Board of Behavioral Sciences

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

Policy and Advocacy Committee
Meeting Notice and Agenda
April 12, 2018
10:00 a.m.

Department of Consumer Affairs
Hearing Room
1625 North Market Blvd., #S-102
Sacramento, CA 95834

While the Board intends to webcast this meeting, it may not be possible to webcast the entire meeting due to technical difficulties or limitations on resources. If you wish to participate or to have a guaranteed opportunity to observe, please plan to attend at the physical location.

I. Call to Order and Establishment of Quorum

II. Introductions*

III. Approval of February 3, 2017 Meeting Minutes

IV. Discussion and Possible Recommendation Regarding Assembly Bill 456 (Thurmond) Healing Arts: Associate Clinical Social Workers, 90 Day Rule

V. Discussion and Possible Recommendation Regarding Assembly Bill 767 (Quirk-Silva) Master Business License Act

VI. Discussion and Possible Recommendation Regarding Assembly Bill 1436 (Levine) Board of Behavioral Sciences: Suicide Prevention Training

VII. Discussion and Possible Recommendation Regarding Assembly Bill 1779 (Nazarian) Sexual Orientation Change Efforts

VIII. Discussion and Possible Recommendation Regarding Assembly Bill 1973 (Quirk) Reporting Crimes

IX. Discussion and Possible Recommendation Regarding Assembly Bill 2088 (Santiago) Patient Records: Addenda

X. Discussion and Possible Recommendation Regarding Assembly Bill 2138 (Chiu) Licensing Boards: Denial of Application: Criminal Conviction

XI. Discussion and Possible Recommendation Regarding Assembly Bill 2143 (Cabalerro) Licensed Mental Health Service Provider Education Program: Providers

XII. Discussion and Possible Recommendation Regarding Assembly Bill 2296 (Waldron) Professional Clinical Counselors

XIII. Discussion and Possible Recommendation Regarding Assembly Bill 2302 (Baker) Child Abuse: Sexual Assault: Mandated Reporters

XIV. Discussion and Possible Recommendation Regarding Assembly Bill 2409 (Kiley) Professions and Vocations: Occupational Regulations

XV. Discussion and Possible Recommendation Regarding Assembly Bill 2483 (Voepl) Department of Consumer Affairs: Office of Supervision of Occupational Boards

XVI. Discussion and Possible Recommendation Regarding Assembly Bill 2608 (Stone) Licensed Mental Health Service Provider Education Program: Former Foster Youth

XVII. Discussion and Possible Recommendation Regarding Assembly Bill 2780 (Bloom) Family Law: Support Orders and Child Custody

XVIII. Discussion and Possible Recommendation Regarding Assembly Bill 2943 (Low) Unlawful Business Practices: Sexual Orientation Change Efforts

XIX. Discussion and Possible Recommendation Regarding Assembly Bill 2968 (Levine) Therapist Sexual Behavior and Sexual Contact

XX. Discussion and Possible Recommendation Regarding Senate Bill 906 (Beall) Medi-Cal: Mental Health Service: Peer, Parent, Transition-Age and Family Support Specialist Certification

XXI. Discussion and Possible Recommendation Regarding Senate Bill 968 (Pan) Postsecondary Education: Mental Health Counselors

XXII. Discussion and Possible Recommendation Regarding Assembly Bill 1116 (Grayson) Peer Support and Crisis Referral Services Act

XXIII. Discussion and Possible Recommendation Regarding Senate Bill 399 (Portantino) Health Care Coverage: PDD or Autism

XXIV. Discussion and Possible Recommendation Regarding California Code of Regulations Section 1815.5: Telehealth Regulations

XXV. Status on Board-Sponsored Legislation

a. Assembly Bill 2117 (Arambula) Licensing Process Bill: Proposed Revisions to Business and Professions Code sections 4980.72, 4984.01, 4996.17, 4996.28, 4999.60, 4999.100

b. Senate Bill 1491 Omnibus Bill – Proposed Technical and Non-Substantive Amendments to Business and Professions Code sections 27, 650.4, 865, 2290.5, 4980.37, 4980.39, 4980.41, 4980.72, 4980.78, 4980.79, 4990.30, 4992, 4996.17, 4999.14, 4999.22, 4999.32, 4999.48, 4999.60, 4999.62, 4999.63, 4999.100, and Family Code section 6924

c. Assembly Bill 93 (Medina): Healing Arts: Marriage and Family Therapists: Clinical Social Workers: Professional Clinical Counselors: Required Experience and Supervision

XXVI. Status of Board Rulemaking Proposals

a. Enforcement Process: Amend Title 16, California Code of Regulations sections 1823, 1845, 1858, 1881, 1886.40, 1888 and Uniform Standards Related to Substance Abuse and Disciplinary Guidelines

b. Contact Information; Application Requirements; Incapacitated Supervisors: Amend Title 16, California Code of Regulations, sections 1804, 1805 and 1820.7; Add section 1815.8

c. Application Processing Times and Registrant Advertising: Amend Title 16, California Code of Regulations, Sections 1805.1 and 1811

d. Examination Rescoring, Abandonment of Application and Associate Professional Clinical Counselor Application Fee: Add Title 16, California Code of Regulations Section 1805.08; Amend Sections 1806 and 1816.1; Repeal Section 1816.3

XXVII. Public Comment for Items Not on the Agenda

Note: The Board may not discuss or take action on any matter raised during this public comment section, except to decide whether to place the matter on the agenda of a future meeting. [Government Code Sections 11125, 1125.7(a)]

XXVIII. Suggestions for Future Agenda Items

XXIX. 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.

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

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Board of Behavioral Sciences

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

Policy and Advocacy Committee
Draft Meeting Minutes
February 3, 2017

Department of Consumer Affairs
El Dorado Room
1625 North Market Blvd., #N220
Sacramento, CA 95835

Members Present
Christina Wong, Chair, LCSW Member
Deborah Brown, Public Member
Betty Connolly, LEP Member

Members Absent
Samara Ashley, Public Member

Staff Present
Kim Madsen, Executive Officer
Steve Sodergren, Assistant Executive Officer
Rosanne Helms, Legislative Analyst
Christy Berger, Regulatory Analyst
Kurt Hepler, Legal Counsel
Spencer Walker, Legal Counsel
Christina Kitamura, Administrative Analyst

I. Call to Order and Establishment of Quorum

Christina Wong, Chair of the Policy and Advocacy Committee (Committee), called the meeting to order at 10:48 a.m. Christina Kitamura called roll, and a quorum was established.

II. Introductions

The Committee, Board staff, and attendees introduced themselves.

III. Approval of the September 30, 2016 Committee Meeting Minutes

Three minor amendments were recommended.

Christina Wong moved to approve the September 30, 2016 Committee Meeting Minutes as amended. Deborah Brown seconded. The Committee voted to pass the motion.

Committee vote:
Deborah Brown – yes
Betty Connolly – yes
Christina Wong – yes

IV. Discussion and Possible Recommendation Regarding Proposed Rulemaking to Amend California Code of Regulations, Title 16, Sections 1823 – Unprofessional Conduct; 1845 - Unprofessional Conduct; 1858 - Unprofessional Conduct; 1881 – Unprofessional Conduct; and 1886.40 - Amount of Fines

Staff proposed several revisions to the Board's enforcement regulations.

1. Unprofessional Conduct Sections: Delete Provisions that are Already in Statute (§§ 1845 (LMFTs), 1858 (LEPs), and 1881 (LCSWs)

   Proposed amendments delete the duplicative provisions in regulation.

2. Unprofessional Conduct Sections: Certified Copies of Records (§§1823 (LPCCs), 1845, 1858, and 1881)

   The unprofessional conduct sections requires licensees or registrants to provide copies of records to the Board upon request for investigative purposes. In order to ensure the authenticity of the records, certified copies from the issuing agency are required; however, the guidelines do not currently state that the copies must be certified. The proposed amendments will specify that the records must be certified documents.

3. Unprofessional Conduct Sections: Failure to Cooperate in an Investigation (§§1823, 1845, 1858, and 1881)

   Current regulations state that it is unprofessional conduct to fail to cooperate in a board investigation pending against *the* licensee or registrant. The proposed amendment states that it is unprofessional conduct to fail to cooperate in a board investigation pending against *a* licensee or *a* registrant. This amendment clarifies that failure to cooperate in an investigation involving another licensee or registrant is a violation.

4. Unprofessional Conduct Sections: Failure to Provide Documentation Regarding Arrest and/or Conviction (§§1823, 1845, 1858, and 1881)

   The unprofessional conduct sections currently state that a licensee or registrant must, upon request, provide documentation regarding his or her arrest.

   To determine if disciplinary action is necessary for public protection purposes, the Board also requires documentation regarding a *conviction* of a licensee or registrant. The proposed amendment states that it is unprofessional conduct for failure to provide, upon request of the Board, documentation regarding an arrest *and/or conviction.* The proposed amendment also includes language requiring that the documentation must be certified copies.

5. Violation of Confidentiality of Medical Information Act: Amount of Fines

The Confidentiality of Medical Information Act begins with Civil Code (CC) §56, and discusses how medical providers may and may not disclose confidential medical information. CC §56.36 discusses the amount of fines that may be levied for disclosing confidential medical information.

§1886.40 of the Board's regulations defines a "citable offense" and lists the amount of fines the Board may levy for various violations of the law. It states that the Board may assess a fine of up to $5,000 for a violation involving unlawful or unauthorized breach of confidentiality. This amount was derived from CC §56.36.

To establish a point of reference for the origin of the $5,000 maximum fine, the proposed amendment references the Confidentiality of Medical Information Act in regulation §1886.40.

Jill Epstein, California Association of Marriage and Family Therapists (CAMFT), expressed concerns regarding the failure to cooperate in an investigation, stating that the concept is vague. For example, the witness may have a conflict regarding attorney/client privilege. Ms. Epstein explained that the CAMFT code of ethics permits members to assist colleagues, if they choose to, without turning the colleague in.

Dr. Ben Caldwell, Association for Marriage and Family Therapy (AAMFT), expressed concern in compelling a witness to cooperate with an investigation under the threat of an unprofessional conduct charge versus providing an opportunity for the witness to be helpful with an investigation if they so choose.

Rosanne Helms stated that the revision was recommended by the Board's former legal counsel.

Spencer Walker, Legal Counsel, stated that if it has not posed any problems in the past, then it is his opinion to be an unnecessary change.

Janlee Wong, National Association of Social Workers, California Division (NASW-CA), agreed with Ms. Epstein and Dr. Caldwell.

Kurt Hepler, Legal Counsel, opined that if the Board's "enforcement staff and the Deputy Attorney General have not recognized the need for this to be changed as an impediment or impairment to an investigatory case," then he would be reluctant to advise the Board to make the change.

Christina Wong moved to recommend to the Board to commence rulemaking to amend California Code of Regulations, Title 16, sections 1823, 1845, 1858, 1881, and 1886.40; and to leave the language as is in sections 1823(b), 1845(b), 1858(b), 1858(c), and 1881(d). Betty Connolly seconded. The Committee voted to pass the motion.

Committee vote:
Deborah Brown – yes
Betty Connolly – yes
Christina Wong – yes

V. Discussion and Possible Recommendation Regarding Proposed Rulemaking to Amend California Code of Regulations, Title 16, Section 1888 – Uniform Standards Related to Substance Abuse and Disciplinary Guidelines

Staff is proposing several revisions to the Board's Uniform Standards Related to Substance Abuse and Disciplinary Guidelines, which are incorporated by reference into California Code of Regulations (CCR) Title 16, §1888.

- Amendment to CCR §1888: References to Disciplinary Guidelines

  This section refers to the "Disciplinary Guidelines" as listed in the "Uniform Standards Related to Substance Abuse and Disciplinary Guidelines" document, which is incorporated by reference in this section. However, there is not an actual section in the document identified as "Disciplinary Guidelines." There is a section identified as "Penalty Guidelines." Language referencing sections of this document have been revised for clarity. The proposed language provides references to "Uniform Standards Related to Substance Abuse," and to "Penalty Guidelines."

- Amendment to CCR §1888 and Uniform Standards: Violations Involving Abuse of Drugs and/or Alcohol

  As written, this section states that every violation that involves the <u>use</u> of drugs and/or alcohol must comply with the Uniform Standards Related to Substance Abuse.

  The Attorney General's Office issued a formal opinion stating that boards must use the Uniform Standards in all cases which they apply, and that boards may establish a regulation defining a "substance abusing licensee" for purpose of determining who is subject to the Uniform Standards, as long as the regulation is consistent with Business and Professions Code (BPC) §315. The Department of Consumer Affairs' (DCA) Legal Division has since concurred that a board may use discretion in imposing the Uniform Standards based on whether a licensee is found to be a substance abusing licensee.

  Based on these new determinations, DCA Legal has recommended §1888 be amended to clarify that if a violation involves the <u>abuse</u> of drugs and/or alcohol, then the violation is presumed to be a substance abuse violation. If the licensee does not rebut the presumption, then the Uniform Standards apply.

  A paragraph clarifying the process of determining substance abuse has also been added to Section I of the "Uniform Standards Related to Substance Abuse and Disciplinary Guidelines."

- Add to Penalty Guidelines: Engaging in Sexual Orientation Change Efforts with a Patient Under Age 18

  SB 1172 made it unprofessional conduct to engage in any sexual orientation change efforts with a patient under the age of 18. This violation is not included in the Penalty Guidelines.

  The proposed amendment would add minimum and maximum penalties for engaging in sexual orientation change efforts with a minor, to the Penalty Guidelines.

- Add to Penalty Guidelines: Consumer Protection Enforcement Initiative Unprofessional Conduct Provisions

  The Board added five unprofessional conduct provisions via regulation for each license type based on direction from the DCA's Consumer Protection Enforcement Initiative. These provisions, which became effective July 1, 2013, pertain to Board investigations, and include such violations as failing to provide records or arrest documentation, or failure to cooperate in a Board investigation. These new violations are not included in the Penalty Guidelines.

  The proposed amendment would add minimum and maximum penalties for each of these five new unprofessional conduct provisions to the Penalty Guidelines.

- Amendment to Optional Term and Condition of Probation: Education and Law and Ethics Course

  Proposed language specifies that required educational coursework must be taken either from an approved educational institution, or through a course approved by the Board. Language specifying the course must be taken at a graduate-level institution offering a qualifying degree has been removed.

  At its August 2016 meeting, the Board indicated that in some cases, requiring a probationer to take and pass the California Law and Ethics examination may be more meaningful than requiring a law and ethics course. There are currently three violations for which taking a law and ethics course is listed as a minimum penalty:

  - General Unprofessional Conduct;
  - Commission of a Dishonest, Corrupt, or Fraudulent Act; and
  - Paying, Accepting, or Soliciting a fee for Referrals.

  Proposed language in the Penalty Guidelines state that if warranted, the minimum penalty can be either taking a law and ethics course or taking and passing the licensure examination(s).

- Amendment to Optional Term and Condition of Probation: Take and Pass Licensure Examinations

  At its August 2016 meeting, the Board directed staff to add a requirement to take and pass the California law and ethics examination as an optional term and condition of probation.

  Currently, the Guidelines include optional term #7, "Take and Pass Licensure Examinations." Upon review of the term, staff believes that as written, this term could be interpreted to mean that the probationer must take the California Law and Ethics exam, the clinical exam, both of these exams, or the LEP exam (as applicable). However, it is not completely clear if all licensing exams must be taken, or if only one may be prescribed.

  Instead, staff has amended the existing language to clarify that the Board may prescribe a probationer to take one or both of the required licensing exams, as it deems appropriate.

- New Optional Term and Condition of Probation: Attend Dependency Support Program

  The proposed language adds a new optional term of probation requiring, if the Board so chooses, the probationer to attend a dependency support program.

  Attending a dependency support program has also been added, if warranted, as a minimum term in the Penalty Guidelines for violations involving substance abuse.

- New Optional Term and Condition of Probation: Relapse Prevention Program

  The proposed language adds a new optional term of probation requiring, if the Board so chooses, the probationer to attend a dependency support program.

  Attending a relapse prevention program has also been added, if warranted, as a minimum term in the Penalty Guidelines for violations involving substance abuse.

- Amendment to Standard Term and Condition of Probation: Change of Place of Employment or Place of Residence

  This item will be cut from the amendments. Regulation §1804 will be amended since a change of address notification for a place of employment is not required to be reported to the Board.

Discussion

- New Optional Term and Condition of Probation: Attend Dependency Support Program

  Dr. Caldwell expressed concern regarding mandating methods of rehabilitation that are not well-supported by research.

- New Optional Term and Condition of Probation: Relapse Prevention Program

  Dr. Caldwell expressed the same concern as expressed for the dependency support program.

- Amendment to Standard Term and Condition of Probation: Failure to Practice – Tolling

  Proposed amendment: *"The failure to practice for a total of two years shall be a violation of probation."*

  Alternative amendment agreed by the Committee and staff: *"The failure to practice for a total of two years, absence of good cause, shall be a violation of probation."*

Christina Wong moved to recommend to the Board that it commence rulemaking to amend California Code of Regulations, Title 16, §1888 as amended. Betty Connolly seconded. The Committee voted to pass the motion.

Committee vote:
Deborah Brown – yes

Betty Connolly – yes
Christina Wong – yes

Ms. Wong called for a break at 12:32 p.m. The Committee reconvened at 1:09 p.m.

VI. Discussion and Possible Recommendation Regarding Proposed Rulemaking to Amend California Code of Regulations, Title 16, Sections 1804 – Filing of Addresses; 1805 – Applications; 1820.7 – Confirmation of Qualifications to Treat Couples and Families; and 1856 - Experience Equivalent to Three (3) Years Full-Time Experience as Credentialed School Psychologist

Legal counsel suggested that the Board put its current practices into regulations.

A. Amendments to §1804 – Applicant and Licensee Contact Information
   1. 1804(a): Reporting of Addresses:
      - Remove "professional corporation" as the Board discontinued registration of corporations in 2000.
      - Clarify the acceptable types of addresses.
      - Clarify that each licensee's and registrant's address of record will be disclosed to the public.
      - Clarify that applicants must provide an address of record, but it will not be made public until a license or registration is issued.
      - Disallow the use of an address in "care of" or "c/o" another person.
   2. 1804(b),(c),(d): Reporting of Telephone Numbers and Email Addresses
      - State that telephone numbers and email addresses are confidential information.
      - Codify the Board's current practice of requiring an applicant's telephone number and email address on applications for licensure or registration.
      - Newly require all current licensees and registrants to provide the Board with a telephone number and email address.
      - Require Board notification of changes to a telephone number or email address within 30 calendar days in writing.

B. Amendments to §1805 – Applications
   1. 1805(b): Specify the documentation required to be submitted with an application for registration or licensure, in order to codify current practice.
   2. 1805(b) & (c): Specify the documentation required to be submitted with an application for licensure in order to codify current practice, and to clarify that those who previously applied for a registration are not required to resubmit specified documentation if still on file.
   3. Required documentation may include:
      - Verification of supervised experience including contact information for the supervisor and employer.
      - Verification of passing a national clinical examination, if required.

- A signed examination security agreement.

4. 1805(d) & (e): Specify the documentation required to be submitted with an application expedite request for a veteran or military spouse/domestic partner.

5. 1805(f): Require applications for registration or licensure to be signed under penalty of perjury.

6. 1805(g): Allow the Board to use discretion in accepting other documentation that establishes the applicant's qualifications.

C. Amendments to §1820.7 – LPCC Confirmation of Qualifications to Assess or Treat Couples and Families

- Clarify that confirmation of qualifications is necessary not just to treat, but also to assess couples and families, consistent with the wording of §4999.20 of the BPC.
- 1820.7(c): Codify the Board's current practice of requiring official transcripts, and course descriptions or syllabi when necessary.
- 1820.7(d): Clarify the specific information that must be included on the required documentation of experience with couples, families or children.
- 1820.7(e): Minor technical changes.
- Change "intern" to "associate" in accordance with SB 1478.

D. Amendments to §1856 – LEP Experience Requirements

The proposed changes would codify the Board's current practice pertaining to verification of the experience required for licensure as an educational psychologist, and specifies the information that must be included in the verifications.

E. Signatures under Penalty of Perjury

The proposed changes would require signatures on certain forms and applications to be made under penalty of perjury:

- Applicant's signature on licensure and registration applications;
- Supervisor's signature on verification of experience forms;
- A school district employee verifying LEP experience;
- Licensee and registrant signatures on renewal applications;
- Applicant's signature on license "reactivation" applications.

Christina Wong moved to recommend to the Board that it commence rulemaking to amend California Code of Regulations, Title 16, sections 1804 - filing of addresses, 1805 - applications, 1820.7 - confirmation of qualifications to treat couples and families, and 1856 - experience equivalent to three years, full-time experience as credentialed school psychologist as proposed. Betty Connolly seconded. The Committee voted to pass the motion.

Committee vote:
Deborah Brown – yes

Betty Connolly – yes
Christina Wong – yes

VII. Discussion and Possible Recommendation Regarding Proposed Rulemaking to Amend California Code of Regulations, Title 16, Section 1820.5 – Exemptions for Working with Couples or Families

An LPCC cannot assess or treat couples or families until a licensee has met certain educational and supervised experience requirements. One of those requirements is 500 hours of supervised experience with couples, families or children. Current regulations state that an intern or a licensee can treat couples or families only if they are gaining that supervised experience.

The proposed regulatory changes would clarify who can supervise LPCCs and PCIs who are gaining experience in assessing or treating couples, families or children, and who wish to count that experience toward meeting the 500-hour requirement. The acceptable types of supervisors are currently implied by the regulation but needs to be made explicit.

The acceptable supervisors are:

- LPCCs who already meet the requirements
- A supervisor who is an LCSW, licensed psychologist, or licened physician who is board certified in psychiatry, who has sufficient education and experience in treating couples and families to competently practice couple and family therapy in California.

Christina Wong moved to recommend to the Board that it commence rulemaking to amend California Code of Regulations, Title 16, section 1820.5 – exemptions for working with couples or families. Betty Connolly seconded. The Committee voted to pass the motion.

Committee vote:
Deborah Brown – yes
Betty Connolly – yes
Christina Wong – yes

VIII. Discussion and Possible Recommendation Regarding Assembly Bill 93 (Medina) – Healing Arts: Marriage and Family Therapists, Clinical Social Workers, Professional Clinical Counselors: Required Experience and Supervision

The Board approved the original language for AB 93 at it's November 2106 meeting. The bill was introduced in January 2017.

Staff identified and suggested minor technical changes:

1. Change section references in statute that need to be updated due to renumbering.
2. Update title designations of individuals in the licensure process to more accurately identify them.
3. Change references from "intern" to "associate" to be in compliance with the title change effective January 1, 2018.

4. Clarify 9-Day Rule for LMFT and LPCC Applicants.
5. Clarify Six-Year Rule.
6. Clarify Pre-Degree Practicum/Field Study Experience.
7. Clarify Limits on Supervisees.

Deborah Brown moved to recommend to the Board that it approve statutory amendments to AB 93. Christina Wong seconded. The Committee voted to pass the motion.

Committee vote:
Deborah Brown – yes
Betty Connolly – yes
Christina Wong – yes

IX. Discussion and Possible Recommendation Regarding Proposed Board Policy to Remove Board Newsletters from the Board Website

At its April 2016 meeting, the Policy and Advocacy Committee discussed whether the Board should retain the newsletter on its website and the length of time it should remain on the website. The Committee addressed concerns regarding the newsletter's reference to citations, fines, and formal disciplinary actions.

The Committee decided that "Enforcement Citations" should be revised to "Administrative Actions". Also, revising "Administrative Actions" to "Formal Disciplinary Actions" and revise the definition to indicate a higher level of discipline would provide further clarification to the public and licensees/respondents. The Committee was advised that these modifications could be done without any formal direction from the Board.

The remaining issue to consider was should the Board establish a policy to specify the removal of newsletters from the Board's website that complies with five-year requirement specified in BPC §4990.09. Currently, a policy does not exist.

The Committee voted to recommend the Board establish a policy to remove the Board's newsletters from its website within a specified period of time.

At its August 2016 meeting, the Board voted to establish a policy to remove the Board newsletters five years from the date the newsletter was posted on the Board's website.

Christina Wong moved to recommend that the Board approve the proposed policy number B-17-1 regarding retention schedule for Board newsletters on the Board's website. Betty Connolly seconded. The Committee voted to pass the motion.

Committee vote:
Deborah Brown – yes
Betty Connolly – yes
Christina Wong – yes

X. Discussion and Possible Recommendation to Rescind Board Policy L-98-01 Inactive Licenses

This item was removed.

XI. Status of Board-Sponsored 2017 Legislation

AB 93 Healing Arts: Marriage and Family Therapists: Clinical Social Workers: Professional Clinical Counselors: Required Experience and Supervision.

This bill was discussed under agenda item VIII.

Omnibus Legislation

This bill is run every year by the Senate Business, Professions, and Economic Development Committee. The bill proposal makes minor, technical, and non-substantive amendments to add clarity and consistency to current licensing law. Language has been submitted, but has not been introduced yet. The deadline for the legislators to introduce bills for the year is February 17th.

XII. Status of Board Rulemaking Proposals

English as a Second Language: Additional Examination Time: Add Title 16, CCR Section 1805.2

Office of Administrative Law (OAL) did not approve this regulatory proposal. However, the Board has a 120-day extension to make revisions.

The proposed language outlined three criteria to qualify for an ESL accommodation. Two of the criteria were not clear enough:

1. Requirement to provide documentation, acceptable to the Board, that the school had granted an accommodation for English as a second language;
2. Requirement to provide documentation to the satisfaction of the Board, proving that the school's program was outside of the United States and presented in a language primarily other than English.

OAL stated that the Board must specify acceptable documentation. OAL also requested a more specific term for "primarily."

Board staff will update the language and bring it back to the Board for approval in March. OAL has agreed to review the language before staff brings it to the Board. If the Board approves the language, staff will run a 15-day notice. Staff has until June 2nd to get the new language back to OAL for approval.

XIII. Suggestions for Future Agenda Items

1. Dependency support groups:
   - Consider alternatives to dependency support that have some demonstrative research;
   - Research the effectiveness of AA or similar groups;
   - Invite a subject matter expert in substance abuse to present to the Board on new modalities.
2. Discuss LEPs supervision duplication and determine if there is need to keep it, or if it is appropriate to remove it.

3. Discuss changing the titles of registrants to a “limited license” or an “associate license” in a manner that is consistent with other states.

XIV. Public Comment for Items not on the Agenda

No public comments were presented.

XV. Adjournment

The Committee adjourned at 2:15 p.m.

Board of Behavioral Sciences

CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES BILL ANALYSIS

BILL NUMBER: AB 456 **VERSION:** AMENDED APRIL 2, 2018

AUTHOR: THURMOND **SPONSOR:**
- SENECA FAMILY OF AGENCIES
- LINCOLN FAMILIES

PREVIOUS POSITION: SUPPORT

SUBJECT: HEALING ARTS: ASSOCIATE CLINICAL SOCIAL WORKERS

Summary: This bill would extend the Board's "90-day rule" to applicants for registration as an associate clinical social worker (ASW). Currently, the 90-day rule allows applicants for registration as an associate marriage and family therapist or an associate professional clinical counselor to count post-degree hours of supervised experience before receiving a registration number, if they apply for their associate registration within 90 days of the granting of their qualifying degree.

Existing Law:

1) Requires all persons seeking licensure as a marriage and family therapist to register with the Board as an associate to be credited with postdegree supervised experience toward licensure. (Business and Professions Code (BPC) §4980.43(g))

2) Allows an exception to the requirement to register as an associate MFT to be credited with postdegree supervised experience, if the applicant applies for the associate registration within 90 days of the granting of the qualifying degree, and is thereafter granted the registration by the Board. (BPC §4980.43(g), (h))

3) Prohibits an LMFT applicant from being employed or volunteering in a private practice until registered as an associate. (BPC §4980.43(h))

4) Requires an applicant seeking licensure as a professional clinical counselor to register with the Board as an associate to be credited with postdegree supervised experience toward licensure. (BPC §4999.46(d))

5) Allows an exception to the requirement to register as an associate PCC to be credited with postdegree supervised experience, if the applicant applies for the associate registration within 90 days of the granting of the qualifying degree, and is thereafter granted the associate registration by the Board. (BPC §4999.46(d))

6) Prohibits an LPCC applicant from being employed or volunteering in a private practice until registered as an associate. (BPC §4999.46(d))

This Bill:

1) Allows an applicant seeking registration as an associate clinical social worker to be credited with preregistered post-degree hours of supervised experience if he or she complies with all the following (BPC §4996.23(b)):

a) The applicant applies for the associate registration and the Board receives the application within 90 days of the granting of the qualifying master's or doctoral degree;

b) For applicants completing graduate study on or after January 1, 2020, the experience is obtained at a workplace that requires live scan fingerprinting prior to the applicant gaining supervised experience;

c) The applicant provides the Board with a copy of the completed fingerprinting that the workplace required when applying for licensure; and

d) The Board subsequently grants the associate registration.

2) Prohibits an applicant for registration from being employed or volunteering in a private practice until issued the associate registration (BPC §4996.23(c))

3) Reduces the amount of supervised experience required for LCSW licensure from 3,200 hours to 3,000 hours. (BPC §4996.23(a)) *(Note: This change is also being proposed in the Board's sponsored bill, AB 93, and the change has already been approved by the Board.)*

4) Allows the 90-day rule to also apply to an applicant who possesses a master's degree from a school or department of social work that is a candidate for accreditation by the Commission on Accreditation of the Council on Social Work Education. (BPC §4996.18(c))

Comments:

1) Background. The 90-day rule has been included in LMFT licensing law for many years. When the LPCC licensure act was created, it was modeled after LMFT law and included the 90-day rule. LCSW law does not contain the 90-day rule.

Historically, the purpose of the rule has been to assist recent graduates in obtaining some of their supervised experience hours during the time they are waiting for their registration number. Currently, the Board strives to keep its registration processing times to under 30 days. However, in the past due to high seasonal application volumes, budget constraints, or furloughs, processing times were higher.

2) Author's Intent. The author's office states that the delay between graduation and receipt of a registration number creates a hiring barrier for ASW applicants, and creates an unnecessary inequity between ASW applicants, who cannot utilize the

90-day rule, and associate MFT and PCC applicants, who can. They note that removal of barriers for the public mental health workforce has been recognized as a major priority of both the California Office of Statewide Health Planning and Development (OSHPD) and the Mental Health Services Act (MHSA).

3) **Related Legislation: AB 93 and the 90-Day Rule.** AB 93 (Medina) is a Board-sponsored bill running this year to strengthen the Board's requirements related to supervision.

   AB 93 affects code sections that contain the 90-day rule. This bill and AB 93 both became two-year bills last year, due to consumer-protection related concerns in the Senate. The Senate had concerns that the 90-day rule allowed unregistered individuals to provide mental health services without a fingerprint clearance.

   After extensive discussion and collaboration between the Board, stakeholders, the sponsors of AB 456, and the Senate Business and Professions Committee, a compromise was reached that satisfied the Senate's concerns. The 90-day rule could remain in LMFT and LPCC law, if the applicant's workplace requires live scan fingerprints prior to the gaining of supervised experience, and the applicant can provide the Board with proof of such fingerprinting.

   At the time it approved the amended AB 93 language, the Board also expressed that it was supportive of allowing the 90-day rule for LCSW applicants, with the same provisions.

   AB 93 has been amended to contain the agreed-upon 90-day rule language for LMFT and LPCC applicants. AB 456 adds the 90-day rule for LCSW applicants, with the same agreed-upon language.

4) **Double Jointing Language: AB 93 and AB 456.** AB 93 makes significant amendments to several of the Board's statutes related to supervised experience. This includes both sections contained in this bill: BPC sections 4996.18 and 4996.23.

   If AB 93 passes, the two code sections in this bill will be significantly structurally different than current law. To account for this, double-jointing language is needed. Double-jointing language is used by the legislature, typically at the end of session (August or September) to make sure that if two bills affecting the same code sections pass, one does not overwrite the other.
   Because AB 93 will cause the language in AB 456 to be significantly amended from its current format, staff has requested that the legislature draft double jointing language early, in time for the Board's May meeting. This way, the Board can maintain a current position on AB 456. This means that the Board will consider two versions of AB 456's language: one if AB 93 were to pass, and one if it were to fail.

   The authors of both bills and the legislature's counsel have agreed to amend both bills to contain the double jointing language in mid-to late April.

5) **Technical Amendments Needed.** Staff has identified the need for three technical amendments in the current version of AB 456:

a) **BPC §4996.23(b)(2), last sentence:** the term "applicant for licensure" should be "application for licensure."

b) **BPC §4996.23(d)(3):** The allowed 1,200 hours in client centered advocacy should be reduced to 1,000, to account for the 200-hour reduction in total required supervised experience. This is consistent with the amendments in AB 93.

c) **BPC §4996.23(g):** This subsection can be struck, and it is already stated in subsection (a).

6) **Previous Board Position.** At its May 2017 meeting, the Board took a "support" position on the March 27, 2017 version of this bill.

7) **Support and Opposition.**

Support:
- Seneca Family of Agencies (Sponsor)
- Lincoln Families (Sponsor)
- California Alliance of Child and Family Services
- California Association of Marriage and Family Therapists
- CaliforniaHealth+ Advocates
- National Association of Social Workers

Opposition:
- None at this time.

8) **History**

2017
06/13/17 In committee: Set, first hearing. Hearing canceled at the request of author.
05/31/17 In committee: Hearing postponed by committee.
05/18/17 Referred to Com. on B., P. & E.D.
05/04/17 In Senate. Read first time. To Com. on RLS. for assignment.
05/04/17 Read third time. Passed. Ordered to the Senate. (Ayes 76. Noes 0. Page 1389.)
04/27/17 Read second time. Ordered to Consent Calendar.
04/26/17 From committee: Do pass. To Consent Calendar. (Ayes 16. Noes 0.) (April 26).
04/04/17 From committee: Do pass and re-refer to Com. on APPR. (Ayes 15. Noes 0.) (April 4). Re-referred to Com. on APPR.
03/28/17 Re-referred to Com. on B. & P.
03/27/17 From committee chair, with author's amendments: Amend, and re-refer to Com. on B. & P. Read second time and amended.
02/27/17 Referred to Com. on B. & P.
02/14/17 From printer. May be heard in committee March 16.
02/13/17 Read first time. To print.

AMENDED IN SENATE APRIL 2, 2018

AMENDED IN ASSEMBLY MARCH 27, 2017

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 456

Introduced by Assembly Member Thurmond

February 13, 2017

An act to amend Sections 4996.18 and 4996.23 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 456, as amended, Thurmond. Healing arts: associate clinical social workers.

Existing law provides for the licensure and regulation of clinical social workers by the Board of Behavioral Sciences, which is within the Department of Consumer Affairs. Existing law requires an applicant for licensure to comply with specified educational and experience ~~requirements and~~ *requirements. Existing law* requires a person who wishes to be credited with experience toward licensure to register with the board as an associate clinical social worker prior to obtaining that experience.

This bill would *revise and recast these provisions. The bill would instead require each applicant to have an active registration with the board as an associate clinical social worker in order to gain hours of supervised experience, except that the bill would* authorize ~~postgraduate~~ *pre-registered postdegree* hours of experience to be credited toward licensure ~~so long as the person applies for registration as an associate clinical social worker the board receives the application within 90 days of the granting of the qualifying master's degree or doctoral degree and~~

~~the applicant is granted registration by the board. The bill would prohibit an applicant from being employed or volunteering in a private practice until the applicant is granted registration by the board.~~ *in certain circumstances. The bill would allow for this crediting of hours toward licensure if the applicant applies for the associate registration, the board receives the application within 90 days of the granting of the qualifying master's or doctoral degree, and the board subsequently grants the associate registration. The bill would also require, for applicants completing graduate study on or after January 1, 2020, that their experience be obtained at a workplace that requires completed live scan fingerprinting, and that the applicant provide the board with a copy of a completed live scan form, as specified.*

Existing law requires each applicant seeking to qualify for licensure as a clinical social worker to complete 3,200 hours of post-master's degree supervised experience related to the practice of clinical social work.

This bill would reduce the number of hours of post-master's degree supervised experience for licensure as a clinical social worker to 3,000 hours.

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

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

SECTION 1. Section 4996.18 of the Business and Professions Code is amended to read:

4996.18. (a) ~~A person who wishes to be credited with experience toward licensure requirements shall register with the board as an associate clinical social worker prior to obtaining that experience, except as provided in subdivision (j). The application shall be made on a form prescribed by the board.~~ *Except as provided in subdivision (b) of Section 4996.23, each applicant shall have an active registration with the board as an associate clinical social worker in order to gain hours of supervised experience.*

(b) An applicant for registration shall satisfy the following requirements:

(1) Possess a master's degree from an accredited school or department of social work.

97

(2) Have committed no crimes or acts constituting grounds for denial of licensure under Section 480.

(3) Commencing January 1, 2014, have completed training or coursework, which may be embedded within more than one course, in California law and professional ethics for clinical social workers, including instruction in all of the following areas of study:

(A) Contemporary professional ethics and statutes, regulations, and court decisions that delineate the scope of practice of clinical social work.

(B) The therapeutic, clinical, and practical considerations involved in the legal and ethical practice of clinical social work, including, but not limited to, family law.

(C) The current legal patterns and trends in the mental health professions.

(D) The psychotherapist-patient privilege, confidentiality, dangerous patients, and the treatment of minors with and without parental consent.

(E) A recognition and exploration of the relationship between a practitioner's sense of self and human values, and his or her professional behavior and ethics.

(F) Differences in legal and ethical standards for different types of work settings.

(G) Licensing law and process.

(c) An applicant who possesses a master's degree from a school or department of social work that is a candidate for accreditation by the Commission on Accreditation of the Council on Social Work Education shall be eligible, and shall be required, except as provided in subdivision ~~(j)~~, *(b) of Section 4996.23*, to register as an associate clinical social worker in order to gain experience toward licensure if the applicant has not committed any crimes or acts that constitute grounds for denial of licensure under Section 480. That applicant shall not, however, be eligible to take the clinical examination until the school or department of social work has received accreditation by the Commission on Accreditation of the Council on Social Work Education.

(d) All applicants and registrants shall be at all times under the supervision of a supervisor who shall be responsible for ensuring that the extent, kind, and quality of counseling performed is consistent with the training and experience of the person being supervised, and who shall be responsible to the board for

compliance with all laws, rules, and regulations governing the practice of clinical social work.

(e) Any experience obtained under the supervision of a spouse or relative by blood or marriage shall not be credited toward the required hours of supervised experience. Any experience obtained under the supervision of a supervisor with whom the applicant has a personal relationship that undermines the authority or effectiveness of the supervision shall not be credited toward the required hours of supervised experience.

(f) An applicant who possesses a master's degree from an accredited school or department of social work shall be able to apply experience the applicant obtained during the time the accredited school or department was in candidacy status by the Commission on Accreditation of the Council on Social Work Education toward the licensure requirements, if the experience meets the requirements of Section 4996.23. This subdivision shall apply retroactively to persons who possess a master's degree from an accredited school or department of social work and who obtained experience during the time the accredited school or department was in candidacy status by the Commission on Accreditation of the Council on Social Work Education.

(g) An applicant for registration or licensure trained in an educational institution outside the United States shall demonstrate to the satisfaction of the board that he or she possesses a master's of social work degree that is equivalent to a master's degree issued from a school or department of social work that is accredited by the Commission on Accreditation of the Council on Social Work Education. These applicants shall provide the board with a comprehensive evaluation of the degree and shall provide any other documentation the board deems necessary. The board has the authority to make the final determination as to whether a degree meets all requirements, including, but not limited to, course requirements regardless of evaluation or accreditation.

(h) A registrant shall not provide clinical social work services to the public for a fee, monetary or otherwise, except as an employee.

(i) A registrant shall inform each client or patient prior to performing any professional services that he or she is unlicensed and is under the supervision of a licensed professional.

~~(j) Postdegree hours of experience shall be credited toward licensure so long as the applicant applies for the associate clinical social worker registration the board receives the application within 90 days of the granting of the qualifying master's or doctoral degree and the applicant is thereafter granted the associate clinical social worker registration by the board. An applicant shall not be employed or volunteer in a private practice until registered as an associate clinical social worker by the board.~~

SEC. 2. Section 4996.23 of the Business and Professions Code is amended to read:

4996.23. (a) To qualify for ~~licensure as specified in Section 4996.2,~~ *licensure,* each applicant shall complete ~~3,200~~ *3,000* hours of post-master's degree supervised experience related to the practice of clinical social work. ~~The~~ *Except as provided in subdivision (b), experience shall not be gained until the applicant is registered as an associate clinical social worker.*

(b) Preregistered postdegree hours of experience shall be credited toward licensure if all of the following apply:

(1) The registration applicant applies for the associate registration and the board receives the application within 90 days of the granting of the qualifying master's or doctoral degree.

(2) For applicants completing graduate study on or after January 1, 2020, the experience is obtained at a workplace that, prior to the registration applicant gaining supervised experience hours, requires completed live scan fingerprinting. The applicant shall provide the board with a copy of that completed "State of California Request for Live Scan Service" form with his or her applicant for licensure.

(3) The board subsequently grants the associate registration.

(c) The applicant shall not be employed or volunteer in a private practice until he or she has been issued an associate registration by the board.

(d) The experience shall ~~comply with the following:~~ *be as follows:*

(1) At least 1,700 hours shall be gained under the supervision of a licensed clinical social worker. The remaining required supervised experience may be gained under the supervision of a licensed mental health professional acceptable to the board as defined by a regulation adopted by the board.

(2) A minimum of 2,000 hours in clinical psychosocial diagnosis, assessment, and treatment, including psychotherapy or counseling.

(3) A maximum of 1,200 hours in client centered advocacy, consultation, evaluation, research, direct supervisor contact, and workshops, seminars, training sessions, or conferences directly related to clinical social work that have been approved by the applicant's supervisor.

(4) Of the 2,000 clinical hours required in paragraph (2), no less than 750 hours shall be face-to-face individual or group psychotherapy provided to clients in the context of clinical social work services.

(5) A minimum of two years of supervised experience is required to be obtained over a period of not less than 104 weeks and shall have been gained within the six years immediately preceding the date on which the application for licensure was filed.

(6) Experience shall not be credited for more than 40 hours in any week.

(b) An individual who submits an application for examination eligibility between January 1, 2016, and December 31, 2020, may alternatively qualify under the experience requirements that were in place on January 1, 2015.

(c) "Supervision" means responsibility for, and control of, the quality of clinical social work services being provided. Consultation or peer discussion shall not be considered to be supervision.

(d) (1) Prior to the commencement of supervision, a supervisor shall comply with all requirements enumerated in Section 1870 of Title 16 of the California Code of Regulations and shall sign under penalty of perjury the "Responsibility Statement for Supervisors of an Associate Clinical Social Worker" form.

(2) Supervised experience shall include at least one hour of direct supervisor contact for a minimum of 104 weeks. For purposes of this subdivision, "one hour of direct supervisor contact" means one hour per week of face-to-face contact on an individual basis or two hours of face-to-face contact in a group conducted within the same week as the hours claimed.

(3) An associate shall receive at least one additional hour of direct supervisor contact for every week in which more than 10 hours of face-to-face psychotherapy is performed in each setting

in which experience is gained. No more than six hours of supervision, whether individual or group, shall be credited during any single week.

(4) Supervision shall include at least one hour of direct supervisor contact during each week for which experience is gained in each work setting. Supervision is not required for experience gained attending workshops, seminars, training sessions, or conferences as described in paragraph (3) of subdivision (a).

(5) The six hours of supervision that may be credited during any single week pursuant to paragraph (3) shall apply only to supervision hours gained on or after January 1, 2010.

(6) Group supervision shall be provided in a group of not more than eight supervisees and shall be provided in segments lasting no less than one continuous hour.

(7) Of the 104 weeks of required supervision, 52 weeks shall be individual supervision, and of the 52 weeks of required individual supervision, not less than 13 weeks shall be supervised by a licensed clinical social worker.

(8) Notwithstanding paragraph (2), an associate clinical social worker working for a governmental entity, school, college, or university, or an institution that is both a nonprofit and charitable institution, may obtain the required weekly direct supervisor contact via live two-way videoconferencing. The supervisor shall be responsible for ensuring that client confidentiality is preserved.

(e) The supervisor and the associate shall develop a supervisory plan that describes the goals and objectives of supervision. These goals shall include the ongoing assessment of strengths and limitations and the assurance of practice in accordance with the laws and regulations. The associate shall submit to the board the initial original supervisory plan upon application for licensure.

(f) Experience shall only be gained in a setting that meets both of the following:

(1) Lawfully and regularly provides clinical social work, mental health counseling, or psychotherapy.

(2) Provides oversight to ensure that the associate’s work at the setting meets the experience and supervision requirements set forth in this chapter and is within the scope of practice for the profession as defined in Section 4996.9.

(g) Except as provided in subdivision (j) of Section 4996.18, experience shall not be gained until the applicant has been registered as an associate clinical social worker.

(h) Employment in a private practice as defined in subdivision (i) shall not commence until the applicant has been registered as an associate clinical social worker.

(i) A private practice setting is a setting that is owned by a licensed clinical social worker, a licensed marriage and family therapist, a licensed psychologist, a licensed professional clinical counselor, a licensed physician and surgeon, or a professional corporation of any of those licensed professions.

(j) Associates shall not be employed as independent contractors, and shall not gain experience for work performed as an independent contractor, reported on an IRS Form 1099, or both.

(k) If volunteering, the associate shall provide the board with a letter from his or her employer verifying his or her voluntary status upon application for licensure.

(*l*) If employed, the associate shall provide the board with copies of his or her W-2 tax forms for each year of experience claimed upon application for licensure.

(m) While an associate may be either a paid employee or volunteer, employers are encouraged to provide fair remuneration to associates.

(n) An associate shall not do any of the following:

(1) Receive any remuneration from patients or clients and shall only be paid by his or her employer.

(2) Have any proprietary interest in the employer's business.

(3) Lease or rent space, pay for furnishings, equipment, or supplies, or in any other way pay for the obligations of his or her employer.

(o) An associate, whether employed or volunteering, may obtain supervision from a person not employed by the associate's employer if that person has signed a written agreement with the employer to take supervisory responsibility for the associate's social work services.

