

24 (c) The CBMT grants the Music Therapist-Board Certified  
25 (MT-BC) credential to music therapists who have demonstrated  
26 the knowledge, skills, and abilities for competence in the current  
27 practice of music therapy. The purpose of board certification in  
28 music therapy is to provide an objective national standard that can  
29 be used as a measure of professionalism and competence by  
30 interested agencies, groups, and individuals.

31 (d) The MT-BC is awarded by the CBMT to an individual upon  
32 successful completion of an academic and clinical training program  
33 approved by the AMTA or an international equivalent and  
34 successful completion of an objective written examination  
35 demonstrating current competency in the profession of music

1 therapy. The CBMT administers this examination, which is based  
2 on a nationwide music therapy practice analysis that is reviewed  
3 and updated every five years to reflect current clinical practice.

4 (e) Once certified, a music therapist must adhere to the CBMT  
5 Code of Professional Practice and recertify every five years through  
6 either a program of continuing education or reexamination.

7 4652. It is the intent of the Legislature that this chapter do the  
8 following:

9 (a) Provide statutory definitions relating to the practice of music  
10 therapy.

11 (b) Enable consumers and state and local agencies to more easily  
12 identify qualified music therapists.

13 4653. As used in this ~~act~~ *chapter*:

14 (a) “Music therapy” means the clinical and evidence-based use  
15 of music therapy interventions in developmental, rehabilitative,  
16 habilitative, medical, mental health, preventive, wellness care, or  
17 educational settings to accomplish individualized goals for people  
18 of all ages and ability levels within a therapeutic relationship by  
19 a qualified individual. Music therapy includes all of the following:

20 (1) The development of music therapy treatment plans specific  
21 to the needs and strengths of the client who may be seen  
22 individually or in groups.

23 (2) Individualized treatment plans for each client.

24 (3) The establishment of goals, objectives, and potential  
25 strategies of the music therapy services appropriate for the client  
26 and setting.

27 (b) “Music therapy interventions” include, but are not limited  
28 to, music improvisation, receptive music listening, song writing,  
29 lyric discussion, music and imagery, singing, music performance,  
30 learning through music, music combined with other arts,  
31 music-assisted relaxation, music-based patient education, electronic  
32 music technology, adapted music intervention, and movement to  
33 music.

34 (c) “Qualified individual” includes an individual who has  
35 completed the education and clinical training requirements  
36 established by the American Music Therapy Association and who  
37 holds current board certification from the Certification Board for  
38 Music Therapists.

39 4654. *Only qualified persons, as defined in subdivision (c) of*  
40 *Section 4653, shall be permitted to perform music therapy*

1 *interventions in the State of California. An individual providing*  
2 *music therapy interventions shall not refer to himself or herself*  
3 *using the title of “Board Certified Music Therapist” unless the*  
4 *individual meets the criteria specified in subdivision (c) of Section*  
5 *4653 and has been awarded the MT-BC credential from the*  
6 *Certification Board of Music Therapists.*

O



CERTIFICATION  
BOARD FOR  
MUSIC  
THERAPISTS

# SCOPE OF MUSIC THERAPY PRACTICE

2015

## Preamble

The scope of music therapy practice defines the range of responsibilities of a fully qualified music therapy professional with requisite education, clinical training, and board certification. Such practice also is governed by requirements for continuing education, professional responsibility and accountability. This document is designed for music therapists, clients, families, health and education professionals and facilities, state and federal legislators and agency officials, private and public payers, and the general public.

## Statement of Purpose

The purpose of this document is to define the scope of music therapy practice by:

1. Outlining the knowledge, skills, abilities, and experience for qualified clinicians to practice safely, effectively and ethically, applying established standards of clinical practice and performing harm to the public;
2. Defining the potential for harm by individuals without formalized music therapy training and credentials; and
3. Describing the education, clinical training, board certification, and continuing education requirements for music therapists.

## Definition of Music Therapy and Music Therapist

Music therapy is defined as the clinical and evidence-based use of music interventions to accomplish individualized goals for people of all ages and ability levels within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program. A music therapist is an individual who has completed the education and clinical training requirements established by the American Music Therapy Association (AMTA) and who holds current board certification from The Certification Board for Music Therapists (CBMT).

## Assumptions

The scope of music therapy practice is based on the values of non-maleficence, beneficence, ethical practice; professional integrity, respect, excellence; and diversity. The following assumptions are the foundation for this document:

- **Public Protection.** The public is entitled to have access to qualified music therapists who practice competently, safely, and ethically.
- **Requisite Training and Skill Sets.** The scope of music therapy

practice includes professional and advanced competencies. The music therapist only provides services within the scope of practice that reflect his/her level of competence. The music therapy profession is not defined by a single music intervention or experience, but rather a continuum of skills sets (simple to complex) that make the profession unique.

- **Evidence-Based Practice.** A music therapist's clinical practice is guided by the integration of the best available research evidence, the client's needs, values, and preferences, and the expertise of the clinician.
- **Overlap in Services.** Music therapists recognize that in order for clients to benefit from an integrated, holistic treatment approach, there will be some overlap in services provided by multiple professions. We acknowledge that other professionals may use music, as appropriate, as long as they are working within their scope.
- **Professional Collaboration.** A competent music therapist will make referrals to other providers (music therapists and non-music therapists) when faced with issues or situations beyond the original clinician's own practice competence, or where greater competence or specialty care is determined as necessary or helpful to the client's condition.
- **Client-Centered Care.** A music therapist is respectful of, and responsive to the needs, values, and preferences of the client and the family. The music therapist involves the client in the treatment planning process, when appropriate.

## Music Therapy Practice

*Music therapy* means the clinical and evidence-based use of music interventions to accomplish individualized goals for people of all ages and ability levels within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program. Music therapists develop music therapy treatment plans specific to the needs and strengths of the client who may be seen individually or in groups. Music therapy treatment plans are individualized for each client. The



goals, objectives, and potential strategies of the music therapy services are appropriate for the client and setting. The music therapy interventions may include music improvisation, receptive music listening, song writing, lyric discussion, music and imagery, singing, music performance, learning through music, music combined with other arts, music-assisted relaxation, music-based patient education, electronic music technology, adapted music intervention, and movement to music. Music therapy clinical practice may be in developmental, rehabilitative, habilitative, medical, mental health, preventive, wellness care, or educational areas. Standards of practice in music therapy include:

- Accepting referrals for music therapy services from medical, developmental, mental health, and education professionals; family members; clients; caregivers; or others involved and authorized with provision of client services. Before providing music therapy services to a client for an identified clinical or developmental need, the music therapist collaborates, as applicable, with the primary care provider(s) to review the client's diagnosis, treatment needs, and treatment plan. During the provision of music therapy services to a client, the music therapist collaborates, as applicable, with the client's treatment team;
- Conducting a music therapy assessment of a client to determine if treatment is indicated. If treatment is indicated, the music therapist collects systematic, comprehensive, and accurate information to determine the appropriateness and type of music therapy services to provide for the client;
- Developing an individualized music therapy treatment plan for the client that is based upon the results of the music therapy assessment. The music therapy treatment plan includes individualized goals and objectives that focus on the assessed needs and strengths of the client and specify music therapy approaches and interventions to be used to address these goals and objectives;
- Implementing an individualized music therapy treatment plan that is consistent with any other developmental, rehabilitative, habilitative, medical, mental health, preventive, wellness care, or educational services being provided to the client;
- Evaluating the client's response to music therapy and the music therapy treatment plan, documenting change and progress, and suggesting modifications, as appropriate;
- Developing a plan for determining when the provision of music therapy services is no longer needed in collaboration with the client, physician, or other provider of health care or education of the client, family members of the client, and any other appropriate person upon whom the client relies for support;
- Minimizing any barriers to ensure that the client receives music therapy services in the least restrictive environment;
- Collaborating with and educating the client and the family, caregiver of the client, or any other appropriate person regarding the needs of the client that are being addressed in music therapy and the manner in which the music therapy treatment addresses those needs; and
- Utilizing appropriate knowledge and skills to inform practice including use of research, reasoning, and problem solving skills to determine appropriate actions in the context of each specific clinical setting.

Music therapists are members of an interdisciplinary team of healthcare, education, and other professionals who work collaboratively to address the needs of clients while protecting client confidentiality and privacy. Music therapists function as independent clinicians within the context

of the interdisciplinary team, supporting the treatment goals and co-treating with physicians, nurses, rehabilitative specialists, neurologists, psychologists, psychiatrists, social workers, counselors, behavioral health specialists, physical therapists, occupational therapists, speech-language pathologists, audiologists, educators, clinical case managers, patients, caregivers, and more.

Music therapy-specific assessment, treatment planning, and implementation consider diagnosis and history, are performed in a manner congruent with the client's level of functioning, and address client needs across multiple domains.

### Potential for Harm

Music therapists are trained to independently analyze client non-verbal, verbal, psychological, and physiological responses to music and non-music stimuli in order to be clinically effective and refrain from contra-indicated practices. The music therapist implements ongoing evaluation of client responses and adapts the intervention accordingly to protect the client from negative outcomes.

Music therapists use their knowledge, skills, training and experience to facilitate therapeutic, goal oriented music-based interactions that are meaningful and supportive to the function and health of their clients. These components of clinical practice continue to evolve with advances in basic science, translational research, and therapeutic implementation. Music therapists, therefore, participate in continued education to remain competent, know their limitations in professional practice, and recognize when it is appropriate to seek assistance, advice, or consultation, or refer the client to another therapist or professional. In addition, music therapists practice safely and ethically as defined by the AMTA Code of Ethics, AMTA Standards of Clinical Practice, CBMT Code of Professional Practice, CBMT Board Certification Domains, and other applicable state and federal laws. Both AMTA and CBMT have mechanisms by which music therapists who are in violation of safe and ethical practice are investigated.

The use of live music interventions demands that the therapist not only possess the knowledge and skills of a trained therapist, but also the unique skill set of a trained musician in order to manipulate the music therapy intervention to fit clients' needs. Given the diversity of diagnoses with which music therapists work and the practice settings in which they work independently, clinical training and experience are necessary. Individuals attempting to provide music therapy treatment interventions without formalized music therapy training and credentials may pose risks to clients.

To protect the public from threats of harm in clinical practice, music therapists comply with safety standards and competencies such as, but not limited to:

- Recognize and respond to situations in which there are clear and present dangers to a client and/or others.
- Recognize the potential harm of music experiences and use them with care.
- Recognize the potential harm of verbal and physical interventions during music experiences and use them with care.
- Observe infection control protocols (e.g., universal precautions, disinfecting instruments).

- Recognize the client populations and health conditions for which music experiences are contraindicated.
- Comply with safety protocols with regard to transport and physical support of clients.

### Definition of Governing Bodies

AMTA's mission is to advance public awareness of the benefits of music therapy and increase access to quality music therapy services in a rapidly changing world. AMTA strives to improve and advance the use of music, in both its breadth and quality, in clinical, educational, and community settings for the betterment of the public health and welfare. The Association serves as the primary organization for the advancement of education, clinical practice, research, and ethical standards in the music therapy profession.

#### AMTA is committed to:

- Promoting quality clinical treatment and ethical practices regarding the use of music to restore, maintain, and improve the health of all persons.
- Establishing and maintaining education and clinical training standards for persons seeking to be credentialed music therapists.
- Educating the public about music therapy.
- Supporting music therapy research.

The mission of the CBMT is to ensure a standard of excellence in the development, implementation, and promotion of an accredited certification program for safe and competent music therapy practice. CBMT is an independent, non-profit, certifying agency fully accredited by the National Commission for Certifying Agencies (NCCA). This accreditation serves as the means by which CBMT strives to maintain the highest standards possible in the construction and administration of its national examination and recertification programs, ultimately designed to reflect current music therapy practice for the benefit of the consumer.

#### CBMT is committed to:

- Maintaining the highest possible standards, as established by the Institute for Credentialing Excellence (ICE) and NCCA, for its national certification and recertification programs.
- Maintaining standards for eligibility to sit for the National Examination: Candidates must have completed academic and clinical training requirements established by AMTA.
- Defining and assessing the body of knowledge that represents safe and competent practice in the profession of music therapy and issuing the credential of Music Therapist Board Certified (MT-BC) to individuals that demonstrate the required level of competence.
- Advocating for recognition of the MT-BC credential and for access to safe and competent practice.
- Maintaining certification and recertification requirements that reflect current practice in the profession of music therapy.
- Providing leadership in music therapy credentialing.

The unique roles of AMTA (education and clinical training) and CBMT (credentialing and continuing education) ensure that the distinct, but related, components of the profession are maintained. This scope of music therapy practice document acknowledges the

separate but complementary contributions of AMTA and CBMT in developing and maintaining professional music therapists and evidence-based practices in the profession.

### Education and Clinical Training Requirements

#### A qualified music therapist:

- Must have graduated with a bachelor's degree (or its equivalent) or higher from a music therapy degree program approved by the American Music Therapy Association (AMTA); and
- Must have successfully completed a minimum of 1,200 hours of supervised clinical work through pre-internship training at the AMTA-approved degree program, and internship training through AMTA-approved National Roster or University Affiliated internship programs, or an equivalent.

Upon successful completion of the AMTA academic and clinical training requirements or its international equivalent, an individual is eligible to sit for the national board certification exam administered by the Certification Board for Music Therapists (CBMT).

### Board Certification Requirements

The Music Therapist – Board Certified (MT-BC) credential is granted by the Certification Board for Music Therapists (CBMT) to music therapists who have demonstrated the knowledge, skills, and abilities for competence in the current practice of music therapy. The purpose of board certification in music therapy is to provide an objective national standard that can be used as a measure of professionalism and competence by interested agencies, groups, and individuals. The MT-BC credential may also be required to meet state laws and regulations. Any person representing him or herself as a board certified music therapist must hold the MT-BC credential awarded by CBMT, an independent, nonprofit corporation fully accredited by the National Commission for Certifying Agencies (NCCA).

The board certified music therapist credential, MT-BC, is awarded by the CBMT to an individual upon successful completion of an academic and clinical training program approved by the American Music Therapy Association (or an international equivalent) and successful completion of an objective written examination demonstrating current competency in the profession of music therapy. The CBMT administers this examination, which is based on a nationwide music therapy practice analysis that is reviewed and updated every five years to reflect current clinical practice. Both the practice analysis and the examination are psychometrically sound and developed using guidelines issued by the Equal Employment Opportunity Commission, and the American Psychological Association's standards for test validation.

Once board certified, a music therapist must adhere to the CBMT Code of Professional Practice and recertify every five years through either a program of continuing education or re-examination.

By establishing and maintaining the certification program, CBMT is in compliance with NCCA guidelines and standards that require certifying agencies to: 1) have a plan for periodic recertification, and 2) provide evidence that the recertification program is designed to measure or enhance the continuing competence of the individual.

The CBMT recertification program provides music therapists with guidelines for remaining current with safe and competent practice and enhancing their knowledge in the profession of music therapy.

The recertification program contributes to the professional development of the board certified music therapist through a program of continuing education, professional development, and professional service opportunities. All three recertification categories are reflective of the Practice Analysis Study and relevant to the knowledge, skills and abilities required of the board certified music therapist. Documentation guidelines in the three categories require applying learning outcomes to music therapy practice and relating them to the CBMT Board Certification Domains. Integrating and applying new knowledge with current practice, developing enhanced skills in delivery of services to clients, and enhancing a board certified music therapist's overall abilities are direct outcomes of the recertification program. To support CBMT's commitment of ensuring the competence of the board certified music therapist and protecting the public, certification must be renewed every five years with the accrual of 100 recertification credits.

NCCA accreditation demonstrates that CBMT and its credentialing program undergo review to demonstrate compliance with certification standards set by an impartial, objective commission whose primary focus is competency assurance and protection of the consumer. The program provides valuable information for music therapists, employers, government agencies, payers, courts and professional organizations. By participating in the CBMT Recertification Program, board certified music therapists promote continuing competence and the safe and effective clinical practice of music therapy.

AMTA and CBMT created this document as a resource pertinent to the practice of music therapy. However, CBMT and AMTA are not offering legal advice, and this material is not a substitute for the services of an attorney in a particular jurisdiction. Both AMTA and CBMT encourage users of this reference who need legal advice on legal matters involving statutes to consult with a competent attorney. Music therapists may also check with their state governments for information on issues like licensure and for other relevant occupational regulation information. Additionally, since laws are subject to change, users of this guide should refer to state governments and case law for current or additional applicable materials.

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# CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES

## BILL ANALYSIS

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**BILL NUMBER:** SB 479

**VERSION:** AMENDED APRIL 6, 2015

**AUTHOR:** BATES

**SPONSOR:** CALIFORNIA ASSOCIATION FOR  
BEHAVIOR ANALYSIS

**RECOMMENDED POSITION:** NONE

**SUBJECT:** HEALING ARTS: BEHAVIOR ANALYSIS: LICENSING

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**Overview** This bill establishes licensure for behavior analysts and assistant behavior analysts under the Board of Psychology.