(p) Notwithstanding any other law, associates and applicants for examination shall receive a minimum of one hour of supervision per week for each setting in which he or she is working.

O

97

Board of Behavioral Sciences

CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES BILL ANALYSIS

BILL NUMBER: AB 767 **VERSION:** AMENDED MAY 3, 2017

AUTHOR: QUIRK-SILVA **SPONSOR:** COMMITTEE ON JOBS, ECONOMIC DEVELOPMENT, AND THE ECONOMY

PREVIOUS POSITION: SUPPORT IF AMENDED

SUBJECT: MASTER BUSINESS LICENSE ACT

Summary: This bill creates a master business license system under the Governor's Office of Business and Economic Development (GO-Biz). It would allow a person who needs to apply for more than one business license to submit a single master application through GO-Biz, which would then distribute the application information to the various relevant licensing entities.

Existing Law:

1) Establishes the Governor's Office of Business and Economic Development (GO-Biz). (Government Code (GC) §12096.2)

2) States that the purpose of GO-Biz is to serve the Governor as the lead entity for economic strategy and marketing of California on issues related to business development, private sector investment, and economic growth. (GC §12096.3)

3) Outlines the duties of GO-Biz as including, among other tasks, marketing the business and investment opportunities available in California by partnering with other government and private entities to encourage business development and investment in the state. This may include assisting with obtaining state and local permits. (GC §12096.3(c))

4) Establishes the Permit Assistance Program within GO-Biz to provide permit and regulatory compliance assistance to businesses, and requires the agency to post licensing, permitting, and registration requirements of state agencies on its web site to assist individuals with identifying the types of applications or forms they may need to apply for various licenses and permits. (GC §§12097, 12097.1)

This Bill:

1) Establishes the Master Business License Act, and creates a business license center under GO-Biz that is tasked with the following (GC §§15930, 15932):

a) Developing and administering an online master business license system capable of storing, retrieving, and exchanging license information.

b) Providing a license information service detailing requirements to engage in business in the state.

c) Identifying types of licenses appropriate for inclusion in the master business license system.

d) Incorporating licenses into the master business license system.

2) States the director of GO-Biz shall **encourage** state regulatory entities to participate in the system. (GC §15933(b))

3) Requires each state regulatory agency to cooperate and provide reasonable assistance to GO-Biz in implementing the Master Business License Act. (GC §15934)

4) Allows any person that applies for two or more business licenses that are in GO-Biz's master business license system to submit a master application to GO-Biz to request the issuance of the licenses. (GC §15935(a))

5) Requires GO-Biz to develop an internet-based platform that allows businesses to electronically submit their master application, along with the payment of every fee required to obtain each requested license and a master application fee. (GC §15935(a))

6) Allows GO-Biz and included state agencies to borrow money from the State General Fund to support reasonable costs of integrating into the system. These loans would be repaid from fees collected from the program. (GC §15936)

7) Requires the fees collected under the master business license system to be allocated to the relevant respective licensing agencies. (GC §15937)

8) Defines a "license" to mean any state agency permit, license, certificate, approval, registration, charter, or any form or permission required by law, including by regulation, to engage in any activity. (GC §15931(d))

Comments:

1) Author's Intent. The author's office states that the most common form of business in California are sole proprietorships, citing that 3.1 million of the 4 million firms in California have no employees. They note that these small businesses face regulatory hurdles when starting or expanding.

GO-Biz has already built a California Business Portal website, through which businesses can identify which permits and licenses are required. If a business uses this website, it can follow the individual links to apply for each required license. The goal of this bill is to take the existing website to the next level, by creating a single online interface to use for numerous application processes.

2) Cal-Gold. Go-Biz's current business portal for permitting and licensing assistance is called Cal-Gold. The portal allows an individual to enter the city or county that they

are in, and their type of business. The database will return a list of required permits or licenses needed for their business.

Permitting and licensing information for licensees of this Board is not currently included in the database. To get an idea of the type of information provided, staff did a search for requirements for an optometry business located in the city and county of Sacramento. **Attachment A** shows the results. It includes information such as business license information (city jurisdiction), fire inspection information (city jurisdiction), air tank permit information (state jurisdiction), corporation filing information (state jurisdiction), facility licensing information (state jurisdiction), and licensing information (state (DCA) jurisdiction), among others. The site includes links to each of these entity's websites where an applicant can go for further information.

3) **Effect on Board Applicants.** There can be many permits that a business owner needs to obtain to operate in a city or county, depending on the profession. Having a database that can compile this information into a master list in one place may be very helpful for a potential business owner.

   However, applicants for this Board's license types go to college specifically to obtain a Master's degree toward licensure with the Board. The educational institution helps prepare these students to apply for licensure, and by the end of their respective graduate programs, they are aware that the Board of Behavioral Sciences is their licensing entity.

   Obtaining a license with the Board is typically a process, with an applicant first becoming a registrant and gaining experience hours, applying to the Board for exam eligibility, and finally obtaining a license once the required examinations are passed. Having an entity that is not familiar with the details of the process for each license type accepting applications could add an unnecessary level of complexity to the licensure process.

   It also may be unreasonable to assume that an outlying agency can take on the task of tracking the licensing requirements for each of the Department of Consumer Affairs' (DCAs') many boards and bureaus, and keeping that information up-to-date. For example, for our optometry business search shown in **Attachment A,** Cal-Gold directs registered dispensing opticians to the Medical Board of California for licensing. However, according to the Medical Board's website, the Optometry Board assumed responsibility for registering and regulating dispensing opticians effective January 1, 2016.

4) **Board Acceptance of Online Applications.** Aside from renewal applications, the Board does not currently accept online applications. The Board hopes to be able to build this capability into the Breeze system over the next several years.

5) **Fiscal Impact.** The fiscal impact for each DCA board or bureau has not been calculated at this time. However, the Assembly Committee on Appropriations' committee analysis dated January 18, 2018 reported that DCA has estimated a one-time IT cost of $18.7 million for administrative and system modifications, as well as

$240,000 annually in ongoing costs. There are approximately 113 license types under DCA.

6) **Recommended Position.** At its May 12, 2017 meeting, the Board took a "support if amended" position on this bill. While the Board recognized and appreciated the effort to make the licensing and permitting processes more business-friendly, the consensus was that the process of licensure is best handled directly with the Board. Therefore, the Board requested that its license types not be included in the proposed master application system.

7) **Support and Opposition.**

Support:
- Assembly Committee on Jobs, Economic Development, and the Economy (Sponsor)
- California Association for Health Services at Home

Oppose:
- Unknown

History

2018
03/15/18 Referred to Com. on B., P. & E.D.
01/29/18 In Senate. Read first time. To Com. on RLS. for assignment.
01/29/18 Read third time. Passed. Ordered to the Senate. (Ayes 75. Noes 0.)
01/22/18 Read second time. Ordered to third reading.
01/18/18 From committee: Do pass. (Ayes 17. Noes 0.) (January 18).
01/18/18 In committee: Set, second hearing. Referred to APPR. suspense file.
2017
05/17/17 In committee: Set, first hearing. Hearing canceled at the request of author.
05/04/17 Re-referred to Com. on APPR.
05/03/17 Read second time and amended.
05/02/17 From committee: Amend, and do pass as amended and re-refer to Com. on APPR. (Ayes 7. Noes 0.) (April 25).
03/02/17 Referred to Com. on J., E.D., & E.
02/16/17 From printer. May be heard in committee March 18.
02/15/17 Read first time. To print.

Attachment

Attachment A: GO-Biz Cal Gold Database Search Result: Business Permits and Other Requirements for Optometry in the City of Sacramento

AMENDED IN ASSEMBLY MAY 3, 2017

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 767

Introduced by Assembly Member Quirk-Silva

February 15, 2017

An act to add Part 12.5 (commencing with Section 15930) to Division 3 of Title 2 of the Government Code, relating to economic development.

LEGISLATIVE COUNSEL'S DIGEST

AB 767, as amended, Quirk-Silva. Master Business License Act.

Existing law authorizes various state agencies to issue permits and licenses in accordance with specified requirements to conduct business within this state. Existing law establishes the Governor's Office of Business and Economic Development to serve the Governor as the lead entity for economic strategy and the marketing of California on issues relating to business development, private sector investment, and economic growth. Existing law creates within the Governor's Office of Business and Economic Development the Office of Small Business Advocate to advocate for the causes of small ~~business~~ *businesses* and to provide small businesses with the information they need to survive in the marketplace.

This bill would create within the Governor's Office of Business and Economic Development, or its successor, a business license center to develop and administer ~~a computerized~~ *an online* master business license system to simplify the process of engaging in business in this state. The bill would set forth the duties and responsibilities of the business license center. The bill would require each state *regulatory* agency to cooperate and provide reasonable assistance to the office to implement these provisions.

This bill would authorize a person that applies for 2 or more business licenses that have been incorporated into the master business license system to submit a master application to the office requesting the issuance of the licenses. The bill would require the office to develop and adopt an Internet-based platform that allows the ~~business~~ *businesses* to electronically submit the master application to the office, as well as the payment of every fee required to obtain each requested license and a master application fee, which would be deposited into the Master License Fund, which would be created by the bill. *The bill would authorize the office to borrow up to $140,000 from the General Fund. The bill would authorize a state agency that the office has determined to have a license and fee that is appropriate for inclusion in the master business license system to borrow money as needed from the General Fund to support the reasonable costs of integrating into the system. The bill would require these General Fund moneys to be deposited into the Master License Fund.* The bill would authorize moneys in the fund, upon appropriation, to be expended only to administer this bill or be transferred to the appropriate licensing agencies. The bill would also require, upon issuance of the license or licenses, the office to transfer the fees, except for the master license fee, to the appropriate accounts under the applicable statutes for those regulatory agencies' licenses.

The bill would require the office to establish a reasonable fee for each master license application and to collect those fees for deposit into the Master License Fund established by this bill. Funds derived from the master license application fees would be expended to administer the master business license program upon appropriation by the Legislature. The bill would require the license fees of the regulatory agencies deposited into the fund to be transferred to the appropriate accounts of the regulatory agencies, as provided.

The bill would require the office, in consultation with other regulatory agencies, to establish a uniform business identification number for each business that would be recognized by all affected state agencies and used to facilitate the information sharing between state agencies and to improve customer service to businesses.

The bill would also require *the office, including* the Director of Small Business ~~Advocate~~ *Advocate,* to work with small business owners and all regulatory agencies to ensure the state's implementation of a consolidated business license and permit system.

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

98

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

SECTION 1. Part 12.5 (commencing with Section 15930) is added to Division 3 of Title 2 of the Government Code, to read:

PART 12.5. MASTER BUSINESS LICENSE ACT

Chapter 1. General Provisions

15930. This part may be known, and may be cited as, the Master Business ~~Licence~~ *License* Act.

15931. As used in this part, the following words shall have the following meanings:

(a) "Business license center" means the business registration and licensing center established by this part and located in and under the administrative control of the office.

(b) "Director" means the Director of the Governor's Office of Business and Economic Development.

(c) "License information packet" means a collection of information about licensing requirements and application procedures custom assembled for each request.

(d) "License" means the whole or part of any state agency permit, license, certificate, approval, registration, charter, or any form or permission required by law, including agency regulation, to engage in any activity.

(e) "Master application" means a document incorporating pertinent data from existing applications for licenses covered under this part.

(f) "Master business license system" or "system" means the mechanism by which licenses are issued, license and regulatory information is disseminated, and account data is exchanged by state agencies.

(g) "Office" means the Governor's Office of Business and Economic Development or its successor.

(h) "Person" means any individual, sole proprietorship, partnership, association, cooperative, corporation, nonprofit organization, state or local government agency, and any other organization required to register with the state to do business in the state and to obtain one or more licenses from the state or any of its agencies.

(i) "Regulatory" means all licensing and other governmental or statutory requirements pertaining to business activities.

(j) "Regulatory agency" means any state agency, board, commission, or division that regulates one or more industries, businesses, or activities.

Chapter 2. Business License Center

15932. (a) There is created within the office a business license center.

(b) The duties of the center shall include, but not be limited to, all of the following:

(1) Developing and administering ~~a computerized onestop~~ *an online* master business license system capable of storing, retrieving, and exchanging license information with due regard to privacy statutes.

(2) Providing a license information service detailing requirements to establish or engage in business in this state.

(3) Identifying types of licenses appropriate for inclusion in the master business license system.

(4) Recommending in reports to the Governor and the Legislature the elimination, consolidation, or other modification of duplicative, ineffective, or inefficient ~~licensing or inspection requirements.~~ *licensing.*

(5) Incorporating licenses into the master business license system.

15933. (a) The ~~director may~~ *office shall* adopt regulations as may be necessary to effectuate the purposes of this part.

(b) The director shall encourage state ~~entities~~ *regulatory entities* to participate in the online master business license system.

15934. Each state *regulatory* agency shall cooperate and provide reasonable assistance to the office in the implementation of this part.

Chapter 3. Master License

15935. (a) Any person that applies for two or more business licenses that have been incorporated into the master business license system may submit a master application to the office requesting the issuance of the licenses. The office shall develop

and adopt an Internet-based platform that allows the business to electronically submit the master application to the office, as well as the payment of every fee required to obtain each requested license and a master application fee established pursuant to Section 15936.

(b) Irrespective of any authority delegated to the office to implement this part, the authority for approving the issuance and renewal of any requested license that requires a prelicensing or renewal investigation, inspection, testing, or other judgmental review by the regulatory agency otherwise legally authorized to issue the license shall remain with that agency.

(c) Upon receipt of the application and proper fee payment for any license for which issuance is subject to regulatory agency action under subdivision (a), the office shall immediately notify the business of receipt of the application and fees.

15936. *(a)* The office shall establish a fee for each master application that does *not* exceed the reasonable costs of administering this part and collect that fee.

(b) The office may borrow up to one hundred forty thousand dollars ($140,000) from the General Fund in the State Treasury.

(c) A state agency that the office has determined to have a license and fee that is appropriate for inclusion in the master business license system may borrow money from the General Fund in the State Treasury in an amount necessary to support the reasonable cost of integrating into the system.

(d) The loans made pursuant to subdivisions (b) and (c) shall be repaid with interest, calculated at the rate earned by the Pooled Money Investment Account at the time of the transfer from the General Fund, from the fees collected pursuant to this section.

15937. All fees collected under the master business license system, including the master license application fee and the fees of the regulatory agencies, *and all moneys borrowed under Section 15936* shall be deposited into the Master License Fund, which is hereby created in the State Treasury. Moneys in the fund from master application fees may, upon appropriation by the Legislature, be expended only to administer this part or be transferred to the appropriate licensing agencies. Moneys in the fund from other fees shall be transferred to the appropriate accounts under the applicable statutes for those regulatory agencies' licenses.

CHAPTER 4. UNIFORM BUSINESS IDENTIFICATION NUMBER

15940. (a) The office, in consultation with other regulatory agencies, shall establish a uniform business identification number for each business. The uniform business identification number shall be recognized by all affected state agencies and shall be used by state agencies to facilitate information sharing between state agencies and to improve customer service to businesses.

(b) It is the intent of the Legislature that the uniform business number would permit the office to do both of the following:

(1) Register a business with multiple state agencies electronically as licenses and permits are processed.

(2) Input and update information regarding a business once, thereby reducing the number of duplicate or conflicting records from one state agency to another.

CHAPTER 5. OVERSIGHT

15945. The *office, including the* Director of Small Business Advocate from the Governor's Office of ~~Planning and Research~~ *Business and Economic Development* shall work with small business owners and all regulatory agencies to ensure the state's implementation of a consolidated business license and permit system under this part.

O

98

Governor's Office of Business and Economic Development GO-Biz (http://business.ca.gov/)

ATTACHMENT A

Search Results

Business permits and other requirements in the City of Sacramento (Sacramento County) for business types:

- Optometry

Permits & Licenses | Resources Available to Help You | Print List

Business License - Business Tax Certificate

city

Required for all entities doing business within city limits. See "County Unincorporated" for businesses located outside of city limits.

applies to:
Optometry

City of Sacramento
City Finance, Revenue Department
Business License
915 I Street, 5th Floor
Sacramento, CA, 95814
Phone: 916-808-5845
website (http://portal.cityofsacramento.org/Finance/Revenue/Business-Operation-Tax/Apply-for-a-Business-Operation-Tax-Account)

Fire Prevention Information/Inspection

city

Businesses may be subject to a yearly inspection of facility - annual fee may be charged.

applies to:
Optometry

City of Sacramento
City Fire Department
5770 Freeport Blvd, Suite 200
Sacramento, CA, 95822
Phone: 916-808-1300
website (http://www.sacfire.org/prevention-safety/fire-prevention/)

Land Use Permit/Zoning Clearance

city

Example: zone change, variance, conditional use permit. Required if business located within incorporated city limits.

applies to:
Optometry

City of Sacramento
City Planning Services
Planning Services
300 Richards Boulevard, 3rd Floor
Sacramento, CA, 95814
Phone: 916-264-5011
website (http://portal.cityofsacramento.org/Economic-Development/Business-Resources/Permitting-Zoning)

Police Regulations/Public Safety Issues

city

Some city police departments offer business crime prevention programs and may also issue permits for certain activities i.e. burglar alarm, solicitors etc. - requirements vary from city to city.

applies to:
Optometry

City of Sacramento
Police Department
5770 Freeport Blvd, Suite 100
Sacramento, CA, 95822
Phone: 916-808-1300
Fax: 916-808-1629
website (http://www.sacpd.org/faq/permits/)

Business Property Statement

county

Businesses are required to report all equipment, fixtures, supplies, and leasehold improvements held for business use at each location.

agency note:
Property Statements are due January 1 of each year

applies to:
Optometry

County of Sacramento
Assessor's Office
3701 Power Inn Road, Suite 3000
Sacramento, CA, 95826
Phone: 916-875-0730
website (http://www.assessor.saccounty.net/Pages/Forms-BusinessPersonalProperty.aspx)

Fictitious Business Name - Doing Business As Statement

county

A Fictitious Business Name (FBN) or Doing Business As (DBA) statement is required when the business name does not include the surname of the individual owner(s) and each of the partners; or the business name suggests the existence of additional owners; or the nature of the business in not clearly evident by the name of the business. For example Bill Smith and Sons Plumbing would require a FBN because the name implies additional owners, Bill Smith Plumbing does not require a FBN. Bill Smith Industries would require a FBN because it does not identify the nature of the business.

applies to:
Optometry

County of Sacramento
Treasurer Tax Collector's Office
Fictitious Business Name
700 H Street, Room 1710
PO Box 508
Sacramento, CA, 95814
Phone: 916-874-6644
Fax: 916-874-8909
website (http://www.finance.saccounty.net/Tax/Pages/BusLicForms.aspx)

Air Tanks Permit

state

Required of all businesses using (1) pressurized tanks with a volume greater than 1.5 cubic feet and containing greater than 150 PSI (pounds per square inch) of air; (2) Steam boilers over 15 PSI; or (3) retail stationary propane tanks.

agency note:
"To apply for a "Permit to Operate" for an air tank, liquefied petroleum tank or a boiler, click on the link Pressure Vessel Inspection Request Form."

applies to:
Optometry

Department of Industrial Relations
Pressure Vessel Unit-North
1515 Clay Street, Suite 1302
Oakland, CA, 94612
Phone: 510-622-3066
Fax: 510-622-3063
website (http://www.dir.ca.gov/dosh/pressure.html)

Corporation, Company or Partnership Filings

state

If you are considering becoming a corporation, (either stock or nonprofit), a limited liability company or a partnership (limited, or limited liability), you must file with the Secretary of State's Office.

agency note:

Also, if you are conducting business as one of the following, you must file a bond with the Secretary of State's Office: immigration consultant, credit services organization, dance studio, discount buying organization, employment agency, employment counseling service, invention developer, job listing service, nurses registry, or auctioneer or auction company.

applies to:
Optometry

Secretary of State
1500 11th Street
Sacramento, CA, 95814
Phone: 916-657-5448
website (http://www.sos.ca.gov/business/be/forms.htm)

Discrimination Law

state

Harassment or discrimination in employment is prohibited if it is based on a person's race, ancestry, national origin, color, sex (including pregnancy), sexual orientation, religion, physical disability (including AIDS), mental disability, marital status, medical condition (cured cancer), and refusal of family care leave. Discrimination in housing, public services and accommodations is also prohibited.

agency note:
Employers must post the Harassment or Discrimination in Employment notice (DFEH 162) and provide their employees with a copy of the DFEH's information sheet on sexual harassment (DFEH 185) or a statement that contains equivalent information. Employers must also provide notice of an employee's right to request pregnancy disability leave or transfer, as well as notice to request a family or medical care leave (CFRA). Employers with 5 or more employees must maintain all personnel records for a minimum of 2 years.

applies to:
Optometry

Department of Fair Employment and Housing
2218 Kausen Drive, Suite 100
Elk Grove, CA, 95758
Phone: 800-884-1684
website (http://www.dfeh.ca.gov/files/2016/09/DFEH-162-2015.pdf)

Facility Licensing and Certification

state

Licensing and certification of health care facilities and providers such as General Acute Care Hospitals, Skilled Nursing Facilities, Home Health Agencies, and Clinics.

agency note:
Licenses different types of health care facilities and providers so they can legally do business in California. Certifies to the federal government health care facilities and providers that are eligible for payments under the Medicare and Medicaid (Medi-Cal) programs

applies to:
Optometry

Department of Public Health
Licensing and Certification Program
12440 E. Imperial Highway, Room 522
Norwalk, CA, 90650
Phone: 562-345-6884
Fax: 562-409-5096
website (https://www.cdph.ca.gov/Programs/CEH/Pages/CLPR.aspx)

Medical Waste Generator Registration and Treatment/Transfer Station Permitting

state

Medical wastes include sharps and biohazardous waste from the diagnosis, treatment, immunization, or research of human beings or animals, the production or testing of biologicals, or regulated waste from a trauma scene waste management practitioner

agency note:
Large quantity generators (LQGs)(>200 lbs./mo) and small quantity generators (SQGs) (<200 lbs./mo) of medical wastes are registered with the Department. Facilities treating medical waste or serving as medical waste or transfer station are registered and permitted by the Department. Medical waste haulers are DTSC-registered hazardous waste transporters which must also register with the Department. Click on Medical Waste Management Program's web site to locate the enforcing agency for medical waste management program in your area.

applies to:
Optometry

Department of Public Health
Medical Waste Management Program
PO Box 997377, MS 0500
Sacramento, CA, 95899
Phone: 916-558-1784
website (http://www.dhs.ca.gov/ps/ddwem/environmental/Med_Waste/default.htm)

Occupational Safety and Health Information

state

Businesses with employees must prepare an Injury and Illness Prevention Plan. The state provides a no-fee consultation service to assist employers with preventing unsafe working conditions and workplace hazards.

agency note:
Certain permits/licenses/certifications may be required for compliance with Health & Safety Standards, General Industry Safety Order, Carcinogen regulations and Construction Safety orders i.e. excavation/trenching, asbestos related work, crane/derrick operation, air/liquid petroleum gas tanks, etc.

applies to:
Optometry

Department of Industrial Relations
Cal/OSHA Consultation Services
2424 Arden Way, Ste. 300
Sacramento, CA, 95825
Phone: 916-263-2803
Fax: 916-263-2824
website (http://www.dir.ca.gov/occupational_safety.html)

Radiation Source Registration

state

Those possessing radiation-emitting machines or devices containing radioactive material. Examples include physicians, dentists, hospitals, and industrial plants.

agency note:
Mailing address: P.O. Box 997414, MS 7610 Sacramento, CA 95899

applies to:
Optometry

Department of Public Health
Radiologic Health Branch
PO Box 997377, MS 0500
Sacramento, CA, 95899
Phone: 916-558-1784
website (http://www.cdph.ca.gov/pubsforms/forms/Pages/RHBLicensingForms.aspx)

Registered Contact Lens Dispenser

state

Persons who fit, adjust and dispense contact lenses with prescription are required to be registered

applies to:
Optometry

Department of Consumer Affairs
Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, CA, 95815
Phone: 916-263-2380
Fax: 916-263-2944
website (http://www.dca.ca.gov/proflic/medicalbd.shtml)

Registered Dispensing Optician

state

Optician stores that fit, adjust, and dispense eyeglass and contact lens prescriptions must obtain this certificate

applies to:
Optometry

Department of Consumer Affairs
Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, CA, 95815
Phone: 916-263-2380
Fax: 916-263-2944
website (http://www.dca.ca.gov/proflic/medicalbd.shtml)

Registered Spectacle Lens Dispenser

state

Persons who fill, adjust, and dispense eyeglass lenses with prescription must be registered.

applies to:
Optometry

Department of Consumer Affairs
Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, CA, 95815
Phone: 916-263-2380
Fax: 916-263-2944
website (http://www.dca.ca.gov/proflic/medicalbd.shtml)

Registration Form for Employers

state

Required to file a registration form within 15 days after paying more than $100.00 in wages to one or more employees. No distinction is made between full-time and part-time or permanent and temporary employees in meeting this requirement.

applies to:
Optometry

Employment Development Department
Employment Tax Customer Service Office
P.O. Box 2068
Rancho Cordova, CA, 95741
Phone: 888-745-3886
website (http://www.edd.ca.gov/payroll_taxes/am_i_required_to_register_as_an_emplo
For more information... (http://www.edd.ca.gov/Office_Locator/)

Sales & Use Permit (Seller's Permit)

state

All businesses selling or leasing tangible property must obtain a Seller's Permit.

agency note:
For Additional information about RESALE CERTIFICATE go to this website: www.boe.ca.gov/sutax/faqresale.htm

applies to:
Optometry

Department of Tax and Fee Administration
Sales/Use Tax Division
PO Box 942879
Sacramento, CA, 94279
Phone: 800-400-7115
website (http://www.boe.ca.gov/info/reg.htm)
For more information... (http://www.boe.ca.gov/info/phone.htm)

State EPA Identification Number

state

Required of businesses that generate, surrender to be transported, transport, treat, or dispose of hazardous waste.

agency note:
DTSC issues State Generator EPA ID Numbers. You may be referred to Federal EPA if you generate over 100 kg per month of RCRA waste (1-415-495-8895) or 1 *800) 6186942 or outside California (916) 255=1136

applies to:
Optometry

Department of Toxic Substances Control
Generator Information Services
1001 I Street
Sacramento, CA, 95814
Phone: 800-728-6942
website (http://www.dtsc.ca.gov/contactDTSC/regulatory-assistance-officers.cfm)

State Income Tax Information

state

Businesses should obtain the appropriate State income tax forms from the Franchise Tax Board.

agency note:
All businesses are required to submit a Business Income Tax statement annually.

applies to:
Optometry

Franchise Tax Board
Business Entities Division
PO Box 1468
Sacramento, CA, 95812
Phone: 800-338-0505
website (https://www.ftb.ca.gov/businesses/index.shtml?WT.mc_id=Global_Business

Wage/Hour Laws

state

Businesses with employees must comply with laws establishing minimum standards for wages, hours and working conditions.

applies to:
Optometry

Department of Industrial Relations
Labor Commissioner's Office
1515 Clay Street, STE 401, Oakland, CA, 94612
Oakland, CA, 94612
Phone: 510-285-3502
Fax: 510-286-1366
website (http://www.dir.ca.gov/DLSE/dlse.html)

Workers' Compensation Information

state

Businesses with employees must maintain Workers' Compensation Insurance coverage on either a self-insured basis, or provided through a commercial carrier, or the State Workers' Compensation Insurance Fund.

applies to:
Optometry

Department of Industrial Relations
Division of Workers' Compensation
160 Promenade Circle, Suite 300
Sacramento, CA, 95834
Phone: 916-928-3101
website (http://www.dir.ca.gov/DWC/dwc_home_page.htm)

Employer Identification Number (EIN or SSN)

federal

Employers with employees, business partnerships, and corporations, must obtain an Employer Identification Number from the I.R.S. Businesses can obtain appropriate Federal income tax forms from this location.

agency note:
Additional office locations: http://www.irs.gov/uac/Contact-My-Local-Office-in-California

applies to:
Optometry

U.S. Department of Treasury
Internal Revenue Service
4330 Watt Avenue
Sacramento, CA, 95821
Phone: 800-829-4933
website (http://www.irs.gov/Businesses/Small-Businesses-&-Self-Employed/Apply-for-an-Employer-Identification-Number-(EIN)-Online)

Proof of Residency Requirement

Employees hired after November 6, 1986 must provide proof of eligibility to work in the United States.

applies to:
Optometry

federal

U.S. Immigration and Naturalization Service
Sacramento Field Office
650 Capitol Mall
Sacramento, CA, 95814
Phone: 800-375-5283
website (http://www.uscis.gov/portal/site/uscis/menuitem.eb1d4c2a3e5b9ac89243c6a75/?vgnextoid=84c267ee5cb38210VgnVCM vgnextchannel=84c267ee5cb38210VgnV

Board of Behavioral Sciences

CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES BILL ANALYSIS

BILL NUMBER: AB 1436 **VERSION:** NOT IN PRINT YET[1]

AUTHOR: BERMAN/LEVINE **SPONSOR:** THE STEINBERG INSTITUTE

RECOMMENDED POSITION: NONE

SUBJECT: BOARD OF BEHAVIORAL SCIENCES: LICENSEES: SUICIDE PREVENTION TRAINING

Overview:

This bill would require, beginning January 1, 2021, applicants for licensure as a marriage and family therapist, clinical social worker, or professional clinical counselor to demonstrate completion of at least six hours of coursework or supervised experience in suicide risk assessment and intervention. Current licensees would also be required to demonstrate completion of this coursework or supervised experience in their first renewal period after this date.

Existing Law:

1) Provides that the Board of Behavioral Sciences (Board) is the state licensing entity for marriage and family therapists (LMFTs), educational psychologists (LEPs), clinical social workers (LCSWs) and professional clinical counselors (LPCCs), and sets specific education and experience requirements for licensure. (Business and Professions Code (BPC) §§4980, 4980.36, 4980.37, 4989.12, 4989.20, 4996, 4996.2, 4999.30, 4999.32, 4999.33)

2) 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 to create a more competent licensing population, thereby enhancing public protection. ((Business and Professions Code §166)

3) Requires licensees of the Board of Behavioral Sciences (Board), upon renewal of their license, to certify completion of at least 36 hours of approved continuing education in or relevant to their field of practice. (BPC §§4980.54, 4989.34, 4996.22, 4999.76).

4) Requires LMFT, LCSW, and LPCC applicants to complete specified coursework in spousal or partner abuse assessment, detection, and intervention. (BCP §§4980.36, 4980.41, 4996.2, 4999.32, 4999.33)

5) Requires LMFT, LCSW, and LPCC applicants to complete specified coursework in human sexuality. (BPC §§25, 4980.41, 4996.2, 4999.32, 4999.33, California Code of Regulations (CCR) Title 16 §1807)

[1] AB 1436 currently covers another topic. However, the author's office has indicated they intend to amend the provided language into this bill.

6) Requires all Board applicants to complete specified coursework in child abuse and elder and dependent adult abuse assessment and reporting. (BPC §§28, 4980.36, 4980.41, 4996.2, 4999.32. 4999.33, 16 CCR §1807.2)

7) Requires LMFT, LCSW, and LPCC applicants to complete specified coursework in aging and long-term care. (BPC §§4980.36, 4980.36, 4980.395, 4996.25, 4996.26, 4999.32, 4999.33)

8) Requires all Board applicants to complete specified coursework in alcoholism and other substance dependency. (BPC §§4980.36. 4980.41, 4996.2, 4999.32, 4999.33, 16 CCR §1810)

9) Requires LMFT, LCSW, and LPCC applicants to complete 7 hours of coursework in assessment and treatment of HIV/AIDS as a one-time requirement. Equivalent coursework or proof of teaching or practice experience, may be submitted to the Board in lieu of the coursework requirement. (BPC §32, 16 CCR §1887.3)

This Bill:

*Note: This bill is not officially in print yet. The language the author proposes amending into AB 1436 is shown in **Attachment A**.*

1) Beginning January 1, 2021, requires an applicant for licensure as a marriage and family therapist, educational psychologist, professional clinical counselor, or clinical social worker to show, as part of the application, completion of at least six hours of coursework or applied supervised experience in suicide risk assessment and intervention. The coursework or experience must be gained via one of the following methods (BPC §§4980.396(a), 4989.23(a), 4996.27(a), 4999.66(a)):

a) It was obtained as part of the qualifying degree. The applicant must provide the Board with a written certification from the registrar or training director of the educational institution or program stating the coursework was included; or

b) It was obtained as part of the applicant's applied experience via practicum, internship, formal doctoral placement, or other qualifying supervised professional experience. The applicant must submit to the Board a written certification from the director of training for the program, or from the primary supervisor, stating the required training was included; or

c) It was obtained via a continuing education course from a provider designated as acceptable by the Board. The applicant must submit a certificate of course completion to the Board.

2) Beginning January 1, 2021, requires a licensee, upon his or her license renewal, reactivation, or reinstatement, to have completed at least six hours of coursework or applied supervised experience in suicide risk assessment and intervention, as a one-time requirement. Proof of compliance must be certified under penalty of perjury, and must be retained for submission to the Board upon request. (BPC §§4980.369(b) & (c), 4989.23(b) & (c), 4996.27(b) & (c), 4999.66(b) & (c))

Comments:

1) Author's Intent. The purpose of this bill is to establish a baseline coursework requirement for all licensed marriage and family therapists, clinical social workers, educational

psychologists, and professional clinical counselors in suicide risk assessment and intervention. Several organizations, including the United States Department of Health and Human Services, and the Institute of Medicine, have indicated a need for improved education and training in suicide assessment.

2) **History: Previous Legislation, Governor's Directive, and 2015 Board Findings.** During the 2013-2014 Legislative Session, AB 2198 (Levine) was introduced in an effort to ensure that licensed mental health professionals were receiving adequate training in suicide assessment, treatment, and management. The bill would have required licensees of the Board of Behavioral Sciences (Board) and the Board of Psychology to complete a six-hour training course in the subject. New applicants for licensure would have been required to complete a 15-hour course in the subject.

   While the Board shared the author's concerns that some health care professionals may lack training in suicide assessment, treatment and management, it indicated that it did not believe the bill, as written, would accomplish its objective. At its May 2014 meeting, the Board took an "oppose unless amended" position on the bill, and asked that it be amended to instead form a task force to include members of the Board, stakeholders, the Board of Psychology, county mental health officials, and university educators. However, the bill was not amended per the Board's request.

   The Governor vetoed AB 2198 in September 2014 (**Attachment C**). In his veto message, he asked that the licensing boards evaluate the issues the bill raised, and take any needed actions.

   In response to the Governor's veto message, in the spring of 2015 the Board designed a survey for schools in California offering a degree program intended to lead to Board licensure. The purpose of the 2015 survey was to determine the extent of exposure to the topics of suicide assessment, treatment, and management for students enrolled in these degree programs. These programs were asked to report courses required by the program covering these topics, and the number of hours or units devoted to the subject.

   A total of 28 Master's degree programs responded to the 2015 survey. The Board found that schools commonly integrate the topic of suicide assessment across a variety of courses, including in practicum. In addition, several schools offered additional elective coursework for students wanting further specialization on this topic.

   Because of these findings, the Board concluded that mandating a specific number of hours of suicide assessment coursework is unlikely to be effective, because degree programs are already providing coverage of the topic. It offered alternative solutions as follows:

   - Ensuring front-line health care professionals, such as nurses, physicians assistants, and unlicensed school and county mental health workers, have adequate training on the topic;

   - Formation of a task force to discuss the latest research in suicidality and to develop a model curriculum;

   - Assess resources at the county mental health level to determine if there is an adequate level of support for suicidal individuals; and

   - Increase public awareness through media campaigns to reduce stigma of seeking mental health services, and to identify available local resources.

Attachment D contains the letter written by Board staff to the Department of Consumer Affairs' (DCA's) Division of Legislative and Regulatory Review in 2015 summarizing the survey findings. **Attachment E** summarizes the 2015 survey responses.

Since that time, the Board has taken steps to support its recommendations. Last year, the Board took a "support" position on AB 1372 (Levine), which proposes allowing a crisis stabilization unit to provide medically necessary crisis stabilization services to individuals in crisis beyond the allowable treatment time of 24 hours if the individual needs psychiatric care and beds or services are not reasonably available. AB 1372 is currently a two-year bill.

This year, the Board will consider taking a position on SB 968 (Pan), which would require specified higher education entities in California to hire one full-time mental health counselor per 1,000 students enrolled at each of their campuses.

3) Board of Psychology Actions.

After the Governor's veto of AB 2198 and subsequent directive, the Board of Psychology also conducted two surveys of its graduate programs, internship programs, and post-doctoral training programs. These surveys found that the majority of survey respondents provided some education and training on suicide risk assessment and intervention. However, the amount of education and training varied widely. Approximately 3% of their students were not receiving training in risk assessment and over 7% were not receiving training in suicide intervention.

Due to these findings, the Board of Psychology sponsored AB 89 (Levine, Chapter 182, Statutes of 2017) last year. AB 89 was signed by the Governor, and requires applicants and licensees of the Psychology Board to demonstrate completion of at least six hours of coursework or supervised experience in suicide risk assessment and intervention effective January 1, 2020.

4) 2017-2018 Board Survey.

In late 2017, the Board conducted a second survey to gain updated information about suicide risk assessment and intervention course requirements. The survey, conducted via Survey Monkey (rather than via a questionnaire sent via mail for the 2015 survey), was sent to degree programs intended to lead to licensure with the Board.

The 2017 survey sought to answer the following questions:

a) How many total clock hours of coverage does your school's required degree program curriculum provide on the topic of "suicide risk assessment and intervention"?

b) Is this coursework contained in one course, or integrated across several courses?

c) Which required courses cover this topic, and the clock hours of coverage in each.

A total of 44 school programs responded to the Board's 2017 survey. The findings are shown in **Attachment B** and were as follows:

a) <u>Clock Hours of Suicide Risk Assessment and Intervention Coursework in Required Curriculum</u>

- No responding school programs reported less than 2 hours of coursework coverage.
- Eight school programs (18% of respondents) reported having 3 to 5 hours of coverage.
- Twenty-two school programs (50%) reported having 6 to 10 hours of coverage.
- Eight school programs (18%) reported having 11 to 20 hours of coverage.
- Six school programs (14%) reported having more than 20 hours of coverage.

Attachment B shows a chart of the results.

b) Location of the Suicide Risk Assessment and Intervention Coursework

Approximately 20 percent of school programs indicated that their suicide risk assessment and intervention coursework is contained in one course, while 79 percent indicated it is integrated throughout their program in several courses. **(Attachment B)**

c) Required Courses Covering the Topic

The responses identifying courses containing the suicide risk assessment and intervention coursework varied widely, making it difficult to identify any significant trends. However, commonly mentioned courses were as follows:

- Law and Ethics
- Practicum
- Psychopathology
- Assessment
- Crisis/Trauma
- Substance Abuse

5) Fiscal Impact.
The fiscal impact of this bill would be absorbable within existing resources. Likely effects on Board resources would be as follows:

- Board licensing evaluators would need to verify applicants applying on and after January 1, 2021 included proof of the required suicide risk assessment and intervention coursework or supervised experience with their application for a license.

- The Board would need to verify a licensee who is renewing on or after January 1, 2021, has signed on his or her renewal form that the required hours of coursework or supervised experience have been completed.

- Updates to applications and renewal forms, and possibly minor Breeze changes.

- The Board would need to conduct outreach (likely through its website, Facebook, Twitter, and via consortiums and professional associations) in 2019 and 2020 to ensure licensees and future applicants are aware of the requirements and either have time to complete the required six hours of coursework or experience, or time to gather the appropriate documentation, prior to January 1, 2021.

6) Suggested Technical Amendments.

a) Reference to "supervised professional experience" (§§4980.396(a)(2), 4989.23 (a)(2), 4996.27(a)(2), 4999.66(a)(2)): "Supervised professional experience" is a term defined in the Board of Psychology's regulations. The text of this bill was modeled after AB 89, which placed the requirement in Psychology Board's statute. This Board utilizes the term "supervised experience" in its statutes and regulations. The reference should be corrected to be consistent with this Board's statute.

b) Reference to "formal postdoctoral placement" (§§4980.396(a)(2), 4989.23(a)(2), 4996.27(a)(2), 4999.66(a)(2)): This subsection states that a "formal postdoctoral placement that meets the requirements of this chapter" is one type of applied experience that can be used to meet the suicide risk assessment and intervention requirement. However, the Board's licensing chapters do not set requirements for formal postdoctoral placements. If the Board wishes to accept this type of experience, it should be changed to reference the Board of Psychology's postdoctoral placement requirements.

c) Requirement for Current Licensees (§§4980.396(b), 4989.23(b), 4996.27(b), 4999.66(b)): The proposed language requires current licensees to complete the required coursework in suicide risk assessment and intervention, "as specified in subdivision (a)." It may be clearer to state that they required coursework must be gained "using one of the methods specified in subdivision (a)."

7) Support and Opposition.

Support:

- The Steinberg Institute (Sponsor)

Opposition:

- None at this time.

8) History.

- Not available at this time.

9) Attachments.

- **Attachment A:** Proposed AB 1436 Language
- **Attachment B:** 2017 School Program Survey Results
- **Attachment C:** Governor's Veto Message: AB 2198 (2014)
- **Attachment D:** BBS Letter to DCA Division of Legislative and Regulatory Review (Summarizing 2015 Survey Findings), March 3, 2015
- **Attachment E:** 2015 School Program Survey Results

An act to add Sections 4980.396, 4989.23, 4996.27, and 4999.66 to the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

Bill No.
as introduced, Berman.
General Subject: Board of Behavioral Sciences: licensees: suicide prevention training.

Existing law, the Licensed Marriage and Family Therapist Act, the Educational Psychologist Practice Act, the Clinical Social Worker Practice Act, and the Licensed Professional Clinical Counselor Act, provides for the licensure and regulation of marriage and family therapists, educational psychologists, clinical social workers, and professional clinical counselors, respectively, by the Board of Behavioral Sciences. Existing law requires a person applying for licensure as a marriage and family therapist, educational psychologist, clinical social worker, or professional clinical counselor to complete specified coursework and training, requires licensees to complete specified continuing education requirements, and requires a licensee on inactive status to complete certain continuing education requirements as a condition of having his or her license reactivated.

This bill, on or after January 1, 2021, would require an applicant for licensure as a marriage and family therapist, an educational psychologist, a clinical social worker, or a professional clinical counselor to complete a minimum of 6 hours of coursework or applied experience under supervision in suicide risk assessment and intervention. The bill would require, on or after January 1, 2021, as a one-time requirement, a licensed marriage and family therapist, educational psychologist, clinical social worker, or professional clinical counselor to have completed this suicide risk assessment and intervention training requirement prior to the time of his or her first renewal. The bill would also require, on or after January 1, 2021, a person applying for reactivation or for reinstatement to have completed this suicide risk assessment and intervention training requirement. The bill would require that proof of compliance with requirements be certified under penalty of perjury and be retained for submission to the board upon request. By expanding the crime of perjury, the 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:

SECTION 1. Section 4980.396 is added to the Business and Professions Code, immediately following Section 4980.395, to read:

4980.396. (a) On or after January 1, 2021, an applicant for licensure as a marriage and family therapist shall show, as part of the application, that he or she has completed a minimum of six hours of coursework or applied experience under supervision in suicide risk assessment and intervention. This requirement shall be met in one of the following ways:

(1) Obtained as part of his or her qualifying graduate degree program. To satisfy this requirement, the applicant shall submit to the board a written certification from the registrar or training director of the educational institution or program from which the applicant graduated stating that the coursework required by this section is included within the institution's curriculum required for graduation at the time the applicant graduated, or within the coursework that was completed by the applicant.

(2) Obtained as part of his or her applied experience. Applied experience can be met in any of the following settings: practicum, internship, or formal postdoctoral placement that meets the requirement of this chapter, or other qualifying supervised professional experience. To satisfy this requirement, the applicant shall submit to the board a written certification from the director of training for the program or primary supervisor where the qualifying experience has occurred stating that the training required by this section is included within the applied experience.

(3) By taking a continuing education course that meets the requirements of Section 4980.54. To satisfy this requirement, the applicant shall submit to the board a certification of completion.

(b) On or after January 1, 2021, as a one-time requirement, a licensee prior to the time of his or her first renewal after the operative date of this section, or an applicant for reactivation or reinstatement to an active license status, shall have completed a minimum of six hours of coursework or applied experience under supervision in suicide risk assessment and intervention, as specified in subdivision (a).

(c) Proof of compliance with this section shall be certified under penalty of perjury that he or she is in compliance with this section and shall be retained for submission to the board upon request.

SEC. 2. Section 4989.23 is added to the Business and Professions Code, to read:

4989.23. (a) On or after January 1, 2021, an applicant for licensure as an educational psychologist shall show, as part of the application, that he or she has completed a minimum of six hours of coursework or applied experience under supervision in suicide risk assessment and intervention. This requirement shall be met in one of the following ways:

(1) Obtained as part of his or her qualifying graduate degree program. To satisfy this requirement, the applicant shall submit to the board a written certification from the registrar or training director of the educational institution or program from which the applicant graduated stating that the coursework required by this section is included within the institution's curriculum required for graduation at the time the applicant graduated, or within the coursework that was completed by the applicant.

(2) Obtained as part of his or her applied experience. Applied experience can be met in any of the following settings: practicum, internship, or formal postdoctoral placement that meets the requirement of this chapter, or other qualifying supervised professional experience. To satisfy this requirement, the applicant shall submit to the board a written certification from the director of training for the program or primary supervisor where the qualifying experience has occurred stating that the training required by this section is included within the applied experience.

(3) By taking a continuing education course that meets the requirements of Section 4989.34. To satisfy this requirement, the applicant shall submit to the board a certification of completion.

(b) On or after January 1, 2021, as a one-time requirement, a licensee prior to the time of his or her first renewal after the operative date of this section, or an applicant for reactivation or reinstatement to an active license status, shall have completed a minimum of six hours of coursework or applied experience under supervision in suicide risk assessment and intervention, as specified in subdivision (a).

(c) Proof of compliance with this section shall be certified under penalty of perjury that he or she is in compliance with this section and shall be retained for submission to the board upon request.

SEC. 3. Section 4996.27 is added to the Business and Professions Code, to read:

4996.27. (a) On or after January 1, 2021, an applicant for licensure as a clinical social worker shall show, as part of the application, that he or she has completed a minimum of six hours of coursework or applied experience under supervision in suicide risk assessment and intervention. This requirement shall be met in one of the following ways:

(1) Obtained as part of his or her qualifying graduate degree program. To satisfy this requirement, the applicant shall submit to the board a written certification from the registrar or training director of the educational institution or program from which the applicant graduated stating that the coursework required by this section is included within the institution's curriculum required for graduation at the time the applicant graduated, or within the coursework that was completed by the applicant.

(2) Obtained as part of his or her applied experience. Applied experience can be met in any of the following settings: practicum, internship, or formal postdoctoral placement that meets the requirement of this chapter, or other qualifying supervised professional experience. To satisfy this requirement, the applicant shall submit to the board a written certification from the director of training for the program or primary supervisor where the qualifying experience has occurred stating that the training required by this section is included within the applied experience.

(3) By taking a continuing education course that meets the requirements of Section 4996.22. To satisfy this requirement, the applicant shall submit to the board a certification of completion.

(b) On or after January 1, 2021, as a one-time requirement, a licensee prior to the time of his or her first renewal after the operative date of this section, or an applicant for reactivation or reinstatement to an active license status, shall have completed a minimum of six hours of coursework or applied experience under supervision in suicide risk assessment and intervention, as specified in subdivision (a).

(c) Proof of compliance with this section shall be certified under penalty of perjury that he or she is in compliance with this section and shall be retained for submission to the board upon request.

SEC. 4. Section 4999.66 is added to the Business and Professions Code, to read:

4999.66. (a) On or after January 1, 2021, an applicant for licensure as a professional clinical counselor shall show, as part of the application, that he or she has completed a minimum of six hours of coursework or applied experience under supervision in suicide risk assessment and intervention. This requirement shall be met in one of the following ways:

(1) Obtained as part of his or her qualifying graduate degree program. To satisfy this requirement, the applicant shall submit to the board a written certification from the registrar or training director of the educational institution or program from which the applicant graduated stating that the coursework required by this section is included within the institution's curriculum required for graduation at the time the applicant graduated, or within the coursework that was completed by the applicant.

(2) Obtained as part of his or her applied experience. Applied experience can be met in any of the following settings: practicum, internship, or formal postdoctoral placement that meets the requirement of this chapter, or other qualifying supervised professional experience. To satisfy this requirement, the applicant shall submit to the board a written certification from the director of training for the program or primary supervisor where the qualifying experience has occurred stating that the training required by this section is included within the applied experience.

(3) By taking a continuing education course that meets the requirements of Section 4999.76. To satisfy this requirement, the applicant shall submit to the board a certification of completion.

(b) On or after January 1, 2021, as a one-time requirement, a licensee prior to the time of his or her first renewal after the operative date of this section, or an applicant for reactivation or reinstatement to an active license status, shall have completed a minimum of six hours of coursework or applied experience under supervision in suicide risk assessment and intervention, as specified in subdivision (a).

(c) Proof of compliance with this section shall be certified under penalty of perjury that he or she is in compliance with this section and shall be retained for submission to the board upon request.

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

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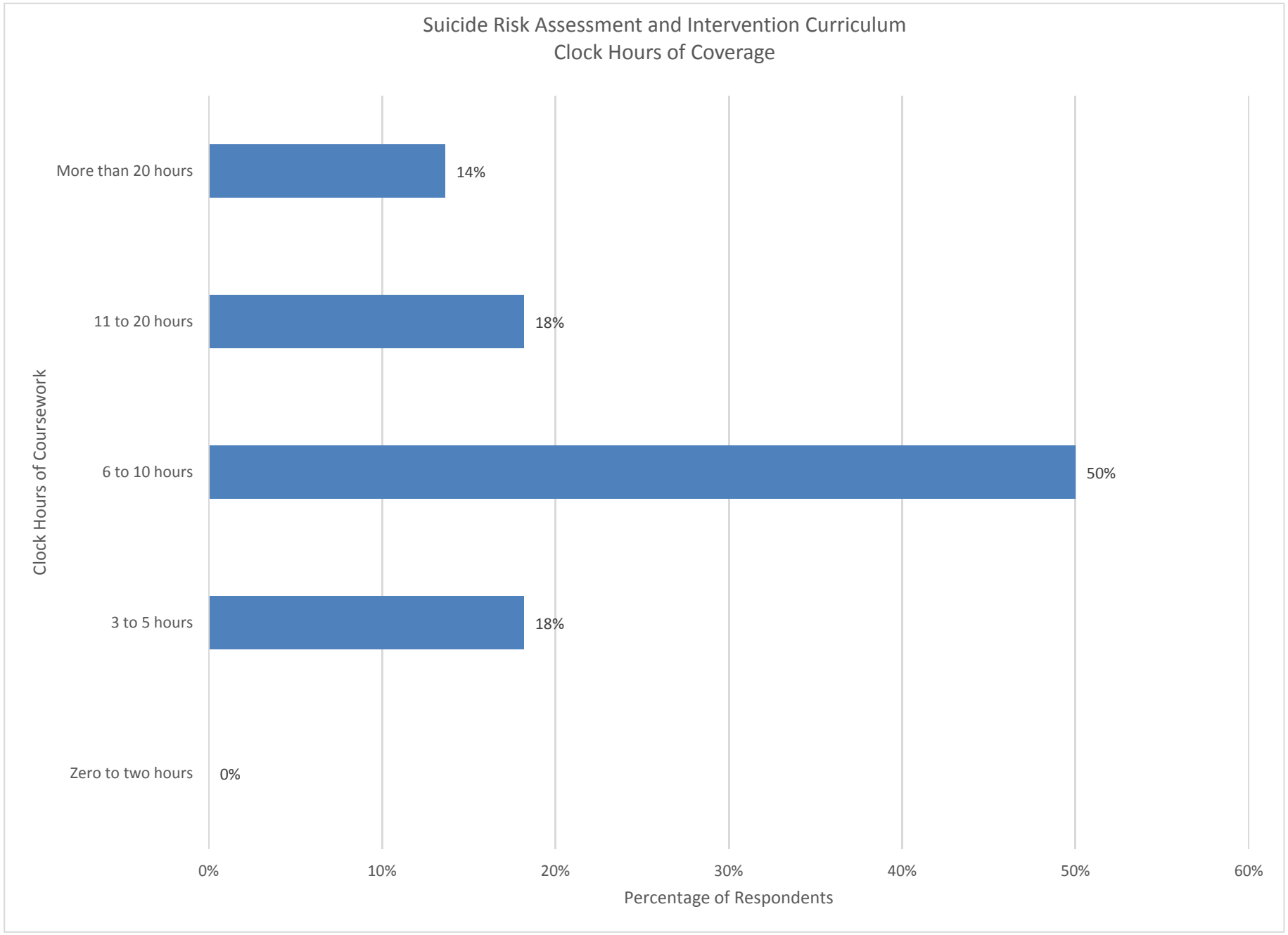
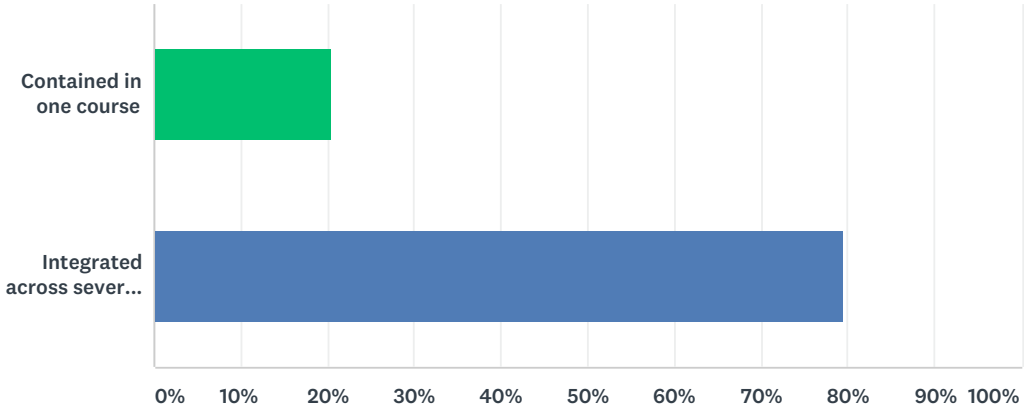
ATTACHMENT B
2017 SCHOOL PROGRAM SURVEY
RESULTS



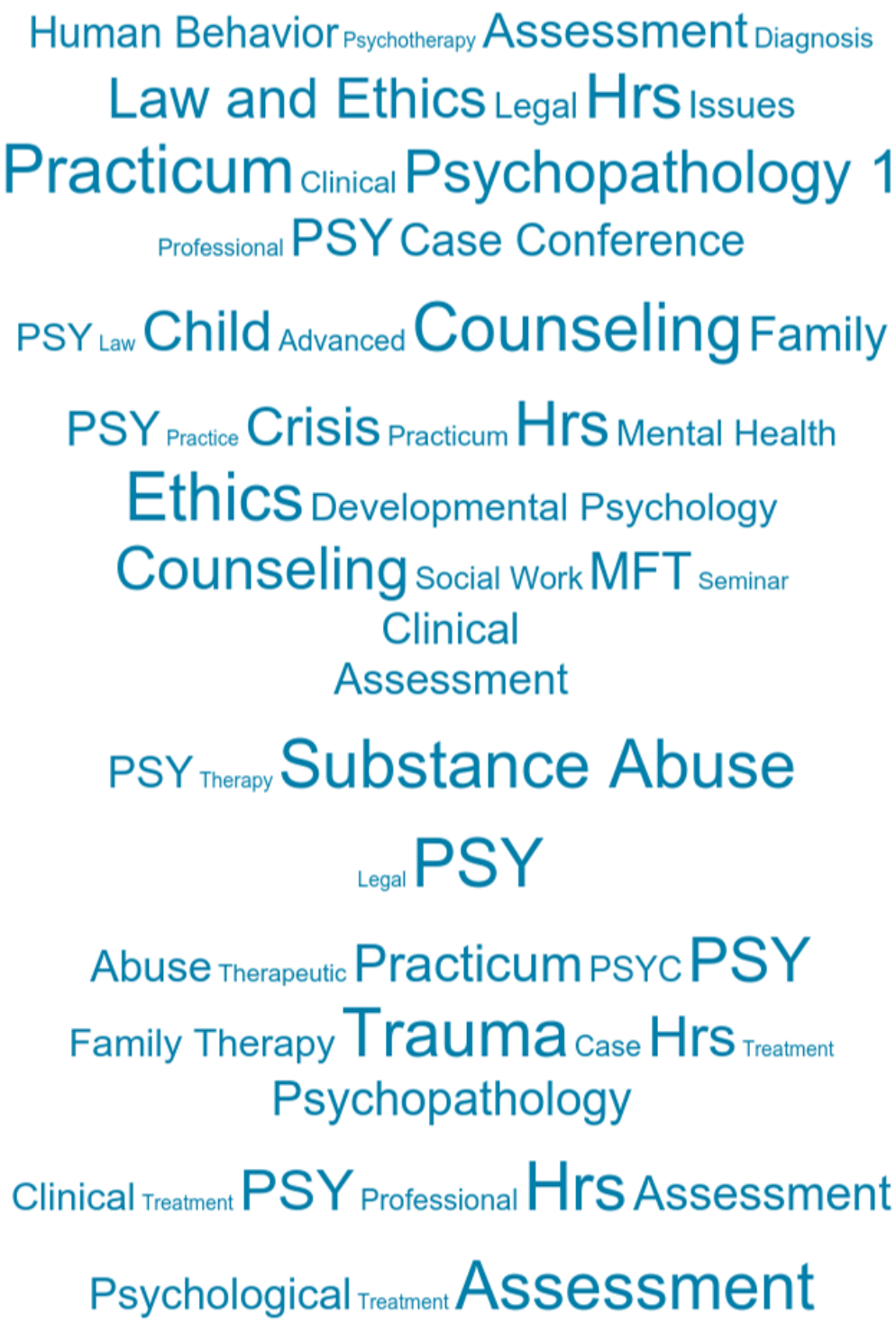
Q2 Is this coursework contained in one course, or integrated across several courses?

Answered: 44 Skipped: 0



ANSWER CHOICES	RESPONSES	
Contained in one course	20.45%	9
Integrated across several courses	79.55%	35
TOTAL		44

Q3 Please list each required course that covers this topic, and the clock hours of coverage on the topic that each course provides.



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ATTACHMENT C
AB 2198 VETO MESSAGE (2014)

BILL NUMBER: AB 2198
VETOED DATE: 09/18/2014

To the Members of the California State Assembly:

I am returning Assembly Bill 2198 without my signature.
This bill would require certain mental health professionals to complete a training program in "suicide assessment, treatment, and management."
California has an extensive regulatory scheme that aims to ensure that California physicians, psychologists and counselors are skilled in the healing arts to which they have committed their lives. Rather than further legislating in this field, I would ask our licensing boards to evaluate the issues which this bill raises and take whatever actions are needed.

Sincerely,

Edmund G. Brown Jr.

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ATTACHMENT D
2015 SUMMARY OF SURVEY FINDINGS

Board of Behavioral Sciences

Memo

1625 North Market Blvd., Suite S-200
Sacramento, CA 95834
(916) 574-7830, (916) 574-8625 Fax
www.bbs.ca.gov

To: Justin Paddock
Assistant Deputy Director Legislation Regulatory Review

Date: March 3, 2015

From: Kim Madsen
Executive Officer

Telephone: (916) 574-7841

Subject: **Mental Health Professionals: Suicide Prevention Training**

Background

During the 2013-2014 Legislative Session, AB 2198 (Levine) was introduced in an effort to ensure that licensed mental health professionals were receiving adequate training in suicide assessment, treatment, and management. The bill would have required licensees of the Board of Behavioral Sciences (Board) and the Board of Psychology to complete a six-hour training course in suicide assessment, treatment, and management. Applicants for licensure would have been required to complete a 15-hour course in this subject area.

While the Board shared the author's concerns that some health care professionals may lack training in in suicide assessment, treatment, and management, it did not believe that the bill, in its current form, would accomplish its objective.

Upon veto of the bill, the Governor asked the licensing boards to evaluate the issues raised and take any needed actions.

Survey of Master's Degree Programs

The Board wanted to determine the extent of exposure to the topics of suicide assessment, treatment, and management, for a student enrolled in a Master's degree program intended to lead to licensure. In order to assess this, the Board designed a survey for schools in California offering a degree program leading to Board licensure. The Board conducted outreach to both stakeholder groups and mental health educator consortiums, in order to emphasize the importance of the topic and encourage participation in the survey.

Degree programs were asked to report the following:

- Courses required by the degree which cover the topic of suicide assessment, treatment, and management;
- Number of units or hours each required course spends on these topics;

- A description of the topics or methods covered by each required course; and

- Additional relevant courses offered as electives in the degree program.

A total of 28 Master's degree programs responded to the survey.

Survey Findings

The survey results strongly indicate that schools are providing adequate training of suicide assessment, treatment, and management:

- The data support the claim by the schools that they commonly integrate the topic across a variety of courses, discussing it as it is relevant to the particular focus of a course.

- Many schools also indicated that the topics in question are discussed in practicum, where the students are doing the most hands-on portion of their learning.

- Several schools offer additional elective coursework on the topic, for students seeking further specialization.

- Schools consistently reported teachings of a wide range of aspects of suicidality, including legal and ethical issues, crisis intervention, assessment instruments for suicide risk factors, and role playing activities.

Conclusion

Mandating a specific number of hours of suicide coursework in a degree program is unlikely to be effective in reducing suicides in the general population, because the degree programs are already providing coverage of the topic. Some of the following solutions may be more effective in addressing the treatment of suicidal individuals:

- Ensuring front-line health care professionals (such as registered and vocational nurses, physician's assistants, and unlicensed school and county mental health care or medical care workers) have adequate training in suicide assessment, treatment, and management.

- Formation of a task force among mental health educators and suicide experts to discuss the latest research in suicidology, and to develop model curriculum so that educators can ensure they are covering the latest suicide assessment techniques and concepts in their programs.

- Assessment of resources at the county mental health care level to determine if there is an adequate level of support for suicidal individuals. Consider seeking additional funding to adequately staff county mental health facilities.

- Increase public awareness through various media campaigns in an effort to reduce the stigma of seeking mental health services and to identify available local resources.

Attachment E
BBS Master's Degree Programs Survey Results
Coverage of Suicide Assessment, Treatment, and Management

2015 SURVEY

Required Courses in Degree Covering Topic	Units or Hours Courses Spend on Topic	Topic Areas Covered	Additional Elective Courses *(Not Required)*
Alliant International University - Couple and Family Therapy Program [1]			
PSY 6310 Law & Ethics	3 hours	Patient rights and responsibilities when patient is danger to self. Voluntary and involuntary hospitalization (5150 holds).	
PSY 6325 Crisis & Trauma	3 hours	Principles & processes of crisis intervention and treatment. Clinical management and treatment of suicidality.	
PSY 6322 MFT Theory and Technique II	2 hours	Clinical assessment of suicidality.	
PSY 6323 MFT Theory and Technique II Lab	2 hours	Students role-play to practice skills at clinical assessment and intervention in suicide.	
PSY 6360 Preparation for Community Practice	3 hours	Community resources for suicidal clients.	
PSY 7314 MFT Assessment	2 hours	Assessment instruments for depression and suicide risk.	
Azusa Pacific University - Master of Social Work Program			
SOCW 514 Practice I - Interviewing and Assessment	5 hours	Students trained using Applied Suicide Intervention Skills Training model as a framework for suicide intervention. Discussion of risk factors, signs. Role playing.	
SOCW 550 Intermediate Praxis	2 hours	Review of risk assessment and intervention	
SOCW 513 Micro Theory and Human Development	3 hours	Suicidality and risk across the life course	
SOCW 534/544 Field Seminar III & IV	3 hours	Risk assessment and intervention reviewed as part of internship training.	
			-SOCW 536 Advanced Practice I: Adult Mental Health (2 hours); Suicide risk associated with various mental health conditions. -SOCW Child and Adolescents (2 hours); Suicide risk & assessment unique to children/adolescents.
California Southern University - MA in Psychology w/ Emphasis in Marriage and Family Therapy			
PSY86502 Counseling Theories and Strategies MFT 86504 Ethical Issues in Marriage Family and Child Therapy PSY 86506 Psychopathology MFT 86510 Child and Adolescent Therapy PSY 86511 Alcoholism/Chemical Dependency Detection and Treatment PSY 86512 Group Psychology PSY 86517 Psychology of Aging MFT 86700 Psychopharmacology PSY 87519 Psychology of Trauma PSY 87534 Dual Diagnosis	Approx. 18 hours total	Risk assessment, suicidality, reporting, treatment, and prevention.	
California State University, Bakersfield - MS in Counseling Psychology			
CPSY 535 Domestic Violence CPSY 630 Clinical Ethics CPSY 631 Legal & Professional Issues in MFT			Suicide assessment, treatment & management is also highlighted in all 3 practicum and traineeships in reference to specific client situations.
California State University, Dominguez Hills - Masters of Science in Marital & Family Therapy			
MFT 530 Community Mental Health Practicum	Approx. 6 hours	-Legal and ethical courses talk about therapist's responsibilities when making clinical decision on suicide. '-Suicidality among specific populations (does not look the same for each gender, culture, or ages) '-Clinical assessments, paperwork, documentation/reporting when conducting a suicide assessment.	
MFT 584 Laws and Ethics	Approx. 6 hours		
MFT 511, 521, 531, 541 Fieldwork Practice	Approx. 6 hours		
MFT 566 Psychopathology in MFT	Approx. 6 hours		
MFT 588 Treatment of Trauma	Approx. 6 hours		

Required Courses in Degree Covering Topic	Units or Hours Courses Spend on Topic	Topic Areas Covered	Additional Elective Courses *(Not Required)*
California State University, Fullerton - Clinical Psychology Program			
501 Professional & Legal Issues	3 hours	Duty to warn and danger to self.	
561 Advanced Psychological Assessment	1.5 hours	Assessment of suicide risk.	
545 Advanced Psychopathology	.5 hours	General assessment and hospitalization.	
549 Marriage, Family, and Child Therapy	2-3 hours	Topic addressed generally in this course in the context of addiction.	
California State University, Fullerton - MS in Counseling			
COUN 511 Pre-Practicum	2 hours	Assessment & suicide prevention (reading, lecture & role plays)	
COUN 522 Techniques in Brief Treatment and Assessment	2 hours	Assessment & intervention management (reading, lecture & role plays)	
COUN 526 Professional, Ethical and Legal Issues in Counseling	1 hour	Ethical issues in suicide assessment, management & prevention (reading, lecture & case scenarios)	
COUN 538 Crisis and Trauma Counseling	2 hours	Suicide intervention & management (reading & role plays)	
COUN 530 Beginning Practicum	2-4 hours	Discussion of suicide assessment, management, and intervention	
COUN 534 Advanced Practicum	2-4 hours	Discussion of suicide assessment, management, and intervention	
California State University, Humboldt - Counseling Masters of Arts			
PSY 660 Law and Ethics in Psychology	2 hours	Assessment, voluntary & involuntary hospitalization.	
PSY 630 Advanced Psychopathology	1 hour	Adjustment w/ depression and disorders w/ suicide risk factors.	
PSY 653 Advanced Psychopathology with Children & Families	16 hours	Understanding suicidal ideation & behavior; understanding prevention practices; Suicide Intervention Model (Snyder) (connect, understand, assist), safe plan options, attitudes toward intervention.	
California State University, Northridge - MS in Counseling - MFT [1]			
659B - Practicum	Approx. 3 hours	These courses cover examples, case studies, intervention techniques, and warning signs.	
672 - Diagnosis	Approx. 3 hours		
California State University, Sacramento - MS in Counseling; specializations in Career Counseling (CC), Marriage & Family Therapy (MFT), School Counseling (SC)			
EDC 212 Gender Roles & Sexuality (required all specializations)	2 hours	law & ethics, 5150/harm to self, LBGTQ risk factors, domestic violence, child abuse, and terminal illness prevalence/risk factors for suicide.	
EDC 216 Counseling Theory (required all specializations)	1 hour	Limits of confidentiality, 5150 harm to self, law & ethics regarding suicide, brief overview of assessment of suicidality.	
EDC 218 Assessment in Counseling (required all specializations)	6 hours	Assessment models of suicide/self-harm, assessment tools for evaluating risk factors, review of legal & ethical responsibilities.	
EDC 231 Diagnosis & Treatment Planning (required all specializations)	6 hours	Discussion of risk factors & their treatment.	
EDC 233 Substance Abuse and the Family (required all specializations)	6 hours	Discussion of risk factors associated with substance abuse & their treatment.	
EDC 242 Play and Art Therapy (Required SC, elective for MFT)	1 hour	Suicidality in young children, treatment of children who have attempted suicide/self harm.	
EDC 244 Trauma & Crisis Counseling (Required CC & MFT, elective for SC	6 hours	Coping strategies to prevent suicide, assessment for risk factors.	
EDC 252 Legal & Ethical Issues in Prof. Counseling (req'd all specializations	6 hours	In depth discussion of legal/ethical responsibilities, analysis of case studies, assessment/evaluation, community resources.	
EDC 254 Counseling & Psychotropic Medicine (Req'd MFT, elective SC and CC)	3 hours	prevalence by age group, risk increase for prescription use, increased suicidality as side effect of prescription use, suicide safety contracts, co-occurring conditions that increase risk.	
EDC 268 Career/Job Search (Required for CC)	3 hours	Impact of unemployment /job loss risk factors	

Required Courses in Degree Covering Topic	Units or Hours Courses Spend on Topic	Topic Areas Covered	Additional Elective Courses *(Not Required)*
EDC 272 Counseling Children & Youth (Required MFT and SC)	6 hours	Suicide assessment in children/adolescents, assessment & treatment of risk factors, legal/ethical responsibilities, community resources.	
EDC 274 Guidance & Consultation in School Counseling (Required for SC)	3 hours	Prevention of suicide through assessment and treatment of risk factors; explore community resources.	
EDC 475 Practicum in Counseling (Required all specializations)	3 hours min.	Discuss practicum cases, review of assessment, treatment, risk factors, legal/ethical responsibilities, discussion of self harm assessment/treatment.	
EDC 480 Field Study in Counseling (Required all specializations)	3 hours min.	Discussion of internship cases, review of assessment techniques, risk factors, treatment protocol for those who have attempted suicide, legal/ethical responsibilities.	
California State University, San Francisco - Master of Science in Marriage, Family & Child Counseling			
COUN 706 Practicum & Counseling Process	3 hours	dangerousness (suicide/homicide) assessment & treatment. Readings, demonstration, role playing, case study.	
COUN 715 Assessment in Counseling	2 assignments	Two homework assignments: identification of psychological tests & reviews that assess suicide/homicide potential. Development of an instrument to measure counselor competence in managing crisis (suicide/homicide).	
COUN 857 Law and Ethics in Counseling	3 hours	Dangerousness (suicide/homicide) assessment & management.	
COUN 858 Couple and Family Counseling		Impact of suicidality within context of families, including prevention strategies.	
COUN 705, 736, 890, 891 Counseling Practicum and Internship		Practicum/internship training program must have an agency crisis protocol, where trainees receive training in assessing/managing suicidal clients.	
California State University, San Jose - MS in Clinical Psychology			
PSY 203A Assessment	3 unit course	Lecture on suicide assessment.	
PSYC 228 Ethics	3 unit course	Discussion of the topic.	
PSYC 211 Child Psychopathology	3 unit course	Topic repeatedly discussed.	
PSYC 260 Crisis and Trauma Counseling	3 unit course	Topic is a focus of a section of the course.	
Chapman University - Master of Arts in Marriage and Family Therapy			
MFT 516 Assessment of Individuals and Families	Approx. 2 hours	Suicide risk assessment methods	
MFT 573 Crisis Management and Clinical Process	6 hours	Suicide assessment & management (handouts & lectures)	
MFT 578 Ethics and Professional Issues for MFTs	1.5 hours	Suicide assessment, relevant CA laws/regulations, ethical code, resources	
The Chicago School of Professional Psychology - Masters in Clinical Psychology w/ Marital & Family Therapy Specialization			
MM520 Adult Psychopathology	6 hours	Mental status exams, risk factors associated with suicide and aggressive behaviors	
MM 511 Law and Professional Ethics	6 hours	Danger to self, danger to others, Tarasoff & Ewing ruling	
Fuller Theological Seminary - Master of Science in Marital and Family Therapy			
FT 530B Clinical Foundations II	3.5 hours		
FT 522 Assessment of Individuals/Couples/Families	2.5 hours		
FT 502 Legal & Ethical Issues in Family Practice	2 hours		
FT 549 Psychopharmacology	0.5 to 1 hour	The use of anti-depressants and their risk of suicidal tendencies in consumers.	
Holy Names University - MA in Counseling Psychology/Dual Counseling and Forensic Psychology			
CPSY 200	1.5 hours	Assessment	
CPSY 215	3 hours	Legal/ethical./reporting/therapeutic approaches: treatment and management	
CPSY 220	3 hours	Human development research on suicidality across lifespan: assessment	
CPSY 271	4 hours	Working with families of traumatic event; management and treatment	-CPSY 270 Trauma Types and Transformation: Assessment; Management

Required Courses in Degree Covering Topic	Units or Hours Courses Spend on Topic	Topic Areas Covered	Additional Elective Courses *(Not Required)*
Hope International University - MA in Marriage & Family Therapy			
PSY 5240 Disaster Trauma & Abuse Response	2 units		
PSY 5230 Family Violence	2 units	Courses cover suicide assessment via vignettes and readings from text.	
PSY 6800 Practicum Course	2 units		
PSY 8120 Professional Ethics & Law	2 units		
Northcentral University; School of Marriage and Family Sciences - MA in Marriage and Family Therapy			
MFT 6201 California Law and Professional Ethics	5 hours	Legal/ethical responsibilities of therapist facing a client expressing suicidal ideations.	
MFT 5103 Systemic Evaluation and Case Management	15 hours	Methods of client risk assessment/assessing issues of safety; case management in crisis situation	
MFT 6106 Families in Crisis	8 hours	Adolescent self harm, suicidal ideations and behaviors, suicide in the elderly, assessment and etiology of suicide.	
Phillips Graduate Institute - MA in Psychology, Emphasis Marriage and Family Therapy [2]			
PSY 520A Abnormal Psychology	2 unit course	Suicidal gestures, self harming behavior, and aggression. Crisis intervention and other levels of counseling intervention are discussed.	
PSY 503 Developmental Psychology	3 unit course	Suicide risk covered with developmental issues.	
PSY 539 Legal, Ethical, & Professional Issues	3 unit course	Managing confidentiality when clients are dangerous to themselves.	
PSY 531A and 531B Applied Therapeutic Methodology	1 unit each	Common clinical emergencies, including assessment and treatment of suicidality and self-harm.	
PSY 533A and 533B Practicum	2 units each	Case discussions, which usually involve experience with crisis situation such as suicide	
Saybrook University - Marriage and Family Therapy License Program			
MFT 2562 (CO) Crisis and Trauma Intervention	Approx. 6 hours	Stages of assessment and intervention; emphasizes interventions for crisis and trauma.	
Touro University Worldwide - Masters of Arts in Marriage and Family Therapy			
MFT 611 Foundation of Psychopathology	5 hours	Covers suicide assessment, treatment, and management	
University of La Verne - Marriage and Family Therapy MS			
PSY 512 Clinical Psychopathology	6 hours	Suicide assessment for high risk diagnostic categories	
PSY 544 Trauma Focused Treatment	2 hours	Trauma response and harm assessment, hospitalization, collaboration of care	
PSY 509 Psychological Testing	3 hours	Suicide assessment/interview techniques	
PSY 550 Community Mental Health Counseling	2 hours	Disaster/trauma response. Harm assessment.	
PSY 580 Fieldwork I	6 hours	Discussion of clinical cases, suicide assessment techniques/steps needed when clients require hospitalization	
PSY 581 Fieldwork II	6 hours		
University of Phoenix (Southern California Campus) - MSC/MFCT			
Legal and Ethical Issues in MFT	3 hours	Duty to warn/protect in cases of danger to self and others	
Introduction to Clinical Assessment	4 hours	Prevalence of suicidal behavior in individuals with mental disorders, evaluation criteria, assessment techniques and strategies for suicidal clients, interventions with suicidal clients.	
Pre-practicum	2 hours	Suicide prevention; strategies of risk assessment of self harm.	Students can take additional seminars that are offered on MFT related topics. One of these is a 4 hour suicide assessment workshop.
University of San Diego - MA in Marital and Family Therapy			
MFTS 528 Psychopathology	1 hour	Video and discussion on suicide assessment.	
MFTS 529 Ethical and Legal Issues in Family Therapy	2 hours	interviewing techniques for suicidal clients, assessment, risk factors, and treatment options.	
EDU 704i Treatment of Severe Mental Illness	5 hours	Suicide risk assessment, treatment, and intervention. Final assignment is treatment plan based on vignette for suicidal patient.	

Required Courses in Degree Covering Topic	Units or Hours Courses Spend on Topic	Topic Areas Covered	Additional Elective Courses *(Not Required)*
USC - Masters in Marriage and Family Therapy			
EDUC 507 Professional Identity and Law and Ethics for Counselors	3 hours	Duties around suicide assessment, suicide assessment practices, suicidal ideation intervention	
EDUC 644 Practicum in Counseling	3 hours		
Other: Fieldwork A and B	Approx. 9 hours	Suicidality discussed throughout fieldwork; hours shown is an estimate.	
USC School of Social Work - Master of Social Work			
SOWK 543 Social Work Practice With Individuals	4 hours	Assessing suicide across the lifespan. Suicide viewed from a micro, mezzo and macro level.	-SOWK 631 Advanced Theories and Clinical Interventions in Health Care (Approx. 1 hr. covering suicide ideation, assessment, & resources) -SOWK 612 Psychopathology and Diagnosis of Mental Disorders (Approx. 4 hrs.) -SOWK 615 Brief Therapy and Crisis Intervention (Approx. 4 hrs.) -SOWK 617 Substance Abuse w/ Consideration of Other Addictive Disorders (Approx. 4 hrs.) -SOWK 618 Systems of Recovery from Mental Illness in Adults (Approx. 4 hrs.) -SOWK 645 Clinical Practice in Mental Health Settings (Approx. 4 hrs.)
Vanguard University - Graduate Program in Clinical Psychology			
PSYG 601, 603, 604, 626, 724, and 726	Lectured in these courses, but no required number of hours. Also discussed in clinical work in practicum course.		PSYG 618 - This course changes each semester, but one offering of this course is specifically on suicide assessment, treatment, and management.
Western Seminary (Sacramento Campus) - Master of Arts in Marriage and Family Therapy			
Tests and Measurements	2 hours	Uses a book teaching clinical and legal standards of care for suicidal patients; students learn instruments for assessment of suicidal clients.	
Psychopathology	5 hours	Studies the dangers of suicide with mentally ill clients, students develop a treatment plan regarding suicide and mental illness.	
Legal and Ethical Issues	3 hours	Studies legal and ethical issues around a suicide crisis, breaking confidentiality, reporting, & hospitalization when patent is a danger to themselves.	
Counseling for Addictions	3 hours	Discussion of drugs & alcohol use/abuse/addiction as risk factors for suicide.	
Emergency Preparedness: Crisis Management	12 hours	Suicide crisis, assessment, prevention, and treatment. Text is focused on developing clinical skills in these areas.	

[1] These programs note that the topic is covered in other elective courses as well, for example, suicidality in specific populations.
[2] This program also offers an emphasis in Art Therapy and School Counseling along with the Marriage and Family Therapy emphasis. All of these programs are required to complete the courses shown.

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Board of Behavioral Sciences

CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES BILL ANALYSIS

BILL NUMBER: AB 1779 **VERSION:** INTRODUCED JANUARY 4, 2018

AUTHOR: NAZARIAN **SPONSOR:** AUTHOR

RECOMMENDED POSITION: NONE

SUBJECT: SEXUAL ORIENTATION: CHANGE EFFORTS

Summary: This bill would prohibit sexual orientation change effort therapy with a patient who is under a conservatorship or guardianship.

Existing Law:

1) Prohibits a mental health provider from engaging in sexual orientation change efforts with a patient under age 18. (Business and Professions Code (BPC) §865.1)

2) Makes it unprofessional conduct for a mental health provider to attempt sexual orientation change efforts on a patient under age 18. Violations are subject to disciplinary action by the mental health provider's licensing entity. (BPC §865.2)

3) Defines a "mental health provider" to include licensees, registrants, and trainees of the Board of Behavioral Sciences. (BPC §865)

4) Defines "sexual orientation change efforts" as any practices by mental health providers seeking to change an individual's sexual orientation, including efforts to change behaviors, gender expressions, or eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. (BPC §865(b)(1))

5) States that sexual orientation change efforts do not include psychotherapies that do not seek to change sexual orientation, or that provide acceptance, support and understanding of or facilitation of clients coping, social support and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices. (BPC §865(b)(2))

6) Establishes a process for a court to appoint a guardian or a conservatorship. (Probate Code (PC) §§1500-1611, 1800-2033)

This Bill:

1) Prohibits a mental health provider from engaging in sexual orientation change efforts with a patient of any age who is under a conservatorship or a guardianship. (BPC §865.1)

Comments:

1) **Author's Intent.** According to the Author's office, this bill seeks to close a loophole in current law to expand the protection of a vulnerable population from the harmful effects of

sexual orientation change effort therapy. They state that individuals whose legal rights are limited by their disabilities and are under conservatorships or guardianships should receive the same protection from sexual orientation change therapy as underage individuals.

2) **Previous Legislation.** SB 1172 (Lieu, Chapter 835, Statutes of 2012) established the existing law referenced above that prohibits a mental health provider from engaging in sexual orientation change efforts with a patient under 18. After extensive work with the author's office and stakeholders to establish a precise definition of "sexual orientation change efforts," the Board took a "support" position on the bill.

3) **Support and Opposition.**

Support:

- None at this time.

Oppose:

- None at this time.

4) **History.**

2018

01/22/18 Referred to Com. on B. & P.
01/05/18 From printer. May be heard in committee February 4.
01/04/18 Read first time. To print.

ASSEMBLY BILL No. 1779

Introduced by Assembly Member Nazarian

January 4, 2018

An act to amend Section 865.1 of the Business and Professions Code, relating to sexual orientation.

LEGISLATIVE COUNSEL'S DIGEST

AB 1779, as introduced, Nazarian. Sexual orientation: change efforts.

Existing law provides for licensing and regulation of various professions in the healing arts, including physicians and surgeons, psychologists, psychiatric technicians, marriage and family therapists, educational psychologists, clinical social workers, and licensed professional clinical counselors. Existing law prohibits mental health providers, as defined, from performing sexual orientation change efforts, as specified, with a patient under 18 years of age. Existing law provides that any sexual orientation change efforts attempted on a patient under 18 years of age by a mental health provider shall be considered unprofessional conduct and shall subject the provider to discipline by the provider's licensing entity.

This bill would additionally prohibit a mental health provider from engaging in sexual orientation change efforts with a patient, regardless of age, under a conservatorship or a guardianship.

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

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

SECTION 1. Section 865.1 of the Business and Professions Code is amended to read:

865.1. Under no circumstances shall a mental health provider engage in sexual orientation change efforts with a patient under 18 years of ~~age.~~ *age, or with a patient, regardless of age, under a conservatorship or a guardianship.*

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99

Board of Behavioral Sciences

CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES BILL ANALYSIS

BILL NUMBER: AB 2088 **VERSION:** INTRODUCED FEBRUARY 7, 2018

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

RECOMMENDED POSITION: NONE

SUBJECT: PATIENT RECORDS: ADDENDA

Summary:

This bill would include minors in the allowance that any patient that inspects his or her patient records may provide a written addendum to the record for any item or statement that he or she believes is incomplete or incorrect. Currently, this provision is only allowed for adult patients.

Existing Law:

1) Permits a minor age 12 or older to consent to mental health treatment or counseling services if, in the opinion of the attending professional person, the minor is mature enough to participate intelligently in the services. (Health and Safety Code (HSC) §124260(b), Family Code (FC) §6924(b))

2) Allows, except under certain specified circumstances, an adult patient, or a minor patent authorized by law to consent to medical treatment to inspect his or her patient records upon request to the health care provider. ((HSC) §123110)

3) Makes violation of item #2 above unprofessional conduct subject to disciplinary action by the applicable licensing board. (HSC §123110(i))

4) Allows any adult patient who inspects his or her patient records to provide the health care provider with a written addendum, of up to 250 words, to any item or statement in the records that the patient believes is incomplete or incorrect. (HSC §123111(a))

5) Requires the health care provider to attach the addendum to the patient's records and to include it when the provider discloses that portion of the records to any third party. (HSC §123111(b))

6) Allows for certain circumstances under which a health care provider may decline to permit inspection or provide copies of mental health records, if the provider determines there is a substantial risk of significant adverse or detrimental

consequences to the patient in seeing or receiving the records. In such a case, the health care provider must do the following (HSC §123115(b)):

- Provide a written explanation of the reason for the decision; and
- Permit the records to be inspected by a licensed physician or other specified licensed mental health professional designated by the patient.

This Bill:

1) Allows any patient (adult or minor) who inspects his or her patient records to provide the health care provider with a written addendum, of up to 250 words, to any item or statement in the records that the patient believes is incomplete or incorrect. (HSC §123111(a))

Comment:

1) Author's Intent. According to the bill's fact sheet from the author's office, the right to addend a treatment record "is critical given that these records may be subject to disclosure and have the potential to impact the patients' lives and their ability to pursue various endeavors. Since minors 12 years of age and older can consent to their own treatment, are generally the holders of the psychotherapist-patient privilege, and are entitled to inspect or copy their records, minors should have the right to addend their treatment records in situations where the patient believes the records are inaccurate and/or incomplete."

2) Support and Opposition.

Support:
- California Association of Marriage and Family Therapists (CAMFT) (Sponsor)
- California Association for Licensed Professional Clinical Counselors (CALPCC)

Opposition:
- None at this time.

3) History

2018

03/21/18 From committee: Do pass and re-refer to Com. on APPR. (Ayes 15. Noes 0.) (March 20). Re-referred to Com. on APPR.
02/16/18 Referred to Com. on HEALTH.
02/08/18 From printer. May be heard in committee March 10.
02/07/18 Read first time. To print.

ASSEMBLY BILL No. 2088

Introduced by Assembly Member Santiago

February 7, 2018

An act to amend Section 123111 of the Health and Safety Code, relating to patient records.

LEGISLATIVE COUNSEL'S DIGEST

AB 2088, as introduced, Santiago. Patient records: addenda.

Existing law requires a health care provider to allow an adult patient who inspects his or her patient records to provide to the health care provider a written addendum with respect to any item or statement in his or her records that the patient believes to be incomplete or incorrect. Existing law authorizes any minor patient authorized by law to consent to a medical treatment to inspect his or her patient records, as specified. A violation of these provisions is punishable as a crime.

This bill would require a health care provider to allow a patient, regardless of his or her ages, who inspects his or her patient records to provide to the health care provider a written addendum with respect to any item or statement in his or her records that the patient believes to be incomplete or incorrect. By increasing the scope of a crime, this bill would create a state-mandated local program. The bill would additionally correct an erroneous cross reference.

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:

SECTION 1. Section 123111 of the Health and Safety Code is amended to read:

123111. (a) ~~Any adult~~*A* patient who inspects his or her patient records pursuant to Section 123110 ~~shall have~~ *has* the right to provide to the health care provider a written addendum with respect to any item or statement in his or her records that the patient believes to be incomplete or incorrect. The addendum shall be limited to 250 words per alleged incomplete or incorrect item in the patient's record and shall clearly indicate in writing that the patient ~~wishes~~ *requests* the addendum to be made a part of his or her record.

(b) The health care provider shall attach the addendum to the patient's records and shall include that addendum ~~whenever~~ *if* the health care provider makes a disclosure of the allegedly incomplete or incorrect portion of the patient's records to any third party.

(c) The receipt of information in a patient's addendum which contains defamatory or otherwise unlawful language, and the inclusion of this information in the patient's records, in accordance with subdivision (b), shall not, in and of itself, subject the health care provider to liability in any civil, criminal, administrative, or other proceeding.

(d) Subdivision ~~(f)~~ *(i)* of Section 123110 and Section 123120 ~~shall be~~ *are* applicable with respect to any violation of this section by a health care provider.

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

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Board of Behavioral Sciences

CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES BILL ANALYSIS

BILL NUMBER: AB 2143 **VERSION:** AMENDED APRIL 2, 2018

AUTHOR: CABALLERO **SPONSOR:** CALIFORNIA PSYCHIATRIC ASSOCIATION

RECOMMENDED POSITION: NONE

SUBJECT: MENTAL HEALTH: LICENSED MENTAL HEALTH SERVICE PROVIDER EDUCATION PROGRAM

Summary: This bill would include the Board's Licensed Educational Psychologist (LEP) licensees in the Mental Health Practitioner Education Fund loan repayment grant program.

Existing Law:

1) Establishes a maximum biennial renewal fee that LMFT, LEP, LCSW, and LPCC licensees must pay to renew a license. (Business and Professions Code (BPC) §§4984, 4984.7, 4989.32, 4989.68, 4996.3, 4996.6, 4999.102, 4999.120)

2) Sets the amount for the LMFT renewal fee at $130 (California Code of Regulations (CCR) Title 16, Section 1816(d)).

3) Sets the amount for the LEP renewal fee at $80 (16 CCR §1816(e)).

4) Sets the amount for the LCSW renewal fee at $100 (16 CCR §1816(f)).

5) Sets the amount for the LPCC renewal fee at $175 (16 CCR §1816(g))

6) Effective July 1, 2018, requires that in addition to the regular biennial license renewal fee, LMFTs, LCSWs, and LPCCs must pay an additional $20 biennial fee at renewal, which shall be deposited in the Mental Health Practitioner Education Fund. (BPC §§4984.75, 4996.65, 4999.121)

7) Creates the Licensed Mental Health Service Provider Education Program within the Health Professions Education Foundation. Funds from this program are administered by the Office of Statewide Health Planning and Development (OSHPD). (Health and Safety Code (HSC) §§128454(a), 128458)

8) Allows any licensed mental health service provider who provides direct patient care in a publicly funded facility or a mental health professional shortage area to apply for

grants under this program to reimburse educational loans related to a career as a licensed mental health service provider. (HSC §128454(c))

9) Defines a "licensed mental health service provider" to include several types of licensed mental health professionals, including marriage and family therapists, associate MFTs, licensed clinical social workers, associate clinical social workers, licensed professional clinical counselors, and associate professional clinical counselors. (HSC §128454(b))

10) Defines a "mental health professional shortage area" as an area given this designation by the Health Resources and Services Administration of the U.S. Department of Health and Human Services. (HSC §128454(b))

11) Requires the Health Professions Education Foundation to develop the grant program, and allows it to make recommendations to the director of OSHPD regarding the following (HSC §128454(d) and (e)):

- The length of the contract that a grant recipient must sign obligating him or her to work in a publicly funded facility or a mental health professional shortage area (the law requires it to be at least one year);

- The maximum allowable total grant per person and the maximum annual grant per person;

12) When selecting loan repayment recipients, requires the Foundation to take into consideration the mental health workforce needs, including cultural and linguistic needs, of the state in general and of the qualifying facilities and mental health professional shortage areas. (22 California Code of Regulation (CCR) §97930.7)

13) Requires a recipient of a loan repayment grant to provide service for 24 months for no less than 32 hours per week. (22 CCR §97930.8(a))

This Bill:

1) Beginning July 1, 2019, requires the Board to collect an additional $20 fee from LEPs upon license renewal, for deposit into the Mental Health Practitioner Education Fund. (BPC §§4989.69)

2) Also extends the program to psychiatric mental health nurse practitioners and physician assistants. (BPC §§2815.2, 3521.4)

3) Allows LEPs, psychiatric mental health nurse practitioners and physician assistants to be eligible to apply for grants to reimburse education loans under the Licensed Mental Health Service Provider Education Program if they are providing direct patient care in a publicly funded facility or a mental health professional shortage area. (HSC §128454)

Comment:

1) Author's Intent. The author's intent is to provide incentives for LEPs, physician assistants, and psychiatric mental health nurse practitioners to practice in

community mental health or in underserved settings, by extending the Licensed Mental Health Service Provider Education loan repayment program to them. They hope that doing so will attract these professionals to underserved communities, and will also decrease wait times for services in these communities.