### **Existing Law:**

- 1) 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 (PDD/A). (Health and Safety Code (HSC) §1374.73(a), Insurance Code (IC) §10144.51(a))
- 2) Requires these health care service plans and health insurers subject to this provision to maintain an adequate network of qualified autism service providers. (HSC §1374.73(b), IC §10144.51(b))
- 3) Defines “behavioral health treatment” as professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs which develop or restore the functioning of an individual with pervasive developmental disorder or autism, and meets the following criteria (HSC §1374.73(c), IC §10144.51(c):
  - 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 and administered by such a provider or by a qualified autism service professional under supervision and employment of 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.
- 4) Defines a “qualified autism service provider” as either (HSC §1374.73(c), IC §10144.51(c)):
- A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited and which designs, supervises, or provides treatment for pervasive developmental disorder or autism; or
  - A person who is licensed as a specified healing arts practitioner, including a psychologist, marriage and family therapist, educational psychologist, clinical social worker, or professional clinical counselor. The licensee must design, supervise, or provide treatment for pervasive developmental disorder or autism and be within his or her experience and competence.
- 5) Defines a “qualified autism service professional” as someone who meets all of the following (HSC §1374.73(c), IC §10144.51(c)):
- Provides behavioral health treatment;
  - Is employed and supervised by a qualified autism service provider;
  - Provides treatment according to a treatment plan developed and approved by the qualified autism service provider.
  - Is a behavioral service provider approved by a regional center to provide services as an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program as defined in Section 54342 of Title 17 of the California Code of Regulations (CCR); and
  - Has training and experience providing services for pervasive developmental disorder or autism pursuant to the Lanterman Developmental Disabilities Services Act.
- 6) Defines a “qualified autism service paraprofessional” as an unlicensed and uncertified person who meets all of the following (HSC §1374.73(c), IC §10144.51(c)):
- Is employed and supervised by a qualified autism service provider;
  - Provides treatment according to a treatment plan developed and approved by the qualified autism service provider;

- Meets criteria set forth in regulations regarding use of paraprofessionals in group practice providing behavioral intervention services; and
  - Is certified by a qualified autism service provider as having adequate education, training, and experience.
- 7) Establishes billing service codes and definitions for the following types of professionals used in regional centers for functions related to behavioral analysis for persons with developmental disabilities: (17 California Code of Regulations (CCR) §54342(a))
- Associate Behavior Analyst;
  - Behavior Analyst;
  - Behavior Management Assistant; and
  - Behavior Management Consultant.

**This Bill:**

- 1) Establishes the Behavior Analyst Act to license behavior analysts and assistant behavior analysts under the Board of Psychology beginning January 1, 2018. (Business and Professions Code (BPC) §2999.10, et. seq.)
- 2) Defines the “practice of behavior analysis” as the design, implementation, and evaluation of instructional and environmental modifications to produce socially significant improvements in human behavior. It includes the following (BPC §2999.12):
  - a) Empirical identification of functional relations between behavior and environmental factors;
  - b) Interventions based on scientific research and direct observation and measurement of behavior and the environment; and
  - c) Utilization of contextual factors, motivating operations, antecedent stimuli, positive reinforcement, and other consequences to help develop new behaviors, increase or decrease existing behaviors, and emit behaviors under specific environmental conditions.
- 3) Specifies that the practice of behavior analysis does not include psychological testing, diagnosis of a mental or physical disorder, neuropsychology, psychotherapy, cognitive therapy, sex therapy, psychoanalysis, hypnotherapy, or counseling. (BPC §2999.12)
- 4) Creates the Behavior Analyst Committee, under the jurisdiction of the Board of Psychology, with the mandate to protect the public from unauthorized and unqualified practice of applied behavior analysis. (BPC §2999.25)

**5) Licensure as a Behavior Analyst (BPC §§2999.31 and 2999.32)**

- i. Requires an applicant for licensure as a Behavior Analyst to maintain active status as a certified behavior analyst with the Behavior Analyst Certification Board (BACB), or a national organization with a behavior analyst certification program approved by the board and accredited by the National Commission for Certifying Agencies. The applicant must also have passed the BACB's exam and be in compliance with its ethical and disciplinary standards. The applicant must also pass a California Law and Ethics Exam.
- ii. Requires the applicant to have met the following requirements:
  - a. Possess a master's degree or higher in behavior analysis or other field related to behavior analysis approved by the certifying entity.
  - b. Completion of one of the following options:

**Option One:**

Completion of 270 hours of graduate level coursework in specified content areas and either 1,500 hours of supervised independent field work in behavior analysis, 1,000 hours of supervised practicum in behavior analysis, 750 hours of supervised intensive practicum in behavior analysis, or a combination thereof.

**Option Two:**

Completion of one academic year as a full time faculty at a college or university where he or she taught classes on principals of behavior analysis, and conducted and published research on behavior analysis, and either 1,500 hours of supervised independent field work in behavior analysis, 1,000 hours of supervised practicum in behavior analysis, 750 hours of supervised intensive practicum in behavior analysis, or a combination thereof.

**Option Three:**

Possess a doctoral degree conferred at least ten years prior to application, in behavior analysis, psychology, education, or related field, and have ten years verified and documented postdoctoral experience practicing behavior analysis.

**6) Licensure as an Assistant Behavior Analyst (BPC §§2999.33 and 2999.34)**

- i. Requires an applicant for licensure as an Assistant Behavior Analyst to maintain active status as a certified assistant behavior analyst with the Behavior Analyst Certification Board (BACB), or a national organization with a behavior analyst certification program approved by the board and accredited by the National Commission for Certifying Agencies. The applicant must also have passed the BACB's exam and be in compliance with its ethical and

disciplinary standards. The applicant must also pass a California Law and Ethics Exam.

- ii. Requires the applicant to provide proof of ongoing supervision by a licensed behavior analyst.
  - iii. Requires the applicant to have a bachelor's degree from an accredited institution.
  - iv. Requires the applicant to complete 180 hours of undergraduate or graduate instruction in specified content areas, and either 1,000 hours of supervised independent field work in behavior analysis, 670 hours of supervised practicum in behavior analysis, 500 hours of supervised intensive practicum in behavior analysis, or a combination thereof.
- 7) Prohibits a person from engaging in the practice of behavior analysis, representing his or her self as a licensed behavior analyst or licensed assistant behavior analyst, or using the title or letters, without being licensed (BPC §2999.36).
- 8) Exempts the following practitioners from the provisions of this licensing act if the person is acting within the scope of his or her licensed scope of practice and within the scope of his or her training and competence (BPC §2999.37):
- a) Licensed psychologists;
  - b) Licensed occupational therapists;
  - c) Licensed physical therapists;
  - d) **Licensed marriage and family therapists;**
  - e) **Licensed educational psychologists;**

Any of the above individuals must not represent that they are a licensed behavior analyst or licensed assistant behavior analyst, unless they actually hold that license.

- 9) Exempts certain other, nonlicensed persons from the provisions of this licensing act, including the following (BPC §2999.37):
- a) A person acting under authority and direction of a licensed behavior analyst, assistant licensed behavior analyst, or one of the licensed professionals listed in Item 8 above;
  - b) A family member of a recipient of behavior analysis services acting under the authority and direction of a licensed behavior analyst or licensed assistant behavior analyst;
  - c) A college or university student practicing as part of a course of study or practicum, under supervision;
  - d) An unlicensed individual pursuing supervised experience in behavior analysis;
  - e) An individual vendorized by a regional center.



**10)** Allows reciprocity by permitting the Board of Psychology to license a person as a behavior analyst or assistant behavior analyst if he or she is licensed in another state, if that state has comparable license requirements, and if that state offers reciprocity to California licensees. The applicant must be in good standing and must also pass the California law and ethics exam. (BPC §2999.40)

**11)** Sets forth criteria for renewing a license. (BPC §§2999.44-2999.46)

**12)** Sets forth unprofessional conduct provisions. (BPC §2999.62)

**Comments:**

**1) Intent of This Bill.** Applied Behavior Analysis (ABA) is commonly used to treat autism spectrum disorders. During the past decade, there has been increasing evidence that ABA therapy is effective in the treatment of autism, and there has been an increase in the practice of this profession in California. State law now mandates that insurance plans provide coverage for ABA treatment. However, the California Business and Professions Code does not apply any standard requirements to the practice of ABA.

Because there is no licensure for ABAs, it is difficult for consumers to make an informed decision when choosing an applied behavior analyst. In some cases, ABA programs may be designed, supervised, and/or implemented by someone who lacks training and experience.

The goal of this bill is establish licensure for behavior analysts and assistant behavior analysts, so that individuals with autism are protected from unqualified practitioners.

**2) Certification Requirement.** In order to qualify for licensure, this bill would require an applicant for a behavior analyst or assistant behavior analyst license to hold an active certification with the Behavior Analyst Certification Board (BACB).

The BACB is a nonprofit corporation that certifies Board Certified Behavior Analysts (BCBAs) and Board Certified Assistant Behavior Analysts (BCaBAs). The Behavior Analyst Certification Board's BCBA and BCaBA credentialing programs are accredited by the National Commission for Certifying Agencies in Washington, DC.

According to the author's office, as of March 2014 there were 2,198 practitioners certified by the BACB in California.

Individuals who wish to become a BCBA must meet the following requirements:

- a. Possess a Master's Degree;
- b. Have 270 classroom hours of specific graduate-level coursework;
- c. Meet supervised experience requirements; and
- d. Pass the Board Certified Behavior Analyst Examination.

Persons wishing to become a BCaBA must meet the following requirements:

- a. Possess a Bachelor's Degree;
- b. Have 180 classroom hours of specific coursework;
- c. Meet supervised experience requirements; and
- d. Pass the Board Certified Assistant Behavior Analyst Examination.

All BACB certificants must accumulate continuing education credit to maintain their credentials.

- 3) Exemptions from Licensure.** Section 2999.37 of this bill exempts licensed psychologists, licensed marriage and family therapists, and licensed educational psychologists from needing a license to practice ABA, provided they are acting within their scope of practice and also within the scope of their training and competence.

However, licensed clinical social workers and licensed professional clinical counselors are not included in this exemption. It is unknown why these two license types were excluded.

SB 946 (Chapter 650, Statutes of 2011), which is the Steinberg bill requiring health plans to cover behavioral health treatment for autism, defines a "qualified autism service provider." That definition includes all of BBS's licensees, as follows:

Health and Safety Code 1374.73(c):

(3) "Qualified autism service provider" means either of the following:

(A) A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person, entity, or group that is nationally certified.

(B) A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.

- 4) Reciprocity.** This bill allows reciprocity for licensed behavior analysts or assistant behavior analysts in other states, as long as the state in which licensed has comparable licensing requirements, and if that state offers reciprocity to California licensees. The applicant must be licensed in good standing and must pass a California law and ethics exam.

According to the author's office, approximately 17 other states have some form of licensure or certification for behavior analysts. The reciprocity policies of these states are unknown, however, it may be punitive to exclude an otherwise qualified licensee from licensure in California, simply because the state in which he or she is licensed does not offer reciprocity.

**5) Related Legislation.** AB 796 (Nazarian) proposes modifying the definition of "qualified autism service professional" and "qualified autism service paraprofessional" to allow insurance coverage for types of behavioral health treatment other than ABA.

**6) Previous Legislation.** AB 1282 (Steinberg, 2010) was proposed in 2010. This bill, which failed passage, attempted to establish a certification process for practitioners of behavior analysis. It would have established the California Behavioral Certification Organization (CBCO), a nonprofit organization that would have provided for the certification and registration of applied behavioral analysis practitioners if they met certain conditions, one of which was being certified by the BACB or a similar entity. The Board took an oppose position on this legislation.

AB 1205 (Berryhill, 2011), proposed licensing behavior analysts and assistant behavior analysts under the Board of Behavioral Sciences. The Board did not take a position on this legislation. The bill died in the Assembly Appropriations Committee.

SB 946 (Chapter 650, Statutes of 2011) requires every health care service plan contract and insurance policy that provides hospital, medical, or surgical coverage shall also provide coverage for behavioral health treatment for pervasive developmental disorder or autism, effective July 1, 2012.

SB 126 (Chapter 680, Statutes of 2013) extended the provisions of SB 946 until January 1, 2017.

## **7) Support and Opposition.**

*None at this time.*

## **8) History.**

### **2015**

04/10/15 Set for hearing April 27.

04/09/15 Re-referred to Com. on B., P. & E.D.

04/06/15 From committee with author's amendments. Read second time and amended. Re-referred to Com. on RLS.

03/12/15 Referred to Com. on RLS.

02/27/15 From printer. May be acted upon on or after March 29.

02/26/15 Introduced. Read first time. To Com. on RLS. for assignment. To print.

AMENDED IN SENATE APRIL 6, 2015

**SENATE BILL**

**No. 479**

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**Introduced by Senator Bates**

February 26, 2015

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*An act to amend Sections 27 and 2920 of, to amend, repeal, and add Sections 2922, 2923, and 2927 of, to add Chapter 6.7 (commencing with Section 2999.10) to Division 2 of, and to repeal Section 2999.25 of, the Business and Professions Code, relating to healing arts.*

LEGISLATIVE COUNSEL'S DIGEST

SB 479, as amended, Bates. ~~Healing arts: arts: behavior analysis: licensing.~~

Existing law provides for the licensure and regulation of various healing arts licensees by various boards, as defined, within the Department of Consumer Affairs, including the Board of Behavioral Sciences and the Board of Psychology. *Under existing law, until January 1, 2017, the board is vested with the power to enforce the Psychology Licensing Law, and consists of 9 members, 4 of whom are public members and 5 of whom are licensed psychologists. Existing law requires the board to post information on its licensees, as specified, including, among others, psychological assistants. Existing law specifies that a quorum of the board requires 5 members.*

~~This bill would declare the intent of the legislature to enact legislation to license and regulate the profession of applied behavioral analysis.~~

*This bill would, on and after July 1, 2017, increase the number of members on the board to 11, and would increase the number of members for a quorum to 6 members. The bill would require the 2 new members to meet certain requirements, including, but not limited to, that they practice behavior analysis, as defined.*

*This bill would establish the Behavior Analyst Act. The bill would require a person to apply for and obtain a license from the board prior to engaging in the practice of behavior analysis, as defined, either as a behavior analyst or an assistant behavior analyst. The bill would require applicants to, among other things, meet certain educational and training requirements, and submit fingerprints for both a state and federal criminal background check.*

*This bill would, until January 1, 2021, vest the board with the power to enforce the Behavior Analyst Act, and would require the board to, among other things, post information regarding licensed behavior analysts and licensed assistant behavior analysts, as specified. The bill would, until January 1, 2021, create the Behavior Analyst Committee within the jurisdiction of the board, and would require the committee to be comprised of 5 members who shall be appointed as specified. The bill would authorize the committee to make recommendations to the board regarding the implementation of the act.*

*This bill would define certain terms for these purposes. The bill would require the board to conduct disciplinary hearings, as specified. The bill on and after January 1, 2018, make it unlawful to, among other things, practice behavior analysis without being licensed by the board, except as specified.*

*This bill would make a violation of any of these provisions a misdemeanor punishable by 6 months in the county jail or a fine not to exceed \$2,500, or by both imprisonment and a fine. By creating a new crime, this bill would result in a state-mandated local program.*

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

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

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

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

- 1     SECTION 1. Section 27 of the Business and Professions Code
- 2     is amended to read:
- 3     27. (a) Each entity specified in subdivisions (c), (d), and (e)
- 4     shall provide on the Internet information regarding the status of

1 every license issued by that entity in accordance with the California  
2 Public Records Act (Chapter 3.5 (commencing with Section 6250)  
3 of Division 7 of Title 1 of the Government Code) and the  
4 Information Practices Act of 1977 (Chapter 1 (commencing with  
5 Section 1798) of Title 1.8 of Part 4 of Division 3 of the Civil Code).  
6 The public information to be provided on the Internet shall include  
7 information on suspensions and revocations of licenses issued by  
8 the entity and other related enforcement action, including  
9 accusations filed pursuant to the Administrative Procedure Act  
10 (Chapter 3.5 (commencing with Section 11340) of Part 1 of  
11 Division 3 of Title 2 of the Government Code) taken by the entity  
12 relative to persons, businesses, or facilities subject to licensure or  
13 regulation by the entity. The information may not include personal  
14 information, including home telephone number, date of birth, or  
15 social security number. Each entity shall disclose a licensee's  
16 address of record. However, each entity shall allow a licensee to  
17 provide a post office box number or other alternate address, instead  
18 of his or her home address, as the address of record. This section  
19 shall not preclude an entity from also requiring a licensee, who  
20 has provided a post office box number or other alternative mailing  
21 address as his or her address of record, to provide a physical  
22 business address or residence address only for the entity's internal  
23 administrative use and not for disclosure as the licensee's address  
24 of record or disclosure on the Internet.

25 (b) In providing information on the Internet, each entity specified  
26 in subdivisions (c) and (d) shall comply with the Department of  
27 Consumer Affairs' guidelines for access to public records.

28 (c) Each of the following entities within the Department of  
29 Consumer Affairs shall comply with the requirements of this  
30 section:

31 (1) The Board for Professional Engineers, Land Surveyors, and  
32 Geologists shall disclose information on its registrants and  
33 licensees.

34 (2) The Bureau of Automotive Repair shall disclose information  
35 on its licensees, including auto repair dealers, smog stations, lamp  
36 and brake stations, smog check technicians, and smog inspection  
37 certification stations.

38 (3) The Bureau of Electronic and Appliance Repair, Home  
39 Furnishings, and Thermal Insulation shall disclose information on  
40 its licensees and registrants, including major appliance repair

1 dealers, combination dealers (electronic and appliance), electronic  
2 repair dealers, service contract sellers, and service contract  
3 administrators.