2) **Fee Comparison.** Below is a chart comparing the current biennial renewal fee for LEPs with what the biennial renewal fee would be if this bill became law.

License Type	Current Renewal Fee			Proposed Renewal Fee		
	Renewal Fee	MHP Edu. Fund Fee	**Total Fee**	Renewal Fee	MHP Edu. Fund Fee	**Total Fee**
LEP	$80	$0	**$80**	$80	$20	**$100**

3) **LEP Licensees.** If this bill became law, each LEP would pay an extra $20 upon license renewal every other year.

The Board currently has approximately 1,300 active LEP licensees. Therefore, the additional $20 fee could raise approximately $13,000 per year.

4) **Delayed Implementation.** This bill is an urgency statute, meaning its provisions are added to law immediately upon the bill's signing. However, the provisions of the bill have a delayed implementation date of July 1, 2019. This should provide sufficient time to prepare updated renewal forms and update the Breeze database system.

5) **Previous Legislation.** AB 1188 (Chapter 557, Statutes of 2018), increased the Mental Health Practitioner fee that LMFTs and LCSWs pay upon license renewal from $10 to $20. It also requires LPCCs to pay a $20 fee into the fund upon license renewal (they previously were not included in the program), and allows LPCCs and associate PCCs to apply for the loan repayment grant if they work in a mental health professional shortage area.

The Board had a "support" position on AB 1188, and negotiated a 6-month delayed implementation date for the bill so that it could implement the change properly.

6) **Related Legislation.** AB 2608 (Stone) is a bill proposal running this year. It creates a new fund under the Mental Health Practitioner Education Fund loan repayment grant program specifically for loan repayment grants for LMFT and LCSW licensees and registrants who were formerly in California's foster youth care system. The program would be funded by levying an additional $10 fee on LMFT and LCSWs each renewal cycle.

7) **Support and Opposition.**

Support:

- California Psychiatric Association (Sponsor)
- California Association of School Psychologists (CASP)
- Association of California Healthcare Districts

- California Access Coalition
- Steinberg Institute
- California Council of Community Behavioral Health Agencies
- California ACEP (American College of Emergency Physicians)

Opposition:

- None at this time.

8) History

2018

04/02/18 Read second time and amended.
03/22/18 From committee: Amend, and do pass as amended and re-refer to Com. on HEALTH. (Ayes 13. Noes 0.) (March 20).
03/01/18 Referred to Coms. on B. & P. and HEALTH.
02/13/18 From printer. May be heard in committee March 15.
02/12/18 Read first time. To print.

AMENDED IN ASSEMBLY APRIL 2, 2018

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 2143

Introduced by Assembly Member Caballero

February 12, 2018

~~An act to amend Section 128454 of the Health and Safety Code, relating to mental health.~~ *An act to add Sections 2815.2, 3521.4, and 4989.69 to the Business and Professions Code, and to amend, repeal, and add Sections 128454 and 128456 of, the Health and Safety Code, relating to mental health, and declaring the urgency thereof, to take effect immediately.*

LEGISLATIVE COUNSEL'S DIGEST

AB 2143, as amended, Caballero. ~~Licensed Mental Health Service Provider Education Program: providers.~~ *Mental health: Licensed Mental Health Service Provider Education Program.*

Existing law establishes the Licensed Mental Health Service Provider Education Program within the Health Professions Education Foundation. Existing law authorizes a licensed mental health service provider, as defined, including, among others, a psychologist and a marriage and family therapist, who provides direct patient care in a publicly funded facility or a mental health professional shortage area to apply for grants under the program to reimburse his or her educational loans related to a career as a licensed mental health service provider, as specified. Existing law establishes the Mental Health Practitioner Education Fund in the State Treasury and provides that moneys in that fund are available, upon appropriation, for expenditure by the Office of Statewide Health Planning and Development for purposes of the program.

~~This bill would add physician assistants who specialize in mental health services and psychiatric-mental health nurse practitioners to those licensed mental health service providers eligible for grants under the program.~~

This bill would, on and after July 1, 2019, add nurse practitioners listed as psychiatric-mental health nurses, physician assistants who specialize in mental health services, and licensed educational psychologists, as specified, to those licensed mental health service providers eligible for grants to reimburse educational loans, and would make other conforming changes. Commencing July 1, 2019, the bill would also add the Physician Assistant Board and the Board of Registered Nursing to the list of entities from which the Health Professions Education Foundation must solicit advice in developing the program.

The Nursing Practice Act makes the Board of Registered Nursing responsible for the licensure and regulation of registered nurses. That act requires the board to assess a license renewal fee, as specified. Existing law requires the board to charge an additional $10 fee to be deposited in the Registered Nurse Education Fund for purposes of the California Registered Nurse Education Program.

This bill would, on and after July 1, 2019, require the board to collect an additional $20 fee at the time of license renewal from a nurse practitioner who is listed by the board as a psychiatric mental health nurse and would require that those funds be deposited in the Mental Health Practitioner Education Fund.

The Physician Assistant Practice Act makes the Physician Assistant Board responsible for the licensure and regulation of physician assistants. That act requires the board to establish and assess a license renewal fee, as specified.

This bill would, on and after July 1, 2019, require the board to collect an additional $20 fee at the time of renewal of the license of a physician assistant participating in the Licensed Mental Health Service Provider Education Program. The bill would require that the fee be deposited in the Mental Health Practitioner Education Fund.

The Educational Psychologist Practice Act makes the Board of Behavioral Sciences responsible for the licensure and regulation of educational psychologists. That act requires the board to assess a license renewal fee, as specified.

This bill would, on and after July 1, 2019, require the board to collect an additional $20 fee at the time of renewal of a license for a licensed

educational psychologist for deposit in the Mental Health Practitioner Education Fund.

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

Vote: ~~majority~~ *2/3*. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

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

SECTION 1. Section 2815.2 is added to the Business and Professions Code, to read:

2815.2. (a) Notwithstanding subdivision (d) of Section 2815, the board shall do both of the following:

(1) In addition to the fees charged pursuant to subdivision (d) of Section 2815 for the biennial renewal of a license, collect from a nurse practitioner who is listed by the board as a "psychiatric mental health nurse" under Section 2732.05 an additional fee of twenty dollars ($20) at the time of renewal.

(2) Transfer the additional fee described in paragraph (1) to the Controller, who shall deposit the funds into the Mental Health Practitioner Education Fund.

(b) This section shall become operative on July 1, 2019.

SEC. 2. Section 3521.4 is added to the Business and Professions Code, to read:

3521.4. (a) Notwithstanding subdivision (c) of Section 3521.1, after receiving a notice from the Health Professions Education Foundation described in paragraph (2) of subdivision (c) of Section 128454 of the Health and Safety Code, the board shall do both of the following:

(1) In addition to the fees charged pursuant to Section 3521.1 for the biennial renewal of a license, collect an additional fee of twenty dollars ($20) from the licensee identified in the notice at the time of renewal of his or her license.

(2) Transfer the additional fee described in paragraph (1) to the Controller, who shall deposit the funds into the Mental Health Practitioner Education Fund.

(b) This section shall become operative on July 1, 2019.

SEC. 3. Section 4989.69 is added to the Business and Professions Code, to read:

4989.69. (a) Notwithstanding paragraph (3) of subdivision (a) of Section 4989.68 the board shall do both of the following:

(1) In addition to the fees charged pursuant to Section 4989.68 for the biennial renewal of a license, collect an additional fee of twenty dollars ($20) at the time of renewal.

(2) Transfer the additional fee described in paragraph (1) to the Controller who shall deposit the funds into the Mental Health Practitioner Education Fund.

(b) This section shall become operative on July 1, 2019.

SEC. 4. Section 128454 of the Health and Safety Code, as added by Section 9 of Chapter 557 of the Statutes of 2017, is amended to read:

128454. (a) There is hereby created the Licensed Mental Health Service Provider Education Program within the Health Professions Education Foundation.

(b) For purposes of this article, the following definitions shall apply:

(1) "Licensed mental health service provider" means a psychologist licensed by the Board of Psychology, registered psychologist, postdoctoral psychological assistant, postdoctoral psychology trainee employed in an exempt setting pursuant to Section 2910 of the Business and Professions Code or employed pursuant to a State Department of Health Care Services waiver pursuant to Section 5751.2 of the Welfare and Institutions Code, marriage and family therapist, associate marriage and family therapist, licensed clinical social worker, associate clinical social worker, licensed professional clinical counselor, and associate professional clinical counselor.

(2) "Mental health professional shortage area" means an area designated as such by the Health Resources and Services Administration (HRSA) of the United States Department of Health and Human Services.

(c) Commencing January 1, 2005, any licensed mental health service provider, including a mental health service provider who is employed at a publicly funded mental health facility or a public or nonprofit private mental health facility that contracts with a county mental health entity or facility to provide mental health services, who provides direct patient care in a publicly funded facility or a mental health professional shortage area may apply for grants under the program to reimburse his or her educational

loans related to a career as a licensed mental health service provider.

(d) The Health Professions Education Foundation shall make recommendations to the director of the office concerning all of the following:

(1) A standard contractual agreement to be signed by the director and any licensed mental health service provider who is serving in a publicly funded facility or a mental health professional shortage area that would require the licensed mental health service provider who receives a grant under the program to work in the publicly funded facility or a mental health professional shortage area for at least one year.

(2) The maximum allowable total grant amount per individual licensed mental health service provider.

(3) The maximum allowable annual grant amount per individual licensed mental health service provider.

(e) The Health Professions Education Foundation shall develop the program, which shall comply with all of the following requirements:

(1) The total amount of grants under the program per individual licensed mental health service provider shall not exceed the amount of educational loans related to a career as a licensed mental health service provider incurred by that provider.

(2) The program shall keep the fees from the different licensed providers separate to ensure that all grants are funded by those fees collected from the corresponding licensed provider groups.

(3) A loan forgiveness grant may be provided in installments proportionate to the amount of the service obligation that has been completed.

(4) The number of persons who may be considered for the program shall be limited by the funds made available pursuant to Section 128458.

(f) This section shall become operative on July 1, 2018.

(g) This section shall become inoperative on July 1, 2019, and as of January 1, 2020, is repealed.

SEC. 5. Section 128454 is added to the Health and Safety Code, to read:

128454. (a) There is hereby created the Licensed Mental Health Service Provider Education Program within the Health Professions Education Foundation.

(b) For purposes of this article, the following definitions shall apply:

(1) "Licensed mental health service provider" means the following licensees:

(A) A psychologist licensed by the Board of Psychology, registered psychologist, postdoctoral psychological assistant, or a postdoctoral psychology trainee employed in an exempt setting pursuant to Section 2910 of the Business and Professions Code or employed pursuant to a State Department of Health Care Services waiver pursuant to Section 5751.2 of the Welfare and Institutions Code.

(B) A licensed marriage and family therapist or an associate marriage and family therapist.

(C) A licensed clinical social worker or an associate clinical social worker.

(D) A licensed professional clinical counselor or an associate professional clinical counselor.

(E) A licensed educational psychologist.

(F) A physician assistant who specializes in mental health services.

(G) A nurse practitioner licensed to practice pursuant to Article 8 (commencing with Section 2834) of Chapter 6 of Division 2 of the Business and Professions Code and listed by the Board of Registered Nursing as a "psychiatric-mental health nurse."

(2) "Mental health professional shortage area" means an area designated as such by the Health Resources and Services Administration (HRSA) of the United States Department of Health and Human Services.

(c) (1) Any licensed mental health service provider, including a mental health service provider who is employed at a publicly funded mental health facility or a public or nonprofit private mental health facility that contracts with a county mental health entity or facility to provide mental health services, who provides direct patient care in a publicly funded facility or a mental health professional shortage area may apply for grants under the program to reimburse his or her educational loans related to a career as a licensed mental health service provider, including educational loans used to pay for education used to obtain a license as a physician assistant or psychiatric mental health nurse practitioner

as defined in subparagraphs (F) and (G) of paragraph (1) of subdivision (b).

(2) Upon entering into a contractual agreement specified in paragraph (1) of subdivision (d) with a physician assistant described in subparagraph (F) of paragraph (1) of subdivision (b), the Health Professions Education Foundation shall notify the Physician Assistant Board for purposes of collecting the fee required under Section 3521.4 of the Business and Professions Code.

(d) The Health Professions Education Foundation shall make recommendations to the director of the office concerning all of the following:

(1) A standard contractual agreement to be signed by the director and any licensed mental health service provider who is serving in a publicly funded facility or a mental health professional shortage area that would require the licensed mental health service provider who receives a grant under the program to work in the publicly funded facility or a mental health professional shortage area for at least one year.

(2) The maximum allowable total grant amount per individual licensed mental health service provider.

(3) The maximum allowable annual grant amount per individual licensed mental health service provider.

(e) The Health Professions Education Foundation shall develop the program, which shall comply with all of the following requirements:

(1) The total amount of grants under the program per individual licensed mental health service provider shall not exceed the amount of educational loans related to a career as a licensed mental health service provider incurred by that provider.

(2) The program shall keep the fees from the different licensed providers separate to ensure that all grants are funded by those fees collected from the corresponding licensed provider groups.

(3) A loan forgiveness grant may be provided in installments proportionate to the amount of the service obligation that has been completed.

(4) The number of persons who may be considered for the program shall be limited by the funds made available pursuant to Section 128458.

(f) This section shall become operative on July 1, 2019.

SEC. 6. Section 128456 of the Health and Safety Code is amended to read:

128456. *(a)* In developing the program established pursuant to this article, the Health Professions Education Foundation shall solicit the advice of representatives of the Board of Behavioral Sciences, the Board of Psychology, the State Department of Health Care Services, the County Behavioral Health Directors Association of California, the California Behavioral Health Planning Council, professional mental health care organizations, the California Healthcare Association, the Chancellor of the California Community Colleges, and the Chancellor of the California State University. The foundation shall solicit the advice of representatives who reflect the demographic, cultural, and linguistic diversity of the state.

(b) This section shall become inoperative on July 1, 2019, and as of January 1, 2020, is repealed.

SEC. 7. Section 128456 is added to the Health and Safety Code, to read:

128456. (a) In developing the program established pursuant to this article, the Health Professions Education Foundation shall solicit the advice of representatives of the Board of Behavioral Sciences, the Board of Psychology, the Physician Assistant Board, the Board of Registered Nursing, the State Department of Health Care Services, the County Behavioral Health Directors Association of California, the California Behavioral Health Planning Council, professional mental health care organizations, the California Healthcare Association, the Chancellor of the California Community Colleges, and the Chancellor of the California State University. The foundation shall solicit the advice of representatives who reflect the demographic, cultural, and linguistic diversity of the state.

(b) This section shall become operative on July 1, 2019.

SEC. 8. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the California Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to address the urgent need for licensed mental health practitioners in medically underserved areas, it is necessary that this act take effect immediately.

~~SECTION 1. Section 128454 of the Health and Safety Code, as added by Section 9 of Chapter 557 of the Statutes of 2017, is amended to read:~~

~~128454. (a) There is hereby created the Licensed Mental Health Service Provider Education Program within the Health Professions Education Foundation.~~

~~(b) For purposes of this article, the following definitions shall apply:~~

~~(1) "Licensed mental health service provider" means a psychologist licensed by the Board of Psychology, registered psychologist, postdoctoral psychological assistant, postdoctoral psychology trainee employed in an exempt setting pursuant to Section 2910 of the Business and Professions Code or employed pursuant to a State Department of Health Care Services waiver pursuant to Section 5751.2 of the Welfare and Institutions Code, marriage and family therapist, associate marriage and family therapist, licensed clinical social worker, associate clinical social worker, licensed professional clinical counselor, associate professional clinical counselor, physician assistant who specializes in mental health services, and psychiatric-mental health nurse practitioner licensed to practice pursuant to Article 8 (commencing with Section 2834) of Chapter 6 of Division 2 of the Business and Professions Code.~~

~~(2) "Mental health professional shortage area" means an area designated as such by the Health Resources and Services Administration (HRSA) of the United States Department of Health and Human Services.~~

~~(c) Commencing January 1, 2005, any licensed mental health service provider, including a mental health service provider who is employed at a publicly funded mental health facility or a public or nonprofit private mental health facility that contracts with a county mental health entity or facility to provide mental health services, who provides direct patient care in a publicly funded facility or a mental health professional shortage area may apply for grants under the program to reimburse his or her educational loans related to a career as a licensed mental health service provider.~~

~~(d) The Health Professions Education Foundation shall make recommendations to the director of the office concerning all of the following:~~

~~(1) A standard contractual agreement to be signed by the director and any licensed mental health service provider who is serving in a publicly funded facility or a mental health professional shortage area that would require the licensed mental health service provider who receives a grant under the program to work in the publicly funded facility or a mental health professional shortage area for at least one year.~~

~~(2) The maximum allowable total grant amount per individual licensed mental health service provider.~~

~~(3) The maximum allowable annual grant amount per individual licensed mental health service provider.~~

~~(e) The Health Professions Education Foundation shall develop the program, which shall comply with all of the following requirements:~~

~~(1) The total amount of grants under the program per individual licensed mental health service provider shall not exceed the amount of educational loans related to a career as a licensed mental health service provider incurred by that provider.~~

~~(2) The program shall keep the fees from the different licensed providers separate to ensure that all grants are funded by those fees collected from the corresponding licensed provider groups.~~

~~(3) A loan forgiveness grant may be provided in installments proportionate to the amount of the service obligation that has been completed.~~

~~(4) The number of persons who may be considered for the program shall be limited by the funds made available pursuant to Section 128458.~~

~~(f) This section shall become operative on July 1, 2018.~~

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98

Board of Behavioral Sciences

CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES BILL ANALYSIS

BILL NUMBER: AB 2296 **VERSION:** AMENDED MARCH 23, 2018

AUTHOR: WALDRON **SPONSOR:** CALIFORNIA ASSOCIATION FOR LICENSED PROFESSIONAL CLINICAL COUNSELORS (CALPCC)

RECOMMENDED POSITION: NONE

SUBJECT: LICENSED PROFESSIONAL CLINICAL COUNSELORS: LICENSED CLINICAL SOCIAL WORKERS

Summary: This bill seeks to add licensed professional clinical counselors (LPCCs) and licensed clinical social workers (LCSWs) to areas of California law where other comparable licensed mental health professionals are included. It also makes some changes to LPCC education requirements regarding core content areas of study.

Existing Law:

1) Provides for the licensure of LPCCs by the Board of Behavioral Sciences. (Business and Professions Code (BPC) Chapter 16).

2) Requires applicants for LPCC licensure to obtain a degree containing at least 3 semester units or 4.5 quarter units in specified core content areas. (BPC §§4999.32(c)(1), 4999.33(c)(1), 4999.62(b)(1)(D), 4999.63(b)(1)(D))

3) Allows LPCC applicants to remediate a specified number of required core content areas, except that the required core content areas of assessment and diagnosis may not be remediated and must be contained within the degree. (BPC §§4999.32(d)(1)(B), 4999.33(f)(1)(B), 4999.62(b)(1)(D), 4999.63(b)(1)(D))

This Bill:

1) Adds LPCCs and LCSWs to various statutes where similar mental health professionals are already included, as follows:

   a) Adds LPCCs to the list of mental health professionals who may do work of a psychological nature, if they don't refer to themselves as a "psychologist." (BPC §2908)

   b) Allows LPCCs to be shareholders, officers, directors, or employees of a psychological corporation. (BPC §2995)

   c) Includes LPCCs in the exemption from the Psychiatric Technician Law. (BPC §4507)

d) Amends the Confidentiality of Medical Information Act to include LPCCs and LCSWs in the requirement that a demand for settlement must include an authorization to disclose medical information. (Civil Code §56.105)

e) Adds LPCCs and LCSWs to the list of professionals who may provide a written statement regarding special circumstances that exist for a student to receive consideration for school enrollment outside his or her current attendance area. (Education Code §35160.5)

f) Adds LPCCs to the list of professionals who may be a child custody evaluator. (Family Code §3110.5)

g) Adds LPCCs to the list of professionals who may be involved in certain adoption and custody proceedings. (Family Code §§7663, 7827, 7850, 7851, 8502, 9001)

h) Adds LPCCs to the list of professionals who may provide services in workers compensation cases. (Labor Code §3209.8)

i) Adds LPCCs and LCSWs to the list of professionals who may be a part of a multidisciplinary personnel team in child abuse cases. (Welfare and Institutions Code §§18951, 18961.7)

2) Removes the half-quarter unit requirement for LPCC core content areas (Currently, LPCC applicants must have 3 semester units or 4.5 quarter units of coursework in each core content area. Under this proposal, they would instead need 3 semester units or 4 quarter units of coursework in each core content area.) (BPC §§4999.32, 4999.33, 4999.62, 4999.63)

3) For in-state applicants only, pushes back the requirement that applicants must not be deficient in the "assessment" or "diagnosis" core content areas, until August 31, 2020. Under the proposed amendments, the following individuals must not be deficient in the "assessment" or "diagnosis" core content areas (BPC §§4999.32, 4999.33):

a) Applicants whose application for a license is received after August 31, 2020; or

b) Applicants who are not registered as an associate by August 31, 2020.

Comments:

1) Intent. This is primarily a cleanup measure to add LPCCs to provisions of law where other licensed mental health professionals are already included. LPCCs are the Board's newest license type (the law providing their licensure was signed in 2009), and there are several instances in California law that have not been updated yet to include them.

In addition, this bill makes two other amendments that have previously been considered by the Board or its Policy and Advocacy Committee:

a. It removes the half-quarter unit requirement for LPCC core content areas. (This issue was considered by the Board's Policy and Advocacy Committee in February 2018. The Committee was generally supportive, however at that time it was too late to pursue legislation for this year. The Committee directed staff to bring the issue back for consideration in April if it was not being pursued by CALPCC in a bill).

b. It pushes back the requirements, for in-state applicants only, that an applicant must not be deficient in the "assessment" or "diagnosis" core content areas, until August 31, 2020. (This issue was considered by the Board at its February 22, 2018 meeting. The Board indicated support of the change, however it was likely too late into the legislative session to pursue a new bill proposal. CALPCC indicated to the Board that it was willing to carry the provision in their existing bill.)

2) Core Content Areas – 3 Semester Unit or 4.5 Quarter Unit Requirement. Current law requires LPCC applicants to have the equivalent of at least 3 semester units, or 4.5 quarter units of graduate coursework in specified core content areas to qualify for a license. Generally, one academic semester unit is considered to equal 1.5 quarter units. Therefore, 3 semester units are equivalent to 4.5 quarter units (3 x 1.5 = 4.5).

However, it is rare for degree programs to offer courses in 0.5-unit increments. This is especially true for out-of-state schools, who have not designed their degree programs to lead to a California license. For example, an out-of-state applicant who had 4 quarter units in all 13 core content areas would be ineligible for a license, because only 6 core content areas may be remediated. Relevant coursework integrated elsewhere within the degree may help such an applicant become eligible, but only if that coursework is not already being counted toward fulfilling another requirement.

Staff researched the core content area requirements of several other states and found the following:

Arizona: Has 8 required content areas. If not accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) or the Council on Rehabilitation Education (CORE), applicants are required to have a 3 semester or 4 quarter credit hour course in each content area.

Colorado: Has 8 core areas. If the program is not CACREP accredited, then the student must demonstrate completion of 2 or more graduate semester hours, or 3 or more graduate quarter hours in each core area.

Florida: If the program is not CACREP accredited, then the student must demonstrate completion of 12 specific core content areas, which must be a minimum of 3 semester hours or 4 quarter hours of graduate-level coursework.

Indiana: Requires 12 content areas, but no specific number of units are required in each content area.

Massachusetts: Requires 10 content areas, with a minimum of 3 semester credits or 4 quarter credits taken in each area.

New York: Requires 11 core content areas, but no specific number of units are required in each content area.

Texas: Requires 10 core content areas, and regulations state that an applicant must complete at least one 3 semester hour course in each area.

This topic was considered at the Board's February 2018 Policy and Advocacy Committee meeting. The Committee asked that the topic be brought back for further discussion in April.

3) **Required Core Content Areas – Assessment and Diagnosis.** In 2015, the Board discussed the need to tighten licensing requirements for LPCCs to ensure applicants possessed degrees designed to lead to licensure in professional clinical counseling. There were concerns that the Board was receiving applications, particularly from out-of-state candidates, with degrees that were not specifically designed to prepare the individual to be a clinical counselor.

The Board first considered designating specific degree titles as acceptable or not acceptable for licensure. However, after receiving stakeholder feedback and discussing the matter further, the Board ultimately concluded that a degree should be evaluated based on its content, and not by its title. The discussion shifted to two LPCC core content areas that the Board agreed are fundamental to a clinical counseling degree (Business and Professions Code (BPC) §§4999.32(c)(1)(E) & (G), 4999.33(c)(1)(E) &(G)):

1. **Assessment:** Assessment, appraisal, and testing of individuals, including basic concepts of standardized and nonstandardized testing and other assessment techniques, norm-referenced and criterion-referenced assessment, statistical concepts, social and cultural factors related to assessment and evaluation of individuals and groups, and ethical strategies for selecting, administering, and interpreting assessment instruments and techniques in counseling.

2. **Diagnosis:** Principles of the diagnostic process, including differential diagnosis, and the use of current diagnostic tools, such as the current edition of the Diagnostic and Statistical Manual, the impact of co-occurring substance use disorders or medical psychological disorders, established diagnostic criteria for mental or emotional disorders, and the treatment modalities and placement criteria within the continuum of care.

The Board recommended that these two core content areas be designated as not eligible for remediation, for both in-state and out-of-state degrees. In other words, an LPCC applicant's degree must fully contain these two core areas (3 semester units or 4.5 quarter units), with no exceptions, meaning a new degree would be required for licensure if this requirement is not met. All other core content areas remained eligible for remediation as allowed by current law.

The provision that the assessment and diagnosis core content areas could not be remediated was included in AB 1917 (Obernolte, Chapter 70, Statutes of 2016), and the provision became law for anyone applying for a license or a registration after January 1, 2017.

Since AB 1917 became effective, the Board's licensing unit has encountered situations where in-state applicants were denied licensure, due to the degree not containing the full number of units for the assessment and/or diagnosis core content areas (See **Attachment A**). In some cases, the applicants have argued they were not aware of the new requirement, and that more notice should have been given so that they had time to remediate. In other cases, schools have argued that their degree should qualify, because it falls under the provisions of BPC §4999.32 (which outlines degree requirements for degrees begun before August 1, 2012 and completed before December 31, 2018) and therefore, they believed that any requirements could be finished by the end of 2018.

At its February 2018 Board meeting, the Board considered language that would allow in-state applicants additional time to remediate assessment and diagnosis coursework, until August 31, 2020. The Board indicated support of the language, and CALPCC offered to carry the provision in this bill.

4) **Suggested Amendment.** The language that Legislative Counsel drafted for BPC §§4999.32(d)(1)(B) and 4999.33(f)(1)(B) (the proposal to delay the prohibition on remediating the assessment and diagnosis core content area requirements) is as follows:

> (f) (1) (A) An applicant whose degree is deficient in no more than three of the required areas of study listed in subparagraphs (A) to (M), inclusive, of paragraph (1) of subdivision (c) may satisfy those deficiencies by successfully completing post-master's or postdoctoral degree coursework at an accredited or approved institution, as defined in Section 4999.12.
> (B) Notwithstanding subparagraph (A), ~~no~~ *an* applicant *whose application for a license is received by the board after August 31, 2020, or an applicant who is not registered as an associate by that date,* shall *not* be deficient in the required areas of study specified in subparagraphs (E) or (G) of paragraph (1) of subdivision (c).

However, staff has concerns that this does not adequately capture everyone that the Board seeks to include in the delay. For example, if strictly interpreted, the above language could be interpreted to imply that someone who had previously remediated assessment and diagnosis and then registered as an associate before August 31, 2020, could be rejected when applying for licensure because the assessment and diagnosis core content areas were not part of their degree. To avoid that possibility, staff suggests the following language instead (suggested amendment is shown for 4999.33, but would need to be mirrored in 4999.32 as well):

4999.33 (f) (1) (A) An applicant whose degree is deficient in no more than three of the required areas of study listed in subparagraphs (A) to (M), inclusive, of paragraph (1) of subdivision (c) may satisfy those deficiencies by successfully completing post-master's or postdoctoral degree coursework at an accredited or approved institution, as defined in Section 4999.12.

(B) Notwithstanding subparagraph (A), no applicant shall be deficient in the required areas of study specified in subparagraphs (E) or (G) of paragraph (1) of subdivision (c)~~.~~, unless they meet one of the following criteria and remediate the deficiencies:

(i) The application for licensure was received by the board on or before August 31, 2020; or

(ii) The application for registration was received by the board on or before August 31, 2020, and the registration was subsequently issued by the board.

5) **Previous Legislation.**

- **SB 788 (Wyland) (Chapter 619, Statutes of 2009),** established the licensing and regulation of Licensed Professional Clinical Counselors (LPCCs) and associate professional clinical counselors by the Board of Behavioral Sciences. However, this

bill only added and amended certain sections of the Business and Professions Code. It did not amend all sections of California Code where the addition of LPCCs is necessary.

- **SB 146 (Wyland) (Chapter 381, Statutes of 2011),** added LPCCs to several other statutory code sections where the Board's other license types were already included, with the goal of ensuring that LPCCs be more effectively utilized in California.

- **AB 1917 (Obernolte) (Chapter 70, Statutes of 2016),** made modifications the education requirements for LMFT and LPCC licensure. This included prohibiting remediation of the "assessment" and "diagnosis" core content areas.

6) Support and Opposition.

Support:
- California Association for Licensed Professional Clinical Counselors (CALPCC) (Sponsor)

Oppose:
- None at this time.

7) History.

2018

04/02/18	Re-referred to Com. on B. & P.
03/23/18	From committee chair, with author's amendments: Amend, and re-refer to Com. on B. & P. Read second time and amended.
03/22/18	Referred to Coms. on B. & P. and JUD.
02/14/18	From printer. May be heard in committee March 16.
02/13/18	Read first time. To print.

8) Attachment A: In-State Applicant Denials in 2017 for Assessment and/or Diagnosis Core Content Deficiency

AMENDED IN ASSEMBLY MARCH 23, 2018

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 2296

Introduced by Assembly Member Waldron

February 13, 2018

An act to amend ~~Section 201 of the Business and Professions Code, relating to professions and vocations.~~ *Sections 2908, 2995, 4507, 4999.32, 4999.33, 4999.62, and 4999.63 of the Business and Professions Code, to amend Section 56.105 of the Civil Code, to amend Section 35160.5 of the Education Code, to amend Sections 3110.5, 7663, 7827, 7850, 7851, 8502, and 9001 of the Family Code, to amend Section 3209.8 of the Labor Code, and to amend Sections 18951 and 18961.7 of the Welfare and Institutions Code, relating to healing arts licensees.*

LEGISLATIVE COUNSEL'S DIGEST

AB 2296, as amended, Waldron. ~~Department of Consumer Affairs: administrative expenses: charge.~~ *Licensed professional clinical counselors: licensed clinical social workers.*

(1) The Psychology Licensing Law provides for the licensure and regulation of psychologists by the Board of Psychology and makes a violation of its provisions a crime. This law does not prevent qualified members of specified recognized professional groups from doing work of a psychological nature consistent with the law, as provided. This law describes a psychological corporation as a corporation that is authorized to render professional services if the corporation and its shareholders, officers, directors, and employees rendering professional services are specified healing arts licensees.

Existing law establishes the Board of Behavioral Sciences and makes it responsible for the licensure and regulation of marriage and family

therapists, clinical social workers, professional clinical counselors, and educational psychologists.

This bill would list licensed professional clinical counselors as one of those recognized professional groups not prohibited from doing psychological work and would include a licensed professional clinical counselor as a healing arts licensee allowed to render services in a psychological corporation. By expanding the scope of a crime under the Psychology Licensing Law, the bill would impose a state-mandated local program.

(2) The Psychiatric Technicians Law requires the Board of Vocational Nursing and Psychiatric Technicians of the State of California, which is within the Department of Consumer Affairs, to license and regulate vocational nurses and psychiatric technicians.

This bill would provide that the Psychiatric Technicians Law does not apply to professional clinical counselors.

(3) Existing law requires an applicant seeking licensure as a professional clinical counselor to possess a degree that contains the equivalent of at least 3 semester units or 4½ quarter units of graduate study in specified core content areas. Existing law allows an applicant whose degree is deficient in no more than 2 of the specified required areas of study to satisfy those deficiencies by successfully completing post-master's or postdoctoral degree coursework, except that this option does not apply to the required areas of study relating to assessment, appraisal, and testing of individuals and principles of the diagnostic process.

This bill would instead require the equivalent of at least 3 semester units or 4 quarter units of graduate study in specified core content areas. The bill would allow an applicant whose application is received by the board on or before August 31, 2020, or who is registered as an associate by that date, to satisfy deficiencies in the required areas of study relating to assessment, appraisal, and testing of individuals and principles of the diagnostic process by completing post-master's or postdoctoral degree coursework.

(4) The Confidentiality of Medical Information Act authorizes the disclosure of medical information to the person or organization insuring, responsible for, or defending professional liability that the specified healing arts licensee may incur. A violation of the act that results in economic loss or personal injury to a patient is punishable as a crime.

This bill would expand this provision to include licensed clinical social workers and licensed professional clinical counselors. By

expanding the scope of a crime under the act, the bill would impose a state-mandated local program.

(5) Existing law requires the governing board of a school district to establish an open enrollment policy within the district, as specified, as a condition of receiving certain school apportionments from the State School Fund. Under existing law, the open enrollment policy may provide that special circumstances may exist that might be harmful or dangerous to a pupil in his or her current attendance area. A finding of these special circumstances may be based on a written statement from, among others, specified licensed or registered professionals.

This bill would additionally authorize a finding of special circumstances to be based on a written statement from a licensed professional clinical counselor.

(6) Existing law sets forth the qualifications for a court-connected or private child custody evaluator. Under existing law, in addition to specified education, experience, and training requirements, a person may be a child custody evaluator only if he or she meets one of specified licensure or certification criteria.

This bill would additionally authorize include a licensed professional clinical counselor who meets the education, experience, and training requirements to be a child custody evaluator.

(7) Under existing law, for purposes of terminating parental rights in an adoption proceeding, a court is required to attempt to identify all alleged fathers and presumed parents by causing the mother and any other appropriate person to be questioned, in the case of a stepparent adoption, the licensed clinical social worker or licensed marriage and family therapist who is performing a specified written investigative report.

This bill would additionally authorize a licensed professional clinical counselor who is performing the investigative report to question the mother or other appropriate person under the above-described circumstances.

(8) Existing law authorizes a proceeding to be brought for the purpose of having a child under 18 years of age declared free from the custody and control of either or both parents under specified circumstances, including when the child's parent or parents are mentally disabled and are likely to remain so in the foreseeable future. Under existing law, in support of a finding of mental disability, a court has discretion to call a licensed marriage and family therapist, or a licensed clinical social worker, with specified experience, in circumstances

where the court determines that this testimony is in the best interests of the child and is warranted by the circumstances of the particular family or parenting issues involved.

This bill would additionally authorize the court to call a licensed professional clinical counselor to provide this testimony, as specified.

(9) Existing law authorizes a petition to be filed by an interested person, as defined, for an order or judgment declaring a child free from the custody and control of either or both parents under specified circumstances. Upon the filing of the petition, existing law requires the clerk of the court to notify one of specified agencies or appropriately licensed individuals to investigate the circumstances of the child and report to the court, as specified.

This bill would include a licensed professional clinical counselor as one of the individuals authorized to investigate the circumstances of the child in the above proceedings.

(10) Existing law defines an adoption service provider to include licensed or approved adoption agencies, as specified, and licensed clinical social workers and marriage and family therapists with a minimum of 5 years of experience providing professional social work or adoption casework services, as prescribed. Existing law requires a court, prior to granting or denying a stepparent adoption request, to review and consider a written investigative report, which may be completed by a licensed clinical social worker, a licensed marriage and family therapist, or a private licensed adoption agency, if the petitioner so elects.

This bill would expand the definition of an adoption service provider to include a licensed clinical professional counselor with similar qualifications. The bill would additionally authorize a petitioner in a stepparent adoption request to elect to have the investigative report completed by a licensed professional clinical counselor.

(11) Existing law relating to workers' compensation provides that treatment reasonably required to cure or relieve the effects of an injury include the services of licensed marriage and family therapists and clinical social workers.

This bill would expand those provisions to include the services of licensed professional clinical counselors.

(12) Existing law establishes the Office of Child Abuse Prevention to plan, improve, develop, and carry out programs and activities relating to the prevention, identification, and treatment of child abuse and neglect. Existing law provides for multidisciplinary personnel in this

regard as a team of 3 or more persons trained in the prevention, identification, management, or treatment of child abuse or neglect cases and who are qualified to provide a broad range of services related to child abuse or neglect. Existing law also authorizes a county to establish a child abuse multidisciplinary personnel team within the county to allow provider agencies to share confidential information in order for provider agencies to investigate reports of suspected child abuse or neglect made pursuant to specified provisions. These multidisciplinary entities are similarly defined to include, among others, psychiatrists, psychologists, marriage and family therapists, or other trained counseling personnel.

This bill would expand the definitions of multidisciplinary personnel and child abuse multidisciplinary personnel teams to specifically include clinical social workers and professional clinical counselors.

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

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

~~Existing law provides for the licensure and regulation of various professions and vocations by boards within the Department of Consumer Affairs. Existing law authorizes the department to levy a pro rata share of the department's administrative expenses against any of the boards at the discretion of the Director of Consumer Affairs and with the approval of the Department of Finance.~~

~~This bill would make a nonsubstantive change to that provision.~~

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:

SECTION 1. Section 2908 of the Business and Professions Code is amended to read:

2908. Nothing in this chapter shall be construed to prevent qualified members of other recognized professional groups licensed to practice in the State of California, such as, but not limited to, physicians, clinical social workers, educational psychologists, marriage and family therapists, *licensed professional clinical counselors,* optometrists, psychiatric technicians, or registered

nurses, or attorneys admitted to the ~~California State Bar,~~ *State Bar of California,* or persons utilizing hypnotic techniques by referral from persons licensed to practice medicine, ~~dentistry~~ *dentistry,* or psychology, or persons utilizing hypnotic techniques which offer avocational or vocational self-improvement and do not offer therapy for emotional or mental disorders, or duly ordained members of the recognized clergy, or duly ordained religious practitioners from doing work of a psychological nature consistent with the laws governing their respective professions, provided they do not hold themselves out to the public by any title or description of services incorporating the words "psychological," "psychologist," "psychology," "psychometrist," "psychometrics," or "psychometry," or that they do not state or imply that they are licensed to practice psychology; except that persons licensed under ~~Article 5~~ *Chapter 13.5* (commencing with Section ~~4986) of Chapter 13~~ *4989.10)* of Division 2 may hold themselves out to the public as licensed educational psychologists.

SEC. 2. Section 2995 of the Business and Professions Code is amended to read:

2995. A psychological corporation is a corporation that is authorized to render professional services, as defined in Section 13401 of the Corporations Code, so long as that corporation and its shareholders, officers, directors, and employees rendering professional services who are psychologists, podiatrists, registered nurses, optometrists, marriage and family therapists, *licensed professional clinical counselors*, licensed clinical social workers, chiropractors, acupuncturists, or physicians are in compliance with the Moscone-Knox Professional Corporation Act, this article, and all other statutes and regulations now or hereafter enacted or adopted pertaining to that corporation and the conduct of its affairs.

SEC. 3. Section 4507 of the Business and Professions Code is amended to read:

4507. This chapter shall not apply to the following:

(a) Physicians and surgeons licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2.

(b) Psychologists licensed pursuant to Chapter 6.6 (commencing with Section 2900) of Division 2.

(c) Registered nurses licensed pursuant to Chapter 6 (commencing with Section 2700) of Division 2.

(d) Vocational nurses licensed pursuant to Chapter 6.5 (commencing with Section 2840) of Division 2.

(e) Social workers or clinical social workers licensed pursuant to Chapter ~~17~~ *14* (commencing with Section ~~9000)~~ *4991)* of Division ~~3.~~ *2.*

(f) Marriage and family therapists licensed pursuant to Chapter 13 (commencing with Section 4980) of Division 2.

(g) Professional clinical counselors licensed pursuant to Chapter 16 (commencing with Section 4999.10) of Division 2.

~~(g)~~

(h) Teachers credentialed pursuant to Article 1 (commencing with Section 44200) of Chapter 2 of Part 25 *of Division 3 of Title 2* of the Education Code.

~~(h)~~

(i) Occupational therapists as specified in Chapter 5.6 (commencing with Section 2570) of Division 2.

~~(i)~~

(j) Art therapists, dance therapists, music therapists, and recreation therapists, as defined in Division 5 (commencing with Section 70001) of Title 22 of the California Code of Regulations, who are personnel of health facilities licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.

~~(j)~~

(k) Any other categories of persons the board determines are entitled to exemption from this chapter because they have complied with other licensing provisions of this code or because they are deemed by statute or by regulations contained in the California Code of Regulations to be adequately trained in their respective occupations. The exemptions shall apply only to a given specialized area of training within the specific discipline for which the exemption is granted.

SEC. 4. Section 4999.32 of the Business and Professions Code is amended to read:

4999.32. (a) This section shall apply to applicants for licensure or registration who begin graduate study before August 1, 2012, and complete that study on or before December 31, 2018. Those applicants may alternatively qualify under paragraph (2) of subdivision (a) of Section 4999.33.

(b) To qualify for licensure or registration, applicants shall possess a master's or doctoral degree that is counseling or psychotherapy in content and that meets the requirements of this section, obtained from an accredited or approved institution, as defined in Section 4999.12. For purposes of this subdivision, a degree is "counseling or psychotherapy in content" if it contains the supervised practicum or field study experience described in paragraph (3) of subdivision (c) and, except as provided in subdivision (d), the coursework in the core content areas listed in subparagraphs (A) to (I), inclusive, of paragraph (1) of subdivision (c).

(c) The degree described in subdivision (b) shall contain not less than 48 graduate semester or 72 graduate quarter units of instruction, which shall, except as provided in subdivision (d), include all of the following:

(1) The equivalent of at least three semester units or four ~~and one-half~~ quarter units of graduate study in each of the following core content areas:

(A) Counseling and psychotherapeutic theories and techniques, including the counseling process in a multicultural society, an orientation to wellness and prevention, counseling theories to assist in selection of appropriate counseling interventions, models of counseling consistent with current professional research and practice, development of a personal model of counseling, and multidisciplinary responses to crises, emergencies, and disasters.

(B) Human growth and development across the lifespan, including normal and abnormal behavior and an understanding of developmental crises, disability, psychopathology, and situational and environmental factors that affect both normal and abnormal behavior.

(C) Career development theories and techniques, including career development decisionmaking models and interrelationships among and between work, family, and other life roles and factors, including the role of multicultural issues in career development.

(D) Group counseling theories and techniques, including principles of group dynamics, group process components, developmental stage theories, therapeutic factors of group work, group leadership styles and approaches, pertinent research and literature, group counseling methods, and evaluation of effectiveness.

(E) Assessment, appraisal, and testing of individuals, including basic concepts of standardized and nonstandardized testing and other assessment techniques, norm-referenced and criterion-referenced assessment, statistical concepts, social and cultural factors related to assessment and evaluation of individuals and groups, and ethical strategies for selecting, administering, and interpreting assessment instruments and techniques in counseling.

(F) Multicultural counseling theories and techniques, including counselors' roles in developing cultural self-awareness, identity development, promoting cultural social justice, individual and community strategies for working with and advocating for diverse populations, and counselors' roles in eliminating biases and prejudices, and processes of intentional and unintentional oppression and discrimination.

(G) Principles of the diagnostic process, including differential diagnosis, and the use of current diagnostic tools, such as the current edition of the Diagnostic and Statistical Manual, the impact of co-occurring substance use disorders or medical psychological disorders, established diagnostic criteria for mental or emotional disorders, and the treatment modalities and placement criteria within the continuum of care.

(H) Research and evaluation, including studies that provide an understanding of research methods, statistical analysis, the use of research to inform evidence-based practice, the importance of research in advancing the profession of counseling, and statistical methods used in conducting research, needs assessment, and program evaluation.

(I) Professional orientation, ethics, and law in counseling, including professional ethical standards and legal considerations, licensing law and process, regulatory laws that delineate the profession's scope of practice, counselor-client privilege, confidentiality, the client dangerous to self or others, treatment of minors with or without parental consent, relationship between practitioner's sense of self and human values, functions and relationships with other human service providers, strategies for collaboration, and advocacy processes needed to address institutional and social barriers that impede access, equity, and success for clients.

(2) In addition to the course requirements described in paragraph (1), a minimum of 12 semester units or 18 quarter units of advanced

coursework to develop knowledge of specific treatment issues, special populations, application of counseling constructs, assessment and treatment planning, clinical interventions, therapeutic relationships, psychopathology, or other clinical topics.

(3) Not less than six semester units or nine quarter units of supervised practicum or field study experience that involves direct client contact in a clinical setting that provides a range of professional clinical counseling experience, including the following:

(A) Applied psychotherapeutic techniques.

(B) Assessment.

(C) Diagnosis.

(D) Prognosis.

(E) Treatment.

(F) Issues of development, adjustment, and maladjustment.

(G) Health and wellness promotion.

(H) Other recognized counseling interventions.

(I) A minimum of 150 hours of face-to-face supervised clinical experience counseling individuals, families, or groups.

(d) (1) (A) An applicant whose degree is deficient in no more than two of the required areas of study listed in subparagraphs (A) to (I), inclusive, of paragraph (1) of subdivision (c) may satisfy those deficiencies by successfully completing post-master's or postdoctoral degree coursework at an accredited or approved institution, as defined in Section 4999.12.

(B) Notwithstanding subparagraph (A), ~~no~~ *an* applicant *whose application for a license is received by the board after August 31, 2020, or an applicant who is not registered as an associate by that date,* shall *not* be deficient in the required areas of study specified in subparagraphs (E) or (G) of paragraph (1) of subdivision (c).

(2) Coursework taken to meet deficiencies in the required areas of study listed in subparagraphs (A) to (I), inclusive, of paragraph (1) of subdivision (c) shall be the equivalent of three semester units or four ~~and one-half~~ quarter units of study.

(3) The board shall make the final determination as to whether a degree meets all requirements, including, but not limited to, course requirements, regardless of accreditation.

(e) In addition to the degree described in this section, or as part of that degree, an applicant shall complete the following coursework or training prior to registration as an associate:

(1) A minimum of 15 contact hours of instruction in alcoholism and other chemical substance abuse dependency, as specified by regulation.

(2) A minimum of 10 contact hours of training or coursework in human sexuality as specified in Section 25, and any regulations promulgated thereunder.

(3) A two semester unit or three quarter unit survey course in psychopharmacology.

(4) A minimum of 15 contact hours of instruction in spousal or partner abuse assessment, detection, and intervention strategies, including knowledge of community resources, cultural factors, and same gender abuse dynamics.

(5) A minimum of seven contact hours of training or coursework in child abuse assessment and reporting as specified in Section 28 and any regulations adopted thereunder.

(6) A minimum of 18 contact hours of instruction in California law and professional ethics for professional clinical counselors that includes, but is not limited to, instruction in advertising, scope of practice, scope of competence, treatment of minors, confidentiality, dangerous clients, psychotherapist-client privilege, recordkeeping, client access to records, dual relationships, child abuse, elder and dependent adult abuse, online therapy, insurance reimbursement, civil liability, disciplinary actions and unprofessional conduct, ethics complaints and ethical standards, termination of therapy, standards of care, relevant family law, therapist disclosures to clients, and state and federal laws related to confidentiality of patient health information. When coursework in a master's or doctoral degree program is acquired to satisfy this requirement, it shall be considered as part of the 48 semester unit or 72 quarter unit requirement in subdivision (c).

(7) A minimum of 10 contact hours of instruction in aging and long-term care, which may include, but is not limited to, the biological, social, and psychological aspects of aging. On and after January 1, 2012, this coursework shall include instruction on the assessment and reporting of, as well as treatment related to, elder and dependent adult abuse and neglect.

(8) A minimum of 15 contact hours of instruction in crisis or trauma counseling, including multidisciplinary responses to crises, emergencies, or disasters, and brief, intermediate, and long-term approaches.

(f) This section shall remain in effect only until January 1, 2019, and as of that date is repealed, unless a later enacted statute that is enacted before January 1, 2019, deletes or extends that date.

SEC. 5. Section 4999.33 of the Business and Professions Code is amended to read:

4999.33. (a) This section shall apply to the following:

(1) Applicants for licensure or registration who begin graduate study before August 1, 2012, and do not complete that study on or before December 31, 2018.

(2) Applicants for licensure or registration who begin graduate study before August 1, 2012, and who graduate from a degree program that meets the requirements of this section.

(3) Applicants for licensure or registration who begin graduate study on or after August 1, 2012.

(b) To qualify for licensure or registration, applicants shall possess a master's or doctoral degree that is counseling or psychotherapy in content and that meets the requirements of this section, obtained from an accredited or approved institution, as defined in Section 4999.12. For purposes of this subdivision, a degree is "counseling or psychotherapy in content" if it contains the supervised practicum or field study experience described in paragraph (3) of subdivision (c) and, except as provided in subdivision (f), the coursework in the core content areas listed in subparagraphs (A) to (M), inclusive, of paragraph (1) of subdivision (c).

(c) The degree described in subdivision (b) shall contain not less than 60 graduate semester units or 90 graduate quarter units of instruction, which shall, except as provided in subdivision (f), include all of the following:

(1) The equivalent of at least three semester units or four ~~and one-half~~ quarter units of graduate study in all of the following core content areas:

(A) Counseling and psychotherapeutic theories and techniques, including the counseling process in a multicultural society, an orientation to wellness and prevention, counseling theories to assist in selection of appropriate counseling interventions, models of counseling consistent with current professional research and practice, development of a personal model of counseling, and multidisciplinary responses to crises, emergencies, and disasters.

(B) Human growth and development across the lifespan, including normal and abnormal behavior and an understanding of developmental crises, disability, psychopathology, and situational and environmental factors that affect both normal and abnormal behavior.

(C) Career development theories and techniques, including career development decisionmaking models and interrelationships among and between work, family, and other life roles and factors, including the role of multicultural issues in career development.

(D) Group counseling theories and techniques, including principles of group dynamics, group process components, group developmental stage theories, therapeutic factors of group work, group leadership styles and approaches, pertinent research and literature, group counseling methods, and evaluation of effectiveness.

(E) Assessment, appraisal, and testing of individuals, including basic concepts of standardized and nonstandardized testing and other assessment techniques, norm-referenced and criterion-referenced assessment, statistical concepts, social and cultural factors related to assessment and evaluation of individuals and groups, and ethical strategies for selecting, administering, and interpreting assessment instruments and techniques in counseling.

(F) Multicultural counseling theories and techniques, including counselors' roles in developing cultural self-awareness, identity development, promoting cultural social justice, individual and community strategies for working with and advocating for diverse populations, and counselors' roles in eliminating biases and prejudices, and processes of intentional and unintentional oppression and discrimination.

(G) Principles of the diagnostic process, including differential diagnosis, and the use of current diagnostic tools, such as the current edition of the Diagnostic and Statistical Manual, the impact of co-occurring substance use disorders or medical psychological disorders, established diagnostic criteria for mental or emotional disorders, and the treatment modalities and placement criteria within the continuum of care.

(H) Research and evaluation, including studies that provide an understanding of research methods, statistical analysis, the use of research to inform evidence-based practice, the importance of research in advancing the profession of counseling, and statistical

methods used in conducting research, needs assessment, and program evaluation.

(I) Professional orientation, ethics, and law in counseling, including California law and professional ethics for professional clinical counselors, professional ethical standards and legal considerations, licensing law and process, regulatory laws that delineate the profession's scope of practice, counselor-client privilege, confidentiality, the client dangerous to self or others, treatment of minors with or without parental consent, relationship between practitioner's sense of self and human values, functions and relationships with other human service providers, strategies for collaboration, and advocacy processes needed to address institutional and social barriers that impede access, equity, and success for clients.

(J) Psychopharmacology, including the biological bases of behavior, basic classifications, indications, and contraindications of commonly prescribed psychopharmacological medications so that appropriate referrals can be made for medication evaluations and so that the side effects of those medications can be identified.

(K) Addictions counseling, including substance abuse, co-occurring disorders, and addiction, major approaches to identification, evaluation, treatment, and prevention of substance abuse and addiction, legal and medical aspects of substance abuse, populations at risk, the role of support persons, support systems, and community resources.

(L) Crisis or trauma counseling, including crisis theory; multidisciplinary responses to crises, emergencies, or disasters; cognitive, affective, behavioral, and neurological effects associated with trauma; brief, intermediate, and long-term approaches; and assessment strategies for clients in crisis and principles of intervention for individuals with mental or emotional disorders during times of crisis, emergency, or disaster.

(M) Advanced counseling and psychotherapeutic theories and techniques, including the application of counseling constructs, assessment and treatment planning, clinical interventions, therapeutic relationships, psychopathology, or other clinical topics.

(2) In addition to the course requirements described in paragraph (1), 15 semester units or 22.5 quarter units of advanced coursework to develop knowledge of specific treatment issues or special populations.

(3) Not less than six semester units or nine quarter units of supervised practicum or field study experience that involves direct client contact in a clinical setting that provides a range of professional clinical counseling experience, including the following:

(A) Applied psychotherapeutic techniques.

(B) Assessment.

(C) Diagnosis.

(D) Prognosis.

(E) Treatment.

(F) Issues of development, adjustment, and maladjustment.

(G) Health and wellness promotion.

(H) Professional writing including documentation of services, treatment plans, and progress notes.

(I) How to find and use resources.

(J) Other recognized counseling interventions.

(K) A minimum of 280 hours of face-to-face supervised clinical experience counseling individuals, families, or groups.

(d) The 60 graduate semester units or 90 graduate quarter units of instruction required pursuant to subdivision (c) shall, in addition to meeting the requirements of subdivision (c), include instruction in all of the following:

(1) The understanding of human behavior within the social context of socioeconomic status and other contextual issues affecting social position.

(2) The understanding of human behavior within the social context of a representative variety of the cultures found within California.

(3) Cultural competency and sensitivity, including a familiarity with the racial, cultural, linguistic, and ethnic backgrounds of persons living in California.

(4) An understanding of the effects of socioeconomic status on treatment and available resources.

(5) Multicultural development and cross-cultural interaction, including experiences of race, ethnicity, class, spirituality, sexual orientation, gender, and disability and their incorporation into the psychotherapeutic process.

(6) Case management, systems of care for the severely mentally ill, public and private services for the severely mentally ill, community resources for victims of abuse, disaster and trauma

response, advocacy for the severely mentally ill, and collaborative treatment. The instruction required in this paragraph may be provided either in credit level coursework or through extension programs offered by the degree-granting institution.

(7) Human sexuality, including the study of the physiological, psychological, and social cultural variables associated with sexual behavior, gender identity, and the assessment and treatment of psychosexual dysfunction.

(8) Spousal or partner abuse assessment, detection, intervention strategies, and same gender abuse dynamics.

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

(10) Aging and long-term care, including biological, social, cognitive, and psychological aspects of aging. This coursework shall include instruction on the assessment and reporting of, as well as treatment related to, elder and dependent adult abuse and neglect.

(e) A degree program that qualifies for licensure under this section shall do all of the following:

(1) Integrate the principles of mental health recovery-oriented care and methods of service delivery in recovery-oriented practice environments.

(2) Integrate an understanding of various cultures and the social and psychological implications of socioeconomic position.

(3) Provide the opportunity for students to meet with various consumers and family members of consumers of mental health services to enhance understanding of their experience of mental illness, treatment, and recovery.

(f) (1) (A) An applicant whose degree is deficient in no more than three of the required areas of study listed in subparagraphs (A) to (M), inclusive, of paragraph (1) of subdivision (c) may satisfy those deficiencies by successfully completing post-master's or postdoctoral degree coursework at an accredited or approved institution, as defined in Section 4999.12.

(B) Notwithstanding subparagraph (A), ~~no~~ *an* applicant *whose application for a license is received by the board after August 31, 2020, or an applicant who is not registered as an associate by that date,* shall *not* be deficient in the required areas of study specified in subparagraphs (E) or (G) of paragraph (1) of subdivision (c).

(2) Coursework taken to meet deficiencies in the required areas of study listed in subparagraphs (A) to (M), inclusive, of paragraph (1) of subdivision (c) shall be the equivalent of three semester units or four ~~and one-half~~ quarter units of study.

(3) The board shall make the final determination as to whether a degree meets all requirements, including, but not limited to, course requirements, regardless of accreditation.

SEC. 6. Section 4999.62 of the Business and Professions Code is amended to read:

4999.62. (a) This section applies to persons who apply for licensure or registration on or after January 1, 2016, and who do not hold a license as described in Section 4999.60.

(b) For purposes of Section 4999.61, education is substantially equivalent if all of the following requirements are met:

(1) The degree is obtained from an accredited or approved institution, as defined in Section 4999.12, and consists of, at a minimum, the following:

(A) (i) For an applicant who obtained his or her degree within the timeline prescribed by subdivision (a) of Section 4999.33 the degree shall contain no less than 60 graduate semester units or 90 graduate quarter units of instruction.

(ii) Up to 12 semester units or 18 quarter units of instruction may be remediated, if missing from the degree. The remediation may occur while the applicant is registered as an associate.

(B) For an applicant who obtained his or her degree within the timeline prescribed by subdivision (a) of Section 4999.32 the degree shall contain no less than 48 graduate semester units or 72 graduate quarter units of instruction.

(C) Six semester units or nine quarter units of practicum, including, but not limited to, a minimum of 280 hours of face-to-face supervised clinical experience counseling individuals, families, or groups.

(D) The required areas of study listed in subparagraphs (A) to (M), inclusive, of paragraph (1) of subdivision (c) of Section 4999.33.

(i) (I) An applicant whose degree is deficient in no more than six of the required areas of study listed in subparagraphs (A) to (M), inclusive, of paragraph (1) of subdivision (c) of Section 4999.33 may satisfy those deficiencies by successfully completing graduate level coursework at an accredited or approved institution,

as defined in Section 4999.12. Coursework taken to meet any deficiencies shall be the equivalent of three semester units or four ~~and one-half~~ quarter units of study.

(II) Notwithstanding subclause (I), no applicant shall be deficient in the required areas of study specified in subparagraph (E) or (G) of paragraph (1) of subdivision (c) of Section 4999.33.

(ii) An applicant who completed a course in professional orientation, ethics, and law in counseling as required by subparagraph (I) of paragraph (1) of subdivision (c) of Section 4999.33 that did not contain instruction in California law and ethics shall complete an 18-hour course in California law and professional ethics that includes, but is not limited to, instruction in advertising, scope of practice, scope of competence, treatment of minors, confidentiality, dangerous clients, psychotherapist-client privilege, recordkeeping, client access to records, state and federal laws relating to confidentiality of patient health information, dual relationships, child abuse, elder and dependent adult abuse, online therapy, insurance reimbursement, civil liability, disciplinary actions and unprofessional conduct, ethics complaints and ethical standards, termination of therapy, standards of care, relevant family law, and therapist disclosures to clients. An applicant shall complete this coursework prior to registration as an associate.

(iii) An applicant who has not completed a course in professional orientation, ethics, and law in counseling as required by subparagraph (I) of paragraph (1) of subdivision (c) of Section 4999.33 shall complete this required coursework, including content in California law and ethics. An applicant shall complete this coursework prior to registration as an associate.

(2) The applicant completes any units required by subdivision (c) of Section 4999.33 not already completed in his or her education as follows:

(A) At least 15 semester units or 22.5 quarter units of advanced coursework to develop knowledge of specific treatment issues or special populations. This coursework is in addition to the course requirements described in subparagraph (D) of paragraph (1).

(B) Coursework shall be from an accredited or approved school, college, or university as defined in Section 4999.12.

(3) (A) The applicant completes the following coursework not already completed in his or her education:

(i) A minimum of 10 contact hours of training in human sexuality, as specified in Section 25 and any regulations promulgated thereunder, including the study of the physiological, psychological, and social cultural variables associated with sexual behavior, gender identity, and the assessment and treatment of psychosexual dysfunction.

(ii) A minimum of 15 contact hours of instruction in spousal or partner abuse assessment, detection, intervention strategies, and same-gender abuse dynamics.

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

(iv) A minimum of 10 contact hours of instruction in aging and long-term care, including biological, social, cognitive, and psychological aspects of aging. This coursework shall include instruction on the assessment and reporting of, as well as treatment related to, elder and dependent adult abuse and neglect.

(B) This coursework may be from an accredited or approved school, college, or university as defined in Section 4999.12, or from a continuing education provider that is acceptable to the board as defined in Section 4999.76. Undergraduate coursework shall not satisfy this requirement.

(4) The applicant completes the following coursework not already completed in his or her education from an accredited or approved school, college, or university as defined in Section 4999.12, or from a continuing education provider that is acceptable to the board as defined in Section 4999.76. Undergraduate coursework shall not satisfy this requirement.

(A) At least three semester units, or 45 hours, of instruction regarding the principles of mental health recovery-oriented care and methods of service delivery in recovery-oriented practice environments, including structured meetings with various consumers and family members of consumers of mental health services to enhance understanding of their experiences of mental illness, treatment, and recovery.

(B) At least one semester unit, or 15 hours, of instruction that includes an understanding of various California cultures and the social and psychological implications of socioeconomic position.

(5) An applicant may complete any units and course content requirements required under paragraph (2), (3), or (4) not already

completed in his or her education while registered with the board as an associate.

SEC. 7. Section 4999.63 of the Business and Professions Code is amended to read:

4999.63. (a) This section applies to persons who apply for licensure or registration on or after January 1, 2016, and who hold a license as described in Section 4999.60.

(b) For purposes of Section 4999.60, education is substantially equivalent if all of the following requirements are met:

(1) The degree is obtained from an accredited or approved institution, as defined in Section 4999.12, and consists of the following:

(A) (i) For an applicant who obtained his or her degree within the timeline prescribed by subdivision (a) of Section 4999.33 the degree shall contain no less than 60 graduate semester or 90 graduate quarter units of instruction.

(ii) Up to 12 semester units or 18 quarter units of instruction may be remediated, if missing from the degree. The remediation may occur while the applicant is registered as an associate.

(B) For an applicant who obtained his or her degree within the timeline prescribed by subdivision (a) of Section 4999.32 the degree shall contain no less than 48 graduate semester or 72 graduate quarter units of instruction.

(C) Six semester units or nine quarter units of practicum, including, but not limited to, a minimum of 280 hours of face-to-face supervised clinical experience counseling individuals, families, or groups.

(i) An applicant who has been licensed for at least two years in clinical practice, as verified by the board, is exempt from this requirement.

(ii) An out-of-state applicant who has been licensed for less than two years in clinical practice, as verified by the board, who does not meet the practicum requirement, shall remediate the requirement by demonstrating completion of a total of 280 hours of face-to-face supervised clinical experience, as specified in subparagraph (K) of paragraph (3) of subdivision (c) of Section 4999.33. Any postdegree hours gained to meet this requirement are in addition to the 3,000 hours of experience required by this chapter, and shall be gained while the applicant is registered with the board as an associate.

(D) The required areas of study specified in subparagraphs (A) to (M), inclusive, of paragraph (1) of subdivision (c) of Section 4999.33.

(i) (I) An applicant whose degree is deficient in no more than six of the required areas of study specified in subparagraphs (A) to (M), inclusive, of paragraph (1) of subdivision (c) of Section 4999.33 may satisfy those deficiencies by successfully completing graduate level coursework at an accredited or approved institution, as defined in Section 4999.12. Coursework taken to meet any deficiencies shall be the equivalent of three semester units or four ~~and one-half~~ quarter units of study.

(II) Notwithstanding subclause (I), no applicant shall be deficient in the required areas of study specified in subparagraphs (E) or (G) of paragraph (1) of subdivision (c) of Section 4999.33.

(ii) An applicant who completed a course in professional orientation, ethics, and law in counseling as required by subparagraph (I) of paragraph (1) of subdivision (c) of Section 4999.33 that did not contain instruction in California law and ethics shall complete an 18-hour course in California law and professional ethics that includes, but is not limited to, instruction in advertising, scope of practice, scope of competence, treatment of minors, confidentiality, dangerous clients, psychotherapist-client privilege, recordkeeping, client access to records, state and federal laws relating to confidentiality of patient health information, dual relationships, child abuse, elder and dependent adult abuse, online therapy, insurance reimbursement, civil liability, disciplinary actions and unprofessional conduct, ethics complaints and ethical standards, termination of therapy, standards of care, relevant family law, and therapist disclosures to clients. An applicant shall complete this coursework prior to registration as an associate.

(iii) An applicant who has not completed a course in professional orientation, ethics, and law in counseling as required by subparagraph (I) of paragraph (1) of subdivision (c) of Section 4999.33 shall complete this required coursework, including content in California law and ethics. An applicant shall complete this coursework prior to registration as an associate.

(2) The applicant completes any units required under subdivision (c) of Section 4999.33 not already completed in his or her education as follows:

(A) At least 15 semester units or 22.5 quarter units of advanced coursework to develop knowledge of specific treatment issues or special populations. This coursework is in addition to the course requirements described in subparagraph (D) of paragraph (1).

(B) Coursework shall be from an accredited or approved school, college, or university as defined in Section 4999.12.

(3) The applicant completes the following coursework not already completed in his or her education:

(A) A minimum of 10 contact hours of training in human sexuality, as specified in Section 25 and any regulations promulgated thereunder, including the study of the physiological, psychological, and social cultural variables associated with sexual behavior, gender identity, and the assessment and treatment of psychosexual dysfunction.

(B) A minimum of 15 contact hours of instruction in spousal or partner abuse assessment, detection, intervention strategies, and same-gender abuse dynamics.

(C) A minimum of seven contact hours of training or coursework in child abuse assessment and reporting as specified in Section 28 and any regulations promulgated under that section.

(D) A minimum of 10 contact hours of instruction in aging and long-term care, including biological, social, cognitive, and psychological aspects of aging. This coursework shall include instruction on the assessment and reporting of, as well as treatment related to, elder and dependent adult abuse and neglect.

(E) This coursework may be from an accredited or approved school, college, or university as defined in Section 4999.12, or from a continuing education provider that is acceptable to the board as defined in Section 4999.76. Undergraduate coursework shall not satisfy this requirement.

(4) The applicant completes the following coursework not already completed in his or her education from an accredited or approved school, college, or university as defined in Section 4999.12, or from a continuing education provider that is acceptable to the board as defined in Section 4999.76. Undergraduate coursework shall not satisfy this requirement.

(A) At least three semester units or 45 hours of instruction regarding the principles of mental health recovery-oriented care and methods of service delivery in recovery-oriented practice environments, including structured meetings with various

consumers and family members of consumers of mental health services to enhance understanding of their experience of mental illness, treatment, and recovery.

(B) At least one semester unit or 15 hours of instruction that includes an understanding of various California cultures and the social and psychological implications of socioeconomic position.

(5) An applicant may complete any units and course content requirements required by subparagraph (D) of paragraph (1) or paragraphs (2), (3), and (4) not already completed in his or her education while registered with the board as an associate, unless otherwise specified.

SEC. 8. Section 56.105 of the Civil Code is amended to read:

56.105. Whenever, prior to the service of a complaint upon a defendant in any action arising out of the professional negligence of a person holding a valid physician's and surgeon's certificate issued pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, ~~or~~ a person holding a valid license as a marriage and family therapist issued pursuant to Chapter 13 (commencing with Section 4980) of Division 2 of the Business and Professions Code, *a person holding a valid license as a clinical social worker issued pursuant to Chapter 14 (commencing with Section 4991) of Division 2 of the Business and Professions Code, or a person holding a valid license as a professional clinical counselor issued pursuant to Chapter 16 (commencing with Section 4999.10) of Division 2 of the Business and Professions Code,* a demand for settlement or offer to compromise is made on a patient's behalf, the demand or offer shall be accompanied by an authorization to disclose medical information to persons or organizations insuring, responsible for, or defending professional liability that the certificate holder may incur. The authorization shall be in accordance with Section 56.11 and shall authorize disclosure of that information that is necessary to investigate issues of liability and extent of potential damages in evaluating the merits of the demand for settlement or offer to compromise.

Notice of any request for medical information made pursuant to an authorization as provided by this section shall be given to the patient or the patient's legal representative. The notice shall describe the inclusive subject matter and dates of the materials requested and shall also authorize the patient or the patient's legal

representative to receive, upon request, copies of the information at his or her expense.

Nothing in this section shall be construed to waive or limit any applicable privileges set forth in the Evidence Code except for the disclosure of medical information subject to the patient's authorization. Nothing in this section shall be construed as authorizing a representative of any person from whom settlement has been demanded to communicate in violation of the physician-patient privilege with a treating physician, or to communicate in violation of the psychotherapist-patient privilege with a treating licensed marriage and family therapist, *licensed clinical social worker, or licensed professional clinical counselor,* except for the medical information request.

The requirements of this section are independent of the requirements of Section 364 of the Code of Civil Procedure.

SEC. 9. Section 35160.5 of the Education Code is amended to read:

35160.5. (a) The governing board of a school district that maintains one or more schools containing any of grades 7 to 12, inclusive, as a condition for the receipt of inflation adjustments pursuant to Section 42238.02, as implemented by Section 42238.03, shall establish a school district policy regarding participation in extracurricular and cocurricular activities by pupils in grades 7 to 12, inclusive. The criteria, which shall be applied to extracurricular and cocurricular activities, shall ensure that pupil participation is conditioned upon satisfactory educational progress in the previous grading period.

(1) For purposes of this subdivision, "extracurricular activity" means a program that has all of the following characteristics:

(A) The program is supervised or financed by the school district.

(B) Pupils participating in the program represent the school district.

(C) Pupils exercise some degree of freedom in either the selection, planning, or control of the program.

(D) The program includes both preparation for performance and performance before an audience or spectators.

(2) For purposes of this subdivision, an "extracurricular activity" is not part of the regular school curriculum, is not graded, does not offer credit, and does not take place during classroom time.

(3) For purposes of this subdivision, a "cocurricular activity" is defined as a program that may be associated with the curriculum in a regular classroom.

(4) ~~Any~~ *A* teacher graded or required program or activity for a course that satisfies the entrance requirements for admission to the California State University or the University of California is not an extracurricular or cocurricular activity as defined by this section.

(5) For purposes of this subdivision, "satisfactory educational progress" shall include, but not necessarily be limited to, both of the following:

(A) Maintenance of minimum passing grades, which is defined as at least a 2.0 grade point average in all enrolled courses on a 4.0 scale.

(B) Maintenance of minimum progress toward meeting the high school graduation requirements prescribed by the governing board.

(6) For purposes of this subdivision, "previous grading period" does not include a grading period in which the pupil was not in attendance for all, or a majority of, the grading period due to absences excused by the school for reasons such as serious illness or injury, approved travel, or work. In that event, "previous grading period" is deemed to mean the grading period immediately prior to the grading period or periods excluded pursuant to this paragraph.

(7) A program that has, as its primary goal, the improvement of academic or educational achievements of pupils is not an extracurricular or cocurricular activity as defined by this section.

(8) The governing board of each school district may adopt, as part of its policy established pursuant to this subdivision, provisions that would allow a pupil who does not achieve satisfactory educational progress, as defined in paragraph (5), in the previous grading period to remain eligible to participate in extracurricular and cocurricular activities during a probationary period. The probationary period shall not exceed one semester in length, but may be for a shorter period of time, as determined by the governing board of the school district. A pupil who does not achieve satisfactory educational progress, as defined in paragraph (5), during the probationary period shall not be allowed to participate in extracurricular and cocurricular activities in the subsequent grading period.

(9) ~~Nothing in this subdivision shall~~ *This subdivision does not* preclude the governing board of a school district from imposing a more stringent academic standard than that imposed by this subdivision. If the governing board of a school district imposes a more stringent academic standard, the governing board shall establish the criteria for participation in extracurricular and cocurricular activities at a meeting open to the public pursuant to Section 35145.

(10) The governing board of each school district annually shall review the school district policies adopted pursuant to the requirements of this section.

(b) (1) On or before July 1, 1994, the governing board of each school district, as a condition for the receipt of school apportionments from the state school fund, shall adopt rules and regulations establishing a policy of open enrollment within the district for residents of the district. This requirement does not apply to a school district that has only one school or a school district with schools that do not serve any of the same grade levels.

(2) The policy shall include all of the following elements:

(A) It shall provide that the parent or guardian of each schoolage child who is a resident in the district may select the schools the child shall attend, irrespective of the particular locations of his or her residence within the district, except that school districts shall retain the authority to maintain appropriate racial and ethnic balances among their respective schools at the school districts' discretion or as specified in applicable court-ordered or voluntary desegregation plans.

(B) It shall include a selection policy for a school that receives requests for admission in excess of the capacity of the school that ensures that selection of pupils to enroll in the school is made through a random, unbiased process that prohibits an evaluation of whether a pupil should be enrolled based upon his or her academic or athletic performance. The governing board of a school district shall calculate the capacity of the schools in the district for purposes of this subdivision in a nonarbitrary manner using pupil enrollment and available space. However, school districts may employ existing entrance criteria for specialized schools or programs if the criteria are uniformly applied to all applicants. This subdivision shall not be construed to prohibit school districts from using academic performance to determine eligibility for, or

placement in, programs for gifted and talented pupils established pursuant to former Chapter 8 (commencing with Section 52200) of Part 28 of Division 4, as that chapter read on January 1, 2014.

(C) It shall provide that ~~no~~ *a* pupil who currently resides in the attendance area of a school shall *not* be displaced by pupils transferring from outside the attendance area.

(3) Notwithstanding the requirement of subparagraph (B) of paragraph (2) that the policy include a selection policy for a school that receives requests for admission in excess of the capacity of the school that ensures that the selection is made through a random, unbiased process, the policy may include either of the following elements:

(A) (i) It may provide that special circumstances exist that might be harmful or dangerous to a particular pupil in the current attendance area of the pupil, including, but not necessarily limited to, threats of bodily harm or threats to the emotional stability of the pupil, that serve as a basis for granting a priority of attendance outside the current attendance area of the pupil. A finding of harmful or dangerous special circumstances shall be based upon either of the following:

(I) A written statement from a representative of the appropriate state or local agency, including, but not necessarily limited to, a law enforcement official or a social worker, or properly licensed or registered professionals, including, but not necessarily limited to, psychiatrists, psychologists, ~~or~~ marriage and family ~~therapists.~~ *therapists, clinical social workers, or professional clinical counselors.*

(II) A court order, including a temporary restraining order and injunction, issued by a judge.

(ii) A finding of harmful or dangerous special circumstances pursuant to this subparagraph may be used by a school district to approve transfers within the district to schools that have been deemed by the school district to be at capacity and otherwise closed to transfers that are not based on harmful or dangerous special circumstances.

(B) It may provide that schools receiving requests for admission shall give priority for attendance to siblings of pupils already in attendance in that school and to pupils whose parent or legal guardian is assigned to that school as his or her primary place of employment.

(4) To the extent required and financed by federal law and at the request of the pupil's parent or guardian, each school district shall provide transportation assistance to the pupil.

SEC. 10. Section 3110.5 of the Family Code is amended to read:

3110.5. (a) ~~No~~ *A* person may be a court-connected or private child custody evaluator under this chapter ~~unless~~ *only if* the person has completed the domestic violence and child abuse training program described in Section 1816 and has complied with Rules 5.220 and 5.230 of the California Rules of Court.

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

(A) The rule shall require a child custody evaluator to declare under penalty of perjury that he or she meets all of the education, experience, and training requirements specified in the rule and, if applicable, possesses a license in good standing. The Judicial Council shall establish forms to implement this section. The rule shall permit court-connected evaluators to conduct evaluations if they meet all of the qualifications established by the Judicial Council. The education, experience, and training requirements to be specified for court-connected evaluators shall include, but not be limited to, knowledge of the psychological and developmental needs of children and parent-child relationships.

(B) The rule shall require all evaluators to utilize comparable interview, assessment, and testing procedures for all parties that are consistent with generally accepted clinical, forensic, scientific, diagnostic, or medical standards. The rule shall also require evaluators to inform each adult party of the purpose, nature, and method of the evaluation.

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

(2) On or before January 1, 2004, the Judicial Council shall include in the statewide rule of court created pursuant to this

section a requirement that all court-connected and private child custody evaluators receive training in the nature of child sexual abuse. The Judicial Council shall develop standards for this training that shall include, but not be limited to, the following:

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

(B) The effects of sexual abuse on children.

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

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

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

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

(c) In addition to the education, experience, and training requirements established by the Judicial Council pursuant to subdivision (b), on or after January 1, 2005, ~~no~~ *a* person may be a child custody evaluator under this chapter, Section 730 of the Evidence Code, or Chapter 15 (commencing with Section 2032.010) of Title 4 of Part 4 of the Code of Civil Procedure ~~unless~~ *only if* the person meets one of the following criteria:

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

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

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

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

(5) He or she is licensed as a professional clinical counselor under Chapter 16 (commencing with Section 4999.10) of Division 2 of the Business and Professions Code.

~~(5)~~

(6) He or she is a court-connected evaluator who has been certified by the court as meeting all of the qualifications for

court-connected evaluators as specified by the Judicial Council pursuant to subdivision (b).

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

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

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

SEC. 11. Section 7663 of the Family Code is amended to read:

7663. (a) In an effort to identify all alleged fathers and presumed parents, the court shall cause inquiry to be made of the mother and any other appropriate person by one of the following:

(1) The State Department of Social Services.

(2) A licensed county adoption agency.

(3) The licensed adoption agency to which the child is to be relinquished.

(4) In the case of a stepparent adoption, the licensed clinical social ~~worker or~~ *worker,* licensed marriage and family ~~therapist~~ *therapist, or licensed professional clinical counselor* who is performing the investigation pursuant to Section 9001, if applicable. In the case of a stepparent adoption in which ~~no~~ *a* licensed clinical social ~~worker or~~ *worker,* licensed marriage and family ~~therapist is~~ *therapist, or licensed professional clinical counselor is not* performing the investigation pursuant to Section 9001, the board of supervisors may assign those inquiries to a licensed county adoption agency, the county department designated by the board of supervisors to administer the public social services program, or the county probation department.

(b) The inquiry shall include all of the following:

(1) Whether the mother was married at the time of conception of the child or at any time thereafter.

(2) Whether the mother was cohabiting with a man at the time of conception or birth of the child.

(3) Whether the mother has received support payments or promises of support with respect to the child or in connection with her pregnancy.

(4) Whether any person has formally or informally acknowledged or declared his or her possible parentage of the child.

(5) The names and whereabouts, if known, of every person presumed or man alleged to be the parent of the child, and the efforts made to give notice of the proposed adoption to each person identified.

(c) The agency that completes the inquiry shall file a written report of the findings with the court.

SEC. 12. Section 7827 of the Family Code is amended to read:

7827. (a) "Mentally disabled" as used in this section means that a parent or parents suffer a mental incapacity or disorder that renders the parent or parents unable to care for and control the child adequately.

(b) A proceeding under this part may be brought ~~where~~ *if* the child is one whose parent or parents are mentally disabled and are likely to remain so in the foreseeable future.

(c) Except as provided in subdivision (d), the evidence of any two experts, each of whom shall be a physician and surgeon, certified either by the American Board of Psychiatry and Neurology or under Section 6750 of the Welfare and Institutions Code, a licensed psychologist who has a doctoral degree in psychology and at least five years of postgraduate experience in the diagnosis and treatment of emotional and mental disorders, is required to support a finding under this section. In addition to this requirement, the court shall have the discretion to call a licensed marriage and family therapist, *a licensed professional clinical counselor,* or a licensed clinical social worker, either of whom shall have at least five years of relevant postlicensure experience, in circumstances ~~where~~ *in which* the court determines that this testimony is in the best interest of the child and is warranted by the circumstances of the particular family or parenting issues involved. However, the court may not call a licensed marriage and family ~~therapist~~

therapist, licensed professional clinical counselor, or licensed clinical social worker pursuant to this section who is the adoption service provider, as defined in Section 8502, of the child who is the subject of the petition to terminate parental rights.

(d) If the parent or parents reside in another state or in a foreign country, the evidence required by this section may be supplied by the affidavits of two experts, each of whom shall be either of the following:

(1) A physician and surgeon who is a resident of that state or foreign country, and who has been certified by a medical organization or society of that state or foreign country to practice psychiatric or neurological medicine.

(2) A licensed psychologist who has a doctoral degree in psychology and at least five years of postgraduate experience in the diagnosis and treatment of emotional and mental disorders and who is licensed in that state or authorized to practice in that country.

(e) If the rights of a parent are sought to be terminated pursuant to this section, and the parent ~~has no~~ *does not have an* attorney, the court shall appoint an attorney for the parent pursuant to Article 4 (commencing with Section 7860) of Chapter 3, whether or not a request for the appointment is made by the parent.

SEC. 13. Section 7850 of the Family Code is amended to read:

7850. Upon the filing of a petition under Section 7841, the clerk of the court shall, in accordance with the direction of the court, immediately notify the juvenile probation officer, qualified court investigator, licensed clinical social worker, licensed marriage and family therapist, *licensed professional clinical counselor,* or the county department designated by the board of supervisors to administer the public social services program, who shall immediately investigate the circumstances of the child and the circumstances which are alleged to bring the child within any ~~of the provisions~~ *provision* of Chapter 2 (commencing with Section 7820).

SEC. 14. Section 7851 of the Family Code is amended to read:

7851. (a) The juvenile probation officer, qualified court investigator, licensed clinical social worker, licensed marriage and family therapist, *licensed professional clinical counselor,* or the county department shall render to the court a written report of the

investigation with a recommendation of the proper disposition to be made in the proceeding in the best interest of the child.

(b) The report shall include all of the following:

(1) A statement that the person making the report explained to the child the nature of the proceeding to end parental custody and control.

(2) A statement of the child's feelings and thoughts concerning the pending proceeding.

(3) A statement of the child's attitude towards the child's parent or parents and particularly whether or not the child would prefer living with his or her parent or parents.

(4) A statement that the child was informed of the child's right to attend the hearing on the petition and the child's feelings concerning attending the hearing.

(c) If the age, or the physical, emotional, or other condition of the child precludes the child's meaningful response to the explanations, inquiries, and information required by subdivision (b), a description of the condition shall satisfy the requirement of that subdivision.

(d) The court shall receive the report in evidence and shall read and consider its contents in rendering the court's judgment.

SEC. 15. Section 8502 of the Family Code is amended to read:

8502. (a) "Adoption service provider" means any of the following:

(1) A licensed private adoption agency.

(2) An individual who has presented satisfactory evidence to the department that he or she is a licensed clinical social worker who also has a minimum of five years of experience providing professional social work services while employed by a licensed California adoption agency or the department.

(3) In a state other than California, or a country other than the United States, an adoption agency licensed or otherwise approved under the laws of that state or country, or an individual who is licensed or otherwise certified as a clinical social worker under the laws of that state or country.

(4) An individual who has presented satisfactory evidence to the department that he or she is a licensed marriage and family therapist who has a minimum of five years of experience providing professional adoption casework services while employed by a licensed California adoption agency or the department. The

department shall review the qualifications of each individual to determine if he or she has performed professional adoption casework services for five years as required by this section while employed by a licensed California adoption agency or the department.

(5) An individual who has presented satisfactory evidence to the department that he or she is a licensed professional clinical counselor who has a minimum of five years' experience providing professional adoption casework services while employed by a licensed California adoption agency or the department. The department shall review the credentials of each individual to determine if he or she has performed professional adoption casework services as required by this paragraph.

(b) If, in the case of a birth parent located in California, at least three adoption service providers are not reasonably available, or, in the case of a birth parent located outside of California or outside of the United States who has contacted at least three potential adoption service providers and been unsuccessful in obtaining the services of an adoption service provider who is reasonably available and willing to provide services, independent legal counsel for the birth parent may serve as an adoption service provider pursuant to subdivision (e) of Section 8801.5. "Reasonably available" means that an adoption service provider is all of the following:

(1) Available within five days for an advisement of rights pursuant to Section 8801.5, or within 24 hours for the signing of the placement agreement pursuant to paragraph (3) of subdivision (b) of Section 8801.3.

(2) Within 100 miles of the birth mother.

(3) Available for a cost not exceeding five hundred dollars ($500) to make an advisement of rights and to witness the signing of the placement agreement.

(c) ~~Where~~ *If* an attorney acts as an adoption service provider, the fee to make an advisement of rights and to witness the signing of the placement agreement shall not exceed five hundred dollars ($500).

SEC. 16. Section 9001 of the Family Code is amended to read:

9001. (a) Except as provided in Section 9000.5, before granting or denying a stepparent adoption request, the court shall review and consider a written investigative report. The report in a stepparent adoption case shall not require a home study unless so

ordered by the court upon request of an investigator or interested person, or on the court's own motion. "Home study" as used in this section means a physical investigation of the premises where the child is residing.

(b) At the time of filing the adoption request, the petitioner shall inform the court in writing if the petitioner is electing to have the investigation and written report completed by a licensed clinical social worker, a licensed marriage and family therapist, *a licensed professional clinical counselor,* or a private licensed adoption agency, in which cases the petitioner shall not be required to pay ~~any~~ *an* investigation fee pursuant to Section 9002 at the time of filing, but shall pay these fees directly to the investigator. Absent that notification, the court may, at the time of filing, collect an investigation fee pursuant to Section 9002, and may assign one of the following to complete the investigation: a probation officer, a qualified court investigator, or the county welfare department, if so authorized by the board of supervisors of the county where the action is pending.

(c) If a private licensed adoption agency conducts the investigation, it shall assign the investigation to a licensed clinical social worker or licensed marriage and family therapist associated with the agency. ~~Any~~ *A* grievance regarding the investigation shall be directed to the licensing authority of the clinical social ~~worker~~ *worker, licensed professional clinical counselor,* or marriage and family therapist, as applicable.

(d) ~~Nothing in this section shall be construed to~~ *This section does not* require the State Department of Social Services to issue regulations for stepparent adoptions.

SEC. 17. Section 3209.8 of the Labor Code is amended to read:

3209.8. Treatment reasonably required to cure or relieve from the effects of an injury shall include the services of marriage and family ~~therapists~~ *therapists, professional clinical counselors,* and clinical social workers licensed by California state law and within the scope of their practice as defined by California state law if the injured person is referred to the marriage and family ~~therapist~~ *therapist, the professional clinical counselor,* or the clinical social worker by a licensed physician and surgeon, with the approval of the employer, for treatment of a condition arising out of the injury. ~~Nothing in this section shall be construed to~~ *This section does not* authorize marriage and family ~~therapists~~ *therapists, professional*

clinical counselors, or clinical social workers to determine disability for the purposes of Article 3 (commencing with Section 4650) of Chapter 2 of Part 2. The requirement of this section that the employer approve the referral by a licensed physician or surgeon shall not be construed to preclude reimbursement for self-procured treatment, found by the appeals board to be otherwise compensable pursuant to this division, ~~where~~ *if* the employer has refused to authorize any treatment for the condition arising from the injury treated by the marriage and family ~~therapist~~ *therapist, professional clinical counselor,* or clinical social worker.

SEC. 18. Section 18951 of the Welfare and Institutions Code is amended to read:

18951. As used in this chapter:

(a) "Child" means an individual under 18 years of age.

(b) "Child services" means services for or on behalf of children, and includes the following:

(1) Protective services.

(2) Caretaker services.

(3) Day care services, including dropoff care.

(4) Homemaker services or family aides.

(5) Counseling services.

(c) "Adult services" means services for or on behalf of a parent of a child, which shall include, but not be limited to, the following:

(1) Access to voluntary placement, long or short term.

(2) Counseling services before and after a crisis.

(3) Homemaker services or family aides.

(d) "Multidisciplinary personnel" means ~~any~~ *a* team of three or more persons who are trained in the prevention, identification, management, or treatment of child abuse or neglect cases and who are qualified to provide a broad range of services related to child abuse or neglect. The team may include, but need not be limited to, any of the following:

(1) Psychiatrists, psychologists, marriage and family therapists, *clinical social workers, professional clinical counselors,* or other trained counseling personnel.

(2) Police officers or other law enforcement agents.

(3) Medical personnel with sufficient training to provide health services.

(4) Social workers with experience or training in child abuse prevention, identification, management, or treatment.

(5) A public or private school teacher, administrative officer, supervisor of child welfare and attendance, or certificated pupil personnel employee.

(6) A CalWORKs case manager whose primary responsibility is to provide cross program case planning and coordination of CalWORKs and child welfare services for those mutual cases or families that may be eligible for CalWORKs services and that, with the informed written consent of the family, receive cross program case planning and coordination.

(e) "Child abuse" as used in this chapter means a situation in which a child suffers from any one or more of the following:

(1) Serious physical injury inflicted upon the child by other than accidental means.

(2) Harm by reason of intentional neglect or malnutrition or sexual abuse.

(3) Going without necessary and basic physical care.

(4) Willful mental injury, negligent treatment, or maltreatment of a child under the age of 18 years by a person who is responsible for the child's welfare under circumstances that indicate that the child's health or welfare is harmed or threatened thereby, as determined in accordance with regulations prescribed by the Director of Social Services.

(5) Any condition that results in the violation of the rights or physical, mental, or moral welfare of a child or jeopardizes the child's present or future health, opportunity for normal development, or capacity for independence.

(f) "Parent" means ~~any~~ *a* person who exercises care, custody, and control of the child as established by law.

SEC. 19. Section 18961.7 of the Welfare and Institutions Code is amended to read:

18961.7. (a) Notwithstanding any other ~~provision of~~ law, a county may establish a child abuse multidisciplinary personnel team within that county to allow provider agencies to share confidential information in order for provider agencies to investigate reports of suspected child abuse or neglect made pursuant to Section 11160, 11166, or 11166.05 of the Penal Code, or for the purpose of child welfare agencies making a detention determination.

(b) For the purposes of this section, the following terms shall have the following meanings:

(1) "Child abuse multidisciplinary personnel team" means ~~any~~ *a* team of two or more persons who are trained in the prevention, identification, or treatment of child abuse and neglect cases and who are qualified to provide a broad range of services related to child abuse. The team may include, but shall not be limited to:

(A) Psychiatrists, psychologists, marriage and family therapists, *clinical social workers, professional clinical counselors,* or other trained counseling personnel.

(B) Police officers or other law enforcement agents.

(C) Medical personnel with sufficient training to provide health services.

(D) Social services workers with experience or training in child abuse prevention.

(E) ~~Any~~ *A* public or private school teacher, administrative officer, supervisor of child welfare attendance, or certified pupil personnel employee.

(2) "Provider agency" means ~~any~~ *a* governmental or other agency that has as one of its purposes the prevention, identification, management, or treatment of child abuse or neglect. The provider agencies serving children and their families that may share information under this section shall include, but not be limited to, the following entities or service agencies:

(A) Social services.

(B) Children's services.

(C) Health services.

(D) Mental health services.

(E) Probation.

(F) Law enforcement.

(G) Schools.

(c) (1) Notwithstanding Section 827 of the Welfare and Institutions Code or any other ~~provision of~~ law, during a 30-day period, or longer if documented good cause exists, following a report of suspected child abuse or neglect, members of a child abuse multidisciplinary personnel team engaged in the prevention, identification, and treatment of child abuse may disclose to and exchange with one another information and writings that relate to any incident of child abuse that may also be designated as confidential under state law if the member of the team having that information or writing reasonably believes it is generally relevant to the prevention, identification, or treatment of child abuse. ~~Any~~

A discussion relative to the disclosure or exchange of the information or writings during a team meeting is confidential and, notwithstanding any other ~~provision of~~ law, testimony concerning that discussion is not admissible in any criminal, civil, or juvenile court proceeding.