4 (4) The Cemetery and Funeral Bureau shall disclose information  
5 on its licensees, including cemetery brokers, cemetery salespersons,  
6 cemetery managers, crematory managers, cemetery authorities,  
7 crematories, cremated remains disposers, embalmers, funeral  
8 establishments, and funeral directors.

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

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

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

22 (8) The California Board of Accountancy shall disclose  
23 information on its licensees and registrants.

24 (9) The California Architects Board shall disclose information  
25 on its licensees, including architects and landscape architects.

26 (10) The State Athletic Commission shall disclose information  
27 on its licensees and registrants.

28 (11) The State Board of Barbering and Cosmetology shall  
29 disclose information on its licensees.

30 (12) The State Board of Guide Dogs for the Blind shall disclose  
31 information on its licensees and registrants.

32 (13) The Acupuncture Board shall disclose information on its  
33 licensees.

34 (14) The Board of Behavioral Sciences shall disclose  
35 information on its licensees, including licensed marriage and family  
36 therapists, licensed clinical social workers, licensed educational  
37 psychologists, and licensed professional clinical counselors.

38 (15) The Dental Board of California shall disclose information  
39 on its licensees.

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

5 (17) The Board of Psychology shall disclose information on its  
6 licensees, including psychologists, psychological assistants, ~~and~~  
7 ~~registered psychologists.~~ *psychologists, behavior analysts, and*  
8 *assistant behavior analysts.*

9 (d) The State Board of Chiropractic Examiners shall disclose  
10 information on its licensees.

11 (e) The Structural Pest Control Board shall disclose information  
12 on its licensees, including applicators, field representatives, and  
13 operators in the areas of fumigation, general pest and wood  
14 destroying pests and organisms, and wood roof cleaning and  
15 treatment.

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

18 *SEC. 2. Section 2920 of the Business and Professions Code is*  
19 *amended to read:*

20 2920. (a) The Board of Psychology shall enforce and  
21 administer this ~~chapter.~~ *chapter and Chapter 6.7 (commencing*  
22 *with Section 2999.10).* The board shall consist of nine members,  
23 four of whom shall be public members.

24 (b) *On and after July 1, 2017, notwithstanding paragraph (a),*  
25 *the board shall consist of 11 members, four of whom shall be public*  
26 *members.*

27 ~~(b)~~

28 (c) This section shall remain in effect only until January 1, 2017,  
29 and as of that date is ~~repealed, unless a later enacted statute, that~~  
30 ~~is enacted before January 1, 2017, deletes or extends that date.~~  
31 *repealed.*

32 ~~(e)~~

33 (d) Notwithstanding any other ~~provision of~~ law, the repeal of  
34 this section renders the board subject to review by the appropriate  
35 policy committees of the Legislature.

36 *SEC. 3. Section 2922 of the Business and Professions Code is*  
37 *amended to read:*

38 2922. (a) In appointing the members of the board, except the  
39 public members, the Governor shall use his or her judgment to



1 select psychologists who represent, as widely as possible, the varied  
 2 professional interests of psychologists in California.

3 ~~The~~

4 (b) ~~The~~ Governor shall appoint two of the public members and  
 5 the five licensed members of the board qualified as provided in  
 6 Section 2923. ~~The Senate Rules Committee on Rules and the~~  
 7 ~~Speaker of the Assembly shall each appoint a public member, and~~  
 8 ~~their initial appointment shall be made to fill, respectively, the first~~  
 9 ~~and second public member vacancies which occur on or after~~  
 10 ~~January 1, 1983. member.~~

11 (c) *This section shall become inoperative on July 1, 2017, and,*  
 12 *as of January 1, 2018, is repealed.*

13 SEC. 4. *Section 2922 is added to the Business and Professions*  
 14 *Code, to read:*

15 2922. (a) *In appointing the licensed members of the board,*  
 16 *the Governor shall use his or her judgment to select psychologists*  
 17 *and behavior analysts who represent, as widely as possible, the*  
 18 *varied professional interests of psychologists and behavior analysts*  
 19 *in California.*

20 (b) *The Governor shall appoint two of the public members and*  
 21 *the seven licensed members of the board qualified as provided in*  
 22 *Section 2923. The Senate Committee on Rules and the Speaker of*  
 23 *the Assembly shall each appoint a public member.*

24 (c) *This section shall become operative on July 1, 2017.*

25 SEC. 5. *Section 2923 of the Business and Professions Code is*  
 26 *amended to read:*

27 2923. (a) Each member of the board shall have all of the  
 28 following qualifications:

29 ~~(a)~~

30 (1) He or she shall be a resident of this state.

31 ~~(b)~~

32 (2) Each member appointed, except the public members, shall  
 33 be a licensed psychologist.

34 ~~The~~

35 (b) *The public members shall not be licentiates of the board or*  
 36 *of any board under this division or of any board referred to in the*  
 37 *Chiropractic Act or the Osteopathic Act.*

38 (c) *This section shall become inoperative on July 1, 2017, and,*  
 39 *as of January 1, 2018, is repealed.*

1 SEC. 6. Section 2923 is added to the Business and Professions  
2 Code, to read:

3 2923. (a) Each member of the board shall be a resident of this  
4 state.

5 (b) Five members of the board shall be licensed as psychologists  
6 under this chapter.

7 (c) One member shall be licensed as a psychologist under this  
8 chapter and shall be qualified to practice behavior analysis, as  
9 defined in Section 2999.12, as follows:

10 (1) For the first appointment after the operative date of this  
11 section, the member shall hold a certificate as a certified behavior  
12 analyst from a certifying entity, as defined in Section 2999.12.

13 (2) For subsequent appointments, the member shall be licensed  
14 as a behavior analyst under Chapter 6.7 (commencing with Section  
15 2999.10).

16 (d) One member shall be qualified to practice behavior analysis,  
17 as defined in Section 2999.12, as follows:

18 (1) For the first appointment after the operative date of this  
19 section, the member shall hold a certificate as a certified behavior  
20 analyst from a certifying entity, as defined in Section 2999.12.

21 (2) For subsequent appointments, the member shall be licensed  
22 as a behavior analyst under Chapter 6.7 (commencing with Section  
23 2999.10).

24 (e) The public members shall not be licentiates of the board or  
25 of any board under this division or of any board referred to in the  
26 Chiropractic Act or the Osteopathic Act.

27 (f) This section shall become operative on July 1, 2017.

28 SEC. 7. Section 2927 of the Business and Professions Code is  
29 amended to read:

30 2927. (a) Five members of the board shall at all times  
31 constitute a quorum.

32 (b) This section shall become inoperative on July 1, 2017, and,  
33 as of January 1, 2018, is repealed.

34 SEC. 8. Section 2927 is added to the Business and Professions  
35 Code, to read:

36 2927. (a) Six members of the board shall at all times constitute  
37 a quorum.

38 (b) This section shall become operative on July 1, 2017.

39 SEC. 9. Chapter 6.7 (commencing with Section 2999.10) is  
40 added to Division 2 of the Business and Professions Code, to read:

CHAPTER 6.7. BEHAVIOR ANALYSTS

Article 1. General Provisions

2999.10. This chapter shall be known and may be cited as the Behavior Analyst Act.

2999.11. (a) The Legislature finds and declares that the practice of behavior analysis in California affects the public health, safety, and welfare, and is subject to regulation to protect the public from the unauthorized and unqualified practice of behavior analysis, and unprofessional, unethical or harmful conduct by persons licensed to practice behavior analysis.

(b) It is the intent of the Legislature that the board begin accepting applications for behavior analyst licensure and assistant behavior analyst licensure no later than January 1, 2018, provided that the funds necessary to implement this chapter have been appropriated by the Legislature as specified in Section 2999.98.

2999.12. For purposes of this chapter, the following terms have the following meanings:

(a) "Board" means the Board of Psychology.

(b) "Certifying entity" means the Behavior Analyst Certification Board or its successor, or a national organization with a behavior analyst certification program approved by the board and accredited by the National Commission for Certifying Agencies.

(c) "Committee" means the Behavior Analyst Committee.

(d) "Department" means the Department of Consumer Affairs.

(e) "Licensed assistant behavior analyst" means a person licensed under this chapter to practice behavior analysis under the supervision of a licensed behavior analyst and who meets the requirements of Section 2999.33.

(f) "Licensed behavior analyst" means a person licensed under this chapter to practice behavior analysis and who meets the requirements of Section 2999.31.

(g) (1) "Practice of behavior analysis" or "to practice behavior analysis" means the design, implementation, and evaluation of instructional and environmental modifications to produce socially significant improvements in human behavior and includes any of the following:

1 (A) *The empirical identification of functional relations between*  
2 *behavior and environmental factors, known as functional*  
3 *assessment and analysis.*

4 (B) *Interventions based on scientific research and the direct*  
5 *observation and measurement of behavior and the environment.*

6 (C) *Utilization of contextual factors, motivating operations,*  
7 *antecedent stimuli, positive reinforcement, and other consequences*  
8 *to help people develop new behaviors, increase or decrease existing*  
9 *behaviors, and emit behaviors under specific environmental*  
10 *conditions.*

11 (2) *The practice of behavior analysis does not include*  
12 *psychological testing, diagnosis of a mental or physical disorder,*  
13 *neuropsychology, psychotherapy, cognitive therapy, sex therapy,*  
14 *psychoanalysis, hypnotherapy, or counseling as treatment*  
15 *modalities.*

16  
17 *Article 2. Administration*  
18

19 2999.20. (a) *The Board of Psychology is vested with the power*  
20 *to administer the provisions and requirements of this chapter, and*  
21 *may make and enforce rules and regulations that are reasonably*  
22 *necessary to carry out its provisions.*

23 (b) *This section shall remain in effect only until January 1, 2021,*  
24 *and as of that date is repealed. Notwithstanding any other law,*  
25 *the repeal of this section renders the board subject to review by*  
26 *the appropriate policy committees of the Legislature.*

27 2999.21. *Protection of the public shall be the highest priority*  
28 *for the board in exercising its licensing, regulatory, and*  
29 *disciplinary functions pursuant to this chapter. Whenever the*  
30 *protection of the public is inconsistent with other interests sought*  
31 *to be promoted, the protection of the public shall be paramount.*

32 2999.22. *Upon recommendation of the committee, the board*  
33 *shall adopt, amend, and repeal regulations to implement the*  
34 *requirements of this chapter. All regulations adopted by the board*  
35 *shall comply with the provisions of Chapter 3.5 (commencing with*  
36 *Section 11340) of Part 1 of Division 3 of Title 2 of the Government*  
37 *Code.*

38 2999.23. *The board may employ, subject to civil service and*  
39 *other laws, employees as may be necessary to carry out the*

1 provisions of this chapter under the direction of the executive  
2 officer of the board.

3 2999.24. The board shall maintain, and make available to the  
4 public, a list of all licensees. The board shall make available on  
5 its Internet Web site information regarding the status of every  
6 license issued by the board under this chapter pursuant to Section  
7 27.

8 2999.25. (a) The Behavior Analyst Committee is hereby  
9 created within the jurisdiction of the board to protect the public  
10 from the unauthorized and unqualified practice of applied behavior  
11 analysis, and unprofessional, unethical, or harmful conduct by  
12 persons licensed to practice behavior analysis.

13 (b) The committee shall consist of five members. Two members  
14 shall be licensed behavior analysts. One member shall be a  
15 psychologist licensed under Chapter 6.6 (commencing with Section  
16 2900) who is also a member of the Board of Psychology and who  
17 holds a license as a behavior analyst. One member shall be a  
18 licensed assistant behavior analyst. One member shall be a public  
19 member who is a consumer of behavior analysis services and who  
20 is not licensed under this chapter, under any chapter within this  
21 division, or by any board referred to in the Chiropractic Act or  
22 the Osteopathic Act.

23 (c) The Governor shall appoint one licensed behavior analyst  
24 member, the licensed psychologist member, and the licensed  
25 assistant behavior analyst member. The Senate Committee on  
26 Rules shall appoint the public member, and the Speaker of the  
27 Assembly shall appoint one licensed behavior analyst member.

28 (d) Notwithstanding subdivisions (b) and (c), the initially  
29 appointed members of the committee shall be appointed as follows:

30 (1) The initial members appointed by the Governor shall be as  
31 follows:

32 (A) One member shall hold a certificate as a certified behavior  
33 analyst from a certifying entity and shall serve an initial term of  
34 one year.

35 (B) One member shall hold a certificate as a certified assistant  
36 behavior analyst from a certifying entity and shall serve an initial  
37 term of two years.

38 (C) One member shall be a licensed psychologist who holds a  
39 certificate as a certified behavior analyst from a certifying entity  
40 and shall serve an initial term of three years.

1 (2) *The initial member appointed by the Senate Committee on*  
2 *Rules shall serve a term of four years.*

3 (3) *The initial member appointed by the Speaker of the Assembly*  
4 *shall hold a certificate as a certified behavior analyst from a*  
5 *certifying entity and shall serve an initial term of four years.*

6 (e) *Except as provided in paragraph (d), each member of the*  
7 *committee shall hold office for a term of four years, and shall serve*  
8 *until the appointment of his or her successor or until one year has*  
9 *elapsed since the expiration of the term for which he or she was*  
10 *appointed, whichever occurs first. Vacancies shall be filled by the*  
11 *appointing power for the unexpired portion of the terms in which*  
12 *they occur. A member shall not serve for more than two consecutive*  
13 *terms.*

14 (f) *All terms shall begin on July 1 and expire on June 30.*

15 (g) *Each member of the committee shall receive per diem and*  
16 *expenses as provided in Sections 103 and 113.*

17 (h) *Three members of the committee shall at all times constitute*  
18 *a quorum.*

19 (i) *This section shall become operative on July 1, 2017.*

20 (j) *This section shall remain in effect only until January 1, 2021,*  
21 *and as of that date is repealed. Notwithstanding any other law,*  
22 *the repeal of this section renders the committee subject to review*  
23 *by the appropriate policy committees of the Legislature.*

24 2999.26. *The committee shall do all of the following:*

25 (a) *Meet at least once per quarter. All meetings of the committee*  
26 *shall be public meetings. Notice of each regular meeting of the*  
27 *board shall be given in accordance with the Bagley-Keene Open*  
28 *Meeting Act (Article 9 (commencing with Section 11120) of*  
29 *Chapter 1 of Part 1 of Division 3 of Title 2 of the Government*  
30 *Code).*

31 (b) *Committee meetings may be called upon reasonable notice*  
32 *at the discretion of the chair, and shall be called at any time upon*  
33 *reasonable notice by a written request of two committee members*  
34 *to the chair.*

35 (c) *The committee shall elect a chair and a vice chair from*  
36 *among its members at the first meeting held in each fiscal year.*  
37 *The chair shall preside at all meetings of the committee and shall*  
38 *work with the executive officer of the board to coordinate the*  
39 *committee's business. If the chair is unable to attend a meeting,*  
40 *the vice chair shall preside at the meeting.*

1 2999.27. (a) *The committee may make recommendations to*  
2 *the board regarding licensing and practice standards.*

3 (b) *The committee may make recommendations to the board*  
4 *regarding the adoption, amendment, and repeal of regulations to*  
5 *implement the requirements of this chapter including, but not*  
6 *limited to, the setting of fees and the establishment of disciplinary*  
7 *actions.*

8 2999.28. *Any action taken by the committee under this chapter*  
9 *shall only be effective after adoption by majority vote of the*  
10 *members of the committee and after adoption by a majority vote*  
11 *of the members of the board.*

12

### 13 Article 3. Licensing

14

15 2999.30. *To qualify for licensure as a licensed behavior analyst*  
16 *or a licensed assistant behavior analyst, each applicant shall meet*  
17 *the board's regulatory requirements for behavior analyst or*  
18 *assistant behavior analyst licensure, as applicable, including all*  
19 *of the following:*

20 (a) *The applicant has not committed acts or crimes constituting*  
21 *grounds for denial of licensure under Section 480.*

22 (b) *The board shall not issue a license or registration to any*  
23 *person who has been convicted of a crime in this state, or another*  
24 *state, or in a territory of the United States that involves sexual*  
25 *abuse of a child, or who is required to register pursuant to Section*  
26 *290 of the Penal Code or the equivalent in another state or*  
27 *territory.*

28 (c) *The applicant has successfully passed a state and federal*  
29 *level criminal offender record information search conducted*  
30 *through the Department of Justice, as follows:*

31 (1) *The board shall direct applicants to electronically submit*  
32 *to the Department of Justice fingerprint images and related*  
33 *information required by the Department of Justice for the purpose*  
34 *of obtaining information as to the existence and content of a record*  
35 *of state and federal level convictions and arrests and information*  
36 *as to the existence and content of a record of state or federal level*  
37 *arrests for which the Department of Justice establishes that the*  
38 *person is free on bail or on his or her own recognizance pending*  
39 *trial or appeal.*

1 (2) *The Department of Justice shall forward the fingerprint*  
2 *images and related information received pursuant to paragraph*  
3 *(1) to the Federal Bureau of Investigation and request a federal*  
4 *summary for criminal history information.*

5 (3) *The Department of Justice shall review the information*  
6 *returned from the Federal Bureau of Investigation and compile*  
7 *and disseminate a response to the board pursuant to paragraph*  
8 *(1) of subdivision (p) of Section 11105 of the Penal Code.*