(2) Disclosure and exchange of information pursuant to this section may occur telephonically and electronically if there is adequate verification of the identity of the child abuse multidisciplinary personnel who are involved in that disclosure or exchange of information.

(3) Disclosure and exchange of information pursuant to this section shall not be made to anyone other than members of the child abuse multidisciplinary personnel team, and those qualified to receive information as set forth in subdivision (d).

(d) The child abuse multidisciplinary personnel team may designate persons qualified pursuant to paragraph (1) of subdivision (b) to be a member of the team for a particular case. A person designated as a team member pursuant to this subdivision may receive and disclose relevant information and records, subject to the confidentiality provisions of subdivision (f).

(e) The sharing of information permitted under subdivision (c) shall be governed by protocols developed in each county describing how and what information may be shared by the child abuse multidisciplinary team to ensure that confidential information gathered by the team is not disclosed in violation of state or federal law. A copy of the protocols shall be distributed to each participating agency and to persons in those agencies who participate in the child abuse multidisciplinary team.

(f) Every member of the child abuse multidisciplinary personnel team who receives information or records regarding children and families in his or her capacity as a member of the team shall be under the same privacy and confidentiality obligations and subject to the same confidentiality penalties as the person disclosing or providing the information or records. The information or records obtained shall be maintained in a manner that ensures the maximum protection of privacy and confidentiality rights.

(g) This section shall not be construed to restrict guarantees of confidentiality provided under state or federal law.

(h) Information and records communicated or provided to the team members by all providers and agencies, as well as information

and records created in the course of a child abuse or neglect investigation, shall be deemed private and confidential and shall be protected from discovery and disclosure by all applicable statutory and common law protections. Existing civil and criminal penalties shall apply to the inappropriate disclosure of information held by the team members.

SEC. 20. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

~~SECTION 1. Section 201 of the Business and Professions Code is amended to read:~~

~~201. (a) (1) A charge for the estimated administrative expenses of the department, not to exceed the available balance in any appropriation for any one fiscal year, may be levied in advance on a pro rata share basis against any of the boards, bureaus, commissions, divisions, and other agencies, at the discretion of the director and with the approval of the Department of Finance.~~

~~(2) The department shall submit a report of the accounting of the pro rata calculation of administrative expenses to the appropriate policy committees of the Legislature on or before July 1, 2015, and on or before July 1 of each subsequent year.~~

~~(b) The department shall conduct a one-time study of its current system for prorating administrative expenses to determine if that system is the most productive, efficient, and cost-effective manner for the department and the agencies comprising the department. The study shall include consideration of whether some of the administrative services offered by the department should be outsourced or charged on an as-needed basis and whether the agencies should be permitted to elect not to receive and be charged for certain administrative services. The department shall include the findings in its report pursuant to paragraph (2) of subdivision (a) that it is required to submit on or before July 1, 2015.~~

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98

Attachment A
In-State Applicant Denials in 2017 for Assessment and/or Diagnosis Core Content Deficiency

School	Degree Qualifying Code Section (BPC) [1]	Degree Title	Missing Content Area	Number of Applicants Denied	Year of Appplicants' Graduation
Azusa Pacific	4999.32	Education Counseling	Diagnosis	3	2009, 2012, 2014
Laverne	4999.32	Education Counseling	Diagnosis	2	2009, 2012
Redlands	4999.32	School Education	Diagnosis	1	2011
Point Loma Nazarene	4999.32	Education Guidance	Diagnosis	1	n/a
La Sierra	4999.32	School Counseling	Diagnosis	1	2008
Pacific Graduate	4999.32	Psych. Counseling	Diagnosis	1	2005
National University	4999.32	Education Counseling	Diagnosis	2	2005, 2008
CSU Northridge	4999.32	School Counseling	Diagnosis	2	1996, 2003
CA Institute of Integral Studies	4999.32	Psychology	Diagnosis	1	2007
Loyola	4999.32	School Counseling	Assessment	1	2012
CSU Fresno	4999.32	Rehabilitation Counseling	Diagnosis	2	2011, 2013
CSU San Diego	4999.32	Rehabilitation Counseling	Diagnosis	2	2010, 2013
Pepperdine	4999.33	Clinical Psychology	Assessment	1	2017
CSU Los Angeles	4999.33	Counseling	Diagnosis	1	2017
Total Applicants Denied				**21**	

[1] Degrees qualifying under Business and Professions Code Section 4999.32 must have begun before August 1, 2012 and completed on or before December 31, 2018. These degrees have 9 required core content areas.
Degrees qualifying under Business and Professions Code Section 4999.33 are degrees begun after August 1, 2012, or are degrees that were begun earlier than this date and not completed by December 31, 2018. These degrees have 13 required core content areas.

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Board of Behavioral Sciences

CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES BILL ANALYSIS

BILL NUMBER: AB 2409 **VERSION:** AMENDED MARCH 23, 2018

AUTHOR: KILEY **SPONSOR:** AUTHOR

RECOMMENDED POSITION: NONE

SUBJECT: PROFESSIONS AND VOCATIONS: OCCUPATIONAL REGULATIONS

Summary:

This bill establishes that a person has a right to engage in a lawful profession without being subject to occupational regulation that imposes a substantial burden on that right. The bill also specifies criteria a licensing board must meet to disqualify a person from obtaining a license based on a criminal record.

Existing Law:

1) Allows a board under the Department of Consumer Affairs (DCA) to deny a license on grounds the applicant has one of the following (Business and Professions Code (BPC) §480(a)):

    a. A criminal conviction. A conviction means a plea or verdict of guilty or a conviction following a plea of nolo contendere.

    b. Committed a dishonest, fraudulent, or deceitful act with intent to substantially benefit his/herself, or with the intent to substantially injure someone else.

    c. Committed an act that, if committed by a licensee, would be grounds to suspend or revoke the license.

2) Only allows a board to deny a license if the crime or act is substantially related to the qualifications, functions, or duties of the profession. (BPC §480(a))

3) Prohibits a board from denying an applicant a license solely because he or she was convicted of a felony, if the applicant has obtained a certificate of rehabilitation. (BPC §480(b))

4) Prohibits a board from denying an applicant a license solely because he or she was convicted of a misdemeanor, if the applicant has met all of the applicable criteria of rehabilitation requirements developed by the Board. (BPC §480(b))

5) Prohibits the denial of a license solely based on a conviction that has been dismissed pursuant to Section 1203.4, 1203.4a, or 1203.41 of the Penal Code. The applicant must provide proof of the dismissal. (BPC §480(c))

6) Permits a board to deny a license because the applicant knowingly made a false statement of a fact that is required to be revealed in the license application. (BPC §480(d))

7) Requires the Board to develop criteria to evaluate a person's rehabilitation when considering the denial, suspension, or revocation of a license. (BPC §482)

8) Requires the Board of Behavioral Sciences to consider the following when evaluating the rehabilitation of an applicant and his or her present eligibility for a license or registration (16 CCR §1813):

    a. The nature and severity of the act or crimes;

    b. Evidence of committing any subsequent acts;

    c. The time elapsed since the acts;

    d. The applicant's compliance with his or her terms of probation, parole, restitution, or other sanctions; and

    e. Any evidence of rehabilitation by the applicant.

9) When denying an application, requires a board to file a statement of issues and to notify the applicant of the denial, giving the reason for the denial and that the applicant has the right to a hearing if a written request is made within 60 days. (BPC §485)

10) When denying an application, requires a board to inform the applicant of the earliest date that he or she may reapply, that evidence of rehabilitation will be considered upon reapplication, and to provide a copy of the board's criteria for rehabilitation. (BPC §486)

11) If the denied applicant requests a hearing, requires the board to conduct the hearing within 90 days. (BPC §487)

12) Requires a state government licensing agency to refuse to issue, reactivate, reinstate, or renew a license, and must suspend a license, if the licensees name is on the State Board of Equalization's or the Franchise Tax Board's list of the 500 largest tax delinquencies. (BPC §494.5)

<u>This Bill:</u>

1) Establishes that, regardless of BPC §480 or any other law, a person has a right to engage in a lawful profession without being subject to occupational regulation that imposes a substantial burden on that right. This includes the right of a person with a criminal record to obtain a license, and a right not to have a board use the person's criminal record as an automatic or mandatory permanent bar to engaging in a profession. (BPC §37(a))

2) States that, overriding any other law, a person behind on taxes or student loans has a right to obtain a license to engage in a profession, and a right not to have a board use the person's status regarding taxes or student loans be an automatic or permanent bar to engaging in a profession. (BPC §37(a))

3) Establishes that a person denied a license may file a petition and appeal to the board. If the person has a criminal record, he or she must include a copy of the criminal record in the

petition, or authorize the board to obtain a copy. The person may also include other information about his or her circumstances, such as the time passed since the offense, evidence of rehabilitation, employment history, and employment aspirations. (BPC §37(b))

4) Permits the board to find the person's criminal record disqualifies him or her from obtaining a license only if all the following are met by clear and convincing evidence (BPC §37(b)):

a) The conviction was for a felony or a violent misdemeanor and the board concludes that the state has an important interest in protecting public safety that is superior to the person's individual right;

b) The offense is substantially related to the qualifications, functions, or duties of the profession;

c) Based on the nature of the specific offense and current circumstances, the person would be put in a position in which he or she is more likely to reoffend by having the license versus not having the license; and

d) A re-offense would cause greater harm that it would if the person did not have a license and was not put in a position in which the person is more likely to reoffend;

5) Requires the board to decide on a petition within 90 days of it being filed. (BPC §37(b))

6) If a board denies a petition, allows the person to file an appeal to a court of general jurisdiction for a declaratory judgement, injunctive relief, or other equitable relief for a violation of his or her right to engage in a lawful profession without being subject to an occupational regulation that imposes a substantial burden on that right. In such a case, it is the board's burden to prove that the challenged regulation meets the decision criteria specified in Item 4 above. If they fail to do so, the court may award reasonable attorney's fees and costs to the plaintiff. (BPC §37(c))

Comments:

1) **Author's Intent.** The author's office is seeking to create a statutory right to challenge unfair licensing requirements that pose unnecessary barriers to work. They state that California's occupational laws are particularly restrictive in comparison to other states, and that these licensing laws make it difficult for people with a criminal record to find jobs.

2) **Current Board Process for Denial.** Current law already outlines a process for an individual to appeal a license denial. The Board's regulations (16 CCR §1813) also outline specific criteria that the Board must consider when evaluating an applicant's rehabilitation.

3) **Unclear Denial Criteria.** To deny a license, this bill requires a board to provide clear and convincing evidence that having a license would make him or her more likely to reoffend, and that a re-offense would cause greater harm than it would if the person did not have a license and was not put in a position where he or she is more likely to reoffend.

The Board's highest priority is protection of the public (BPC §4990.14). In addition, the Board is only allowed to deny a license if the crime or act is substantially related to the qualifications, functions, or duties of the profession. The Board must consider the person's rehabilitation efforts when making this decision.

The Board denies licenses for convictions such as assault, driving under the influence of alcohol/drugs, possession of controlled substances, and theft or fraud. Because therapists

treat a vulnerable population, patterns of such crimes can be substantially related to the profession, depending on the circumstances of the case.

However, it is unclear how the Board would be able to provide "clear and convincing evidence" that having or not having a license would make a person more likely to reoffend. Such a determination would be conjecture, making the Board unable to meet the criteria to deny a license, and potentially putting therapy patients at risk.

4) **Fiscal Impact.** This bill would likely result in significant increased legal costs to the Board. Because it sets unclear criteria that must be met by clear and convincing evidence, it opens the door for costly legal challenges in general court. In addition, this bill decreases the amount of time a board has to decide on a petition (to 90 days, versus the current 90 days to conduct the hearing). This will create a need for additional enforcement staff so that these timelines can be met.

5) **Previous Legislation.**

AB 1424 (Chapter 455, Statutes of 2011) Requires a state government licensing agency to refuse to issue, reactivate, reinstate, or renew a license, and must suspend a license, if the licensees name is on the State Board of Equalization's or the Franchise Tax Board's list of the 500 largest tax delinquencies.

AB 508 (Chapter 195, Statutes of 2017) Removes a healing art board's ability to issue a citation and fine, and its ability to deny an application for a license or renewal of a license due to the licensee or applicant being in default on a U.S. Department of Health and Human Services education loan.

6) **Support and Opposition.**

Support:
- Institute for Justice
- Pacific Legal Foundation

Opposition:
- None at this time.

7) **History**

2018
03/23/18 From committee chair, with author's amendments: Amend, and re-refer to Com. on B. & P. Read second time and amended.
03/22/18 Referred to Coms. on B. & P. and JUD.
02/15/18 From printer. May be heard in committee March 17.
02/14/18 Read first time. To print.

AMENDED IN ASSEMBLY MARCH 23, 2018

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 2409

Introduced by Assembly Member Kiley

February 14, 2018

An act to ~~amend Section 101.6 of~~ *add Section 37 to* the Business and Professions Code, relating to professions and vocations.

LEGISLATIVE COUNSEL'S DIGEST

AB 2409, as amended, Kiley. Professions and ~~vocations.~~ *vocations: occupational regulations.*

Existing law provides for the licensure and regulation of various professions and vocations by ~~boards, bureaus, and commissions~~ *boards* within the Department of Consumer Affairs and provides that those ~~boards, bureaus, and commissions~~ *boards* are established for the purpose of ensuring that those private businesses and professions deemed to engage in activities that have potential impact upon the public health, safety, and welfare are adequately regulated in order to protect the people of California. *Existing law authorizes a board to deny a license if an applicant has been convicted of a crime, done any act involving dishonesty, fraud, or deceit with intent to substantially benefit himself or herself or another or substantially injure another, or does any act that, if done by a licentiate of the business or profession, would be grounds for suspension or revocation.*

This bill would ~~make a nonsubstantive change to that provision.~~ *establish that a person has a right to engage in a lawful profession or vocation without being subject to an occupational regulation, as defined, that imposes a substantial burden on that right, and would require each occupational regulation to be limited to what is demonstrably necessary*

and narrowly tailored to fulfill a legitimate public health, safety, or welfare objective. The bill would include within this the right of a person with a criminal record to obtain a license and not to have a board use the person's criminal record as an automatic or mandatory permanent bar to engaging in a lawful profession or vocation. The bill would also include the right of a person who is behind on his or her taxes or student loans to petition a board not to use these factors against that person, as prescribed.

The bill would authorize a person who is denied a license to file a petition and appeal to the board. The bill would prescribe procedures and legal standards by which a board may determine that a person's criminal record disqualifies that person. The bill would also permit a person, following the response to an administrative petition, to file an appeal to a court for a declaratory judgment or injunctive or other equitable relief, in accordance with certain legal procedures and criteria. The bill would include related definitions and declare the intent of the Legislature in this regard.

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

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

SECTION 1. This act may be known as the "Occupational Opportunity Act."

SEC. 2. The Legislature finds and declares all of the following:

(a) Each individual has the right to pursue a chosen profession and vocation, free from arbitrary or excessive government interference.

(b) The freedom to earn an honest living traditionally has provided the surest means for economic mobility.

(c) In recent years, many regulations of entry into professions and vocations have exceeded legitimate public purposes and have had the effect of arbitrarily limiting entry and reducing competition.

(d) The burden of excessive regulation is borne most heavily by individuals outside the economic mainstream, for whom opportunities for economic advancement are curtailed.

(e) It is in the public interest to do all of the following:

(1) Ensure the right of all individuals to pursue legitimate entrepreneurial and professional opportunities to the limits of their talent and ambition.

(2) Provide the means for the vindication of this right.

(3) Ensure that regulations of entry into professions and vocations are demonstrably necessary and narrowly tailored to fulfill legitimate health, safety, and welfare objectives.

SEC. 3. Section 37 is added to the Business and Professions Code, to read:

37. (a) (1) Notwithstanding Section 480 or any other law, a person has a right to engage in a lawful profession or vocation without being subject to an occupational regulation that imposes a substantial burden on that right. To achieve this purpose, each occupational regulation shall be limited to what is demonstrably necessary and shall be narrowly tailored to fulfill a legitimate public health, safety, or welfare objective.

(2) Notwithstanding any other law, the right set forth in paragraph (1) includes the right of a person with a criminal record to obtain a license to engage in a profession or vocation, and the right to not have a board use the person's criminal record as an automatic or mandatory permanent bar to engaging in a lawful profession or vocation.

(3) Notwithstanding any other law, the right set forth in paragraph (1) also includes the right of a person who is behind on his or her taxes or student loans to obtain a license to engage in a profession or vocation, and the right to not have the board use the person's status with respect to his or her taxes or student loans as an automatic or mandatory permanent bar to engaging in a lawful profession or vocation.

(b) (1) (A) A person denied a license may file a petition and appeal to the board.

(B) If the person has a criminal record, the person shall include in the petition a copy of his or her criminal record or shall authorize the board to obtain a copy that record. The person may additionally include information about his or her current circumstances, including, but not limited to, the time passed since the offense, completion of the criminal sentence, other evidence of rehabilitation, testimonials, employment history, and employment aspirations.

(C) Notwithstanding any other law, the board may find that the person's criminal record disqualifies that person from obtaining a license only if the person's criminal record includes a conviction for a felony or a violent misdemeanor and the board concludes that the state has an important interest in protecting public safety that is superior to the person's individual right. The board may make this conclusion only if it determines, by clear and convincing evidence at the time of the petition, all of the following:

(i) The specific offense for which the person was convicted is substantially related to the qualifications, functions, or duties of the profession or vocation for which application was denied.

(ii) The person, based on the nature of the specific offense for which he or she was convicted and his or her current circumstances, would be put in a position in which that person is more likely to reoffend by having the license than if the person did not obtain that license.

(iii) A reoffense by the person would cause greater harm than it would if the person did not have a license and was not put in a position in which the person is more likely to reoffend.

(2) Within 90 days of a petition filed pursuant to paragraph (1), the board shall make a determination on the appeal, based on the standards set forth in subdivision (a).

(c) (1) Following the response to an administrative petition pursuant to paragraph (2) of subdivision (b), a person may file an appeal to a court of general jurisdiction for a declaratory judgment or injunctive relief or other equitable relief for a violation of subdivision (a).

(2) In such an action, the board bears the burden of proving by preponderance of the evidence that the challenged occupational regulation meets the criteria set forth in paragraph (1) of subdivision (a).

(3) If the board fails to meet the burden of proof and the court finds by a preponderance of evidence that the challenged occupational regulation fails to meet the criteria set forth in paragraph (1) of subdivision (a), the court shall enjoin further enforcement of the occupational regulation and shall award reasonable attorney's fees and costs to the plaintiff.

(4) A court shall liberally construe this section to protect the rights established in paragraph (1) of subdivision (a).

(d) For purposes of this section, the following terms apply:

(1) "Board" has the same meaning as set forth in Section 22.

(2) "License" has the same meaning as set forth in Section 23.7.

(3) "Occupational regulation" means a regulation, rule, policy, condition, test, permit, administrative practice, or other state government-prescribed requirement for a person to engage in a lawful profession or vocation.

~~SECTION 1. Section 101.6 of the Business and Professions Code is amended to read:~~

~~101.6. (a) The boards, bureaus, and commissions in the department are established for the purpose of ensuring that those private businesses and professions deemed to engage in activities that have potential impact upon the public health, safety, and welfare are adequately regulated in order to protect the people of California.~~

~~(b) To this end, they establish minimum qualifications and levels of competency and license persons desiring to engage in the occupations they regulate upon determining that such persons possess the requisite skills and qualifications necessary to provide safe and effective services to the public, or register or otherwise certify persons in order to identify practitioners and ensure performance according to set and accepted professional standards. They provide a means for redress of grievances by investigating allegations of unprofessional conduct, incompetence, fraudulent action, or unlawful activity brought to their attention by members of the public and institute disciplinary action against persons licensed or registered under the provisions of this code when such action is warranted. In addition, they conduct periodic checks of licensees, registrants, or otherwise certified persons in order to ensure compliance with the relevant sections of this code.~~

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98

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Board of Behavioral Sciences

CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES BILL ANALYSIS

BILL NUMBER: AB 2483 **VERSION:** INTRODUCED FEBRUARY 14, 2018

AUTHOR: VOEPEL **SPONSOR:** AUTHOR

RECOMMENDED POSITION: NONE

SUBJECT: DEPARTMENT OF CONSUMER AFFAIRS: OFFICE OF SUPERVISION OF OCCUPATIONAL BOARDS

Summary:

This bill establishes the Office of Supervision of Occupational Boards under the Department of Consumer Affairs (DCA) to provide oversight over DCA's boards, bureaus, and commissions.

Existing Law:

1) Establishes specified licensing board, bureaus, and commissions under DCA. (Business and Professions Code (BPC) §101)

2) Provides that the boards, bureaus, and commissions under DCA are established to ensure that those engaging in business and professions that impact public health, safety, and welfare are adequately regulated to protect California residents. (BPC §101.6)

3) Provides that each board under DCA exists as a separate unit with the functions of setting standards, holding meetings, preparing and conducting exams, passing upon applicants, conducting investigations of its laws, issuing citations, and holding hearings for revocation of licenses, as granted by that board's individual statute. (BPC §108)

4) States the decisions of a board with respect to setting standards, conducting exams, passing candidates, and revoking licenses are final and not subject to review by the director except as follows (BPC §109):

a) The director may initiate an investigation of allegations of misconduct in the preparation, administration, or scoring an exam or in the review of qualifications which are part of the licensing process.

b) The director may intervene in a matter where an investigation discloses probable cause to believe that the conduct or activity of a board or its members or employees is a violation of criminal law.

5) Provides the DCA director with the authority to review and disapprove any proposed regulations of a board, except those related to examinations and qualifications for licensure. (BPC §313.1)

6) Provides that protection of the public shall be the highest priority for the Board of Behavioral Sciences when it is exercising its licensing, regulatory, and disciplinary functions. Whenever protection of the public is inconsistent with other interests sought to be promoted, protection of the public shall be paramount. (BPC §4990.16)

<u>This Bill:</u>

1) Establishes the Office of Supervision of Occupational Boards (Office) within DCA. (BPC §473.2(a))

2) Tasks the Office with exercising active supervision over covered boards within DCA (including the Board of Behavioral Sciences) to ensure compliance with the following policies (BPC §§ 473, 473.2(b)):

a) That occupational licensing laws should be applied to increase economic opportunity, promote competition, and encourage innovation;

b) That regulators should only displace competition through occupational licensing where less restrictive regulation is not sufficient to protect consumers from harm; and

c) An occupational licensing restriction should be enforced against an individual only to the extent the individual sells goods and services included explicitly in the law that defines the occupation's scope of practice.

3) Requires the Office to independently do the following (BPC §473.2(b)):

a) Play a substantial role in the development of a board's rules and policies to ensure they benefit consumers and do not serve private interests;

b) Disapprove a board rule or policy, or terminate any enforcement action that is not consistent with the policies stated in item #2 above;

c) Exercise control over boards by reviewing and approving only rules, policies, and enforcement actions consistent with the policies stated in item #2 above; and

d) Analyze existing and proposed rules and policies and conduct investigations to promote compliance with the above stated policies, including less restrictive regulatory approaches.

4) Requires the Office to review and approve, or reject, any proposed rule, policy, enforcement action, or other occupational licensure action before a board may adopt or implement it. (BPC §473.2(c))

5) Allows any person to file a complaint with the Office about a rule, policy, enforcement action, or licensure action of a board that the person believes is not consistent with the policies stated in item #2 above. The Office would have 90 days to investigate and instruct the board to take the action the Office deems appropriate. (BPC §473.3)

Comments:

1) Author's Intent. According to the author's office, occupational licensing laws should be construed and applied only to increase economic opportunity, promote competition, and encourage innovation. They cite data from the Little Hoover Commission that California licenses more lower-income jobs than other states. Therefore, they wish to establish this oversight office to ensure consumer and licensee cases are fairly evaluated.

2) Fiscal Impact. This bill does not specify a funding source for the Office. Any fiscal impact to the Board will depend on funding sources. However, it is likely the Office would be funded through pro rata costs paid by the Board to DCA for its share of services. Given the extent of duties of the Office, pro rata costs may be significant.

3) Support and Opposition.

Support:
- None at this time.

Opposition:
- None at this time.

4) History

2018

02/15/18 From printer. May be heard in committee March 17.
02/14/18 Read first time. To print.

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ASSEMBLY BILL No. 2483

Introduced by Assembly Member Voepel

February 14, 2018

An act to add Chapter 10 (commencing with Section 473) to Division 1 of the Business and Professions Code, relating to professions.

LEGISLATIVE COUNSEL'S DIGEST

AB 2483, as introduced, Voepel. Department of Consumer Affairs: Office of Supervision of Occupational Boards.

Under existing law, the Department of Consumer Affairs is composed of various boards, bureaus, commissions, committees, and similarly constituted agencies that license and regulate the practice of various professions and vocations for the purpose of protecting the people of California. With certain exceptions, decisions of these entities with respect to setting standards, conducting examinations, passing candidates, and revoking licenses, are final and are not subject to review by the Director of Consumer Affairs.

This bill would establish an Office of Supervision of Occupational Boards within the department to exercise active supervision over a "covered board," defined as specific licensing and regulatory agencies within the department, to ensure compliance with specific policies established in the bill regarding licensing and enforcement (established policies). The bill would require the office, in the exercise of active supervision, to be involved in the development of a covered board's rules and policies, to disapprove the use of any board rule or policy and terminate any enforcement action that is not consistent with the established policies, and to review and affirmatively approve only rules, policies, and enforcement actions consistent with the established

policies. The bill would require the office to review and approve or reject any rule, policy, enforcement action, or other occupational licensure action proposed by each covered board before adoption or implementation. The bill would establish procedures for complaints, investigation, remedial action, and appeal relating to a rule, policy, enforcement action, or other occupational licensure action of a covered board inconsistent with the established policies.

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

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

SECTION 1. Chapter 10 (commencing with Section 473) is added to Division 1 of the Business and Professions Code, to read:

Chapter 10. Office of Supervision of Occupational Boards

473. The following are policies of the state:

(a) Occupational licensing laws should be construed and applied to increase economic opportunity, promote competition, and encourage innovation.

(b) Regulators should displace competition through occupational licensing only where less restrictive regulation will not suffice to protect consumers from present, significant, and substantiated harms that threaten public health, safety, or welfare.

(c) An occupational licensing restriction should be enforced against an individual only to the extent the individual sells goods and services that are included explicitly in the statute or regulation that defines the occupation's scope of practice.

473.1. As used in this chapter:

(a) "Covered board" means any entity listed in Section 101.

(b) "Office" means the Office of Supervision of Occupational Boards established in Section 473.2.

473.2. (a) There is hereby established an Office of Supervision of Occupational Boards within the department.

(b) (1) Notwithstanding Section 109, the office shall be responsible for exercising active supervision over each covered board to ensure compliance with the policies in Section 473.

(2) In exercising active supervision over covered boards under paragraph (1), the office shall independently do the following:

(A) Play a substantial role in the development of a covered board's rules and policies to ensure they benefit consumers and do not serve the private interests of providers of goods and services regulated by the covered board.

(B) Disapprove the use of any rule or policy of a covered board and terminate any enforcement action, including any action pending on January 1, 2019, that is not consistent with Section 473.

(C) Exercise control over each covered board by reviewing and affirmatively approving only rules, policies, and enforcement actions that are consistent with Section 473.

(D) Analyze existing and proposed rules and policies and conduct investigations to gain additional information to promote compliance with Section 473, including, but not limited to, less restrictive regulatory approaches.

(3) In exercising active supervision over covered boards under paragraph (1), the office shall be staffed by not fewer than one attorney who does not provide general counsel to any covered board.

(c) (1) Notwithstanding Section 109, the office shall review and approve or reject any rule, policy, enforcement action, or other occupational licensure action proposed by each covered board before the covered board may adopt or implement the rule, policy, enforcement action, or other occupational licensure action.

(2) For purposes of paragraph (1), approval by the office shall be express and silence or failure to act shall not constitute approval.

473.3. (a) Any person may file a complaint to the office about a rule, policy, enforcement action, or other occupational licensure action of a covered board that the person believes is not consistent with Section 473.

(b) Not later than 90 days after the date on which the office receives a complaint filed under paragraph (1), notwithstanding Section 109, the office shall investigate the complaint, identify remedies, and instruct the covered board to take action as the office determines to be appropriate, and respond in writing to the complainant.

(c) (1) There shall be no right to appeal a decision of the office under subdivision (b) unless the challenged rule, policy, enforcement action, or other occupational licensure action would

prevent the complainant from engaging in a lawful occupation or employing or contracting others for the performance of a lawful occupation and the complainant has taken material steps in an attempt to engage in a lawful occupation or employ or contract others for the performance of a lawful occupation.

(2) Any appeal authorized under paragraph (1) shall be to the superior court.

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99

Board of Behavioral Sciences

CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES BILL ANALYSIS

BILL NUMBER: AB 2608 **VERSION:** AMENDED APRIL 3, 2018

AUTHOR: STONE **SPONSOR:** JOURNEY HOUSE (SPONSOR)

RECOMMENDED POSITION: NONE

SUBJECT: LICENSED MENTAL HEALTH SERVICE PROVIDER EDUCATION PROGRAM: FORMER FOSTER YOUTH

Summary: This bill creates a new fund under the Mental Health Practitioner Education Fund loan repayment grant program specifically for loan repayment grants for LMFT and LCSW licensees and registrants who were formerly in California's foster youth care system. The program would be funded by levying an additional $10 fee on LMFT and LCSWs each renewal cycle.

Existing Law:

1) Establishes a maximum biennial renewal fee that LMFT, LCSW, and LPCC licensees must pay to renew a license. (Business and Professions Code (BPC) §§4984, 4984.7, 4996.3, 4996.6, 4999.102, 4999.120)

2) Sets the amount for the LMFT renewal fee at $130 (California Code of Regulations (CCR) Title 16, Section 1816(d)).

3) Sets the amount for the LCSW renewal fee at $100 (16 CCR §1816(f)).

4) Sets the amount for the LPCC renewal fee at $175 (16 CCR §1816(g))

5) Effective July 1, 2018, requires that in addition to the regular biennial license renewal fee, LMFTs, LCSWs, and LPCCs must pay an additional $20 biennial fee at renewal, which shall be deposited in the Mental Health Practitioner Education Fund. (BPC §§4984.75, 4996.65, 4999.121)

6) Creates the Licensed Mental Health Service Provider Education Program within the Health Professions Education Foundation. Funds from this program are administered by the Office of Statewide Health Planning and Development (OSHPD). (Health and Safety Code (HSC) §§128454(a), 128458)

7) Allows any licensed mental health service provider who provides direct patient care in a publicly funded facility or a mental health professional shortage area to apply for

grants under this program to reimburse educational loans related to a career as a licensed mental health service provider. (HSC §128454(c))

8) Defines a "licensed mental health service provider" to include several types of licensed mental health professionals, including marriage and family therapists, associate MFTs i, licensed clinical social workers, associate clinical social workers, licensed professional clinical counselors, and associate professional clinical counselors. (HSC §128454(b))

9) Defines a "mental health professional shortage area" as an area given this designation by the Health Resources and Services Administration of the U.S. Department of Health and Human Services. (HSC §128454(b))

10) Requires the Health Professions Education Foundation to develop the grant program, and allows it to make recommendations to the director of OSHPD regarding the following (HSC §128454(d) and (e)):

- The length of the contract that a grant recipient must sign obligating him or her to work in a publicly funded facility or a mental health professional shortage area (the law requires it to be at least one year);

- The maximum allowable total grant per person and the maximum annual grant per person;

11) When selecting loan repayment recipients, requires the Foundation to take into consideration the mental health workforce needs, including cultural and linguistic needs, of the state in general and of the qualifying facilities and mental health professional shortage areas. (22 California Code of Regulation (CCR) §97930.7)

12) Requires a recipient of a loan repayment grant to provide service for 24 months for no less than 32 hours per week. (22 CCR §97930.8(a))

<u>This Bill:</u>

1) Beginning January 1, 2019, requires the Board to collect an additional $10 fee to LMFTs and LCSWs upon renewal, for deposit into the Mental Health Practitioner Education Fund. (BPC §§4984.75(b), 4996.65(b))

2) Requires the money deposited from the extra $10 fee to be used solely to fund grants to repay educational loans for applicants who meet the following criteria (HSC §128455(a)(1):

- Commit to provide direct patient care in a publicly funded facility or mental health professional shortage area for at least 24 months;

- Are LMFTs, associate MFTs, LCSWs, or ASWs; and

- Were formerly in California's foster youth care system.

3) Allows this grant to a former foster youth to be combined with other Licensed Mental Health Service Provider Education Program grants, for a total of up to $20,000 in grant funding per applicant. (HSC §128455(a)(2))

4) In addition to this special grant program for former foster youth, requires individuals formerly in California's foster youth system to be given priority over other grant applicants for the regular Mental Health Practitioner Education Fund loan repayment grants. (HSC §128455(b))

Comment:

1) **About the Sponsor.** This bill is sponsored by Journey House, which is an organization that assists former foster youth. Their web site states the following: "By providing education and housing support to former foster youth, along with critically important life-guidance, Journey House helps former foster youth to make a successful transition into self-sufficiency while completing their education and job training."

2) **LPCCs and Associate Professional Clinical Counselors Not Included.** This bill creates a loan repayment grant program for former California foster youth who are marriage and family therapist and clinical social work licensees and registrants. However, LPCC licensees and registrants are not included in the program.

3) **Fee Comparison.** Below is a chart comparing the current biennial renewal fee for each license type with what the biennial renewal fee would be if this bill became law.

License Type	Current Renewal Fee *(As of 7/1/18)*			Proposed Renewal Fee			
	Renewal Fee	MHP Edu. Fund Fee	**Total Fee**	Renewal Fee	MHP Edu. Fund Fee	Foster Youth MHP Edu. Fund Fee [1]	**Total Fee**
LMFT	$130	$20	**$150**	$130	$20	$10	**$160**
LCSW	$100	$20	**$120**	$100	$20	$10	**$130**
LPCC	$175	$20	**$195**	$175	$20	$0	**$195**

[1] LPCCs are currently omitted from this proposed program.

4) **Fiscal Impact and Revenue Generated.** If this bill became law, each LMFT and LCSW would pay an extra $10 every other year.

DCA's Budget office estimates that approximately 26,000 LMFT and LCSW licensees renew each year, resulting in approximately $260,000 in additional fee revenue per year.

5) **Delayed Implementation Needed.** Implementation of this bill will require new fee codes to be established in the Breeze database system. In addition, staff will need to update renewal forms for each license type to reflect the new fee amount. Given

that license renewal notices are sent out three months in advance, and the deadline for the Governor to decide whether or not to sign this bill is September 30, 2018, the current effective date of January 1, 2019 does not allow enough time for implementation. Therefore, staff recommends that the Board consider asking for a delayed implementation date of July 1, 2019.

6) **Previous Legislation.** AB 1188 (Chapter 557, Statutes of 2018), increased the Mental Health Practitioner fee that LMFTs and LCSWs pay upon license renewal from $10 to $20. It also requires LPCCs to pay a $20 fee into the fund upon license renewal (they previously were not included in the program), and allows LPCCs and associate PCCs to apply for the loan repayment grant if they work in a mental health professional shortage area.

   The Board had a "support" position on AB 1188, and negotiated a 6-month delayed implementation date for the bill so that it could implement the change properly.

7) **Support and Opposition.**

   Support:
   - Journey House (Sponsor)

   Opposition:
   - None at this time.

8) **History**

   2018

   04/03/18 From committee chair, with author's amendments: Amend, and re-refer to Com. on B. & P. Read second time and amended.
   03/19/18 Re-referred to Com. on B. & P.
   03/15/18 From committee chair, with author's amendments: Amend, and re-refer to Com. on B. & P. Read second time and amended.
   03/15/18 Referred to Com. on B. & P.
   02/16/18 From printer. May be heard in committee March 18.
   02/15/18 Read first time. To print.

AMENDED IN ASSEMBLY APRIL 3, 2018

AMENDED IN ASSEMBLY MARCH 15, 2018

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 2608

Introduced by Assembly Member Mark Stone

February 15, 2018

An act to amend Sections 4984.75 and 4996.65 of the Business and Professions Code, and to add Section 128455 to the Health and Safety Code, relating to health professions.

LEGISLATIVE COUNSEL'S DIGEST

AB 2608, as amended, Mark Stone. Licensed Mental Health Service Provider Education Program: former foster youth.

Existing law authorizes any licensed mental health service provider, as defined, including a marriage and family therapist, associate marriage and family therapist, licensed clinical social worker, and associate clinical social worker, who provides direct patient care in a publicly funded facility or a mental health professional shortage area, as defined, to apply for grants under the Licensed Mental Health Service Provider Education Program to reimburse his or her educational loans related to a career as a licensed mental health service provider, as specified. Existing law establishes the Mental Health Practitioner Education Fund and provides that moneys in that fund are available, upon appropriation by the Legislature, for purposes of the Licensed Mental Health Service Provider Education Program.

The Licensed Marriage and Family Therapist Act and the Clinical Social Worker Practice Act make the Board of Behavioral Sciences responsible for the licensure and regulation of marriage and family

therapists, associate marriage and family therapists, clinical social workers, and associate clinical social workers, respectively. Those acts require the board to establish and assess biennial license renewal fees, as specified. Those acts also require the board to collect an additional fee at the time of renewal of those licenses and directs the deposit of that additional fee into the Mental Health Practitioner Education Fund.

With respect to grants funded with that fee under the Licensed Mental Health Service Provider Education Program, the bill would require applicants who were formerly in California's foster youth care system to receive priority over other applicants. This bill would also require the Board of Behavioral Sciences to collect an additional $10 fee for deposit into the Mental Health Practitioner Education Fund. The bill would require the $10 fee to be used solely to fund grants to repay educational loans for applicants who commit to practice in specified facilities for ~~up to~~ *at least* 24 months, who are marriage and family therapists, associate marriage and family therapists, licensed clinical social workers, or associate clinical social workers, and who were formerly in California's foster youth care system. The bill would authorize those grants to be combined with other grants provided under the Licensed Mental Health Service Provider Education Program to provide up to $20,000 in grant funding per applicant.

This bill would include a change in state statute that would result in a taxpayer paying a higher tax within the meaning of Section 3 of Article XIII A of the California Constitution, and thus would require for passage the approval of ⅔ of the membership of each house of the Legislature.

Vote: ⅔. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

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

SECTION 1. Section 4984.75 of the Business and Professions Code, as added by Section 4 of Chapter 557 of the Statutes of 2017, is amended to read:

4984.75. (a) In addition to the fees charged pursuant to Section 4984.7 for the biennial renewal of a license pursuant to Section 4984, the board shall collect an additional fee of twenty dollars ($20) at the time of renewal. The board shall transfer this amount to the Controller who shall deposit the funds in the Mental Health Practitioner Education Fund.

97

(b) Commencing on January 1, 2019, in addition to the fees charged pursuant to Section 4984.7 for the biennial renewal of a license, and in addition to the fee charged pursuant to subdivision (a), the board shall collect an additional fee of ten dollars ($10) at the time of renewal. The board shall transfer this amount to the Controller who shall deposit the funds in the Mental Health Practitioner Education Fund.

(c) This section shall become operative on July 1, 2018.

SEC. 2. Section 4996.65 of the Business and Professions Code, as added by Section 6 of Chapter 557 of the Statutes of 2017, is amended to read:

4996.65. (a) In addition to the fees charged pursuant to Section 4996.3 for the biennial renewal of a license pursuant to Section 4996.6, the board shall collect an additional fee of twenty dollars ($20) at the time of renewal. The board shall transfer this amount to the Controller who shall deposit the funds in the Mental Health Practitioner Education Fund.

(b) Commencing on January 1, 2019, in addition to the fees charged pursuant to Section 4996.3 for the biennial renewal of a license pursuant to Section 4996.6, and in addition to the fee charged pursuant to subdivision (a), the board shall collect an additional fee of ten dollars ($10) at the time of renewal. The board shall transfer this amount to the Controller who shall deposit the funds in the Mental Health Practitioner Education Fund.

(c) This section shall become operative on July 1, 2018.

SEC. 3. Section 128455 is added to the Health and Safety Code, to read:

128455. (a) (1) The moneys deposited in the Mental Health Practitioner Education Fund pursuant to subdivision (b) of Section 4984.75 of, and subdivision (b) of Section 4996.65 of, the Business and Professions Code shall be used solely to fund grants, consistent with this article, to repay educational loans for applicants who meet all of the following requirements:

(A) Commit to provide direct patient care in a publicly funded facility or a mental health professional shortage area for ~~up to~~ *at least* 24 months.

(B) Are marriage and family therapists, associate marriage and family therapists, licensed clinical social workers, or associate clinical social workers.

(C) Were formerly in California's foster youth care system.

(2) A grant provided to an applicant pursuant to paragraph (1) may be combined with other grants provided to the applicant under this article to provide a total of up to twenty thousand dollars ($20,000) in grant funding per applicant.

(b) An applicant for a grant under this article, from the moneys deposited in the Mental Health Practitioner Education Fund pursuant to subdivision (a) of Section 4984.75 of, and subdivision (a) of Section 4996.65 of, the Business and Professions Code, who is a marriage and family therapist, associate marriage and family therapist, licensed clinical social worker, or an associate clinical social worker and who was formerly in California's foster youth care system shall be given priority over other grant applicants within the corresponding licensed provider group.

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97

Board of Behavioral Sciences

CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES BILL ANALYSIS

BILL NUMBER: AB 2780 **VERSION:** INTRODUCED FEBRUARY 16, 2018

AUTHOR: BLOOM **SPONSOR:**

- FAMILY LAW EXECUTIVE COMMITTEE OF THE CALIFORNIA LAWYERS ASSOCIATION (FORMERLY FAMILY LAW SECTION OF THE CALIFORNIA STATE BAR)

RECOMMENDED POSITION: NONE

SUBJECT: FAMILY LAW: SUPPORT ORDERS AND CHILD CUSTODY

Summary: This bill would add mediators and court expert witnesses to the list of individuals a court can appoint to conduct a child custody evaluation.

Existing Law:

1) Allows a court to appoint investigative experts when it appears that expert evidence may be needed. Such an expert may render a report and testify as an expert. (Evidence Code (EC) §730)

2) In a contested proceeding involving child custody or visitation rights, permits the court to appoint a child custody evaluator to conduct a child custody evaluation if the court determines it is in the best interest of the child. (Family Code (FC) §3111(a))

3) Requires the Judicial Council to set standards regarding child custody evaluations. (FC §§3111(a), 3117)

4) Requires the Judicial Council to set education, experience, and training requirements for child custody evaluators, in addition to the following (FC §§3110.5(b),(c))

a) A child custody evaluator must be licensed as a physician, psychologist, marriage and family therapist, clinical social worker, or is a court-connected evaluator certified by the court as meeting Judicial Council's requirements for court-connected evaluators.

5) Specifies that a child custody evaluator who is licensed by the Medical Board, Board of Psychology, or Board of Behavioral Sciences shall be subject to disciplinary action by that board for unprofessional conduct. (FC §3110.5(e))

6) Allows a licensing board (including this Board) to access to obtain a child custody report for purposes of investigating allegations of unprofessional conduct of a child custody evaluation who is one of its licensees. (FC §3025.5)

7) Requires superior courts to make mediators available. Mediators may be a member of the professional staff of a family conciliation court, probation department, or mental health services agency, or may be another person designated by the court. (FC §§3160, 3164(a))

8) Requires all mediators to meet the minimum qualifications of a counselor of conciliation, which are as follows (FC §§3164(b), 1815):

a) A master's degree in psychology, social work, marriage, family and child counseling, or other behavioral science substantially related to marriage and family interpersonal relationships.

b) At least two years of experience in counseling or psychotherapy.

c) Knowledge of the California court system and family law case procedures.

d) Knowledge of adult psychopathology and psychology of families.

e) Knowledge of child development, child abuse, clinical issues relating to children, the effects of divorce on children, the effects of domestic violence on children, and child custody research sufficient to enable a counselor to assess the mental health needs of children.

f) Training in domestic violence issues.

9) In divorce proceedings, allows the court to order a party to be examined by a vocational training counselor to assess the party's ability to obtain employment. (FC §4331(a))

10) Specifies that a vocational training counselor must meet certain qualifications, including having a master's degree in the behavioral sciences. (FC §4331(e))

This Bill:

1) Adds a mediator or an expert witness pursuant to Section 730 of the Evidence Code, to the list of individuals a court may appoint to conduct a child custody evaluation. (Under current law, only a child custody evaluator may be appointed, and child custody evaluators must hold a professional license as specified in FC §3110.5(c)). (Family Code (FC) §3111(a))

2) Expands the educational requirements for a vocational training counselor, allowing them to have either a master's degree in the behavioral sciences, or another postgraduate degree that the court finds provides sufficient training to perform a vocational evaluation. (FC §4331)

Comments:

1) Author's Intent. In a conversation with the author's office, they indicated that there is a shortage of child custody evaluators and vocational training counselors. By expanding the individuals who may work on these cases, they hope to increase the supply of evaluators.

2) Inclusion of LPCCs as Child Custody Evaluators. Currently, FC §3110.5 specifies that LMFTs and LCSWs can be child custody evaluators. LPCCs are not included in this list. One way to increase the supply of child custody evaluators would be to allow LPCCs to do these evaluations. AB 2296 (Waldron), sponsored by the California Association for Licensed Professional Clinical Counselors, proposes to do this.

3) **Fiscal Impact.** FC §3110.5(e) subjects a child custody evaluator who is licensed by this board to disciplinary action for unprofessional conduct. This bill adds mediators to those professionals who can conduct child custody evaluations. Although mediators are not required to be licensed, they are required to have a master's degree in psychology, social work, marriage and family therapy, or other related behavioral science. Therefore, some of them may be Board licensees.

   It is unclear whether the Board would be required to investigate a mediator if he or she held a Board license, per FC §3110.5(e). If that were the case, the Board could expect a substantial increase in workload and investigative costs in its Enforcement Unit.

4) **Previous Legislation.** AB 1843 (Chapter 283, Statutes of 2014) was sponsored by this Board. It gave the Board statutory authority to access a child custody evaluation report for the purpose of investigating that one of its licensees, while serving as a child custody evaluator, engaged in unprofessional conduct in the creation of the report. Previously, the law did not give the Board direct access to the child custody evaluation report, leaving the Board unable to investigate, even though it was mandated to do so by law.

5) **Support and Opposition.**

Support:

- Family Law Executive Committee of the California Lawyers' Association (formerly known as the Family Law Section of the California State Bar) (Sponsor)

Oppose:

- None at this time.

6) **History.**

2018

03/08/18	Referred to Com. on JUD.
02/17/18	From printer. May be heard in committee March 19.
02/16/18	Read first time. To print.

7) **Attachments.**

Attachment A: Relevant Code Sections (Evidence Code Section 730, Family Code Sections 1815, 3025.5, 3110, 3110.5, 3111, 3117, 3160, 3164, 3183, 4331)

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ASSEMBLY BILL No. 2780

Introduced by Assembly Member Bloom

February 16, 2018

An act to amend Sections 3111 and 4331 of, and to add Section 4100 to, the Family Code, relating to family law.

LEGISLATIVE COUNSEL'S DIGEST

AB 2780, as introduced, Bloom. Family law: support orders and child custody.

(1) Existing law authorizes the court to appoint a child custody evaluator to conduct a child custody evaluation in a contested proceeding involving child custody or visitation rights.

This bill would authorize a court to appoint a child custody evaluator, a mediator, or an expert witness, as the court deems appropriate, to conduct the child custody evaluation.

(2) Existing law authorizes the court, in a proceeding for dissolution of marriage or for legal separation of the parties, to order a party to submit to an examination by a vocational training counselor to assess the party's ability to obtain certain employment, as specified. Existing law requires a vocational training counselor performing these examinations to possess specific educational and professional experiences, including, among other qualifications, a master's degree in the behavioral sciences.

This bill would modify the required qualification to serve as a vocational training counselor by allowing, in the alternative to the master's degree, a vocational training counselor to possess another postgraduate degree that the court finds provides sufficient training to perform a vocational evaluation.

(3) Existing law requires a court, in a proceeding for court-ordered child support, to follow the statewide uniform guidelines to determine the amount of child support to order, unless special circumstances exist. Existing law also requires a court to adhere to certain principles in these proceedings, including, among others, that each parent should pay for the support of the children according to his or her ability.

This bill would authorize the court, in a proceeding involving child support, except if a parent is receiving need-based public assistance, to order a party to submit to an examination by a vocational training counselor pursuant to conditions and procedures similar to ordering vocational training in a proceeding for dissolution of marriage or for legal separation of the parties. The bill would authorize a court to impose the enumerated sanctions for failure to submit to an ordered examination, provided the sanction is in the best interest of the child or children.

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

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

SECTION 1. Section 3111 of the Family Code is amended to read:

3111. (a) In ~~any~~ *a* contested proceeding involving child custody or visitation rights, the court may appoint a child custody ~~evaluator~~ *evaluator, a mediator pursuant to Article 3 (commencing with Section 3175) of Chapter 11, or an expert witness pursuant to Section 730 of the Evidence Code, as the court deems appropriate,* to conduct a child custody evaluation ~~in cases where~~ *when* the court determines it is in the best interests of the child. The child custody evaluation shall be conducted in accordance with the standards adopted by the Judicial Council pursuant to Section 3117, and all other standards adopted by the Judicial Council regarding child custody evaluations. If directed by the court, the court-appointed child custody evaluator shall file a written confidential report on his or her evaluation. At least 10 days before ~~any~~ *a* hearing regarding custody of the child, the report shall be filed with the clerk of the court in which the custody hearing will be conducted and served on the parties or their attorneys, and any other counsel appointed for the child pursuant to Section 3150. A child custody evaluation, investigation, or assessment, and ~~any~~ *a* resulting report, may be considered by the

court only if it is conducted in accordance with the requirements set forth in the standards adopted by the Judicial Council pursuant to Section ~~3117; however, this~~ *3117. This* does not preclude the consideration of a child custody evaluation report that contains nonsubstantive or inconsequential errors or both.

(b) The report shall not be made available other than as provided in subdivision (a) or Section 3025.5, or as described in Section 204 of the Welfare and Institutions Code or Section 1514.5 of the Probate Code. Any information obtained from access to a juvenile ~~court~~ case file, as defined in subdivision (e) of Section 827 of the Welfare and Institutions Code, is confidential and shall only be disseminated as provided by paragraph (4) of subdivision (a) of Section 827 of the Welfare and Institutions Code.

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

(d) If the court determines that an unwarranted disclosure of a written confidential report has been made, the court may impose a monetary sanction against the disclosing party. The sanction shall be in an amount sufficient to deter repetition of the conduct, and may include reasonable attorney's fees, costs incurred, or both, unless the court finds that the disclosing party acted with substantial justification or that other circumstances make the imposition of the sanction unjust. The court shall not impose a sanction pursuant to this subdivision that imposes an unreasonable financial burden on the party against whom the sanction is imposed. ~~This subdivision shall become operative on January 1, 2010.~~

(e) The Judicial Council shall, by January 1, 2010, do the following:

(1) Adopt a form to be served with every child custody evaluation report that informs the report recipient of the confidentiality of the report and the potential consequences for the unwarranted disclosure of the report.

(2) Adopt a rule of court to require that, when a court-ordered child custody evaluation report is served on the parties, the form specified in paragraph (1) shall be included with the report.

(f) For purposes of this section, a disclosure is unwarranted if it is done either recklessly or maliciously, and is not in the best interests of the child.

SEC. 2. Section 4100 is added to the Family Code, to read:

4100. (a) In a proceeding involving child support, except a proceeding in which a parent is receiving need-based public assistance, the court may order a party to submit to an examination by a vocational training counselor. The examination shall include an assessment of the party's ability to obtain employment based upon the party's age, health, education, marketable skills, employment history, and the current availability of employment opportunities. The focus of the examination shall be on an assessment of the party's ability to obtain employment consistent with their ability to earn.

(b) The order may be made only on motion, for good cause, and on notice to the party to be examined and to all parties. The order shall specify the time, place, manner, conditions, scope of the examination, and the person or persons by whom the examination is to be made.

(c) A party who does not comply with an order under this section is subject to the same consequences provided for failure to comply with an examination ordered pursuant to Chapter 15 (commencing with Section 2032.010) of Title 4 of Part 4 of the Code of Civil Procedure, provided that the sanction is in the best interest of the child or children.

(d) "Vocational training counselor," has the same meaning and qualifications as specified in subdivisions (d) and (e) of Section 4331.

SEC. 3. Section 4331 of the Family Code is amended to read:

4331. (a) In a proceeding for dissolution of marriage or for legal separation of the parties, the court may order a party to submit to an examination by a vocational training counselor. The examination shall include an assessment of the party's ability to obtain employment based upon the party's age, health, education, marketable skills, employment history, and the current availability of employment opportunities. The focus of the examination shall be on an assessment of the party's ability to obtain employment that would allow the party to maintain herself or himself at the marital standard of living.

(b) The order may be made only on motion, for good cause, and on notice to the party to be examined and to all parties. The order shall specify the time, place, manner, conditions, scope of the examination, and the person or persons by whom it is to be made.

(c) A party who does not comply with an order under this section is subject to the same consequences provided for failure to comply with an examination ordered pursuant to Chapter 15 (commencing with Section 2032.010) of Title 4 of Part 4 of the Code of Civil Procedure.

(d) "Vocational training counselor" for the purpose of this section means an individual with sufficient knowledge, skill, experience, training, or education in interviewing, administering, and interpreting tests for analysis of marketable skills, formulating career goals, planning courses of training and study, and assessing the job market, to qualify as an expert in vocational training under Section 720 of the Evidence Code.

(e) A vocational training counselor shall have at least the following qualifications:

(1) A master's degree in the behavioral ~~sciences.~~ *sciences, or other postgraduate degree that the court finds provides sufficient training to perform a vocational evaluation.*

(2) ~~Be qualified~~ *Qualification* to administer and interpret inventories for assessing career potential.

(3) Demonstrated ability in interviewing clients and assessing marketable skills with *an* understanding of age constraints, physical and mental health, previous education and experience, and time and geographic mobility constraints.

(4) Knowledge of current employment conditions, job market, and wages in the indicated geographic area.

(5) Knowledge of education and training programs in the area with costs and time plans for these programs.

(f) The court may order the supporting spouse to pay, in addition to spousal support, the necessary expenses and costs of the counseling, retraining, or education.

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ATTACHMENT A
RELEVANT CODE SECTIONS

EVIDENCE CODE - EVID

DIVISION 6. WITNESSES [700 - 795] *(Division 6 enacted by Stats. 1965, Ch. 299.)*

CHAPTER 3. Expert Witnesses [720 - 733] *(Chapter 3 enacted by Stats. 1965, Ch. 299.)*

ARTICLE 2. Appointment of Expert Witness by Court [730 - 733] *(Article 2 enacted by Stats. 1965, Ch. 299.)*

730. When it appears to the court, at any time before or during the trial of an action, that expert evidence is or may be required by the court or by any party to the action, the court on its own motion or on motion of any party may appoint one or more experts to investigate, to render a report as may be ordered by the court, and to testify as an expert at the trial of the action relative to the fact or matter as to which the expert evidence is or may be required. The court may fix the compensation for these services, if any, rendered by any person appointed under this section, in addition to any service as a witness, at the amount as seems reasonable to the court.

Nothing in this section shall be construed to permit a person to perform any act for which a license is required unless the person holds the appropriate license to lawfully perform that act.

(Amended by Stats. 1990, Ch. 295, Sec. 1.)

FAMILY CODE - FAM

DIVISION 5. CONCILIATION PROCEEDINGS [1800 - 1852] *(Division 5 enacted by Stats. 1992, Ch. 162, Sec. 10.)*

PART 1. FAMILY CONCILIATION COURT LAW [1800 - 1842] *(Part 1 enacted by Stats. 1992, Ch. 162, Sec. 10.)*

CHAPTER 2. Family Conciliation Courts [1810 - 1820] *(Chapter 2 enacted by Stats. 1992, Ch. 162, Sec. 10.)*

1815. (a) A person employed as a supervising counselor of conciliation or as an associate counselor of conciliation shall have all of the following minimum qualifications:

(1) A master's degree in psychology, social work, marriage, family and child counseling, or other behavioral science substantially related to marriage and family interpersonal relationships.

(2) At least two years of experience in counseling or psychotherapy, or both, preferably in a setting related to the areas of responsibility of the family conciliation court and with the ethnic population to be served.

(3) Knowledge of the court system of California and the procedures used in family law cases.

(4) Knowledge of other resources in the community that clients can be referred to for assistance.

(5) Knowledge of adult psychopathology and the psychology of families.

(6) Knowledge of child development, child abuse, clinical issues relating to children, the effects of divorce on children, the effects of domestic violence on children, and child custody research sufficient to enable a counselor to assess the mental health needs of children.

(7) Training in domestic violence issues as described in Section 1816.

(b) The family conciliation court may substitute additional experience for a portion of the education, or additional education for a portion of the experience, required under subdivision (a).

(c) This section does not apply to any supervising counselor of conciliation who was in office on March 27, 1980.

(Amended by Stats. 2006, Ch. 130, Sec. 1. Effective January 1, 2007.)

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FAMILY CODE - FAM

DIVISION 8. CUSTODY OF CHILDREN [3000 - 3465] *(Division 8 enacted by Stats. 1992, Ch. 162, Sec. 10.)*

PART 2. RIGHT TO CUSTODY OF MINOR CHILD [3020 - 3204] *(Part 2 enacted by Stats. 1992, Ch. 162, Sec. 10.)*

CHAPTER 1. General Provisions [3020 - 3032] *(Chapter 1 enacted by Stats. 1992, Ch. 162, Sec. 10.)*

3025.5. (a) In a proceeding involving child custody or visitation rights, if a report containing psychological evaluations of a child or recommendations regarding custody of, or visitation with, a child is submitted to the court, including, but not limited to, a report created pursuant to Chapter 6 (commencing with Section 3110) of this part and a recommendation made to the court pursuant to Section 3183, that information shall be contained in a document that shall be placed in the confidential portion of the court file of the proceeding, and may not be disclosed, except to the following persons:

(1) A party to the proceeding and his or her attorney.

(2) A federal or state law enforcement officer, the licensing entity of a child custody evaluator, a judicial officer, court employee, or family court facilitator of the superior court of the county in which the action was filed, or an employee or agent of that facilitator, acting within the scope of his or her duties.

(3) Counsel appointed for the child pursuant to Section 3150.

(4) Any other person upon order of the court for good cause.

(b) Confidential information contained in a report prepared pursuant to Section 3111 that is disclosed to the licensing entity of a child custody evaluator pursuant to subdivision (a) shall remain confidential and shall only be used for purposes of investigating allegations of unprofessional conduct by the child custody evaluator, or in a criminal, civil, or administrative proceeding involving the child custody evaluator. All confidential information, including, but not limited to, the identity of any minors, shall retain their confidential nature in any criminal, civil, or administrative proceeding resulting from the investigation of unprofessional conduct and shall be sealed at the conclusion of the proceeding and shall not subsequently be released. Names that are confidential shall be listed in attachments separate from the general pleadings. If the confidential information does not result in a criminal, civil, or administrative proceeding, it shall be sealed after the licensing entity decides that no further action will be taken in the matter of suspected licensing violations.

(Amended by Stats. 2014, Ch. 283, Sec. 2. (AB 1843) Effective January 1, 2015.)

FAMILY CODE - FAM

DIVISION 8. CUSTODY OF CHILDREN [3000 - 3465] *(Division 8 enacted by Stats. 1992, Ch. 162, Sec. 10.)*

PART 2. RIGHT TO CUSTODY OF MINOR CHILD [3020 - 3204] *(Part 2 enacted by Stats. 1992, Ch. 162, Sec. 10.)*

CHAPTER 6. Custody Investigation and Report [3110 - 3118] *(Chapter 6 repealed and added by Stats. 1993, Ch. 219, Sec. 116.81.)*

3110. As used in this chapter, "court-appointed investigator" means a probation officer, domestic relations investigator, or court-appointed evaluator directed by the court to conduct an investigation pursuant to this chapter.

(Repealed and added by Stats. 1993, Ch. 219, Sec. 116.81. Effective January 1, 1994.)

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FAMILY CODE - FAM

DIVISION 8. CUSTODY OF CHILDREN [3000 - 3465] *(Division 8 enacted by Stats. 1992, Ch. 162, Sec. 10.)*

PART 2. RIGHT TO CUSTODY OF MINOR CHILD [3020 - 3204] *(Part 2 enacted by Stats. 1992, Ch. 162, Sec. 10.)*

CHAPTER 6. Custody Investigation and Report [3110 - 3118] *(Chapter 6 repealed and added by Stats. 1993, Ch. 219, Sec. 116.81.)*

3110.5. (a) No person may be a court-connected or private child custody evaluator under this chapter unless the person has completed the domestic violence and child abuse training program described in Section 1816 and has complied with Rules 5.220 and 5.230 of the California Rules of Court.

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

(A) The rule shall require a child custody evaluator to declare under penalty of perjury that he or she meets all of the education, experience, and training requirements specified in the rule and, if applicable, possesses a license in good standing. The Judicial Council shall establish forms to implement this section. The rule shall permit court-connected evaluators to conduct evaluations if they meet all of the qualifications established by the Judicial Council. The education, experience, and training requirements to be specified for court-connected evaluators shall include, but not be limited to, knowledge of the psychological and developmental needs of children and parent-child relationships.

(B) The rule shall require all evaluators to utilize comparable interview, assessment, and testing procedures for all parties that are consistent with generally accepted clinical, forensic, scientific, diagnostic, or medical standards. The rule shall also require evaluators to inform each adult party of the purpose, nature, and method of the evaluation.

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

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

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

(B) The effects of sexual abuse on children.

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

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

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

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

(c) In addition to the education, experience, and training requirements established by the Judicial Council pursuant to subdivision (b), on or after January 1, 2005, no person may be a child custody evaluator under this chapter, Section 730 of the Evidence Code, or Chapter 15 (commencing with Section 2032.010) of Title 4 of Part 4 of the Code of Civil Procedure unless the person meets one of the following criteria:

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

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

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

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

(5) He or she is a court-connected evaluator who has been certified by the court as meeting all of the qualifications for court-connected evaluators as specified by the Judicial Council pursuant to subdivision (b).

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

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

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

(Amended by Stats. 2004, Ch. 811, Sec. 1.5. Effective January 1, 2005. Operative July 1, 2005, by Sec. 16 of Ch. 811.)

Up^ << Previous Next >> cross-reference chaptered bills PDF | Add To My Favorites Highlight

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PART 2. RIGHT TO CUSTODY OF MINOR CHILD [3020 - 3204] *(Part 2 enacted by Stats. 1992, Ch. 162, Sec. 10.)*

CHAPTER 6. Custody Investigation and Report [3110 - 3118] *(Chapter 6 repealed and added by Stats. 1993, Ch. 219, Sec. 116.81.)*

3111. (a) In any contested proceeding involving child custody or visitation rights, the court may appoint a child custody evaluator to conduct a child custody evaluation in cases where the court determines it is in the best interests of the child. The child custody evaluation shall be conducted in accordance with the standards adopted by the Judicial Council pursuant to Section 3117, and all other standards adopted by the Judicial Council regarding child custody evaluations. If directed by the court, the court-appointed child custody evaluator shall file a written confidential report on his or her evaluation. At least 10 days before any hearing regarding custody of the child, the report shall be filed with the clerk of the court in which the custody hearing will be conducted and served on the parties or their attorneys, and any other counsel appointed for the child pursuant to Section 3150. A child custody evaluation, investigation, or assessment, and any resulting report, may be considered by the court only if it is conducted in accordance with the requirements set forth in the standards adopted by the Judicial Council pursuant to Section 3117; however, this does not preclude the consideration of a child custody evaluation report that contains nonsubstantive or inconsequential errors or both.

(b) The report shall not be made available other than as provided in subdivision (a) or Section 3025.5, or as described in Section 204 of the Welfare and Institutions Code or Section 1514.5 of the Probate Code. Any information obtained from access to a juvenile court case file, as defined in subdivision (e) of Section 827 of the Welfare and Institutions Code, is confidential and shall only be disseminated as provided by paragraph (4) of subdivision (a) of Section 827 of the Welfare and Institutions Code.

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

(d) If the court determines that an unwarranted disclosure of a written confidential report has been made, the court may impose a monetary sanction against the disclosing party. The sanction shall be in an amount sufficient to deter repetition of the conduct, and may include reasonable attorney's fees, costs incurred, or both, unless the court finds that the disclosing party acted with substantial justification or that other circumstances make the imposition of the sanction unjust. The court shall not impose a sanction pursuant to this subdivision that imposes an unreasonable financial burden on the party against whom the sanction is imposed. This subdivision shall become operative on January 1, 2010.

(e) The Judicial Council shall, by January 1, 2010, do the following:

(1) Adopt a form to be served with every child custody evaluation report that informs the report recipient of the confidentiality of the report and the potential consequences for the unwarranted disclosure of the report.

(2) Adopt a rule of court to require that, when a court-ordered child custody evaluation report is served on the parties, the form specified in paragraph (1) shall be included with the report.

(f) For purposes of this section, a disclosure is unwarranted if it is done either recklessly or maliciously, and is not in the best interests of the child.

(Amended by Stats. 2015, Ch. 130, Sec. 1. (SB 594) Effective January 1, 2016.)

Up^ << Previous Next >> cross-reference chaptered bills PDF | Add To My Favorites

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CHAPTER 6. Custody Investigation and Report [3110 - 3118] *(Chapter 6 repealed and added by Stats. 1993, Ch. 219, Sec. 116.81.)*

3117. The Judicial Council shall, by January 1, 1999, do both of the following:

(a) Adopt standards for full and partial court-connected evaluations, investigations, and assessments related to child custody.

(b) Adopt procedural guidelines for the expeditious and cost-effective cross-examination of court-appointed investigators, including, but not limited to, the use of electronic technology whereby the court-appointed investigator may not need to be present in the courtroom. These guidelines shall in no way limit the requirement that the court-appointed investigator be available for the purposes of cross-examination. These guidelines shall also provide for written notification to the parties of the right to cross-examine these investigators after the parties have had a reasonable time to review the investigator's report.

(Added by Stats. 1996, Ch. 761, Sec. 3. Effective January 1, 1997.)

Up^ << Previous Next >> cross-reference chaptered bills PDF | Add To My Favorites

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PART 2. RIGHT TO CUSTODY OF MINOR CHILD [3020 - 3204] *(Part 2 enacted by Stats. 1992, Ch. 162, Sec. 10.)*

CHAPTER 11. Mediation of Custody and Visitation Issues [3160 - 3188] *(Chapter 11 repealed and added by Stats. 1993, Ch. 219, Sec. 116.87.)*

ARTICLE 1. General Provisions [3160 - 3165] *(Article 1 added by Stats. 1993, Ch. 219, Sec. 116.87.)*

3160. Each superior court shall make a mediator available. The court is not required to institute a family conciliation court in order to provide mediation services.

(Repealed and added by Stats. 1993, Ch. 219, Sec. 116.87. Effective January 1, 1994.)

Up^ << Previous Next >> cross-reference chaptered bills PDF | Add To My Favorites

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PART 2. RIGHT TO CUSTODY OF MINOR CHILD [3020 - 3204] *(Part 2 enacted by Stats. 1992, Ch. 162, Sec. 10.)*

CHAPTER 11. Mediation of Custody and Visitation Issues [3160 - 3188] *(Chapter 11 repealed and added by Stats. 1993, Ch. 219, Sec. 116.87.)*

ARTICLE 1. General Provisions [3160 - 3165] *(Article 1 added by Stats. 1993, Ch. 219, Sec. 116.87.)*

3164. (a) The mediator may be a member of the professional staff of a family conciliation court, probation department, or mental health services agency, or may be any other person or agency designated by the court.

(b) The mediator shall meet the minimum qualifications required of a counselor of conciliation as provided in Section 1815.

(Added by Stats. 1993, Ch. 219, Sec. 116.87. Effective January 1, 1994.)

Up^ << Previous Next >> cross-reference chaptered bills PDF | Add To My Favorites

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CHAPTER 11. Mediation of Custody and Visitation Issues [3160 - 3188] *(Chapter 11 repealed and added by Stats. 1993, Ch. 219, Sec. 116.87.)*

ARTICLE 3. Mediation Proceedings [3175 - 3188] *(Article 3 added by Stats. 1993, Ch. 219, Sec. 116.87.)*

3183. (a) Except as provided in Section 3188, the mediator may, consistent with local court rules, submit a recommendation to the court as to the custody of or visitation with the child, if the mediator has first provided the parties and their attorneys, including counsel for any minor children, with the recommendations in writing in advance of the hearing. The court shall make an inquiry at the hearing as to whether the parties and their attorneys have received the recommendations in writing. If the mediator is authorized to submit a recommendation to the court pursuant to this subdivision, the mediation and recommendation process shall be referred to as "child custody recommending counseling" and the mediator shall be referred to as a "child custody recommending counselor." Mediators who make those recommendations are considered mediators for purposes of Chapter 11 (commencing with Section 3160), and shall be subject to all requirements for mediators for all purposes under this code and the California Rules of Court. On and after January 1, 2012, all court communications and information regarding the child custody recommending counseling process shall reflect the change in the name of the process and the name of the providers.

(b) If the parties have not reached agreement as a result of the mediation proceedings, the mediator may recommend to the court that an investigation be conducted pursuant to Chapter 6 (commencing with Section 3110) or that other services be offered to assist the parties to effect a resolution of the controversy before a hearing on the issues.

(c) In appropriate cases, the mediator may recommend that restraining orders be issued, pending determination of the controversy, to protect the well-being of the child involved in the controversy.

(Amended by Stats. 2010, Ch. 352, Sec. 16. (AB 939) Effective January 1, 2011.)

Up^ << Previous Next >> cross-reference chaptered bills PDF | Add To My Favorites

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DIVISION 9. SUPPORT [3500 - 5700.905] *(Division 9 enacted by Stats. 1992, Ch. 162, Sec. 10.)*

PART 3. SPOUSAL SUPPORT [4300 - 4360] *(Part 3 enacted by Stats. 1992, Ch. 162, Sec. 10.)*

CHAPTER 3. Spousal Support Upon Dissolution or Legal Separation [4330 - 4339] *(Chapter 3 enacted by Stats. 1992, Ch. 162, Sec. 10.)*

4331. (a) In a proceeding for dissolution of marriage or for legal separation of the parties, the court may order a party to submit to an examination by a vocational training counselor. The examination shall include an assessment of the party's ability to obtain employment based upon the party's age, health, education, marketable skills, employment history, and the current availability of employment opportunities. The focus of the examination shall be on an assessment of the party's ability to obtain employment that would allow the party to maintain herself or himself at the marital standard of living.

(b) The order may be made only on motion, for good cause, and on notice to the party to be examined and to all parties. The order shall specify the time, place, manner, conditions, scope of the examination, and the person or persons by whom it is to be made.

(c) A party who does not comply with an order under this section is subject to the same consequences provided for failure to comply with an examination ordered pursuant to Chapter 15 (commencing with Section 2032.010) of Title 4 of Part 4 of the Code of Civil Procedure.

(d) "Vocational training counselor" for the purpose of this section means an individual with sufficient knowledge, skill, experience, training, or education in interviewing, administering, and interpreting tests for analysis of marketable skills, formulating career goals, planning courses of training and study, and assessing the job market, to qualify as an expert in vocational training under Section 720 of the Evidence Code.

(e) A vocational training counselor shall have at least the following qualifications:

(1) A master's degree in the behavioral sciences.

(2) Be qualified to administer and interpret inventories for assessing career potential.

(3) Demonstrated ability in interviewing clients and assessing marketable skills with understanding of age constraints, physical and mental health, previous education and experience, and time and geographic mobility constraints.

(4) Knowledge of current employment conditions, job market, and wages in the indicated geographic area.

(5) Knowledge of education and training programs in the area with costs and time plans for these programs.

(f) The court may order the supporting spouse to pay, in addition to spousal support, the necessary expenses and costs of the counseling, retraining, or education.

(Amended by Stats. 2004, Ch. 182, Sec. 35. Effective January 1, 2005. Operative July 1, 2005, by Sec. 64 of Ch. 182.)

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Board of Behavioral Sciences

CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES BILL ANALYSIS

BILL NUMBER: AB 2943 **VERSION:** AMENDED MARCH 23, 2018

AUTHOR: LOW **SPONSOR:**
- EQUALITY CALIFORNIA
- NATIONAL CENTER OF LESBIAN RIGHTS
- TREVOR PROJECT

RECOMMENDED POSITION: NONE

SUBJECT: UNLAWFUL BUSINESS PRACTICES: SEXUAL ORIENTATION CHANGE EFFORTS

Summary: This bill would make advertising, offering to engage in, or engaging in sexual orientation change efforts with an individual an unfair or deceptive act under the Consumer Legal Remedies Act, allowing harmed consumers to bring legal action against violators to recover damages.

Existing Law:

1) Establishes the Consumers Legal Remedies Act (Act). (Civil Code (CC) §1750)

2) States that the act shall be liberally construed and applied to promote the following (CC §1760):

- Protecting consumers against unfair and deceptive business practices; and
- Providing efficient and economical procedures to secure this protection.

3) Defines "Services," as used in the Act, to include work, labor, and services for other than a commercial or business use. (CC §1761(b))

4) Specifies certain unfair methods of competition and unfair or deceptive acts or practices undertaken by a person in a transaction that results in the sale of goods or services to a consumer are unlawful. (CC §1770)

5) Provides that a consumer who suffers damage as a result of the use of an unlawful act or practice specified in CC §1770 may bring an action against that person for actual damages, an order enjoining the acts or practices, restitution of property, punitive damages, or any other relieve the court deems proper. (CC §1780(a))

6) States that a consumer entitled to bring an action under Section 1780 may bring an action on behalf of other consumers to recover damages, if the act or practice also caused damage to those others. (CC §1781(a))

7) States that any action brought under CC §1770 must commence not more than three years from the date of commission of the method, act, or practice. (CC §1783)

8) Prohibits a mental health provider from engaging in sexual orientation change efforts with a patient under age 18. (Business and Professions Code (BPC) §865.1)

9) Makes it unprofessional conduct for a mental health provider to attempt sexual orientation change efforts on a patient under age 18. Violations are subject to disciplinary action by the mental health provider's licensing entity. (BPC §865.2)

10) Defines a "mental health provider" to include licensees, registrants, and trainees of the Board of Behavioral Sciences. (BPC §865)

11) Defines "sexual orientation change efforts" as any practices by mental health providers seeking to change an individual's sexual orientation, including efforts to change behaviors, gender expressions, or eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. (BPC §865(b)(1))

12) States that sexual orientation change efforts do not include psychotherapies that do not seek to change sexual orientation, or that provide acceptance, support and understanding of or facilitation of clients coping, social support and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices. (BPC §865(b)(2))

<u>This Bill:</u>

1) The author of this bill cites several studies, including one by the American Psychological Association in 2009 that is summarized in **Attachment A**, that have issued findings that sexual orientation change efforts can pose critical health risks. (Section 1 of AB 2943)

2) Defines "sexual orientation change efforts" for purposes of the Consumer Legal Remedies Act. The definition is very similar to the definition currently in BPC §865 (for prohibition of sexual orientation change efforts between a mental health provider and a patient under ager 18). The one difference is the proposed language does not specify that the sexual orientation change effort has to be by a mental health provider (as BPC §865 does):

- "Sexual orientation change efforts" means any practices that seek to change an individual's sexual orientation. This includes efforts to change behaviors or gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. (CC §1761(i)(1))

- "Sexual orientation change efforts" does not include psychotherapies that (A) provide acceptance, support, and understanding of clients or the facilitation of clients' coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices; and (B) do not seek to change sexual orientation. (CC §1761(i)(2))

3) Provides that advertising, offering to engage in, or engaging in sexual orientation change efforts with an individual is an unlawful and unfair or deceptive act or practice for purposes of the Consumer Legal Remedies Act. (CC §1770(a)(28))

Comments:

1) **Author's Intent.** The author's office states the following:

   Conversion therapy is a set of dangerous and discredited practices that falsely claim to be able to change a person's sexual orientation from homosexual to heterosexual, change their gender identity or expression, or lessen their same-sex sexual attraction. The American Psychiatric Association, American Psychological Association, the American Counseling Association, the National Association of Social Workers, and the American Medical Association all oppose the practice on the basis that it is not evidence-based and potentially harmful to a patient's mental health. (Author's fact sheet, March 2018)

   The author's office also notes that since the passage of California's SB 1172 in 2012 (banning conversion therapy for minors), nine other states, the District of Columbia, and 32 local municipalities have also banned the therapy for minors.

2) **Board Action for Unprofessional Conduct.** This bill bans sexual orientation change efforts with patients of all ages via the Civil Code. It is unclear how this would affect a licensing board's ability to take disciplinary action for unprofessional conduct, as the bill does not add provisions making it unprofessional conduct into the Business and Professions Code. For example, it could be added as unprofessional conduct in BPC §865.2 (which states sexual orientation change efforts with a minor are unprofessional conduct) or in the unprofessional conduct provisions for each of the Board's license types (BPC §§4982, 4989.54, 4992.3, and 4999.90)

   If this bill passes and sexual orientation efforts becomes an unlawful practice via the Consumer Legal Remedies Act in the Civil Code, the Board may be able to take disciplinary action for unprofessional conduct via one of its more general unprofessional conduct provisions, such as "conviction of a crime substantially related to the qualifications functions or duties of a licensee or registrant," "gross negligence," or "intentionally or recklessly causing physical or emotional harm to any client."

3) **Previous Legislation.** SB 1172 (Lieu, Chapter 835, Statutes of 2012) established the existing law that prohibits a mental health provider from engaging in sexual orientation change efforts with a patient under 18. After extensive work with the author's office and stakeholders to establish a precise definition of "sexual orientation change efforts," the Board took a "support" position on the bill.

4) **Support and Opposition.**

Support:
- Equality California (Co-sponsor)
- National Center of Lesbian Rights (Co-sponsor)
- Trevor Project (Co-sponsor)
- LA LGBT Center

Oppose:
- None at this time.

5) History.

2018
03/23/18 From committee chair, with author's amendments: Amend, and re-refer to Com. on P. & C.P. Read second time and amended.
03/15/18 Referred to Coms. on P. & C.P. and JUD.
02/17/18 From printer. May be heard in committee March 19.
02/16/18 Read first time. To print.

6) Attachments.

Attachment A: Executive Summary of the American Psychological Association, *Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation* (2009), *available at* www.APA.org/pi/LGBT/Resources/Therapeutic-Response.pdf.

AMENDED IN ASSEMBLY MARCH 23, 2018

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 2943

Introduced by Assembly Member Low
(Principal coauthors: Assembly Members Cervantes, Eggman, and Gloria)
(Principal coauthors: Senators Atkins, Galgiani, Lara, and Wiener)

February 16, 2018

An act to amend Sections 1761 and 1770 of the Civil Code, relating to unlawful business practices.

LEGISLATIVE COUNSEL'S DIGEST

AB 2943, as amended, Low. Unlawful business practices: sexual orientation change efforts.

Existing law, the Consumer Legal Remedies Act, makes unlawful certain unfair methods of competition and unfair or deceptive acts or practices undertaken by any person in a transaction intended to ~~result~~ *result,* or which ~~results~~ *results,* in the sale or lease of goods or services to any consumer. Existing law authorizes any consumer who suffers damages as a result of these unlawful practices to bring an action against that person to recover damages, among other things.

Existing law prohibits mental health providers, as defined, from performing sexual orientation change efforts, as specified, with a patient under 18 years of age. Existing law requires a violation of this provision to be considered unprofessional conduct and subjects the provider to discipline by the provider's licensing entity.

This bill would include, as an unlawful practice prohibited under the Consumer Legal Remedies Act, advertising, offering to engage in, or

engaging in sexual orientation change efforts with an individual. The bill would also declare the intent of the Legislature in this regard.

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

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

SECTION 1. The Legislature finds and declares the following:

(a) Contemporary science recognizes that being lesbian, gay, bisexual, or transgender is part of the natural spectrum of human identity and is not a disease, disorder, or illness.

(b) The American Psychological Association convened the Task Force on Appropriate Therapeutic Responses to Sexual Orientation. The task force conducted a systematic review of peer-reviewed journal literature on sexual orientation change efforts and issued a report in 2009. The task force concluded that sexual orientation change efforts can pose critical health risks to lesbian, gay, and bisexual people, including confusion, depression, guilt, helplessness, hopelessness, shame, social withdrawal, suicidality, substance abuse, stress, disappointment, self-blame, decreased self-esteem and authenticity to others, increased self-hatred, hostility and blame toward parents, feelings of anger and betrayal, loss of friends and potential romantic partners, problems in sexual and emotional intimacy, sexual dysfunction, high-risk sexual behaviors, a feeling of being dehumanized and untrue to self, a loss of faith, and a sense of having wasted time and resources.

(c) The American Psychological Association issued a resolution on Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts in 2009, stating: "[T]he [American Psychological Association] advises parents, guardians, young people, and their families to avoid sexual orientation change efforts that portray homosexuality as a mental illness or developmental disorder and to seek psychotherapy, social support, and educational services that provide accurate information on sexual orientation and sexuality, increase family and school support, and reduce rejection of sexual minority youth."

(d) The American Psychiatric Association published a position statement in March of 2000, stating:

"Psychotherapeutic modalities to convert or 'repair' homosexuality are based on developmental theories whose

scientific validity is questionable. Furthermore, anecdotal reports of 'cures' are counterbalanced by anecdotal claims of psychological harm. In the last four decades, 'reparative' therapists have not produced any rigorous scientific research to substantiate their claims of cure. Until there is such research available, [the American Psychiatric Association] recommends that ethical practitioners refrain from attempts to change individuals' sexual orientation, keeping in mind the medical dictum to first, do no harm.

The potential risks of reparative therapy are great, including depression, anxiety and self-destructive behavior, since therapist alignment with societal prejudices against homosexuality may reinforce self-hatred already experienced by the patient. Many patients who have undergone reparative therapy relate that they were inaccurately told that homosexuals are lonely, unhappy individuals who never achieve acceptance or satisfaction. The possibility that the person might achieve happiness and satisfying interpersonal relationships as a gay man or lesbian is not presented, nor are alternative approaches to dealing with the effects of societal stigmatization discussed.

Therefore, the American Psychiatric Association opposes any psychiatric treatment such as reparative or conversion therapy which is based upon the assumption that homosexuality per se is a mental disorder or based upon the a priori assumption that a patient should change his/her sexual homosexual orientation."

(e) The American Academy of Pediatrics published an article in 1993 in its journal, Pediatrics, stating: "Therapy directed at specifically changing sexual orientation is contraindicated, since it can provoke guilt and anxiety while having little or no potential for achieving changes in orientation."

(f) The American Medical Association Council on Scientific Affairs prepared a report in ~~1994~~ *1994*, stating: "Aversion therapy (a behavioral or medical intervention which pairs unwanted behavior, in this case, homosexual behavior, with unpleasant sensations or aversive consequences) is no longer recommended for gay men and lesbians. Through psychotherapy, gay men and lesbians can become comfortable with their sexual orientation and understand the societal response to it."

(g) The National Association of Social Workers prepared a 1997 policy statement, stating: "Social stigmatization of lesbian, gay and bisexual people is widespread and is a primary motivating

factor in leading some people to seek sexual orientation changes. Sexual orientation conversion therapies assume that homosexual orientation is both pathological and freely chosen. No data demonstrates that reparative or conversion therapies are effective, and, in fact, they may be harmful."

(h) The American Counseling Association Governing Council issued a position statement in April of 1999, stating: "We oppose 'the promotion of "reparative therapy" as a "cure" for individuals who are homosexual.'"

(i) The American School Counselor Association issued a position statement in 2014, stating: "It is not the role of the professional school counselor to attempt to change a student's sexual orientation or gender identity. Professional school counselors do not support efforts by licensed mental health professionals to change a student's sexual orientation or gender as these practices have been proven ineffective and harmful."

(j) The American Psychoanalytic Association issued a position statement in June 2012 on attempts to change sexual orientation, gender, identity, or gender expression, stating: "As with any societal prejudice, bias against individuals based on actual or perceived sexual orientation, gender identity or gender expression negatively affects mental health, contributing to an enduring sense of stigma and pervasive self-criticism through the internalization of such prejudice.

Psychoanalytic technique does not encompass purposeful attempts to 'convert,' 'repair,' change or shift an individual's sexual orientation, gender identity or gender expression. Such directed efforts are against fundamental principles of psychoanalytic treatment and often result in substantial psychological pain by reinforcing damaging internalized attitudes."

(k) The American Academy of Child and Adolescent Psychiatry published an article in 2012 in its journal, Journal of the American Academy of Child and Adolescent Psychiatry, stating: "Clinicians should be aware that there is no evidence that sexual orientation can be altered through therapy, and that attempts to do so may be harmful. There is no empirical evidence adult homosexuality can be prevented if gender nonconforming children are influenced to be more gender conforming. Indeed, there is no medically valid basis for attempting to prevent homosexuality, which is not an illness. On the contrary, such efforts may encourage family

rejection and undermine self-esteem, connectedness and caring, important protective factors against suicidal ideation and attempts. Given that there is no evidence that efforts to alter sexual orientation are effective, beneficial or necessary, and the possibility that they carry the risk of significant harm, such interventions are contraindicated."

(*l*) The Pan American Health Organization, a regional office of the World Health Organization, issued a statement in May of 2012, stating: "These supposed conversion therapies constitute a violation of the ethical principles of health care and violate human rights that are protected by international and regional agreements." The organization also noted that reparative therapies "lack medical justification and represent a serious threat to the health and well-being of affected people."

(m) The American Association of Sexuality Educators, Counselors and Therapists (AASECT) issued a statement in ~~2014~~ *2014*, stating: "[S]ame sex orientation is not a mental disorder and we oppose any 'reparative' or conversion therapy that seeks to 'change' or 'fix' a person's sexual orientation. AASECT does not believe that sexual orientation is something that needs to be 'fixed' or 'changed.' The rationale behind this position is the following: Reparative therapy, for minors, in particular, is often forced or nonconsensual. Reparative therapy has been proven harmful to minors. There is no scientific evidence supporting the success of these interventions. Reparative therapy is grounded in the idea that nonheterosexual orientation is 'disordered.' Reparative therapy has been shown to be a negative predictor of psychotherapeutic benefit."

(n) The American College of Physicians wrote a position paper in 2015, stating: "The College opposes the use of 'conversion,' 'reorientation,' or 'reparative' therapy for the treatment of LGBT persons. . . . Available research does not support the use of reparative therapy as an effective method in the treatment of LGBT persons. Evidence shows that the practice may actually cause emotional or physical harm to LGBT individuals, particularly adolescents or young persons."

(o) In October 2015, the Substance Abuse and Mental Health Services Administration of the United States Department of Health and Human Services issued a report titled "Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth." The report

found that "[i]nterventions aimed at a fixed outcome, such as gender conformity or heterosexual orientation, including those aimed at changing gender identity, gender expression, and sexual orientation are coercive, can be harmful, and should not be part of behavioral health treatment."

(p) ~~Courts~~ *Courts, including in California,* have recognized the practice of sexual orientation change efforts as a commercial ~~service, and~~ *service. Therefore,* claims that sexual orientation change efforts are effective in changing an individual's sexual orientation, may constitute unlawful, unfair, or fraudulent business practices under state consumer protection laws. *This bill intends to make clear that sexual orientation change efforts are an unlawful practice under California's Consumer Legal Remedies Act.*

(q) California has a compelling interest in protecting the physical and psychological well-being of lesbian, gay, bisexual, and transgender individuals.

(r) California has a compelling interest in protecting consumers from false and deceptive practices that claim to change sexual orientation and in protecting consumers against exposure to serious harm caused by sexual orientation change efforts.

SEC. 2. Section 1761 of the Civil Code is amended to read:

1761. As used in this title:

(a) "Goods" means tangible chattels bought or leased for use primarily for personal, family, or household purposes, including certificates or coupons exchangeable for these goods, and including goods that, at the time of the sale or subsequently, are to be so affixed to real property as to become a part of real property, whether or not they are severable from the real property.

(b) "Services" means work, labor, and services for other than a commercial or business use, including services furnished in connection with the sale or repair of goods.

(c) "Person" means an individual, partnership, corporation, limited liability company, association, or other group, however organized.

(d) "Consumer" means an individual who seeks or acquires, by purchase or lease, any goods or services for personal, family, or household purposes.

(e) "Transaction" means an agreement between a consumer and another person, whether or not the agreement is a contract

enforceable by action, and includes the making of, and the performance pursuant to, that agreement.

(f) "Senior citizen" means a person who is 65 years of age or older.

(g) "Disabled person" means a person who has a physical or mental impairment that substantially limits one or more major life activities.

(1) As used in this subdivision, "physical or mental impairment" means any of the following:

(A) A physiological disorder or condition, cosmetic disfigurement, or anatomical loss substantially affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive; digestive; genitourinary; hemic and lymphatic; skin; or endocrine.

(B) A mental or psychological disorder, including intellectual disability, organic brain syndrome, emotional or mental illness, and specific learning disabilities. "Physical or mental impairment" includes, but is not limited to, diseases and conditions that include orthopedic, visual, speech, and hearing impairment, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disability, and emotional illness.

(2) "Major life activities" means functions that include caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

(h) "Home solicitation" means a transaction made at the consumer's primary residence, except those transactions initiated by the consumer. A consumer response to an advertisement is not a home solicitation.

(i) (1) "Sexual orientation change efforts" means any practices that seek to change an individual's sexual orientation. This includes efforts to change behaviors or gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex.

(2) "Sexual orientation change efforts" does not include psychotherapies that: (A) provide acceptance, support, and understanding of clients or the facilitation of clients' coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful

conduct or unsafe sexual practices; and (B) do not seek to change sexual orientation.

SEC. 3. Section 1770 of the Civil Code is amended to read:

1770. (a) The following unfair methods of competition and unfair or deceptive acts or practices undertaken by any person in a transaction intended to result or that results in the sale or lease of goods or services to any consumer are unlawful:

(1) Passing off goods or services as those of another.

(2) Misrepresenting the source, sponsorship, approval, or certification of goods or services.

(3) Misrepresenting the affiliation, connection, or association with, or certification by, another.

(4) Using deceptive representations or designations of geographic origin in connection with goods or services.

(5) Representing that goods or services have sponsorship, approval, characteristics, ingredients, uses, benefits, or quantities that they do not have or that a person has a sponsorship, approval, status, affiliation, or connection that he or she does not have.

(6) Representing that goods are original or new if they have deteriorated unreasonably or are altered, reconditioned, reclaimed, used, or secondhand.

(7) Representing that goods or services are of a particular standard, quality, or grade, or that goods are of a particular style or model, if they are of another.

(8) Disparaging the goods, services, or business of another by false or misleading representation of fact.

(9) Advertising goods or services with intent not to sell them as advertised.

(10) Advertising goods or services with intent not to supply reasonably expectable demand, unless the advertisement discloses a limitation of quantity.

(11) Advertising furniture without clearly indicating that it is unassembled if that is the case.

(12) Advertising the price of unassembled furniture without clearly indicating the assembled price of that furniture if the same furniture is available assembled from the seller.

(13) Making false or misleading statements of fact concerning reasons for, existence of, or amounts of, price reductions.

(14) Representing that a transaction confers or involves rights, remedies, or obligations that it does not have or involve, or that are prohibited by law.

(15) Representing that a part, replacement, or repair service is needed when it is not.

(16) Representing that the subject of a transaction has been supplied in accordance with a previous representation when it has not.

(17) Representing that the consumer will receive a rebate, discount, or other economic benefit, if the earning of the benefit is contingent on an event to occur subsequent to the consummation of the transaction.

(18) Misrepresenting the authority of a salesperson, representative, or agent to negotiate the final terms of a transaction with a consumer.

(19) Inserting an unconscionable provision in the contract.

(20) Advertising that a product is being offered at a specific price plus a specific percentage of that price unless (A) the total price is set forth in the advertisement, which may include, but is not limited to, shelf tags, displays, and media advertising, in a size larger than any other price in that advertisement, and (B) the specific price plus a specific percentage of that price represents a markup from the seller's costs or from the wholesale price of the product. This subdivision shall not apply to in-store advertising by businesses that are open only to members or cooperative organizations organized pursuant to Division 3 (commencing with Section 12000) of Title 1 of the Corporations Code where more than 50 percent of purchases are made at the specific price set forth in the advertisement.