9 (4) *The board shall request from the Department of Justice*  
10 *subsequent arrest notification service, pursuant to Section 11105.2*  
11 *of the Penal Code, for each person who submitted information*  
12 *pursuant to paragraph (1).*

13 (5) *The Department of Justice shall charge a fee sufficient to*  
14 *cover the cost of processing the request described in this section.*

15 2999.31. (a) *To obtain a license as a behavior analyst, an*  
16 *individual shall submit an application on a form approved by the*  
17 *board accompanied by the fees required by the board as specified*  
18 *in Section 2999.93.*

19 (b) *The board shall verify with the certifying entity that the*  
20 *applicant meets all of the following requirements:*

21 (1) *Has passed the Board Certified Behavior Analyst*  
22 *examination administered by the Behavior Analyst Certification*  
23 *Board.*

24 (2) *Maintains an active status as a certified behavior analyst*  
25 *with the certifying entity.*

26 (3) *Is in compliance with all ethical and disciplinary standards*  
27 *published by the certifying entity.*

28 (c) *Each applicant shall obtain a passing score on a California*  
29 *law and ethics examination administered by the board.*

30 2999.32. (a) *In order for an individual to be licensed as a*  
31 *behavior analyst under this chapter, he or she shall possess a*  
32 *master's degree or higher level of education from an institution,*  
33 *which meets the requirements described in Section 2999.35, that*  
34 *was conferred in behavior analysis or other natural science,*  
35 *education, human services, engineering, medicine, or a field related*  
36 *to behavior analysis and approved by the certifying entity.*

37 (b) *In addition to subdivision (a), an individual shall meet one*  
38 *of the following in order to be licensed under this chapter:*

39 (1) *An individual shall have completed both of the following:*



- 1 (A) Completed 270 hours of classroom graduate-level  
2 instruction in the following content areas:
- 3 (i) Ethical and professional conduct coursework consisting of  
4 45 hours. The content must be taught in one or more freestanding  
5 courses devoted to ethical and professional conduct of behavior  
6 analysts.
- 7 (ii) Concepts and principles of behavior analysis consisting of  
8 45 hours.
- 9 (iii) Research methods in behavior analysis, consisting of 25  
10 hours of measurement, including data analysis, and 20 hours of  
11 experimental design.
- 12 (iv) Applied behavior analysis, consisting of 45 hours of  
13 fundamental elements of behavior change and specific behavior  
14 change procedures, 30 hours of identification of the problem and  
15 assessment, 10 hours of intervention and behavior change  
16 considerations, 10 hours of behavior change systems, and 10 hours  
17 of implementation, management and supervision.
- 18 (v) Discretionary coursework in behavior analysis consisting  
19 of 30 hours.
- 20 (B) Obtained experience by any of the following:
- 21 (i) Completed 1,500 hours of independent field work in behavior  
22 analysis supervised in accordance with the requirements of the  
23 certifying entity.
- 24 (ii) Completed, with a passing grade, 1,000 hours of supervised  
25 practicum in behavior analysis within a university practicum  
26 approved by the certifying entity and taken for graduate academic  
27 credit.
- 28 (iii) Completed, with a passing grade, 750 hours of supervised  
29 intensive practicum in behavior analysis within a university  
30 practicum approved by the certifying entity and taken for graduate  
31 academic credit.
- 32 (iv) Completed a combination of the supervised experience in  
33 clause (i), (ii), or (iii). Hours may be completed in any combination  
34 of the categories of supervised experience. Hours accrued through  
35 a combination of supervised experience shall be proportionately  
36 calculated.
- 37 (2) An individual shall have done both of the following:
- 38 (A) Completed one academic year as a full-time faculty  
39 appointment at a college or university, as described in Section  
40 2999.35, during which he or she did all of the following:

- 1 (i) Taught classes on basic principles of behavior, single-subject  
2 research methods, applications of basic principles of behavior in  
3 applied settings, and ethical issues.
- 4 (ii) Conducted and published research in behavior analysis.
- 5 (B) Obtained experience by any of the following:
- 6 (i) Completed 1,500 hours of independent field work in behavior  
7 analysis supervised in accordance with the requirements of the  
8 certifying entity.
- 9 (ii) Completed, with a passing grade, 1,000 hours of supervised  
10 practicum in behavior analysis within a university practicum  
11 approved by the certifying entity and taken for graduate academic  
12 credit.
- 13 (iii) Completed, with a passing grade, 750 hours of supervised  
14 intensive practicum in behavior analysis within a university  
15 practicum approved by the certifying entity and taken for graduate  
16 academic credit.
- 17 (iv) Completed a combination of the supervised experience in  
18 clause (i), (ii), or (iii). Hours may be completed in any combination  
19 of the categories of supervised experience. Hours accrued through  
20 a combination of supervised experience shall be proportionately  
21 calculated.
- 22 (3) An individual shall have both of the following:
- 23 (i) A doctoral degree, conferred at least 10 years prior to the  
24 date of application in the field of behavior analysis, psychology,  
25 education, or a related field approved by the certifying entity.
- 26 (ii) Ten years of verified and documented postdoctoral  
27 experience practicing behavior analysis.
- 28 (c) If an individual is certified by a certifying entity whose  
29 requirements for initial certification as a certified behavior analyst  
30 at the time of license application meet or surpass the requirements  
31 in subdivisions (a) and (b), the applicant for licensure shall be  
32 deemed to have satisfied the requirements in subdivisions (a) and  
33 (b).
- 34 2999.33. (a) To obtain a license as an assistant behavior  
35 analyst, an individual shall submit an application on a form  
36 approved by the board accompanied by the fees required by the  
37 board as specified in Section 2999.93.
- 38 (b) The board shall verify with the certifying entity that the  
39 applicant meets all of the following requirements:

- 1     (1) *Has passed the Board Certified Assistant Behavior Analyst*  
2 *examination administered by the certifying entity.*
- 3     (2) *Maintains an active status as a board certified assistant*  
4 *behavior analyst with the certifying entity.*
- 5     (3) *Is in compliance with all ethical and disciplinary standards*  
6 *published by the certifying entity.*
- 7     (c) *Each applicant shall obtain a passing score on a California*  
8 *law and ethics examination administered by the board.*
- 9     (d) *Each applicant shall provide proof of ongoing supervision*  
10 *by a licensed behavior analyst in a manner consistent with the*  
11 *certifying entity's requirements for supervision of assistant*  
12 *behavior analysts.*
- 13     2999.34. (a) *In order for an individual to be licensed as an*  
14 *assistant behavior analyst under this chapter, he or she shall*  
15 *possess a baccalaureate degree or higher level of education from*  
16 *an institution that meets the requirements described in Section*  
17 *2999.35.*
- 18     (b) *In addition to subdivision (a), an individual shall meet both*  
19 *of the following in order to be licensed under this chapter:*
- 20         (1) *Completed 180 classroom hours of undergraduate or*  
21 *graduate level instruction in the following content areas:*
- 22             (A) *Ethical and professional conduct coursework of behavior*  
23 *analysis consisting of 15 hours.*
- 24             (B) *Concepts and principles of behavior analysis consisting of*  
25 *45 hours.*
- 26             (C) *Research methods in behavior analysis, consisting of 10*  
27 *hours of measurement, including data analysis, and five hours of*  
28 *experimental design.*
- 29             (D) *Applied behavior analysis, consisting of 45 hours of*  
30 *fundamental elements of behavior change and specific behavior*  
31 *change procedures, 30 hours of identification of the problem and*  
32 *assessment, five hours of intervention and behavior change*  
33 *considerations, five hours of behavior change systems, and five*  
34 *hours of implementation, management and supervision.*
- 35             (E) *Discretionary coursework in behavior analysis consisting*  
36 *of 15 hours.*
- 37         (2) *Obtained experience by any of the following:*
- 38             (A) *Completed 1,000 hours of independent field work in behavior*  
39 *analysis supervised in accordance with the requirements of the*  
40 *certifying entity.*

1 (B) Completed, with a passing grade, 670 hours of supervised  
2 practicum in behavior analysis within a university practicum  
3 approved by the certifying entity and taken for academic credit.

4 (C) Completed, with a passing grade, 500 hours of supervised  
5 intensive practicum in behavior analysis within a university  
6 practicum approved by the certifying entity and taken for academic  
7 credit.

8 (D) Completed a combination of the supervised experience in  
9 paragraph (A), (B), or (C). Hours may be completed in any  
10 combination of the categories of supervised experience. Hours  
11 accrued through a combination of supervised experience shall be  
12 proportionately calculated.

13 (c) If an individual is certified by a certifying entity whose  
14 requirements for initial certification as a certified assistant  
15 behavior analyst at the time of license application meet or surpass  
16 the requirements in subdivisions (a) and (b), the applicant for  
17 licensure shall be deemed to have satisfied the requirements in  
18 subdivisions (a) and (b).

19 2999.35. The education required to obtain a behavior analyst  
20 license or an assistant behavior analyst license shall be from any  
21 of the following:

22 (a) A United States institution of higher education listed by the  
23 Council for Higher Education Accreditation.

24 (b) A Canadian institution of higher education that is a member  
25 of the Association of Universities and Colleges of Canada or the  
26 Association of Canadian Community Colleges.

27 (c) An institution of higher education located outside the United  
28 States or Canada that, at the time the applicant was enrolled and  
29 at the time the applicant graduated, maintained a standard of  
30 training equivalent to the standards of training of those institutions  
31 accredited in the United States as demonstrated by a member of  
32 the National Association of Credential Evaluation Services.

33 2999.36. On and after January 1, 2018, it shall be unlawful  
34 for any person to engage in any of the following acts:

35 (a) Engage in the practice of behavior analysis, as defined in  
36 Section 2999.12, without first having complied with the provisions  
37 of this chapter and without holding a current, valid, and active  
38 license as required by this chapter.

- 1     **(b)** Represent himself or herself by the title “licensed behavior  
2 analyst,” or “licensed assistant behavior analyst” without being  
3 duly licensed according to the provisions of this chapter.
- 4     **(c)** Make any use of any title, words, letters, or abbreviations  
5 that may reasonably be confused with a designation provided by  
6 this chapter to denote a standard of professional or occupational  
7 competence without being duly licensed.
- 8     **(d)** Materially refuse to furnish the board information or records  
9 required or requested pursuant to this chapter.
- 10    2999.37. This chapter does not apply to any of the following:
- 11     **(a)** An individual licensed to practice psychology in this state  
12 under Chapter 6.6 (commencing with Section 2900), if the practice  
13 of behavior analysis engaged in by the licensed psychologist is  
14 within the licensed psychologist’s training and competence.
- 15     **(b)** An occupational therapist licensed under Chapter 5.6  
16 (commencing with Section 2570), a physical therapist licensed  
17 under Chapter 5.7 (commencing with Section 2600), a marriage  
18 and family therapist licensed under Chapter 13 (commencing with  
19 Section 4980) or an educational psychologist licensed under  
20 Chapter 13.5 (commencing with Section 4980.10) acting within  
21 his or her licensed scope of practice and within the scope of his  
22 or her training and competence, provided that he or she does not  
23 represent himself or herself as a licensed behavior analyst or  
24 licensed assistant behavior analyst.
- 25     **(c)** An individual, including a paraprofessional technician,  
26 acting under the authority and direction of a licensed behavior  
27 analyst, a licensed assistant behavior analyst, or an individual  
28 described in paragraph (a) or (b).
- 29     **(d)** A family member of a recipient of behavior analysis services  
30 who acts under the extended authority and direction of a licensed  
31 behavior analyst or a licensed assistant behavior analyst.
- 32     **(e)** A matriculated college or university student who practices  
33 behavior analysis as a part of a defined program of study, course,  
34 practicum, internship, or postdoctoral fellowship, provided that  
35 the behavior analysis activities are directly supervised by a  
36 licensed behavior analyst or by an instructor in a course sequence  
37 approved by the certifying entity.
- 38     **(f)** An unlicensed individual pursuing supervised experience in  
39 behavior analysis consistent with the experience requirements of

1 *the certifying entity, provided such experience is supervised in*  
2 *accordance with the requirements of the certifying entity.*

3 *(g) An individual who teaches behavior analysis or conducts*  
4 *behavior analytic research, provided that such teaching or*  
5 *research does not involve the direct delivery of behavior analysis*  
6 *services.*

7 *(h) A behavior analyst licensed in another state or certified by*  
8 *the certifying entity to practice independently, and who temporarily*  
9 *provides behavior analysis services in California during a period*  
10 *of not more than 90 days in a calendar year.*

11 *(i) An individual who is vendorized by one or more regional*  
12 *centers of the California Department of Developmental Services*  
13 *while practicing behavior analysis services authorized under that*  
14 *vendorization. That individual shall not represent himself or herself*  
15 *as a licensed behavior analyst or licensed assistant behavior*  
16 *analyst unless he or she holds a license under this chapter, and*  
17 *shall not offer behavior analysis services to any person or entity*  
18 *other than the regional centers with which he or she is vendorized*  
19 *or accept remuneration for providing behavior analysis services*  
20 *other than the remuneration received from those regional centers.*

21 *(j) An individual employed by a school board performing the*  
22 *duties of his or her position, provided that he or she shall only*  
23 *offer behavior analysis services within the scope of that*  
24 *employment by the school board.*

25 *2999.40. (a) The board shall issue a license to a person who*  
26 *is licensed as a behavior analyst or an assistant behavior analyst*  
27 *in another state, if that state currently imposes comparable*  
28 *licensure requirements as those required by this state and if that*  
29 *state offers reciprocity to individuals licensed under this chapter.*  
30 *Applicants for a license under reciprocity shall submit an*  
31 *application on a form approved by the board accompanied by the*  
32 *fees required by the board as specified in Section 2999.93. Each*  
33 *applicant shall complete any other eligibility requirements*  
34 *established by the board, including, but not limited to, the criminal*  
35 *background check required by Section 2999.30.*

36 *(b) The board shall verify that the applicant meets all of the*  
37 *following:*

38 *(1) Holds an active license as a licensed behavior analyst or*  
39 *licensed assistant behavior analyst in another state.*

1 (2) *Is not subject to any disciplinary action by another state or*  
2 *certifying entity.*

3 (3) *Maintains an active status as board certified behavior*  
4 *analyst or board certified assistant behavior analyst with the*  
5 *certifying entity.*

6 (4) *Is in compliance with all ethical and disciplinary standards*  
7 *published by the certifying entity.*

8 (c) *Each applicant shall obtain a passing score on a California*  
9 *law and ethics examination administered by the board.*

10 2999.41. *A licensee shall give written notice to the board of a*  
11 *name change within 30 days after each change, giving both the*  
12 *old and new names. A copy of the legal document authorizing the*  
13 *name change, such as a court order or marriage certificate, shall*  
14 *be submitted with the notice.*

15 2999.44. (a) *A license shall expire and become invalid two*  
16 *years after it is issued at 12 midnight on the last day of the month*  
17 *in which it was issued, if not renewed.*

18 (b) *To renew an unexpired license, the licensee shall, on or*  
19 *before the date on which it would otherwise expire, apply for*  
20 *renewal on a form provided by the board, accompanied by the*  
21 *renewal fee set by the board. The board shall obtain verification*  
22 *from the certifying entity that the renewal applicant maintains an*  
23 *active certification status with the certifying entity.*

24 (c) *To renew an assistant behavior analyst license, in addition*  
25 *to the requirements in paragraph (b), the licensee shall submit*  
26 *proof of ongoing supervision by a licensed behavior analyst in a*  
27 *manner consistent with the certifying entity's requirements for*  
28 *supervision of assistant behavior analysts.*

29 2999.45. (a) *A license that has expired may be renewed at any*  
30 *time within three years after its expiration by applying for renewal*  
31 *on a form provided by the board, payment of all accrued and*  
32 *unpaid renewal fees, and the delinquency fee specified in Section*  
33 *2999.93. The board shall obtain verification from the certifying*  
34 *entity of the licensee's active certification status with the certifying*  
35 *entity.*

36 (b) *Except as provided in Section 2999.46, a license that is not*  
37 *renewed within three years of its expiration shall not be renewed,*  
38 *restored, or reinstated, and the license shall be canceled*  
39 *immediately upon expiration of the three year-period.*

1 2999.46. (a) *A suspended license is subject to expiration and*  
2 *shall be renewed as provided in this article, but such renewal does*  
3 *not entitle the licensee, while the license remains suspended, and*  
4 *until it is reinstated, to engage in the licensed activity or in any*  
5 *other activity or conduct in violation of the order or judgment by*  
6 *which the license was suspended.*

7 (b) *A license revoked on disciplinary grounds is subject to*  
8 *expiration as provided in this article, but it may not be renewed.*  
9 *If it is reinstated after its expiration, the licensee, as a condition*  
10 *of reinstatement, shall pay a reinstatement fee in an amount equal*  
11 *to the renewal fee, plus the delinquency fee and any fees accrued*  
12 *at the time of its revocation.*

13  
14 *Article 4. Enforcement*  
15

16 2999.60. *The board may on its own, and shall, upon the receipt*  
17 *of a complaint from any person, investigate the actions of any*  
18 *licensee. The board shall review a licensee's alleged violation of*  
19 *statute, regulation, or any other law and any other complaint*  
20 *referred to it by the public, a public agency, or the department,*  
21 *and may upon a finding of a violation take disciplinary action*  
22 *under this article.*

23 2999.61. *A license issued under this chapter may be denied,*  
24 *revoked, or otherwise sanctioned upon demonstration of*  
25 *ineligibility for licensure, including, but not limited to, failure to*  
26 *maintain active certification by the certifying entity or falsification*  
27 *of documentation submitted to the board for licensure or submitted*  
28 *to the certifying authority for certification.*

29 2999.62. *The board may deny a license application, may issue*  
30 *a license with terms and conditions, may suspend or revoke a*  
31 *license, or may place a license on probation if the applicant or*  
32 *licensee has been guilty of unprofessional conduct. Unprofessional*  
33 *conduct shall include, but not be limited to:*

34 (a) *Conviction of a crime substantially related to the*  
35 *qualifications, functions, or duties of a licensed behavior analyst*  
36 *or a licensed assistant behavior analyst.*

37 (b) *Use of any controlled substance as defined in Division 10*  
38 *(commencing with Section 11000) of the Health and Safety Code,*  
39 *dangerous drug, or any alcoholic beverage to an extent or in a*  
40 *manner dangerous to himself or herself, any other person, or the*



- 1 *public, or to an extent that this use impairs his or her ability to*  
2 *safely perform the practice of behavior analysis.*
- 3 *(c) Fraudulently or neglectfully misrepresenting the type or*  
4 *status of a license actually held.*
- 5 *(d) Impersonating another person holding a license or allowing*  
6 *another person to use his or her license.*
- 7 *(e) Use of fraud or deception in applying for a license or in*  
8 *passing any examination required by this chapter.*
- 9 *(f) Paying, offering to pay, accepting, or soliciting any*  
10 *consideration, compensation, or remuneration, whether monetary*  
11 *or otherwise, for the referral of clients.*
- 12 *(g) Violating Section 17500.*
- 13 *(h) Willful, unauthorized communication of information received*  
14 *in professional confidence.*
- 15 *(i) Violating any rule of professional conduct promulgated by*  
16 *the board and set forth in regulations duly adopted under this*  
17 *chapter.*
- 18 *(j) Being grossly negligent in the practice of his or her*  
19 *profession.*
- 20 *(k) Violating any of the provisions of this chapter or regulations*  
21 *duly adopted thereunder.*
- 22 *(l) The aiding or abetting of any person to engage in the*  
23 *unlawful practice of behavior analysis.*
- 24 *(m) The suspension, revocation, or imposition of probationary*  
25 *conditions or other disciplinary action by another state or country*  
26 *of a license, certificate, or registration to practice behavior*  
27 *analysis issued by that state or country to a person also holding*  
28 *a license issued under this chapter if the act for which the*  
29 *disciplinary action was taken constitutes a violation of this section.*  
30 *A certified copy of the decision or judgment of the other state or*  
31 *country shall be conclusive evidence of that action.*
- 32 *(n) The commission of any dishonest, corrupt, or fraudulent*  
33 *act.*
- 34 *(o) Any act of sexual abuse or sexual relations with a patient*  
35 *or former patient within two years following termination of therapy,*  
36 *or sexual misconduct that is substantially related to the*  
37 *qualifications, functions, or duties of a licensed behavior analyst*  
38 *or a licensed assistant behavior analyst.*

1 (p) Functioning outside of his or her particular field or fields  
2 of competence as established by his or her education, training,  
3 and experience.

4 (q) Willful failure to submit, on behalf of an applicant for  
5 licensure, verification of supervised experience to the board.

6 (r) Repeated acts of negligence.

7 (s) Failure to comply with all ethical and disciplinary standards  
8 published by the certifying entity.

9 2999.63. (a) Except as provided in subdivisions (b), (c), and  
10 (e), any accusation filed against a licensee pursuant to Section  
11 11503 of the Government Code shall be filed within three years  
12 from the date the board discovers the alleged act or omission that  
13 is the basis for disciplinary action, or within seven years from the  
14 date the alleged act or omission that is the basis for disciplinary  
15 action occurred, whichever occurs first.

16 (b) An accusation filed against a licensee pursuant to Section  
17 11503 of the Government Code alleging the procurement of a  
18 license by fraud or misrepresentation is not subject to the  
19 limitations set forth in subdivision (a).

20 (c) The limitation provided for by subdivision (a) shall be tolled  
21 for the length of time required to obtain compliance when a report  
22 required to be filed by the licensee or registrant with the board  
23 pursuant to Article 11 (commencing with Section 800) of Chapter  
24 1 is not filed in a timely fashion.

25 (d) If an alleged act or omission involves a minor, the seven-year  
26 limitations period provided for by subdivision (a) and the 10-year  
27 limitations period provided for by subdivision (e) shall be tolled  
28 until the minor reaches the age of majority.

29 (e) An accusation filed against a licensee pursuant to Section  
30 11503 of the Government Code alleging sexual misconduct shall  
31 be filed within three years after the board discovers the act or  
32 omission alleged as the ground for disciplinary action, or within  
33 10 years after the act or omission alleged as the ground for  
34 disciplinary action occurs, whichever occurs first.

35 (f) The limitations period provided by subdivision (a) shall be  
36 tolled during any period if material evidence necessary for  
37 prosecuting or determining whether a disciplinary action would  
38 be appropriate is unavailable to the board due to an ongoing  
39 criminal investigation.

1 2999.64. *Notwithstanding Section 2999.62, any proposed*  
2 *decision or decision issued under this chapter in accordance with*  
3 *the procedures set forth in Chapter 5 (commencing with Section*  
4 *11500) of Part 1 of Division 3 of Title 2 of the Government Code*  
5 *that contains any finding of fact that the licensee engaged in any*  
6 *act of sexual contact, as defined in Section 728, when that act is*  
7 *with a patient, or with a former patient, within two years following*  
8 *termination of services, shall contain an order of revocation. The*  
9 *revocation shall not be stayed by the administrative law judge.*

10 2999.66. *The board may deny an application for, or issue*  
11 *subject to terms and conditions, or suspend or revoke, or impose*  
12 *probationary conditions upon, a license or registration after a*  
13 *hearing as provided in Section 2999.70.*

14 2999.67. *A plea or verdict of guilty or a conviction following*  
15 *a plea of nolo contendere made to a charge which is substantially*  
16 *related to the qualifications, functions, and duties of a licensed*  
17 *behavior analyst or licensed assistant behavior analyst is deemed*  
18 *to be a conviction within the meaning of this article. The board*  
19 *may order the license suspended or revoked, or may decline to*  
20 *issue a license when the time for appeal has elapsed, the judgment*  
21 *of conviction has been affirmed on appeal, or when an order*  
22 *granting probation is made suspending the imposition of sentence,*  
23 *irrespective of a subsequent order under Section 1203.4 of the*  
24 *Penal Code allowing the person to withdraw his or her plea of*  
25 *guilty and to enter a plea of not guilty, or setting aside the verdict*  
26 *of guilty, or dismissing the accusation, information, or indictment.*

27 2999.68. *Any person required to register as a sex offender*  
28 *pursuant to Section 290 of the Penal Code, is not eligible for*  
29 *licensure by the board.*

30 2999.69. *An administrative disciplinary decision that imposes*  
31 *terms of probation may include, among other things, a requirement*  
32 *that the licensee who is being placed on probation pay the*  
33 *monetary costs associated with monitoring the probation.*

34 2999.70. *The proceedings under this article shall be conducted*  
35 *by the board in accordance with Chapter 5 (commencing with*  
36 *Section 11500) of Part 1 of Division 3 of Title 2 of the Government*  
37 *Code.*

38 2999.80. *A person who violates any of the provisions of this*  
39 *chapter is guilty of a misdemeanor punishable by imprisonment*  
40 *in a county jail not exceeding six months or by a fine not exceeding*

1 two thousand five hundred dollars (\$2,500), or by both that fine  
2 and imprisonment.

3 2999.81. In addition to other proceedings provided in this  
4 chapter, whenever any person has engaged, or is about to engage,  
5 in any acts or practices that constitute, or will constitute, an offense  
6 against this chapter, the superior court in and for the county  
7 wherein the acts or practices take place, or are about to take place,  
8 may issue an injunction or other appropriate order restraining  
9 that conduct on application of the board, the Attorney General,  
10 or the district attorney of the county. Proceedings under this  
11 section shall be governed by Chapter 3 (commencing with Section  
12 525) of Title 7 of Part 2 of the Code of Civil Procedure, except  
13 that it shall be presumed that there is no adequate remedy at law  
14 and that irreparable damage will occur if the continued violation  
15 is not restrained or enjoined. On the written request of the board,  
16 or on its own motion, the board may commence an action in the  
17 superior court under this section.

18

19

#### Article 5. Revenue

20

21 2999.90. The board shall report each month to the Controller  
22 the amount and source of all revenue received pursuant to this  
23 chapter and at the same time deposit the entire amount thereof in  
24 the State Treasury for credit to the Psychology Fund established  
25 by Section 2980.

26 2999.91. (a) The moneys credited to the Psychology Fund  
27 under Section 2999.90 shall, upon appropriation by the  
28 Legislature, be used for the purposes of carrying out and enforcing  
29 the provisions of this chapter.

30 (b) The board shall keep records that will reasonably ensure  
31 that funds expended in the administration of each licensing  
32 category bear a reasonable relation to the revenue derived from  
33 each category, and shall so notify the department no later than  
34 May 31 of each year.

35 2999.93. The board shall assess fees for the application for  
36 and the issuance and renewal of licenses to cover, but not exceed,  
37 administrative and operating expenses of the board related to this  
38 chapter. The fees shall be fixed by the board in regulations that  
39 are duly adopted under this chapter. Fees assessed pursuant to  
40 this section shall not exceed the following:

- 1 (a) The fee for the application for licensure shall be not more  
2 than \_\_\_\_ dollars (\$\_\_\_\_).
- 3 (b) The fee for the law and ethics examination shall be not more  
4 than \_\_\_\_ dollars (\$\_\_\_\_).
- 5 (c) The fee for the issuance of a license shall be not more than  
6 \_\_\_\_ dollars (\$\_\_\_\_).
- 7 (d) The fee for a biennial renewal of a license shall be not more  
8 than \_\_\_\_ dollars (\$\_\_\_\_).
- 9 (e) The delinquency fee shall be 50 percent of the biennial  
10 renewal fee.
- 11 (f) The fee for rescoring an examination shall be twenty dollars  
12 (\$20).
- 13 (g) The fee for issuance of a replacement license shall be twenty  
14 dollars (\$20).
- 15 (h) The fee to change a name or address on the board's records  
16 shall be twenty dollars (\$20).
- 17 (i) The fee for issuance of a certificate or letter of good standing  
18 shall be twenty-five dollars (\$25).
- 19 2999.94. (a) A person licensed under this chapter is exempt  
20 from the payment of the renewal fee in any one of the following  
21 instances:
- 22 (1) While engaged in full-time active service in the Army, Navy,  
23 Air Force, or Marines.
- 24 (2) While in the United States Public Health Service.
- 25 (3) While a volunteer in the Peace Corps or Vista.
- 26 (b) Every person exempted from the payment of the renewal fee  
27 by this section shall not engage in any private practice and shall  
28 become liable for the fee for the current renewal period upon the  
29 completion of his or her period of full-time active service and shall  
30 have a period of 60 days after becoming liable within which to  
31 pay the fee before the delinquency fee becomes applicable. Any  
32 person who completes his or her period of full-time active service  
33 within 60 days of the end of a renewal period is exempt from the  
34 payment of the renewal fee for that period.
- 35 (c) The time spent in that full-time active service or full-time  
36 training and active service shall not be included in the computation  
37 of the three-year period for renewal of an expired license specified  
38 in Section 2999.45.
- 39 (d) The exemption provided by this section shall not be  
40 applicable if the person engages in any practice for compensation

1 *other than full-time service in the Army, Navy, Air Force or*  
2 *Marines or in the United States Public Health Service or the Peace*  
3 *Corps or Vista.*

4 2999.98. *The licensing and regulatory program under this*  
5 *chapter shall be supported from fees assessed to applicants and*  
6 *licensees. Startup funds to implement this program shall be derived,*  
7 *as a loan, from the reserve fund of the Board of Psychology, subject*  
8 *to an appropriation by the Legislature in the annual Budget Act.*  
9 *The board shall not implement this chapter until funds have been*  
10 *appropriated.*

11 *SEC. 10. No reimbursement is required by this act pursuant*  
12 *to Section 6 of Article XIII B of the California Constitution because*  
13 *the only costs that may be incurred by a local agency or school*  
14 *district will be incurred because this act creates a new crime or*  
15 *infraction, eliminates a crime or infraction, or changes the penalty*  
16 *for a crime or infraction, within the meaning of Section 17556 of*  
17 *the Government Code, or changes the definition of a crime within*  
18 *the meaning of Section 6 of Article XIII B of the California*  
19 *Constitution.*

20 ~~SECTION 1. It is the intent of the legislature to enact legislation~~  
21 ~~to license and regulate the profession of applied behavioral~~  
22 ~~analysis.~~

# CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES

## BILL ANALYSIS

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**BILL NUMBER: SB 614**

**VERSION: AMENDED APRIL 6, 2015**

**AUTHOR: LENO**

**SPONSOR: COUNTY BEHAVIORAL HEALTH  
DIRECTORS ASSOCIATION**

**RECOMMENDED POSITION: NONE**

**SUBJECT: MEDI-CAL: MENTAL HEALTH SERVICES: PEER AND FAMILY SUPPORT  
SPECIALIST CERTIFICATION**

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### **Overview:**

This bill requires the State Department of Health Care Services to develop a peer and family support specialist certification program.

### **Existing Law:**

- 1) States that certain essential mental health and substance use disorder services are covered Medi-Cal benefits effective January 1, 2014. (Welfare and Institutions Code (WIC) §14132.03)

### **This Bill:**

- 1) Establishes the Peer and Family Support Specialist Certification Program Act of 2015. (WIC Article 1.4, §§ 14045.10 – 14045.20)
- 2) By July 1, 2016, requires the State Department of Health Care Services (DHCS) to establish a certification body and to provide statewide certification for adult peer support specialists, family peer support specialists, and parent peer support specialists (WIC §14045.13)
- 3) Requires DHCS to establish the following for peer and family support specialists (WIC §14045.13):
  - a) The range of responsibilities and practice guidelines;
  - b) Curriculum and core competencies, including areas of specialization;
  - c) Training requirements allowing for multiple qualified training entities, and requires training to include individuals with practical experience as peer support service consumers;
  - d) Continuing education requirements;

- e) Clinical supervision requirements;
  - f) A code of ethics and a process for revocation of certification;
  - g) A process for certification renewal; and
  - h) A process to allow those currently employed in the peer support field to obtain certification.
- 4) Requires DHCS to collaborate with the Office of Statewide Health Planning and Development (OSHPD), the County Behavioral Health Director's Association of California, the California Mental Health Planning Council, health plans participating in the Medi-Cal program, and other interested parties, when developing, implementing, and administering the peer and family support specialist certification program. (WIC §14045.14)
  - 5) Requires DHCS to amend its Medicaid state plan to include a peer and family support specialist as a provider type, and to include peer support specialists as a distinct service type. (WIC §14045.16)
  - 6) Allows DHCS to use Mental Health Services Act Funds, as well as funds from certain other specified programs, to develop and administer the peer and family support specialist certification program. (WIC §14045.18)
  - 7) Allows DHCS to implement this law via plan letters, bulletins, or similar instructions, without regulations, until regulations are adopted. Regulations must be adopted by July 1, 2018.

**Comments:**

- 1) **Background.** The author's office defines a peer provider as someone who "uses his or her lived experience with mental illness and recovery, plus skills learned in formal training, to deliver services in a behavioral health setting to promote mind-body recovery and resiliency." (SB 614 fact sheet, March 2015) The author's office notes that peers can be persons with experience as clients, family members, or caretakers.

The author cites benefits of peer certification including establishing a standard of practice and code of ethics, providing peer support employees with a professional voice, and qualifying peer services for federal financial participation.

- 2) **Intent of This Bill.** According to the author's office, the goal of this bill is twofold:
  - Require DHCS to establish a peer support specialist certification program; and
  - Authorize DHCS to add peer support providers as a provider type within the Medi-Cal program.



- 3) Peer Certification in Other States.** In 2013, 31 states and the federal Department of Veteran’s Affairs certified and employed peer specialists. The services peer specialists provide in these states are Medicaid billable.<sup>1</sup>

In 2007, the federal Centers for Medicare and Medicaid released guidance for states to establish a certification program for peers to enable the use of federal Medicaid.

California has not established a peer certification program at this time. There is a stakeholder group, the “Working Well Together Statewide Technical Assistance Center” which in 2013 released a report of recommendations about certification. The Executive Summary of this report is in **Attachment B**.

**4) Examples of Requirements in Other States.**

Several other states recognize certified peer counselors.

Washington

The state of Washington allows peer counselors to work in various settings, such as community clinics, hospitals, and crisis teams. Peer counselors must be supervised by a mental health professional. Examples of things they may do include assisting an individual in identifying services that promote recovery, share their own recovery stories, advocacy, and modeling skills in recovery and self-management.

In order to become a peer counselor in Washington, a person must be accepted as a training applicant. They must complete a 40 hour training program and pass a state exam.

Tennessee

According to the State of Tennessee’s Department of Mental Health and Substance Abuse Services, Certified Peer Recovery Specialists must complete an extensive application. If accepted, they complete an intensive 40 hour training program. They must be supervised by a mental health professional or a substance use disorder professional.

New Mexico

The State of New Mexico offers peer support worker certification. Applicants must demonstrate 2 years of sustained recovery, complete a written application and phone interview, complete a 40 hour training program, and pass an examination.

- 5) Lack of a Clear Definition.** This bill specifically identifies several uses for peer and family support specialists, including providing increased family support, providing as part of a wraparound continuum of services, and collaborating with others providing care or support. However, it does not provide an exact definition of a peer and family support specialist. It also does not define a scope of practice. These tasks appear to be delegated to DHCS.

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<sup>1</sup> “Peer Certification: What are we Waiting For?,” by the California Mental Health Planning Council, February 2015

**6) Fingerprinting and Examination Not Required for Certification.** This bill does not specify fingerprinting or passage of an examination as requirements to obtain certification as a peer and family support specialist.

**7) Requirements Not Established in Legislation.** This bill requires DHCS to establish the requirements of the peer certification program, including curriculum, continuing education, training, supervision, and renewal, via regulation. Assuming this bill was to pass, it would become effective January 1, 2016, and the certification program must be established by July 1, 2016. Regulations must be established by July 1, 2018. However, the bill leaves discretion to DHCS to implement the program via various instructions, until regulations are adopted.

## **8) Support and Opposition.**

### Support:

- County Behavioral Health Directors Association of California (sponsor)
- Association of California Health Care Districts
- California Association of Mental Health Peer-Run Organizations
- California Association of Social Rehabilitation Agencies
- California Council of Community Mental Health Agencies
- California State Association of Counties
- Disability Rights California
- National Alliance on Mental Illness California
- Pacific Clinics
- Peers Envisioning and Engaging in Recovery Services (PEERS)
- Sacramento County Board of Supervisors
- SEIU California
- Steinberg Institute
- Western Center on Law and Poverty

### Oppose:

- None received.

## **9) History.**

### **2015**

04/06/15 From committee with author's amendments. Read second time and amended.

Re-referred to Com. on HEALTH.

03/20/15 Set for hearing April 15.

03/12/15 Referred to Com. on HEALTH.

03/02/15 Read first time.

03/02/15 From printer. May be acted upon on or after April 1.

02/27/15 Introduced. To Com. on RLS. for assignment. To print.

**10) Attachments.**

**Attachment A:** *“Peer Certification: What are we Waiting For?”* by the California Mental Health Planning Council, February 2015

**Attachment B:** Executive Summary from *“Final Report: Recommendations from the Statewide Summit on Certification of Peer Providers,”* Working Well Together, 2013

AMENDED IN SENATE APRIL 6, 2015

**SENATE BILL**

**No. 614**

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**Introduced by Senator Leno**

February 27, 2015

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An act to add Article 1.4 (commencing with Section 14045.10) to Chapter 7 of Part 3 of Division 9 of, the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

SB 614, as amended, Leno. Medi-Cal: mental health services: peer and family support specialist certification.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income persons receive health care benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid provisions. Existing law provides for a schedule of benefits under the Medi-Cal program and provides for various services, including various behavioral and mental health services.

Existing law, the Mental Health Services Act (*MHSA*), an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, establishes the continuously appropriated Mental Health Services Fund to fund various county mental health programs. The act also requires funds to be reserved for the costs for the State Department of Health Care Services, the California Mental Health Planning Council, the Office of Statewide Health Planning and Development (OSHPD), the Mental Health Services Oversight and Accountability Commission, the State Department of Public Health, and any other state agency to implement all duties pursuant to certain programs provided for by the act, subject to appropriation in the annual

Budget Act. The act provides that it may be amended by the Legislature by a  $\frac{2}{3}$  vote of each house as long as the amendment is consistent with and furthers the intent of the act, and that the Legislature may also clarify procedures and terms of ~~he~~ *the* act by majority vote.

This bill would require the State Department of Health Care Services to establish, by July 1, 2016, a statewide peer and family support specialist certification program, as a part of the state's comprehensive mental health delivery system *and the Medi-Cal program*. The bill would include 3 certification categories: adult peer support specialists, family peer support specialists, and parent peer support specialists. The certification program's components would include, among others, defining responsibilities and practice guidelines, determining curriculum and core competencies, specifying training and continuing education requirements, and establishing a code of ethics and certification revocation processes.

This bill would require the department to collaborate with OSHPD and interested stakeholders in developing the certification program, and to obtain technical assistance pursuant to a specified joint state-county decisionmaking process. The bill would authorize the department to use funding provided through the MHSA and designated funds administered by OSHPD, to develop and administer the program.

This bill would require the department to amend the Medicaid state plan to include a certified peer and family support specialist as a provider type for purposes of the Medi-Cal program, but would implement this provision only if and to the extent that federal financial participation is available and the department obtains all necessary federal approvals. *The bill would authorize the department to enter into exclusive or nonexclusive contracts on a bid or nonbid basis, as specified, on a statewide or more limited geographic basis. This bill also would authorize the department to implement, interpret, or make specific its provisions by various informational documents until regulations are adopted.*

This bill would declare that it clarifies terms and procedures under the Mental Health Services Act.

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

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

1 SECTION 1. Article 1.4 (commencing with Section 14045.10)  
2 is added to Chapter 7 of Part 3 of Division 9 of the Welfare and  
3 Institutions Code, to read:

4  
5 Article 1.4. Peer and Family Support Specialist Certification

6  
7 14045.10. This article shall be known, and may be cited, as  
8 the Peer and Family Support Specialist Certification Program Act  
9 of 2015.

10 14045.11. The Legislature finds and declares all of the  
11 following:

12 (a) With the enactment of the Mental Health Services Act in  
13 2004, support to include peer providers identified as consumers,  
14 parents, and family members for the provision of services has been  
15 on the rise.

16 (b) There are over 6,000 peer support specialists in California  
17 who provide individualized support, coaching, facilitation, and  
18 education to clients with mental health care needs, in a variety of  
19 settings, yet no statewide scope of practice, standardized  
20 curriculum, training standards, supervision standards, or  
21 certification protocol is available.

22 (c) The United States Department of Veterans Affairs and over  
23 30 states utilize standardized curricula and certification protocols  
24 for peer provider services.

25 (d) The federal Centers for Medicare and Medicaid Services  
26 (CMS) recognizes peer support services as an evidence-based  
27 mental health model of care and notes it is an important component  
28 in a state's delivery of effective treatment. The CMS encourages  
29 states to offer peer support services as a component of a  
30 comprehensive mental health delivery system and federal financial  
31 participation is available for this purpose.

32 (e) A substantial number of research studies demonstrate that  
33 peer providers improve client functioning, increase client  
34 satisfaction, reduce family burden, alleviate depression and other  
35 symptoms, reduce hospitalizations and hospital days, increase  
36 client activation, and enhance client self-advocacy.

37 (f) Certification at the state level can incentivize the public  
38 mental health system *and the Medi-Cal program*, to increase the

1 number, diversity, and availability of peer providers and  
2 peer-driven services.

3 14045.12. It is the intent of the Legislature that the peer and  
4 family support specialist certification program, established under  
5 this article, achieve all of the following:

6 (a) Establish the ongoing provision of peer support services for  
7 beneficiaries with mental health care needs by certified peer support  
8 specialists, including adults 18 years of age or older.

9 (b) Provide increased family support, building on the strengths  
10 of families and helping them achieve desired outcomes.

11 (c) Provide a part of a wraparound continuum of services, in  
12 conjunction with other community mental health services.

13 (d) Collaborate with others providing care or support to the  
14 beneficiary or family.

15 (e) Assist parents, when applicable, in developing coping  
16 mechanisms and problem-solving skills.

17 (f) Provide an individualized focus on the beneficiary, the  
18 family, or both, as needed.

19 (g) Promote socialization, recovery, self-sufficiency,  
20 self-advocacy, development of natural supports, and maintenance  
21 of skills learned in other support services.

22 14045.13. No later than July 1, 2016, the department shall  
23 establish a certified peer and family support specialist ~~program,~~  
24 ~~which program that,~~ at a minimum, shall do all of the following:

25 (a) *Establish a certifying body to provide for the certification*  
26 *of peer and family support specialists.*

27 ~~(a)~~

28 (b) Provide for a statewide certification for each of the following  
29 ~~categories:~~ *categories of peer support specialist providers, as*  
30 *contained in federal guidance issued by the Centers for Medicare*  
31 *and Medicaid Services, State Medical Director Letter (SMDL)*  
32 *#07-011:*

33 (1) Adult peer support specialists, 18 years of age or older.

34 (2) Family peer support specialists.

35 (3) Parent peer support specialists.

36 ~~(b)~~

37 (c) Define the range of responsibilities and practice guidelines  
38 for peer support specialists.

39 ~~(e)~~

1 (d) Determine curriculum and core competencies, including  
2 areas of specialization, such as veterans, family support, and  
3 forensics.

4 ~~(d)~~

5 (e) Specify ~~required training and continuing education~~  
6 ~~requirements for certification.~~ *training requirements, allowing for*  
7 *multiple qualified training entities, and requiring training to*  
8 *include individuals with practical experience as consumers of peer*  
9 *support services, or their family members.*

10 (f) *Specify required continuing education requirements for*  
11 *certification.*

12 ~~(e)~~

13 (g) Determine clinical supervision requirements for personnel  
14 certified under this section.

15 ~~(f)~~

16 (h) Establish a code of ethics and processes for revocation of  
17 certification.

18 ~~(g)~~

19 (i) Determine the process for certification renewal.

20 (j) *Determine a process for allowing existing personnel*  
21 *employed in the peer support field to obtain certification under*  
22 *this article, at their option.*

23 14045.14. The department shall closely collaborate with the  
24 Office of Statewide Health Planning and Development (OSHPD)  
25 and its associated workforce collaborative, and regularly consult  
26 with interested stakeholders, including peer support and family  
27 organizations, mental health providers and organizations, the  
28 County Behavioral Health Directors ~~Association~~, *Association of*  
29 *California, health plans participating in the Medi-Cal managed*  
30 *care program*, the California Mental Health Planning Council, and  
31 other interested parties, as deemed appropriate by the department,  
32 in developing, implementing, and administering the peer and family  
33 support specialist certification program.

34 14045.15. The department may contract to obtain technical  
35 assistance for the development of the peer and family support  
36 specialist certification program, as provided in Section 4061.

37 14045.16. (a) ~~The department shall amend its Medicaid state~~  
38 ~~plan to include a peer and family support specialist pursuant to~~  
39 ~~this article as a provider type for purposes of this chapter.~~ *do both*  
40 *of the following:*



1 (1) *Include a peer and family support specialist certified*  
2 *pursuant to this article as a provider type for purposes of this*  
3 *chapter.*

4 (2) *Include peer support specialist services as a distinct service*  
5 *type for purposes of this chapter.*

6 (b) The department may seek any federal waivers or other state  
7 plan amendments as necessary to implement the certification  
8 program provided for under this article.

9 (c) This article shall be implemented only if and to the extent  
10 that federal financial participation under Title XIX of the federal  
11 Social Security Act (42 U.S.C. Sec. 1396 et seq.) is available and  
12 all necessary federal approvals have been obtained.

13 14045.17. It is not the intent of the Legislature in enacting this  
14 article to modify the Medicaid state plan in any manner that would  
15 otherwise change or nullify the requirements, billing, or  
16 reimbursement of the “other qualified provider” provider type, as  
17 currently authorized by the Medicaid state plan.

18 14045.18. The department may utilize Mental Health Services  
19 Act funds, as authorized in subdivision (d) of Section 5892, and  
20 any designated Workforce Education and Training Program  
21 resources, including funding, as administered by OSHPD pursuant  
22 to Section 5820, to develop and administer the peer and family  
23 support specialist certification program.

24 14045.19. *For the purposes of implementing this article, the*  
25 *department may enter into exclusive or nonexclusive contracts on*  
26 *a bid or negotiated basis, including contracts for the purpose of*  
27 *obtaining subject matter expertise or other technical assistance.*  
28 *Contracts may be statewide or on a more limited geographic basis.*

29 14045.20. *Notwithstanding Chapter 3.5 (commencing with*  
30 *Section 11340) of Part 1 of Division 3 of Title 2 of the Government*  
31 *Code, the department may implement, interpret, or make specific*  
32 *this article by means of plan letters, plan or provider bulletins, or*  
33 *similar instructions, without taking regulatory action, until the*  
34 *time regulations are adopted. The department shall adopt*  
35 *regulations by July 1, 2018, in accordance with the requirements*  
36 *of Chapter 3.5 (commencing with Section 11340) of Part 1 of*  
37 *Division 3 of Title 2 of the Government Code. Notwithstanding*  
38 *Section 10231.5 of the Government Code, beginning six months*  
39 *after the effective date of this article, the department shall provide*  
40 *semiannual status reports to the Legislature, in compliance with*

1 *Section 9795 of the Government Code, until regulations have been*  
2 *adopted.*

3 SEC. 2. The Legislature finds and declares that this act clarifies  
4 procedures and terms of the Mental Health Services Act within  
5 the meaning of Section 18 of the Mental Health Services Act.

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## PEER CERTIFICATION:

CHAIRPERSON  
Cindy Clafin

EXECUTIVE OFFICER  
Jane Adcock

## WHAT ARE WE WAITING FOR?

- **Advocacy**
- **Evaluation**
- **Inclusion**

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*Examining the Opportunities, Barriers, and Precedents for the Official  
Recognition and Certification of Peer Specialists in California.*

February 2015

*<sup>1</sup> “When you talk to people who have been through these programs and ask them what helped them, it is not the drugs, not the diagnosis. It's the lasting, one-on-one relationships with adults who listen....”*

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<sup>1</sup> <http://www.npr.org/blogs/health/2014/10/20/356640026/halting-schizophrenia-before-it-starts>

## ***Leading the Way, yet Lagging Behind:***

California is accustomed to being at the forefront of progressive, compassionate policy and legislation. Voters passed the Mental Health Services Act because they couldn't stand to see the misery of unaddressed mental illness and the state was an early adopter of parity laws and Medicaid expansion. As a state, we have been proud of our leadership. So, where has California lagged behind? California has yet to follow the example of 31 other states and the Veterans Administration in establishing and utilizing a standardized curriculum and certification protocol for Peer Specialists' services.

Peers are persons with lived experience as consumers and family members or caretakers of individuals living with mental illness. Their experiences make Peer Specialists invaluable members of a service team. Employment and certification simultaneously bridges the gap between those that need it and those that can best provide it while reinforcing the peer provider's own wellness and sense of purpose.

Right now, more than half of the United States has a Peer Certification Program in place – people practicing, producing, and billing. Making a difference in the lives of people they intimately understand because they have already staved off the same potential devastation. Because if you ask somebody struggling with a life-altering, all-consuming episode of any type of mental distress if they have sought help yet, the response - more often than not - would be *“they don't understand”* or *“I just can't deal with the process of getting that help”*. California has not been able to summon up the political will it would take to make the most basic and meaningful connection with somebody who needs it the most.

*“A leader is not someone who stands before you, but someone who stands with you<sup>2</sup>”*

## ***What are Peer Specialists?***

Peer Specialists are empathetic guides and coaches who understand and model the process of recovery and healing while offering moral support and encouragement to people who need it. Moral support and encouragement have proven to result in greater compliance with treatment/services, better health function, lower usage of emergency departments, fewer medications and prescriptions, and a higher sense of purpose and connectedness on the part of the consumer.

Peer Specialists also model and train on communication between health care provider and consumer in order to educate both on potential barriers or side effects of existing medications or treatment plans. In a world where primary care intersects with mental health care, but

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<sup>2</sup> Native American Proverb

medical records are not necessarily shared, this alone is huge. Bridging that gap becomes one of the single highest predictors of effective treatment plans and positive outcomes. In a population with mortality rates that average 25 years sooner than non-SMI groups - for conditions that could be easily managed or cured - this one benefit alone is worth the investment.

It might be easier to describe Peer specialists by defining what they are NOT. Peer Specialists differ from Case Managers in that they do not identify resources, arrange for social or supportive services, or facilitate job trainings, educational opportunities, or living arrangements. They are not certified to offer medical advice or diagnoses, psychiatric or otherwise, or suggest, prescribe, or manage medications. Their function is not to “do for” but rather to “do with” and ultimately model and train wellness principles and self-sufficiency.

### ***What is Peer Specialist Certification?***

Peer Specialist Certification is an official recognition by a certifying body that the practitioner has met qualifications that include lived experience and training from a standardized curriculum on mental health issues. The standardized curriculum has been approved by the certifying body and includes a mandatory number of hours of training in various topics pertaining to mental health care, coaching, and ethics. The “specialist” designation is conferred when additional hours of training specific to special populations or age groups has been completed and the candidate has demonstrated thorough knowledge, skills, and ability within that subgroup.

The standardized curriculum includes topics such as documentation, boundaries and ethics, communication skills, working with specific populations, developing wellness plans, systems of care, principles of practices (i.e., engagement, strength-based planning, WRAP plans, case management); and advocacy, to name a few. At this time, there are several courses available through the community college system, but not on a statewide basis. Working Well Together has compiled an excellent comprehensive report - *Certification of Consumer, Youth, Family, and Parent Providers; A Review of the Research* – which provides detailed information, background, and context.<sup>3</sup>

### ***Why Certification?***

*“Regardless of the means selected to demonstrate competency, it is critical that the core competencies of a peer (knowledge, skills, job tasks, and performance domains of the profession) are identified according to a recognized process, such as a job task analysis or role delineation study. **This is because –all other program requirements, policies, and standards must tie back to the core competencies of the profession being credentialed.**”<sup>4</sup>*

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<sup>3</sup> [http://www.inspiredatwork.net/uploads/WWT\\_Peer\\_Certification\\_Research\\_Report\\_FINAL\\_6.20.12\\_\\_1\\_.pdf](http://www.inspiredatwork.net/uploads/WWT_Peer_Certification_Research_Report_FINAL_6.20.12__1_.pdf)

<sup>4</sup> Hendry, P., Hill, T., Rosenthal, H. Peer Services Toolkit: A Guide to Advancing and Implementing Peer-run Behavioral Health Services. ACMHA: The College for Behavioral Health Leadership and Optum, 2014

Defining and standardizing the classification of Peer Specialist through certification prevents engagement outside one's expertise. Like any other profession, the certification defines the level of care and services so that the parameters established by the standardized curriculum and certification requirements are respected and understood statewide. Any hiring organization can expect these levels of qualifications, training, and expertise in the person they hire and can plan their organizational functions around the duties encompassed by that expertise. It also provides guidance to the peer practitioner through an established code of ethics. This means that roles and functions of other providers will not be usurped or second-guessed by the Peer Specialists.

The role of the certified peer specialist is to encourage partners and lead through example on the best ways to advocate for oneself. Sometimes it is not enough to suggest resources and make recommendations for services – sometimes you have to walk the walk along with the person for the first few steps, or even the first few miles. In this respect, the Peer Specialist is the Sherpa of the mental health care world. As partners, they teach participants how to communicate with care providers, navigate insurance companies and bureaucracies, and lessen the anxieties that arise from these various interactions. As models, they demonstrate that recovery *is* possible.

### ***The Time is Now***

First and foremost, the time is now because Affordable Health Care, Mental Health Parity, Coordinated Care Initiative, and potentially even the Public Safety Realignment create workforce shortages, particularly in the area of rehabilitative services. The time is now because recognizing the value of Peer Specialists does not translate into standardized training, skill sets, duties, or pay scales. This will make it difficult to operationalize and maintain utilization on a scale sufficient to meet the workforce needs or government standards and requirements for reimbursement. In other words “failing to plan is planning to fail”.

The Center for Medicaid Services gave California permission to amend its State Plan to include Peer Providers in 2007, stating “*We encourage States to consider comprehensive programs but note that regardless of how a State models its mental health and substance use disorder service delivery system, the State Medicaid agency continues to have the authority to determine the service delivery system, medical necessity criteria, and to define the amount, duration, and scope of the service*”<sup>5</sup>.

The time is now because the state is starting to fully understand the concept and value of peer services as part of both mental health care and the larger arena of primary care. Examples of this are their inclusion in the SB 82 (Steinberg) Investment in Mental Health and Wellness Act

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<sup>5</sup> Center for Medicare and Medicaid Services; SMDL #07-011; August 15, 2007

grant requirements for mobile crisis teams; the intent in the original Prop 63 language to include peers, family members, and parent providers as part of the MHSA workforce; and a one-time dedicated state budget allocation of training funds to the Office of Statewide Health Planning and Development for peers to be trained as mobile crisis team members. All of these components will be working together as part of the larger mental health network of care, but run the risk of operating at disparate training levels, scope of work, code of ethics, and pay levels from county to county.

Finally, the time is now because trying to standardize the classification after a piecemeal acceptance is put into place is inefficient and uninformative to potential employers. Moreover, it is unfair to people who are willing to share their expertise and demonstrate their commitment to this important and effective aspect of care and services.

To draw a timely comparison, the classification of drug and alcohol counselors, which often has a strong peer component as part of the qualifications for employment, received an early welcome into the workforce. However, this acceptance was unaccompanied by any defined training, experience, or education requirements. There has been an attempt to retroactively achieve some standardization across the lines, but proponents are finding that, due to the unstructured engagement of their services, there is no uniform requirement or skill level across treatment sites. Worse, there is a reluctance to champion a certification process, due to potential hardships and setbacks created for current successful peer employees who might not meet certification standards after the fact.

### ***Is it Cost-Effective?***

In Alameda County, a Peer Mentoring pilot project provided 40 hours of training to 26 peers called “The Art of Facilitating Self-Determination” and matched them with people recently released from psychiatric hospitals. Those accepting a peer mentor experienced a 72% reduction in readmissions to the hospital. The cost savings for Alameda County was over a million dollars with an initial investment of \$238K- making a 470% return on investment<sup>6</sup>.

The Pew Trusts reported recently “In Georgia, a 2003 study compared patients diagnosed with schizophrenia, bipolar disorder and major depression whose treatment had included peer support, with patients who received traditional day treatment services without peers. The patients who had peer support had better health outcomes—and at a lower cost. The average annual cost of day treatment services is \$6,400 per person, while support services cost about \$1,000.”<sup>7</sup>

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<sup>6</sup> <http://www.oshpd.ca.gov/HWDD/pdfs/wet/PowerPoint-Peer-Support-Specialist-A-Galvez-S-Kuehn.pdf>

<sup>7</sup> <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2013/09/11/peers-seen-easing-mental-health-worker-shortage>; last accessed 11/5/2014



## ***Who Employs Peer Specialists?***

Between October 2013 and January 2015, the Advocacy Committee of the California Mental Health Planning Council (CMHPC) heard presentations from Peer Specialist Advocates and Peer-run programs throughout the state. The programs represented different models ranging from peer-run respite to peer partners in health care, but all of them reported positive outcomes for the participants, cost savings for their respective counties, and a bolstering of their own wellness commitment. Here is a brief review of a few of the models the Advocacy Committee heard from.

### ***Health Navigators USC***

The Peer Health navigator connects consumers to mental health, primary care, substance use, and specialty health care services; teaches them how to advocate for themselves and effectively communicate their needs; create a follow-up plan and other self-management skills through a “modeling, coaching, fading”. They differ from Case Managers or care coordinators in that the health navigator will ultimately step away from the participant once the modeling/coaching/fading process is successful.

Typically a full-time navigator will have 12 – 15 clients at any one time, and averages 30-40 clients annually, depending on how quickly the clients moves into full self-management. Many of the services are Medicaid billable under Targeted Case Management or Rehabilitation providing the documentation reflects justification for the services rendered. Participants are trained on billing codes and documentation. The program has developed its own curriculum and provides its own training and certification.

### ***2nd Story, Santa Cruz***

2nd Story is a SAMHSA-funded program that is an entirely Peer-Run Crisis Center in Santa Cruz. All staff are trained in “Intentional Peer Support” and all wellness class topics are determined by the guests. The program provides its own training. The length of stay is no longer than two weeks, and guests are encouraged to maintain their “normal” life (school, work) during their stay. Outreach is conducted by staff posted at County mental health departments telling potential guests about the program. Referrals are also made by psychiatrists, care managers, and Telecare, a county mental health services provider/contractor, sometimes diverts people to 2nd Story rather than enrolling them in a longer term, more structured social rehabilitation facility. The program is proving to be a key preventative service in Santa Cruz that forestalls or reduces the need for crisis residential and sub-acute stabilization programs.

### ***In-Home Outreach Team (IHOT), San Diego***

As Assisted Outpatient Treatment steadily gains ground in more California counties, a small program in San Diego is providing an effective and legitimate alternative at promoting and facilitating voluntary access to services. IHOT teams consist of a Peer Specialist, family member, personal service coordinator and team lead. They provide in-home outreach to adults with serious mental illness (SMI) who are reluctant or resistant to receiving mental health services. IHOT also provides support and education to family members and/or caretakers of IHOT participants. They work with individuals living with severe mental illness and who may also be dually diagnosed with a substance use disorder or drug dependency. Teams serve a combined 240-300 consumers per year (80-100 per team).

A 2013 San Diego Health and Human Services report notes that the average cost per IHOT participant amounts to \$8,100, compared to an annual cost per individual in a Full Service Partnership (\$20,000 including housing) and Assisted Outpatient Treatment (\$34,000). Staff ratios are similarly proportionate: IHOT = 1:25 staff to client ratio; FSP and AOT each have a 1:10 staff to client ratio.

### ***What Other States Employ and Certify Peer Specialists?***

As of 2013, Certified Peer Specialists were certified and employed in 31 states and the federal Department of Veteran's Affairs. The extent of engagement and responsibility varies from state to state, but all services are Medicaid billable. These 31 states are consistent in their belief and trust in Peer Specialists – when will California join them?

### ***What is Stopping California?***

Despite all of the merits, fiscal and clinical, of Certified Peer Specialists, California has not been able to match its actions to its talk in this area. California embraces the concept of recovery, wellness, and resilience – and recognizes the essential components of both employment and inclusion as part of those processes – but it has failed to turn those concepts to tangible actions.

No State Department feels that it is in their purview to establish, implement or oversee a state certification process. Education may approve a curriculum, but it is not empowered to grant certification. Department of Health Care Services may be able to approve billable services, but is not empowered to establish curriculum or gage mastery of the subject matter. The Office of Statewide Health Planning and Development (OSHPD) has a Workforce Development Division, and is specifically charged with mental health workforce development issues, but without specific language or policy permitting OSHPD to include or pursue the specific classification of Peer Specialist, OSHPD does not felt comfortable facilitating it. In short, the single, largest barrier has been the identification of a lead agency or organization that can be charged with facilitation, implementation, and identification of a certification and oversight

body. There may be philosophical or conceptual agreement on the importance of Peer Specialists, but no policy or political direction to move it forward.

### ***How Can California Catch Up?***

Peer Specialist Certification is a cross-cutting, inclusive, and cost-saving classification that has applications across all vulnerable and at-risk populations in the state – veterans, homeless, Transition Age Youth, elderly, and criminal justice populations to name a few - and has particular utility in integrated services for the dually diagnosed and co-morbid conditions in health care.

The California Mental Health Planning Council (CMHPC) recommends that the Legislature continue and solidify its mission to create a seamless, comprehensive, continuum of mental health services and care by:

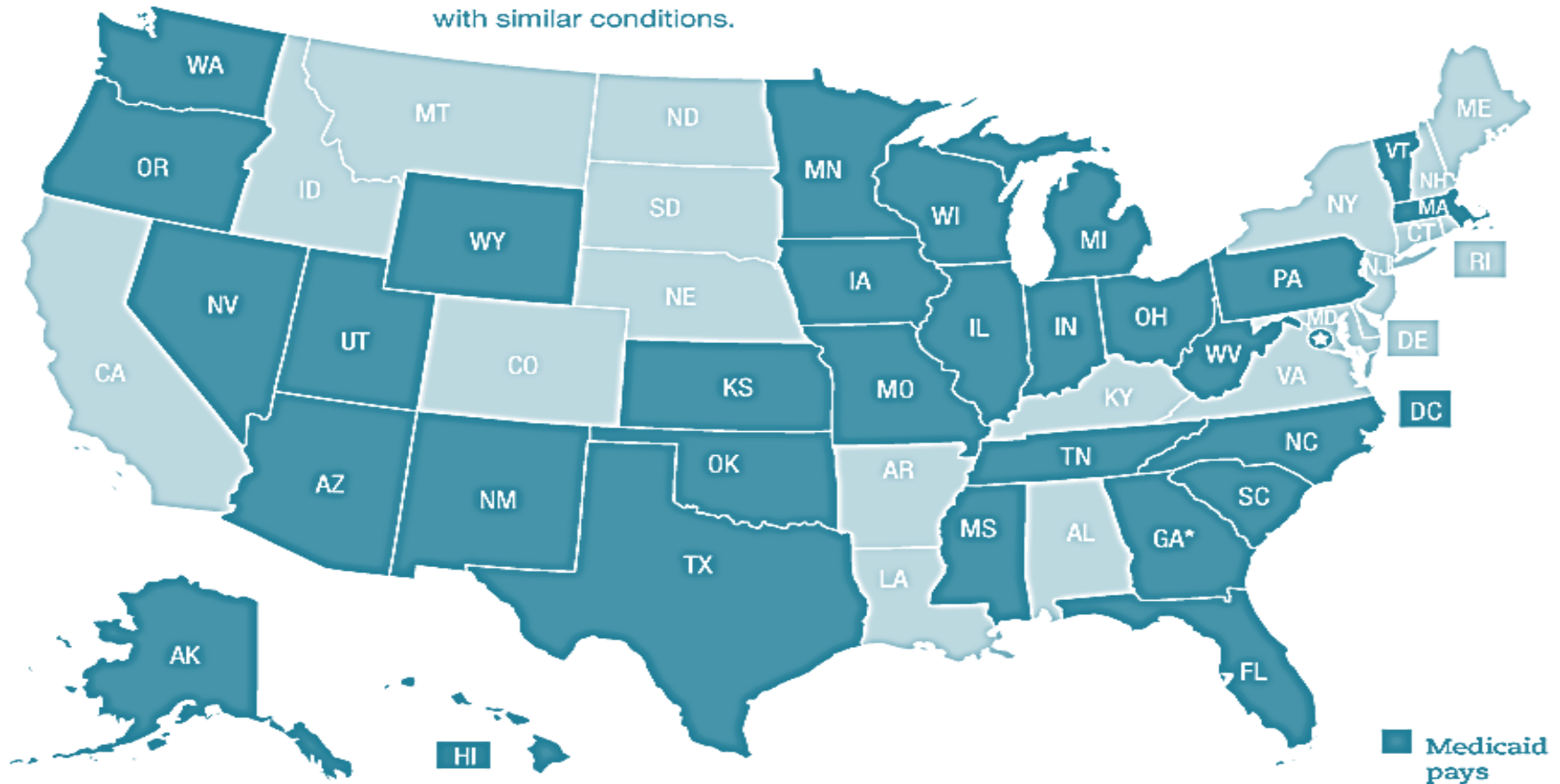
- developing clarifying legislative language that MHSAs and/or other funding may be used to establish an implementation and oversight body for statewide Peer Specialist Certification; and/or
- making Peer Certification a priority of the 2015-16 Legislative Session as a stand-alone issue ; and/or
- requiring the Certification of Peer Specialists in legislation pertaining to workforce expansion or expanded services for vulnerable populations: and/or
- identifying and including funding for the establishment of a Peer Specialist certifying and oversight body through the annual Budget Act.

The CMHPC has been following and supporting the efforts of Inspired at Work, California Association of Mental Health Peer Run Organizations (CAMHPRO), United Advocates for Children and Families (UACF), National Alliance on Mental Illness (NAMI) and the former Working Well Together Group to bring this issue to the forefront of mental health policy. These groups dedicated countless hours to investigating best practices, training models, potential curriculums, and workforce applications for Certified Peer Specialists and have generously shared their time and information to bring the CMHPC and others up to speed. Their work deserves attention and close consideration by anybody that might be in a position to support the implementation process. For detailed information on the background, issues, application, and potential processes, please visit: <http://workingwelltogether.org/resources/recruiting-hiring-and-workforce-retention/wwt-toolkit-employing-individuals-lived> or <http://www.inspiredatwork.net/Resources.html>,

# Mental Health Peer Specialists

## States where Medicaid pays for them

In 31 states, Medicaid pays for licensed peer specialists, counselors recovering from severe mental illness or substance addiction who are trained to help others with similar conditions.



Source: OptumHealth and Appalachian Consulting Group  
 NOTE: In Georgia, Medicaid pays peer specialists to provide "whole health" counseling.

Stateline infographic by Adam Rotmil and Christine Vestal  
 September 11, 2013

# 2013

## Final Report: Recommendations from the Statewide Summit on Certification of Peer Providers



**Working Well Together**

Training and Technical Assistance Center



Report prepared for CAMHRO-PEERS  
under Working Well Together  
by Inspired at Work  
Lucinda Dei Rossi, MPA, CPRP and  
Debra Brasher, MS, CPRP

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## ACKNOWLEDGEMENTS

We'd like to specially recognize Karin Lettau for her diligence, hard work and grace in ensuring that all stakeholders felt heard and understood throughout the process.

## DISCLAIMER

The views expressed in this publication do not necessarily reflect the views of the Office of Statewide Health Planning and Development.

## Executive Summary

Working Well Together is the only statewide organization dedicated to transforming systems to be client and family-driven by supporting the sustained development of client, family member and parent/caregiver employment within every level of the public mental health workforce. As part of this effort Working Well Together has, for the last three years, engaged in researching and evaluating the feasibility of inclusion of Peer Support into a State Plan Amendment for Specialty Mental Health services. This three year effort has included thorough state-wide and national research and extensive stakeholder involvement and has yielded seventeen recommendations for the development of Peer Support as an integral service within the public mental health system.

The statewide survey conducted to evaluate the current practice of hiring consumers and family members into the mental health workforce revealed that most counties have indeed hired people with lived experience of a mental health challenge or parents/family members of individuals with a mental health issue into the mental health workforce. However the survey also revealed that there remain significant workforce issues that must be addressed. Of the thirty responding counties that hire people with lived experience, none required previous training or education beyond a high school diploma as a qualification for hire. This was found to be true even in counties that have developed excellent training programs for Peer Support. Additional findings revealed that a variety of generalist job titles are used to hire Peer Support Specialists, job duties and descriptions vary widely and may or may not include peer support as a job duty.

The stakeholder process exposed a number of workforce issues that must be addressed to further the professional development of Peer Support as a discipline and Peer Support Specialists as practitioners. Perhaps the most pressing issue is the lack of a definition and/or understanding of Peer Support. While most counties have hired individuals with lived experience as well as parents and family members to provide services, many of these practitioners are providing services that are traditionally considered “case management” and include collateral, targeted case management and rehabilitation services. Another identified trend was the use of peer employees as clerical support, transportation providers and social or recreational activities support. Interestingly, while many of these practitioners are providing billable services within the scope of practice of “Other Qualified Provider”, very few

counties (approximately nine) are billing Medi-Cal for these services. Going forward it is vital that Peer Support is identified as a separate and distinct service from other services provided under the current definitions of Specialty Mental Health services. Additional workforce issues identified by stakeholders necessary to advance the development for and respect of Peer Support include the;

1. Creation of welcoming environments that embrace these practitioners.
2. Development of multi-disciplinary teams that respect this new discipline.
3. Education and training of County Directors and Administration as well as the existing workforce on the value, role and legitimacy of peer support.
4. Training and acceptance of Medi-Caid approved use of recovery/resilience/wellness language in documentation.

While stakeholders strongly support the inclusion of peer support into a State Plan Amendment, they also support flexibility in what services individuals with lived experience can provide within the mental health system. Stakeholders strongly support career ladders that include non-certified peer providers as well as people with lived experience continuing their education and advancing into existing positions traditionally used in mental health settings, including supervision and management as well as the development of career ladders that include advancement opportunities within the practice of peer support. In short, stakeholders support maximum flexibility in what people with lived experience can provide and bill for within the existing State Plan as well as the inclusion of peer support as a new service category.

Stakeholders also emphasize the importance of recognizing that there are a number of services that enhance wellness and recovery/resiliency that peers may provide but that may not be reimbursed by Medi-Caid. It will be vital, when considering adding peer support as a new service, that reimbursement for peer support services not become the primary driving focus when offering/providing these services to clients and their families.

Working Well Together has engaged stakeholders in on-going teleconferences, webinars, work-groups, and five regional stakeholder meetings to provide feedback and recommendations that will support the requirements as laid out by the CMS letter regarding inclusion of peer support as a part of services provided under Specialty Mental Health. This resulted in several recommendations in support of the development of a statewide



Certification for Peer Support Specialists. In May of 2013 a final Statewide Stakeholder Summit was convened to provide further vetting with the goal of finalizing recommendations for the inclusion of peer support into the State Plan Amendment as well as the development of a statewide Certification for Peer Support Specialists. By and large the vast majority of stakeholders support the original recommendations, however, where appropriate, adjustments have been made in alignment with stakeholder feedback. Also where appropriate, additional edits to specific recommendations have been made to provide clarity. The seventeen recommendations are listed below.

DRAFT

## Final Stakeholder Recommendations regarding Certification of Peer Support Specialists

### Recommendation 1

Develop a statewide certification for Peer Support Specialists, to include:

- Adult Peer Support Specialists
- Young Adult Peer Support Specialists
- Older Adult Peer Support Specialists
- Family Peer Support Specialists (Adult Services)
- Parent Peer Support Specialists (Child/Family Services)

- 1.1 Require Peer Support Specialists to practice within the adopted Peer Support Specialist Code of Ethics.
  - 1.1.1 Seek final approval of Peer Support Code of Ethics by the Governing Board of Working Well Together.
- 1.2 Develop or adopt standardized content for a state-wide curriculum for training Peer Support Specialists.
- 1.3 Require a total of 80 hours of training for Peer Support Specialist Certification.
  - 1.3.1 55-hour core curriculum of general peer support education that all peer support specialists will receive as part of the required hours towards certification.
  - 1.3.2 25-hours of specialized curriculum specific to each Peer Support Specialist category.
- 1.4 Require an additional 25 hours of training to become certified in a specialty area such as forensics, co-occurring services, whole health and youth in foster care.
- 1.5 Require six months full-time equivalent experience in providing peer support services.
  - 1.5.1 This experience can be acquired through employment, volunteer work or as part of an internship experience.
- 1.6 Require 15 hours of CEU's per year in subject matter relevant to peer support services to maintain certification.
- 1.7 Require re-certification every three years.
- 1.8 Allow a grandfathering-in process in lieu of training.

- 1.8.1 Require one year of full-time equivalent employment in peer support services.
- 1.8.2 Require three letters of recommendation. One letter must be from a supervisor.  
The other letters may come from co-workers or people served.
- 1.9 Require an exam to demonstrate competency.
  - 1.9.1 Provide test-taking accommodations as needed.
  - 1.9.2 Provide the exam in multiple languages and assure cultural competency of exam.

### **Recommendation 2**

Identify or create a single certifying body that is peer-operated and/or partner with an existing peer-operated entity with capacity for granting certification.

### **Recommendation 3**

Include Peer Support as a service and Peer Support Specialist as a provider type within a new State Plan Amendment.

- 3.1 Seek adoption of the definitions of Peer Support Specialist providers and Peer Support services by the Governing Board of Working Well Together for use within the State Plan Amendment.
- 3.2 Maintain the ability for people with lived experience to provide services as “other qualified provider” within their scope of practice, including but not limited to rehabilitation services, collateral and targeted case management.
- 3.2 Acknowledge that there are important and non-billable services that Peer Support Specialists can and do provide.

### **Recommendation 4**

Include in the State Plan the ability to grant site certification for peer-operated agencies to provide billable peer support services.

- 4.1 Allow for peer-operated agencies to provide other services billable under “other qualified provider” within their scope of practice, including but not limited to rehabilitation services, collateral and targeted case management.

### **Recommendation 5**

Address the concern that current practice of documentation for billing may not be aligned with the values and principles of peer support and a wellness, recovery and resiliency orientation.

- 5.1 Engage with partners such as Department of Health Care Services and the California Mental Health Director's Association in order to develop an action plan to advocate for the use of CMS-approved recovery/resiliency-oriented language in documentation.

### **Recommendation 6**

Investigate the options for broadening the definition of "service recipient" to include parents and family members of minors receiving services so that peer support services can be accessed more easily.

### **Recommendation 7**

Convene a working group consisting of Working Well Together, the Mental Health Directors, the Office of Statewide Healthcare Planning and Development (OSHPD) and the Department of Health Care Services to develop buy-in and policies that will create consistency of practice regarding peer support services across the state.

### **Recommendation 8**

Develop standards and oversight for the provider/entity that provides training of Peer Support Specialists.

- 8.1 Allow for multiple qualified training entities.
- 8.2 Training organizations must demonstrate infrastructure capacity that will allow for peer trainers.
- 8.3 Training must be provided by either individuals with lived experience or by a team that includes individuals with lived experience.

### **Recommendation 9**

Establish qualifications for who may supervise Peer Support Specialists.

- 9.1 Engage with the Mental Health Directors to develop a policy that outlines key qualifications necessary for the supervision of Peer Support Specialists.
- 9.2 Preferred supervisors are those individuals with lived experience and expertise in peer support.
- 9.3 Due to capacity issues, supervisors may include qualified people who receive specific training on the role, values and philosophy of peer support.
- 9.4 Recognize and define the specific qualities and skills within supervision that are required for the supervision of Peer Support Specialists. These skills should align with the values and philosophy of peer support.

#### **Recommendation 10**

Develop a plan to provide extensive and expansive training on the values, philosophy and efficacy of peer support to mental health administration and staff.

#### **Recommendation 11**

Develop a plan to ensure that welcoming environments are created that embrace the use of multi-disciplinary teams that can incorporate Peer Support Specialists fully onto mental health teams.

#### **Recommendation 12**

Develop a policy statement that recognizes and defines the unique service components of peer support as separate and distinct from other disciplines and services in order to maintain the integrity of peer support services.

#### **Recommendation 13**

Develop a policy statement and plan that supports the professional development of Peer Support Specialists that allows the practitioner to maintain and hone his/her professional values, ethics and principles.

#### **Recommendation 14**

Develop a plan for funding the development of certification.

- 14.1 Work with the Office of Statewide Healthcare Planning and Development to utilize

state-wide monies from the MHSA Workforce, Education and Training fund.

14.2 Investigate other potential funding sources.

14.3 Develop recommendations for funding of components of certification such as financial assistance with training, exam and certification fees.

**Recommendation 15**

Seek representation on committees and workgroups that are addressing civil service barriers to the employment of Peer Support Specialists.

**Recommendation 16**

Work with Mental Health Directors to seek agreement on a desired workforce minimum of Peer Support Specialists within each county to more fully actualize the intent of the MHSA.

**Recommendation 17**

Develop state-wide models that can inform county leadership on the development of career ladders for Peer Support Specialists that begin with non-certified Peer Support Specialists and creates pathways into management and leadership positions.

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**To:** Committee Members  
**From:** Rosanne Helms  
Legislative Analyst  
**Date:** April 15, 2015  
**Telephone:** (916) 574-7897  
**Subject: Proposed Telehealth Regulations**

---

## Background

As therapy via electronic means (telehealth) increases in popularity, many state licensing entities and professional associations are beginning to adopt laws, regulations and guidelines regarding its use. Reflecting this trend, board staff continues to receive an increasing number of inquiries regarding the lawful practice of telehealth.

At its January 30, 2015 meeting, the Policy and Advocacy Committee discussed several aspects of telehealth, including the following:

- Telehealth laws, regulations, and policies in other states;
- Trainees' ability to perform telehealth lawfully; and
- Utilizing security and encryption in telehealth.

At that meeting, the Committee also discussed an initial draft of proposed telehealth regulations.

## Definition of Telehealth and Current Board Statute

Current law (Business and Professions Code (BPC) §2290.5) defines telehealth for all healing arts professions regulated by the Department of Consumer Affairs (DCA), including the Board's licensees. It sets patient consent and confidentiality standards and it makes failure to comply with these standards unprofessional conduct (**Attachment B**).

However, Board licensing law offers little guidance regarding telehealth practice. The 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. (BPC §§4980, 4989.50, 4996, 4999.30 and 4999.82).

This implies that a licensee in another state may not counsel an individual who is 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, this is not stated specifically.

### **Draft Telehealth Regulations**

Draft telehealth regulations are provided in **Attachment A**. Several changes have been made based on discussion at the January 30, 2015 Policy and Advocacy Committee meeting. Major changes are as follows:

- Deletion of subsections which prescribed specific points to consider when assessing whether a particular client is appropriate for telehealth. It was thought best to leave such considerations to the professional judgment of the therapist. Therefore, this language has been replaced with a more general requirement that the therapist assess whether the client is appropriate for telehealth, including consideration of the client's psychosocial situation.
- Language regarding confidentiality was updated to require the utilization of industry best practices to ensure both client confidentiality and the security of the communication medium.
- Language requiring the therapist to inform the client of specified risks and limitations of telehealth was modified. The language now leaves discussion of specific risks to the therapist's professional judgment, as specifying individual risks was thought to be too prescriptive.
- Deletion of a subsection requiring a licensee or registrant providing telehealth services to follow the mandated reporting requirements in the client's jurisdiction, and to be prepared to refer the client to local services in that jurisdiction. At the January Committee meeting, this subsection raised jurisdictional concerns. Staff discussed this subsection with DCA Legal, which recommended deleting the section. DCA Legal noted that therapists already have an obligation to do this, and that subsection (b) of the draft regulations reinforces this.

### **Items for Discussion**

Staff re-organized the latest version of the telehealth regulations into two categories: tasks a therapist must perform at the initiation of telehealth (intended to be one-time), and tasks a therapist must perform each time telehealth is performed (intended to be ongoing). The committee may wish to discuss which tasks it believes should be performed upon initiation of telehealth, and which tasks should be done on an ongoing basis.

### **Recommendation**

Conduct an open discussion regarding the draft telehealth regulations.

### **Attachments**

**Attachment A:** Draft Telehealth Regulations

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



**Attachment A**  
**Draft Telehealth Regulations**  
**Title 16, Division 18, California Code of Regulations**

**ARTICLE 1. GENERAL PROVISIONS**

**ADD §1815.5. Standards of Practice for Telehealth**

- (a) All persons engaging in the practice of marriage and family therapy, educational psychology, clinical social work, or professional clinical counseling via telehealth, as defined in Section 2290.5 of the Code, with a client who is physically located in this State must have a valid and current license or registration issued by the Board.
- (b) All psychotherapy services offered by board licensees and registrants via telehealth fall within the jurisdiction of the board just as traditional face-to-face services do. Therefore, all psychotherapy services offered via telehealth are subject to the board's statutes and regulations.
- (c) Upon initiation of telehealth services, a licensee or registrant shall do the following:
- i. Obtain informed consent from the client consistent with Section 2290.5 of the Code.
  - ii. Inform the client of the potential risks and limitations of receiving treatment via telehealth.
  - iii. Provide the client with his or her license or registration number and the type of license or registration.
  - iv. Provide the client with written procedures to follow in an emergency situation. This shall include contact information for emergency services near the client's location.
- (d) Each time a licensee or registrant provides services via telehealth, he or she shall do the following:
- i. Verify and document the identity of and the physical location of the client prior to beginning each telehealth session.
  - ii. Assess whether the client is appropriate for telehealth, including consideration of the client's psychosocial situation.

iii. Utilize industry best practices for telehealth to ensure both client confidentiality and the security of the communication medium.

(e) A licensee or registrant of this state may provide telehealth services to clients located in another jurisdiction only if the California licensee or registrant meets the requirements to lawfully provide services in that jurisdiction, and delivery of services via telehealth is allowed by that jurisdiction.

(f) Failure to comply with these provisions shall be considered unprofessional conduct.

**Attachment B**  
**Business and Professions Code Section 2290.5 – Telehealth**

**§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 initiating the use of telehealth shall inform the patient about the use of telehealth and obtain verbal or written consent from the patient for the use of telehealth as an acceptable mode of delivering health care services and public health. The consent shall be documented.

(c) Nothing in this section shall preclude a patient from receiving in-person health care delivery services during a specified course of health care and treatment after agreeing to receive services via telehealth.

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

(e) 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.

(f) 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.

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

(h) (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.

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**To:** Committee Members

**Date:** April 23, 2015

**From:** Rosanne Helms  
Legislative Analyst

**Telephone:** (916) 574-7897

**Subject:** Legislative Update

---

Board staff is currently pursuing the following legislative proposals:

**1. SB 531 (Bates) Board of Behavioral Sciences Enforcement Process**

This bill makes two separate amendments to the law governing the enforcement process:

- a) It modifies the Board's requirements for an individual to petition for a termination of probation or modification of penalty. Under the proposal, the Board may deny a petition without hearing if the petitioner is not in compliance with the terms of his or her probation.
- b) It clarifies that the Board has jurisdiction to investigate and take disciplinary action even if the status of a license or registration changes or if the license or registration expires.

The goal of these changes is to increase the efficiency of the enforcement process.

This bill proposal was approved by the Board at its November 20, 2014 meeting.

*Status: This bill has passed the Senate Business, Professions, and Economic Development Committee and is now in the Senate Appropriations Committee.*

**2. SB 620 (Block) Board of Behavioral Sciences: Licensure Requirements**

This bill streamlines the experience requirements for LMFT and LPCC applicants. It eliminates the complex assortment of minimum and maximum hours of differing types of experience required for licensure (also known as the "buckets" of experience) and instead requires 1,750 hours of the experience to be direct clinical counseling hours. The remaining required 1,250 hours may be non-clinical experience.

The bill also makes amendments to LCSW law to allow LCSW applicants to count some direct supervisor contact hours, as well as some hours spent attending workshops, trainings, conferences, and seminars, toward their required experience.

This bill proposal was approved by the Board at its November 20, 2014 meeting.

*Status: This bill has passed the Senate Business, Professions, and Economic Development Committee and is now in the Senate Appropriations Committee.*

**3. SB 800 (Senate Business, Professions, and Economic Development Committee) Healing Arts (Omnibus Bill)**

This bill proposal, approved by the Board at its November 20, 2014 meeting, makes minor, technical, and non-substantive amendments to add clarity and consistency to current licensing law.

*Status: This bill is in the Senate Business, Professions, and Economic Development Committee.*



This proposal was originally approved by the Board at its meeting in February 2013, and published in its California Regulatory Notice Register on March 15, 2013. However, the proposal was withdrawn in May 2013, as staff learned of implementation conflicts with the new BreEZe database system. For this reason, the effective date of the restructure was delayed until 2016<sup>2</sup>.

The final proposal was approved by the Board at its meeting in August 2014. It was published in its California Regulatory Notice Register on November 14, 2014. The public hearing was held on December 29, 2014, and the 45-day public comment period has ended. This proposal is now under review by the Department of Consumer Affairs.

**Requirements for Licensed Professional Clinical Counselors to Treat Couples or Families: Amend Title 16, CCR Sections 1820.5 and 1822; Add Sections 1820.6 and 1820.7**

This proposal clarifies requirements for LPCCs to treat couples and families, and outlines a process by which LPCCs and PCC Interns would receive Board confirmation that they have met the requirements to treat couples and families.

The final proposal was approved by the Board at its meeting in May 2014. It was published in its California Regulatory Notice Register on March 6, 2015 and the public hearing is scheduled for April 21, 2015.

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<sup>2</sup> SB 821 (Chapter 473, Statutes of 2013)