(21) Selling or leasing goods in violation of Chapter 4 (commencing with Section 1797.8) of Title 1.7.

(22) (A) Disseminating an unsolicited prerecorded message by telephone without an unrecorded, natural voice first informing the person answering the telephone of the name of the caller or the organization being represented, and either the address or the telephone number of the caller, and without obtaining the consent of that person to listen to the prerecorded message.

(B) This subdivision does not apply to a message disseminated to a business associate, customer, or other person having an established relationship with the person or organization making

the call, to a call for the purpose of collecting an existing obligation, or to any call generated at the request of the recipient.

(23) (A) The home solicitation, as defined in subdivision (h) of Section 1761, of a consumer who is a senior citizen where a loan is made encumbering the primary residence of that consumer for purposes of paying for home improvements and where the transaction is part of a pattern or practice in violation of either subsection (h) or (i) of Section 1639 of Title 15 of the United States Code or paragraphs (1), (2), and (4) of subdivision (a) of Section 226.34 of Title 12 of the Code of Federal Regulations.

(B) A third party shall not be liable under this subdivision unless (i) there was an agency relationship between the party who engaged in home solicitation and the third party, or (ii) the third party had actual knowledge of, or participated in, the unfair or deceptive transaction. A third party who is a holder in due course under a home solicitation transaction shall not be liable under this subdivision.

(24) (A) Charging or receiving an unreasonable fee to prepare, aid, or advise any prospective applicant, applicant, or recipient in the procurement, maintenance, or securing of public social services.

(B) For purposes of this paragraph, the following definitions shall apply:

(i) "Public social services" means those activities and functions of state and local government administered or supervised by the State Department of Health Care Services, the State Department of Public Health, or the State Department of Social Services, and involved in providing aid or services, or both, including health care services, and medical assistance, to those persons who, because of their economic circumstances or social condition, are in need of that aid or those services and may benefit from them.

(ii) "Public social services" also includes activities and functions administered or supervised by the United States Department of Veterans Affairs or the California Department of Veterans Affairs involved in providing aid or services, or both, to veterans, including pension benefits.

(iii) "Unreasonable fee" means a fee that is exorbitant and disproportionate to the services performed. Factors to be considered, if appropriate, in determining the reasonableness of a fee, are based on the circumstances existing at the time of the service and shall include, but not be limited to, all of the following:

(I) The time and effort required.

(II) The novelty and difficulty of the services.

(III) The skill required to perform the services.

(IV) The nature and length of the professional relationship.

(V) The experience, reputation, and ability of the person providing the services.

(C) This paragraph shall not apply to attorneys licensed to practice law in California, who are subject to the California Rules of Professional Conduct and to the mandatory fee arbitration provisions of Article 13 (commencing with Section 6200) of Chapter 4 of Division 3 of the Business and Professions Code, when the fees charged or received are for providing representation in administrative agency appeal proceedings or court proceedings for purposes of procuring, maintaining, or securing public social services on behalf of a person or group of persons.

(25) (A) Advertising or promoting any event, presentation, seminar, workshop, or other public gathering regarding veterans' benefits or entitlements that does not include the following statement in the same type size and font as the term "veteran" or any variation of that term:

(i) "I am not authorized to file an initial application for Veterans' Aid and Attendance benefits on your behalf, or to represent you before the Board of Veterans' Appeals within the United States Department of Veterans Affairs in any proceeding on any matter, including an application for such benefits. It would be illegal for me to accept a fee for preparing that application on your behalf." The requirements of this clause do not apply to a person licensed to act as an agent or attorney in proceedings before the Agency of Original Jurisdiction and the Board of Veterans' Appeals within the United States Department of Veterans Affairs when that person is offering those services at the advertised event.

(ii) The statement in clause (i) shall also be disseminated, both orally and in writing, at the beginning of any event, presentation, seminar, workshop, or public gathering regarding veterans' benefits or entitlements.

(B) Advertising or promoting any event, presentation, seminar, workshop, or other public gathering regarding veterans' benefits or entitlements that is not sponsored by, or affiliated with, the United States Department of Veterans Affairs, the California Department of Veterans Affairs, or any other congressionally

chartered or recognized organization of honorably discharged members of the Armed Forces of the United States, or any of their auxiliaries that does not include the following statement, in the same type size and font as the term "veteran" or the variation of that term:

"This event is not sponsored by, or affiliated with, the United States Department of Veterans Affairs, the California Department of Veterans Affairs, or any other congressionally chartered or recognized organization of honorably discharged members of the Armed Forces of the United States, or any of their auxiliaries. None of the insurance products promoted at this sales event are endorsed by those organizations, all of which offer free advice to veterans about how to qualify and apply for benefits."

(i) The statement in this subparagraph shall be disseminated, both orally and in writing, at the beginning of any event, presentation, seminar, workshop, or public gathering regarding veterans' benefits or entitlements.

(ii) The requirements of this subparagraph shall not apply in a case where the United States Department of Veterans Affairs, the California Department of Veterans Affairs, or other congressionally chartered or recognized organization of honorably discharged members of the Armed Forces of the United States, or any of their auxiliaries have granted written permission to the advertiser or promoter for the use of its name, symbol, or insignia to advertise or promote the event, presentation, seminar, workshop, or other public gathering.

(26) Advertising, offering for sale, or selling a financial product that is illegal under state or federal law, including any cash payment for the assignment to a third party of the consumer's right to receive future pension or veteran's benefits.

(27) Representing that a product is made in California by using a Made in California label created pursuant to Section 12098.10 of the Government Code, unless the product complies with Section 12098.10 of the Government Code.

(28) Advertising, offering to engage in, or engaging in sexual orientation change efforts with an individual.

(b) (1) It is an unfair or deceptive act or practice for a mortgage broker or lender, directly or indirectly, to use a home improvement

contractor to negotiate the terms of any loan that is secured, whether in whole or in part, by the residence of the borrower and that is used to finance a home improvement contract or any portion of a home improvement contract. For purposes of this subdivision, "mortgage broker or lender" includes a finance lender licensed pursuant to the California Finance Lenders Law (Division 9 (commencing with Section 22000) of the Financial Code), a residential mortgage lender licensed pursuant to the California Residential Mortgage Lending Act (Division 20 (commencing with Section 50000) of the Financial Code), or a real estate broker licensed under the Real Estate Law (Division 4 (commencing with Section 10000) of the Business and Professions Code).

(2) This section shall not be construed to either authorize or prohibit a home improvement contractor from referring a consumer to a mortgage broker or lender by this subdivision. However, a home improvement contractor may refer a consumer to a mortgage lender or broker if that referral does not violate Section 7157 of the Business and Professions Code or any other law. A mortgage lender or broker may purchase an executed home improvement contract if that purchase does not violate Section 7157 of the Business and Professions Code or any other law. Nothing in this paragraph shall have any effect on the application of Chapter 1 (commencing with Section 1801) of Title 2 to a home improvement transaction or the financing of a home improvement transaction.

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98

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ASSOCIATION

Report of the American Psychological Association Task Force on

Appropriate Therapeutic Responses to Sexual Orientation

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Available online at http://www.apa.org/pi/lgbc/publications/therapeutic-resp.html

Printed copies available from:
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Suggested bibliographic reference:
American Psychological Association, Task Force on Appropriate Therapeutic Responses to Sexual Orientation. (2009). *Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation*. Retrieved from http://www.apa.org/pi/lgbc/publications/therapeutic-resp.html

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August 2009
Printed in the USA

CONTENTS

ABSTRACT

The American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation conducted a systematic review of the peer-reviewed journal literature on sexual orientation change efforts (SOCE) and concluded that efforts to change sexual orientation are unlikely to be successful and involve some risk of harm, contrary to the claims of SOCE practitioners and advocates. Even though the research and clinical literature demonstrate that same-sex sexual and romantic attractions, feelings, and behaviors are normal and positive variations of human sexuality regardless of sexual orientation identity, the task force concluded that the population that undergoes SOCE tends to have strongly conservative religious views that lead them to seek to change their sexual orientation. Thus, the appropriate application of affirmative therapeutic interventions for those who seek SOCE involves therapist acceptance, support, and understanding of clients and the facilitation of clients' active coping, social support, and identity exploration and development, without imposing a specific sexual orientation identity outcome.

EXECUTIVE SUMMARY

In February 2007, the American Psychological Association (APA) established the Task Force on Appropriate Therapeutic Responses to Sexual Orientation and charged the task force with three major tasks:

1. Review and update the 1997 Resolution on Appropriate Therapeutic Responses to Sexual Orientation (APA, 1998).
2. Generate a report that includes discussion of the following:
   - The appropriate application of affirmative therapeutic interventions for children and adolescents who present a desire to change either their sexual orientation or their behavioral expression of their sexual orientation, or both, or whose guardian expresses a desire for the minor to change.
   - The appropriate application of affirmative therapeutic interventions for adults who present a desire to change their sexual orientation or their behavioral expression of their sexual orientation, or both.
   - The presence of adolescent inpatient facilities that offer coercive treatment designed to change sexual orientation or the behavioral expression of sexual orientation.
   - Education, training, and research issues as they pertain to such therapeutic interventions.
   - Recommendations regarding treatment protocols that promote stereotyped gender-normative behavior to mitigate behaviors that are perceived to be indicators that a child will develop a homosexual orientation in adolescence and adulthood.
3. Inform APA's response to groups that promote treatments to change sexual orientation or its behavioral expression and support public policy that furthers affirmative therapeutic interventions.

As part of the fulfillment of its charge, the task force undertook an extensive review of the recent literature on psychotherapy and the psychology of sexual orientation. There is a growing body of evidence concluding that sexual stigma, manifested as prejudice and discrimination directed at non-heterosexual sexual orientations and identities, is a major source of stress for sexual minorities.* This stress, known as *minority stress*, is a factor in mental health disparities found in some sexual minorities. The minority stress model also provides a framework for considering psychotherapy with sexual minorities, including understanding stress, distress, coping, resilience, and recovery. For instance, the affirmative approach to psychotherapy grew out of an awareness that sexual minorities benefit

* We use the term *sexual minority* (cf. Blumenfeld, 1992; McCarn & Fassinger, 1996; Ullerstam, 1966) to designate the entire group of individuals who experience significant erotic and romantic attractions to adult members of their own sex, including those who experience attractions to members of their own and of the other sex. This term is used because we recognize that not all sexual minority individuals adopt a lesbian, gay, or bisexual identity.

when the sexual stigma they experience is addressed in psychotherapy with interventions that reduce and counter internalized stigma and increase active coping.

The task force, in recognition of human diversity, conceptualized affirmative interventions within the domain of cultural competence, consistent with general multicultural approaches that acknowledge the importance of age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status. We see this multiculturally competent and affirmative approach as grounded in an acceptance of the following scientific facts:

- Same-sex sexual attractions, behavior, and orientations per se are normal and positive variants of human sexuality—in other words, they do not indicate either mental or developmental disorders.
- Homosexuality and bisexuality are stigmatized, and this stigma can have a variety of negative consequences (e.g., minority stress) throughout the life span.
- Same-sex sexual attractions and behavior occur in the context of a variety of sexual orientations and sexual orientation identities, and for some, sexual orientation identity (i.e., individual or group membership and affiliation, self-labeling) is fluid or has an indefinite outcome.
- Gay men, lesbians, and bisexual individuals form stable, committed relationships and families that are equivalent to heterosexual relationships and families in essential respects.
- Some individuals choose to live their lives in accordance with personal or religious values (i.e., telic congruence).

Summary of the Systematic Review of the Literature

Efficacy and Safety

In order to ascertain whether there was a research basis for revising the 1997 Resolution on Appropriate Therapeutic Responses to Sexual Orientation (APA, 1998) and providing more specific recommendations to licensed mental health practitioners, the public, and policymakers, the task force performed a systematic review of the peer-reviewed literature to answer three questions:

- Are sexual orientation change efforts (SOCE)** effective at changing sexual orientation?
- Are SOCE harmful?
- Are there any additional benefits that can be reasonably attributed to SOCE?

The review covered the peer-reviewed journal articles in English from 1960 to 2007. Most studies in this area were conducted before 1981, and only a few studies have been conducted in the last 10 years. We found serious methodological problems in this area of research; only a few studies met the minimal standards for evaluating whether psychological treatments such as efforts to change sexual orientation are effective. Few studies—all conducted in the period from 1969 to 1978—could be considered true experiments or quasi-experiments that would isolate and control the factors that might effect change (Birk, Huddleston, Miller, & Cohler, 1971; S. James, 1978; McConaghy, 1969, 1976; McConaghy, Proctor, & Barr, 1972; Tanner, 1974, 1975). Only one of these studies (Tanner, 1974) actually compared people who received a treatment with people who did not and could therefore rule out the possibility that other things, such as being motivated to change, were the true cause of any change the researchers observed in the study participants.

None of the recent research (1999–2007) meets methodological standards that permit conclusions regarding efficacy or safety. The few high-quality studies of SOCE conducted recently are qualitative (e.g., Beckstead & Morrow, 2004; Ponticelli, 1999; Wolkomir, 2001); although they aid in an understanding of the population that undergoes sexual orientation change, they do not provide the kind of information needed for definitive answers to questions of safety and efficacy. Given the limited amount of methodologically sound research, claims that recent SOCE is effective are not supported.

We concluded that the early high-quality evidence is the best basis for predicting what the outcome of valid interventions would be. These studies show that

** In this report, we use the term *sexual orientation change efforts* (SOCE) to describe methods (e.g., behavioral techniques, psychoanalytic techniques, medical approaches, religious and spiritual approaches) that aim to change a person's same-sex sexual orientation to other-sex, regardless of whether mental health professionals or lay individuals (including religious professionals, religious leaders, social groups, and other lay networks, such as self-help groups) are involved.

enduring change to an individual's sexual orientation is uncommon. The participants in this body of research continued to experience same-sex attractions following SOCE and did not report significant change to other-sex attractions that could be empirically validated, though some showed lessened physiological arousal to sexual stimuli. Compelling evidence of decreased same-sex sexual behavior and of engagement in sexual behavior with the other sex was rare. Few studies provided strong evidence that any changes produced in laboratory conditions translated to daily life. Thus, the results of scientifically valid research indicate that it is unlikely that individuals will be able to reduce same-sex attractions or increase other-sex sexual attractions through SOCE.

We found that there was some evidence to indicate that individuals experienced harm from SOCE. Early studies documented iatrogenic effects of aversive forms of SOCE. These negative side effects included loss of sexual feeling, depression, suicidality, and anxiety. High dropout rates characterized early aversive treatment studies and may be an indicator that research participants experienced these treatments as harmful. Recent research reports on religious and nonaversive efforts indicate that there are individuals who perceive they have been harmed. Across studies, it is unclear what specific individual characteristics and diagnostic criteria would prospectively distinguish those individuals who will later perceive that they been harmed by SOCE.

Individuals Who Seek SOCE and Their Experiences

Although the recent SOCE research cannot provide conclusions regarding efficacy or safety, it does provide some information on those individuals who participate in change efforts. SOCE research identified a population of individuals who experienced conflicts and distress related to same-sex attractions. The vast majority of people who participated in the early studies were adult White males, and many of these individuals were court-mandated to receive treatment. In the research conducted over the last 10 years, the population was mostly well-educated individuals, predominantly men, who consider religion to be an extremely important part of their lives and participate in traditional or conservative faiths (e.g., The Church of Jesus Christ of Latter-Day Saints, evangelical Christianity, and Orthodox Judaism). These recent studies included a small number of participants who identified as members of ethnic minority groups, and a few studies included women.

Most of the individuals studied had tried a variety of methods to change their sexual orientation, including psychotherapy, support groups, and religious efforts. Many of the individuals studied were recruited from groups endorsing SOCE. The relation between the characteristics of the individuals in samples used in these studies and the entire population of people who seek SOCE is unknown because the studies have relied entirely on convenience samples.

Former participants in SOCE reported diverse evaluations of their experiences: Some individuals perceived that they had benefited from SOCE, while others perceived that they had been harmed. Individuals who failed to change sexual orientation, while believing they should have changed with such efforts, described their experiences as a significant cause of emotional and spiritual distress and negative self-image. Other individuals reported that SOCE was helpful—for example, it helped them live in a manner consistent with their faith. Some individuals described finding a sense of community through religious SOCE and valued having others with whom they could identify. These effects are similar to those provided by mutual support groups for a range of problems, and the positive benefits reported by participants in SOCE, such as reduction of isolation, alterations in how problems are viewed, and stress reduction, are consistent with the findings of the general mutual support group literature. The research literature indicates that the benefits of SOCE mutual support groups are not unique and can be provided within an affirmative and multiculturally competent framework, which can mitigate the harmful aspects of SOCE by addressing sexual stigma while understanding the importance of religion and social needs.

Recent studies of participants who have sought SOCE do not adequately distinguish between *sexual orientation* and *sexual orientation identity*. We concluded that the failure to distinguish these aspects of human sexuality has led SOCE research to obscure what actually can or cannot change in human sexuality. The available evidence of both early and recent studies suggests that although sexual orientation is unlikely to change, some individuals modified their sexual orientation identity (e.g., individual or group membership and affiliation, self-labeling) and other aspects of sexuality (e.g., values and behavior). They did so in a variety of ways and with varied and

unpredictable outcomes, some of which were temporary. For instance, in some research, individuals, through participating in SOCE, became skilled in ignoring or tolerating their same-sex attractions. Some individuals reported that they went on to lead outwardly heterosexual lives, developing a sexual relationship with an other-sex partner, and adopting a heterosexual identity. These results were less common for those with no prior heterosexual experience.

Literature on Children and Adolescents

To fulfill part of the task force charge, we reviewed the limited research on child and adolescent issues and drew the following conclusions: There is no research demonstrating that providing SOCE to children or adolescents has an impact on adult sexual orientation. The few studies of children with gender identity disorder found no evidence that psychotherapy provided to those children had an impact on adult sexual orientation. There is currently no evidence that teaching or reinforcing stereotyped gender-normative behavior in childhood or adolescence can alter sexual orientation. We have concerns that such interventions may increase self-stigma and minority stress and ultimately increase the distress of children and adolescents.

We were asked to report on adolescent inpatient facilities that offer coercive treatment designed to change sexual orientation or the behavioral expression of sexual orientation. The limited published literature on these programs suggests that many do not present accurate scientific information regarding same-sex sexual orientations to youths and families, are excessively fear-based, and have the potential to increase sexual stigma. These efforts pose challenges to best clinical practices and professional ethics, as they potentially violate current practice guidelines by not providing treatment in the least-restrictive setting possible, by not protecting client autonomy, and by ignoring current scientific information on sexual orientation.

Recommendations and Future Directions

Practice

The task force was asked to report on the appropriate application of affirmative therapeutic interventions for adults who present a desire to change their sexual orientation or their behavioral expression of their sexual orientation, or both. The clinical literature indicated that adults perceive a benefit when they are provided with client-centered, multicultural, evidence-based approaches that provide (a) acceptance and support, (b) a comprehensive assessment, (c) active coping, (d) social support, and (e) identity exploration and development. Acceptance and support include unconditional acceptance of and support for the various aspects of the client; respect for the client's values, beliefs, and needs; and a reduction in internalized sexual stigma. Comprehensive assessment involves an awareness of the complete person, including mental health concerns that could impact distress about sexual orientation. Active coping includes both cognitive and emotional strategies to manage stigma and conflicts, including the development of alternative cognitive frames to resolve cognitive dissonance and the facilitation of affective expression and resolution of losses. Social support, which can mitigate distress caused by isolation, rejection, and lack of role models, includes psychotherapy, self-help groups, or welcoming communities (e.g., ethnic communities, social groups, religious denominations). Identity exploration and development include offering permission and opportunity to explore a wide range of options and reducing the conflicts caused by dichotomous or conflicting conceptions of self and identity without prioritizing a particular outcome.

This framework is consistent with multicultural and evidence-based practices in psychotherapy and is built on three key findings:

- Our systematic review of the early research found that enduring change to an individual's sexual orientation was unlikely.
- Our review of the scholarly literature on individuals distressed by their sexual orientation indicated that clients perceived a benefit when offered interventions that emphasize acceptance, support, and recognition of important values and concerns.
- Studies indicate that experiences of stigma—such as self-stigma, shame, isolation and rejection from relationships and valued communities, lack of emotional support and accurate information, and conflicts between multiple identities and between values and attractions—played a role in creating distress in individuals. Many religious individuals desired to live their lives in a manner consistent with their values (telic congruence); however, telic

congruence based on stigma and shame is unlikely to result in psychological well-being.

In terms of formulating the goals of treatment, we propose that, on the basis of research on sexual orientation and sexual orientation identity, what appears to shift and evolve in some individuals' lives is sexual orientation identity, not sexual orientation. Given that there is diversity in how individuals define and express their sexual orientation identity, an affirmative approach is supportive of clients' identity development without an a priori treatment goal concerning how clients identify or live out their sexual orientation or spiritual beliefs. This type of therapy can provide a safe space where the different aspects of the evolving self can be acknowledged, explored, respected, and potentially rewoven into a more coherent sense of self that feels authentic to the client, and it can be helpful to those who accept, reject, or are ambivalent about their same-sex attractions. The treatment does not differ, although the outcome of the client's pathway to a sexual orientation identity does. Other potential targets of treatment are emotional adjustment, including shame and self-stigma, and personal beliefs, values, and norms.

We were asked to report on the appropriate application of affirmative therapeutic interventions for children and adolescents who present a desire to change either their sexual orientation or the behavioral expression of their sexual orientation, or both, or whose parent or guardian expresses a desire for the minor to change. The framework proposed for adults (i.e., acceptance and support, a comprehensive assessment, active coping, social support, and identity exploration and development) is also pertinent—with unique relevant features—to children and adolescents. For instance, the clinical literature stresses interventions that accept and support the development of healthy self-esteem, facilitate the achievement of appropriate developmental milestones—including the development of a positive identity—and reduce internalized sexual stigma.

For parents who are concerned or distressed by their child's sexual orientation, licensed mental health providers (LMHP) can provide accurate information about sexual orientation and sexual orientation identity and can offer anticipatory guidance and psychotherapy that support family reconciliation.

Research indicates that family interventions that reduce rejection and increase acceptance of their child and adolescent are helpful. For parents who are concerned or distressed by their child's sexual orientation, licensed mental health providers (LMHP) can provide accurate information about sexual orientation and sexual orientation identity and can offer anticipatory guidance and psychotherapy that support family reconciliation (e.g., communication, understanding, and empathy) and maintenance of the child's total health and well-being.

Additionally, the research and clinical literature indicates that increasing social support for sexual minority children and youth by intervening in schools and communities to increase their acceptance and safety is important. Services for children and youth should support and respect age-appropriate issues of self-determination; services should also be provided in the least restrictive setting that is clinically possible and should maximize self-determination. At a minimum, the assent of the youth should be obtained, including whenever possible a developmentally appropriate informed consent to treatment.

Some religious individuals with same-sex attractions experience psychological distress and conflict due to the perceived irreconcilability of their sexual orientation and religious beliefs. The clinical and research literature encourages the provision of acceptance, support, and recognition of the importance of faith to individuals and communities while recognizing the science of sexual orientation. This includes an understanding of the client's faith and the psychology of religion, especially issues such as religious coping, motivation, and identity. Clients' exploration of possible life paths can address the reality of their sexual orientation and the possibilities for a religiously and spiritually meaningful and rewarding life. Such psychotherapy can enhance clients' search for meaning, significance, and a relationship with the sacred in their lives; increase positive religious coping; foster an understanding of religious motivations; help integrate religious and sexual orientation identities; and reframe sexual orientation identities to reduce self-stigma.

LMHP strive to provide interventions that are consistent with current ethical standards. The APA *Ethical Principles of Psychologists and Code of Conduct* (APA, 2002b) and relevant APA guidelines and resolutions (e.g., APA, 2000, 2002c, 2004, 2005a, 2007b) are resources for psychologists, especially Ethical Principles A (Beneficence and Nonmaleficense), D (Justice), and E (Respect for People's Rights and

Dignity, including self-determination). For instance, LMHP reduce potential harm and increase potential benefits by basing their scientific and professional judgments and actions on the most current and valid scientific evidence, such as the evidence provided in this report (see APA, 2002b, Standard 2.04, Bases for Scientific and Professional Judgments). LMHP enhance principles of social justice when they strive to understand the effects of sexual stigma, prejudice, and discrimination on the lives of individuals, families, and communities. Further, LMHP aspire to respect diversity in all aspects of their work, including age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, and socioeconomic status.

Self-determination is the process by which a person controls or determines the course of her or his own life (according to the *Oxford American Dictionary*, 2007). LMHP maximize self-determination by (a) providing effective psychotherapy that explores the client's assumptions and goals, without preconditions on the outcome; (b) providing resources to manage and reduce distress; and (c) permitting the client to decide the ultimate goal of how to self-identify and live out her or his sexual orientation. Although some accounts suggest that providing SOCE increases self-determination, we were not persuaded by this argument, as it encourages LMHP to provide treatment that has not provided evidence of efficacy, has the potential to be harmful, and delegates important professional decisions that should be based on qualified expertise and training—such as diagnosis and type of therapy. Rather, therapy that increases the client's ability to cope, understand, acknowledge, and integrate sexual orientation concerns into a self-chosen life is the measured approach.

Education and Training

The task force was asked to provide recommendations on education and training for LMHP working with this population. We recommend that mental health professionals working with individuals who are considering SOCE learn about evidence-based and multicultural interventions and obtain additional knowledge, awareness, and skills in the following areas:

- Sexuality, sexual orientation, and sexual identity development.
- Various perspectives on religion and spirituality, including models of faith development, religious coping, and the positive psychology of religion.
- Identity development, including integration of multiple identities and the resolution of identity conflicts.
- The intersections of age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status.
- Sexual stigma and minority stress.

We also recommend that APA (a) take steps to encourage community colleges, undergraduate programs, graduate school training programs, internship sites, and postdoctoral programs in psychology to include this report and other relevant material on lesbian, gay, bisexual, and transgender (LGBT) issues in their curriculum; (b) maintain the currently high standards for APA approval of continuing professional education providers and programs; (c) offer symposia and continuing professional education workshops at APA's annual convention that focus on treatment of individuals distressed by their same-sex attractions, especially those who struggle to integrate religious and spiritual beliefs with sexual orientation identities; and (d) disseminate this report widely, including publishing a version of this report in an appropriate journal or other publication.

The information available to the public about SOCE is highly variable and can be confusing and misleading. Sexual minorities, individuals aware of same-sex attractions, families, parents, caregivers, policymakers, the public, and religious leaders can benefit from accurate scientific information about sexual orientation and the appropriate interventions for individuals distressed by their same-sex attractions. We recommend that APA take the lead in creating informational materials for sexual minority individuals, families, parents, and other stakeholders, including religious organizations, on appropriate multiculturally competent and client-centered interventions for those distressed by their sexual orientation and who may seek SOCE. We also recommended that APA collaborate with other relevant organizations, especially religious organizations, to disseminate this information.

Research

The task force was asked to provide recommendations for future research. We recommend that researchers and practitioners investigate multiculturally competent and affirmative evidence-based treatments for sexual

minorities that do not aim to alter sexual orientation. For such individuals, the focus would be on frameworks that include acceptance and support, a comprehensive assessment, active coping, social support, and identity exploration and development without prioritizing one outcome over another.

The research on SOCE has not adequately assessed efficacy and safety. Any future research should conform to best-practice standards for the design of efficacy research. Research on SOCE would (a) use methods that are prospective and longitudinal; (b) employ sampling methods that allow proper generalization; (c) use appropriate, objective, and high-quality measures of sexual orientation and sexual orientation identity; (d) address preexisting and co-occurring conditions, mental health problems, other interventions, and life histories to test competing explanations for any changes; (e) address participants' biases and potential need for monitoring self-impression and life histories; and (f) include measures capable of assessing harm.

Policy

The task force was asked to inform (a) the association's response to groups that promote treatments to change sexual orientation or its behavioral expression and (b) public policy that furthers affirmative therapeutic interventions. We encourage APA to continue its advocacy for LGBT individuals and families and to oppose stigma, prejudice, discrimination, and violence directed at sexual minorities. We recommend that APA take a leadership role in opposing the distortion and selective use of scientific data about homosexuality by individuals and organizations and in supporting the dissemination of accurate scientific and professional information about sexual orientation in order to counteract bias. We encourage APA to engage in collaborative activities with religious communities in pursuit of shared prosocial goals when such collaboration can be done in a mutually respectful manner that is consistent with psychologists' professional and scientific roles.

The 1997 Resolution on Appropriate Responses to Sexual Orientation (APA, 1998) focuses on ethical issues for practitioners and still serves this purpose. However, on the basis of (a) our systematic review of efficacy and safety issues, (b) the presence of SOCE directed at children and adolescents, (c) the importance of religion for those who currently seek SOCE, and (d) the ideological and political disputes that affect this area, the task force recommended that the APA Council of Representatives adopt a new resolution, the **Resolution on Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts**, to address these issues. [The Council adopted the resolution in August 2009.] (See Appendix A.)

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Board of Behavioral Sciences

CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES BILL ANALYSIS

BILL NUMBER: AB 2968 **VERSION:** AMENDED MARCH 23, 2018

AUTHOR: LEVINE **SPONSOR:** BOARD OF PSYCHOLOGY

RECOMMENDED POSITION: NONE

SUBJECT: PSYCHOTHERAPIST-CLIENT RELATIONSHIP: VICTIMS OF SEXUAL BEHAVIOR AND SEXUAL CONTACT: INFORMATIONAL BROCHURE

Summary: This bill makes changes to sections of the Business and Professions Code (BPC) relating to the requirement that the Department of Consumer Affairs (DCA) create a brochure to educate the public about the prohibition of sexual contact in therapy.

Existing Law:

1) Requires DCA to prepare an informational brochure for victims of psychotherapist-patient sexual contact and their advocates. (BPC §337(a))

2) In developing the brochure, requires DCA to consult with the Attorney General's Office and the Sexual Assault Program of the Office of Criminal Justice Planning. (BPC §337(a))

3) Requires the brochure to include at least the following (BPC §337(b)):

- **a)** A legal and informal definition of psychotherapist-patient sexual contact;
- **b)** Common personal reactions and victim histories;
- **c)** A patient's bill of rights;
- **d)** Options and instructions for reporting psychotherapist-patient sexual relations;
- **e)** A description of administrative, civil, and professional association complaint procedures; and
- **f)** A description of support services available for victims.

4) Requires the brochure to be provided to everyone contacting the Medical Board or its affiliated health boards, or the Board of Behavioral Sciences, regarding a complaint involving psychotherapist-patient sexual relations. (BPC §337(c))

5) Requires any psychotherapist or their employer who becomes aware through a patient that the patient had alleged sexual intercourse or sexual contact with a previous psychotherapist during prior treatment, to provide and discuss the above-referenced brochure with the patient. Failure to comply is unprofessional conduct. (BPC §728 (a) and (b))

6) Defines "psychotherapist" to include a physician and surgeon practicing psychiatry or psychotherapy, a psychologist, a clinical social worker, marriage and family therapist, licensed professional clinical counselor, psychological assistant, MFT intern or trainee, PCC intern or trainee, or associate clinical social worker. (BPC §728(c))

7) Defines "sexual contact" as touching an intimate part of another person. (BPC §728(c))

This Bill:

1) Removes the requirement that DCA consult with the Attorney General's Office and the Sexual Assault Program of the Office of Criminal Justice Planning (which no longer exists) in the development of the brochure. (BPC §337(a))

2) Updates the definition of "psychotherapist" to include licensed educational psychologists, and updates the terminology used for other Board license types. (All Board license types are now included: LMFTs, associate MFTs, LPCCs, associate PCCs, LEPs, LCSWs, associate clinical social workers, and MFT and PCC trainees.) (BPC §728(c))

3) Adds a definition of "sexual behavior" to include with "sexual contact." "Sexual behavior" is defined as inappropriate contact or communication of a sexual nature. It does not include the provision of appropriate therapeutic interventions relating to sexual issues. (BPC §728((c))

Comments:

1) **Intent.** This is an effort being led by the Board of Psychology (BOP) to modernize the statutory language regarding the requirements for the "Professional Therapy Never Includes Sex" brochure (**Attachment A**). The BOP has held stakeholder meetings to gain input from this Board and the Medical Board, which are also affected by the law's provisions.

Specific areas of concern being addressed in this bill include outdated terminology that does not include sexual behaviors that have arisen with advances in technology, concern about the requirement to define civil and professional association's complaint procedures, and references to outdated license classifications.

2) **Previous Board Consideration and Suggested Amendment.** The Board considered a draft version of this bill's language at its February 22, 2018 meeting. The Board had two suggestions which were relayed to the BOP and the author's office:

a. Correct some minor errors in the references to Board license types under the definition of a "psychotherapist." (BPC §728(c))(1)); and

b. Make a change to a reference in 728(a). Currently, the language requires a therapist who becomes aware that a client had alleged sexual contact or behavior with a previous therapist must provide a brochure that *"…delineates the rights of, and remedies for, clients who have been involved sexually with their psychotherapists."*

At the meeting, the Board suggested the following change to that language: *"…delineates the rights of, and remedies for, clients who have been ~~involved sexually with~~* the victim of sexual behavior or sexual contact with *their psychotherapists."*

The Board's suggested corrections to license type references in (a) above were amended into the bill. The suggestion in (b) was not. The Board may wish to discuss whether to continue to pursue that amendment.

3) Support and Opposition.

Support:

- Board of Psychology (Sponsor)

Oppose:

- None at this time.

4) History.

2018

03/23/18	From committee chair, with author's amendments: Amend, and re-refer to Com. on B. & P. Read second time and amended.
03/22/18	Referred to Com. on B. & P.
02/17/18	From printer. May be heard in committee March 19.
02/16/18	Read first time. To print.

5) Attachments.

Attachment A: Professional Therapy Never Includes Sex Brochure (Current Version)

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AMENDED IN ASSEMBLY MARCH 23, 2018

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 2968

Introduced by Assembly Member Levine

February 16, 2018

An act to amend ~~Section 105~~ *Sections 337 and 728* of the Business and Professions Code, relating to ~~consumer affairs.~~ *healing arts.*

LEGISLATIVE COUNSEL'S DIGEST

AB 2968, as amended, Levine. ~~Consumer affairs.~~ *Psychotherapist-client relationship: victims of sexual behavior and sexual contact: informational brochure.*

Existing law requires the Department of Consumer Affairs to prepare and disseminate an informational brochure for victims of psychotherapist-patient sexual contact and their advocates, and requires that the brochure be developed by the department in consultation with the office of Criminal Justice Planning and the office of the Attorney General, as specified. Existing law requires the brochure to include specified subjects and requires the brochure to be provided to individuals who contact the Medical Board of California and affiliated health boards or the Board of Behavioral Sciences regarding a complaint involving psychotherapist-patient sexual relations.

This bill would eliminate the requirement that the department develop the brochure in consultation with the office of Criminal Justice Planning and the office of the Attorney General. The bill would require that the brochure also be for victims of psychotherapist-client sexual behavior. The bill would revise the required content of the brochure, and would require the brochure to be provided to each individual contacting the Medical Board of California, the Osteopathic Medical Board of

California, the Board of Psychology, or the Board of Behavioral Sciences regarding a complaint involving psychotherapist-client sexual behavior and sexual contact. The bill would make conforming changes.

Existing law requires a psychotherapist or an employer of a psychotherapist who becomes aware through a patient that the patient had alleged sexual intercourse or alleged sexual contact, as defined, with a previous psychotherapist to provide a brochure developed by the department that delineates the rights of, and remedies for, patients who have been involved sexually with their psychotherapists. Existing law defines "psychotherapist" for purposes of those provisions to include various mental health practitioners and makes a failure to comply unprofessional conduct.

This bill would make this requirement also apply in the case of alleged sexual behavior, as defined, with a previous psychotherapist and would specify that the required brochure is the above-described brochure developed by the department. The bill would also expand the list of mental health practitioners included in the definition of "psychotherapist" for those purposes.

~~Existing law establishes the Department of Consumer Affairs, which is comprised of various boards and requires members of a board to take an oath of office, as specified.~~

~~This bill would make a nonsubstantive change to that provision.~~

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

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

SECTION 1. Section 337 of the Business and Professions Code is amended to read:

337. (a) The department shall prepare and disseminate an informational brochure for victims of ~~psychotherapist-patient~~ *psychotherapist-client sexual behavior and* sexual contact and ~~advocates for those victims.~~ *their advocates.* This brochure shall be developed by the ~~department in consultation with members of the Sexual Assault Program of the Office of Criminal Justice Planning and the office of the Attorney General.~~ *department.*

(b) The brochure shall include, but is not limited to, the following:

(1) A legal and an informal definition of ~~psychotherapist-patient~~ *psychotherapist-client sexual behavior and* sexual contact.

(2) A brief description of common personal ~~reactions and histories of victims and victim's families.~~ *reactions.*

(3) A ~~patient's~~ *client's* bill of rights.

(4) ~~Options~~ *Instructions* for reporting ~~psychotherapist-patient sexual relations and instructions for each reporting option.~~ *psychotherapist-client sexual behavior and sexual contact.*

(5) A full description of ~~administrative, civil, and professional associations~~ *administrative* complaint procedures.

(6) A description of services available for support of victims.

(c) The brochure shall be provided to each individual contacting the Medical Board of ~~California and affiliated health boards~~ *California, the Osteopathic Medical Board of California, the Board of Psychology,* or the Board of Behavioral Sciences regarding a complaint involving ~~psychotherapist-patient sexual relations.~~ *psychotherapist-client sexual behavior and sexual contact.*

SEC. 2. Section 728 of the Business and Professions Code is amended to read:

728. (a) Any psychotherapist or employer of a psychotherapist who becomes aware through a ~~patient~~ *client* that the ~~patient~~ *client* had alleged sexual intercourse or alleged *sexual behavior or* sexual contact with a previous psychotherapist during the course of a prior treatment shall provide to the ~~patient~~ *client* a brochure ~~promulgated~~ *developed* by the department *pursuant to Section 337* that delineates the rights of, and remedies for, ~~patients~~ *clients* who have been involved sexually with their psychotherapists. Further, the psychotherapist or employer shall discuss with the ~~patient~~ *client* the brochure prepared by the department.

(b) Failure to comply with this section constitutes unprofessional conduct.

(c) For the purpose of this section, the following definitions apply:

(1) "Psychotherapist" means ~~a physician and surgeon specializing in the practice of psychiatry or practicing psychotherapy, a psychologist, a clinical social worker, a marriage and family therapist, a licensed professional clinical counselor, a psychological assistant, a marriage and family therapist registered intern or trainee, an intern or clinical counselor trainee, as specified in Chapter 16 (commencing with Section 4999.10), or an associate clinical social worker.~~ *any of the following:*

(A) A physician and surgeon specializing in the practice of psychiatry or practicing psychotherapy.

(B) A psychologist.

(C) A psychological assistant.

(D) A registered psychologist.

(E) A trainee under the supervision of a licensed psychologist.

(F) A marriage and family therapist.

(G) An associate marriage and family therapist.

(H) A marriage and family therapist trainee.

(I) A licensed educational psychologist.

(J) A clinical social worker.

(K) An associate clinical social worker.

(L) A licensed professional clinical counselor.

(M) An associate professional clinical counselor.

(N) A clinical counselor trainee.

(2) "Sexual behavior" means inappropriate contact or communication of a sexual nature. "Sexual behavior" does not include the provision of appropriate therapeutic interventions relating to sexual issues.

~~(2)~~

(3) "Sexual contact" means the touching of an intimate part of another person.

~~(3)~~

(4) "Intimate part" and "touching" have the same meaning as defined in subdivisions (g) and (e), respectively, of Section 243.4 of the Penal Code.

~~(4)~~

(5) "The course of a prior treatment" means the period of time during which a ~~patient~~ *client* first commences treatment for services that a psychotherapist is authorized to provide under his or her scope of practice, or that the psychotherapist represents to the ~~patient~~ *client* as being within his or her scope of practice, until the ~~psychotherapist-patient~~ *psychotherapist-client* relationship is terminated.

~~SECTION 1. Section 105 of the Business and Professions Code is amended to read:~~

~~105. Each member of a board in the department shall take an oath of office as provided in the Constitution and the Government Code.~~

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98

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Professional Therapy Never Includes Sex

TATE OF CALIFORNIA
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DEPARTMENT OF CONSUMER AFFAI

CALIFORNIA BOARD OF BEHAVIORAL SCIENCES

Professional Therapy Never Includes Sex

State of California

Department of Consumer Affairs

Dear Reader:

As a reader of "Professional Therapy Never Includes Sex," you may be a California consumer concerned about the conduct of your therapist. You may be a licensed therapist, or training to become a therapist. In any case, it's good to know more about the high standards of professional conduct expected – and required — in the therapy relationship.

Consumers are looking for professionals they can trust. Therapists value the trust of their patients. When this mutual trust is violated by sexual exploitation, everyone loses. The patient loses an opportunity for improved health and becomes a victim. The therapist stops being a healer and becomes a victimizer. And the profession itself loses when the good reputation of the many is diminished by the illegal conduct of a few.

The California Department of Consumer Affairs is dedicated to working with its professional licensing board partners to protect and educate consumers. If you are a victim of sexual abuse by a therapist, it's important for you to report your experience to the board that licenses your therapist.

This booklet offers guidance and resources for consumers. For more consumer guidelines and information, you may contact the appropriate licensing board or professional association, or contact the Department of Consumer Affairs at 1-800-952-5210 or www.dca.ca.gov.

California Department of Consumer Affairs

Professional Therapy Never Includes Sex

Publishing Information

The 2011 edition of "Professional Therapy Never Includes Sex" is published by the California Department of Consumer Affairs. This publication is a joint project of the California Board of Psychology, the California Board of Behavioral Sciences and the Department of Consumer Affairs' Office of Publications, Design & Editing.

This booklet is available in the "Publications" section of the Department of Consumer Affairs' Web site at www.dca.ca.gov.

Single copies of the publication are available at no charge from the boards listed above and from *Publications Office, California Department of Consumer Affairs, P.O. Box 989004, West Sacramento, CA 95798-0004.*

Acknowledgments

The Department of Consumer Affairs, the Board of Psychology and the Board of Behavioral Sciences wish to thank former Senator Diane Watson, whose Senate Task Force on Psychotherapist and Patient Sexual Relations prompted the development of "Professional Therapy Never Includes Sex" in 1990.

Table of Contents

Introduction

Professional psychotherapy never includes sex. It also never includes verbal sexual advances or any other kind of sexual contact or behavior. Sexual contact of any kind between a therapist and a patient is unethical and illegal in the state of California. Additionally, with regard to former patients, sexual contact within two years after termination of therapy is also illegal and unethical.

Sexual contact between a therapist and a patient can also be harmful to the patient. Harm may arise from the therapist's exploitation of the patient to fulfill his or her own needs or desires, and from the therapist's loss of the objectivity necessary for effective therapy. All therapists are trained and educated to know that this kind of behavior is inappropriate and can result in the revocation of their professional license.

Therapists are trusted and respected, and it is common for patients to admire and feel attracted to them. However, a therapist who accepts or encourages these normal feelings in a sexual way — or tells a patient that sexual involvement is part of therapy — is using the trusting therapy relationship to take advantage of the patient. And once sexual involvement begins, therapy for the patient ends. The original issues that brought the patient to therapy are postponed, neglected, and sometimes lost.

Many people who endure this kind of abusive behavior from therapists suffer harmful, long-lasting emotional and psychological effects. Family life and friendships are often disrupted, or sometimes ruined.

California's lawmakers, licensing boards, professional associations and ethical therapists want such inappropriate sexual behavior stopped. This booklet was developed to help patients who have been sexually exploited by their therapists. It outlines their rights and options for reporting what happened. It also defines therapist sexual exploitation, gives warning signs of unprofessional behavior, presents a "Patient Bill of Rights," and answers some frequently asked questions.

Definition of Terms

Throughout this booklet, the terms “therapist,” “therapy” and “patient” will be used. “Therapist” refers to anyone who is licensed to practice psychotherapy, or is training to become licensed, and includes:

- Psychiatrists (physicians practicing psychotherapy)
- Psychologists
- Registered psychologists
- Psychological interns
- Psychological assistants
- Licensed clinical social workers
- Registered associate clinical social workers
- Licensed marriage and family therapists
- Marriage and family therapist registered interns and trainees
- Licensed professional clinical counselors
- Professional clinical counselor interns

The terms “therapy,” “therapist” and “patient” in this booklet also refer to educational psychology, educational psychologists and their clients. Though educational psychologists do not practice psychotherapy, these licensed professionals work with clients, performing educational evaluations, diagnosis and test interpretation.

“Therapy” includes any type of mental health counseling from any of the licensed or registered, therapists listed above. “Patient” refers to anyone receiving therapy or counseling.

According to California laws:

- Any act of sexual contact, sexual abuse, sexual exploitation, sexual misconduct or sexual relations by a therapist with a patient is unprofessional, illegal, as well as unethical as set forth in Business and Professions Code sections 726, 729, 2960(o), 4982(k), 4992.3(l), 4989.54(n), and 4999.90(k).
- “Sexual contact” means the touching of an intimate part of another person, including sexual intercourse.
- “Touching” means physical contact with another person either through the person’s clothes or directly with the person’s skin.
- “Intimate part” means the sexual organ, anus, groin or buttocks of any person and the breast of a female.

Sexual exploitation can include sexual intercourse, sodomy, oral copulation, or any other sexual contact between a therapist and a patient or a former patient under certain circumstances. Sexual misconduct includes a much broader range of activity, which may include fondling, kissing, spanking, nudity, verbal suggestions, innuendoes or advances. This kind of sexual behavior by a therapist with a patient is unethical, unprofessional and illegal.

Professional Therapy
Never Includes Sex

Warning Signs

In most sexual abuse or exploitation cases, other inappropriate behavior comes first. While it may be subtle or confusing, it usually feels uncomfortable to the patient. Some clues or warning signs are:

- Telling sexual jokes or stories.
- "Making eyes at" or giving seductive looks to the patient.
- Discussing the therapist's sex life or relationships excessively.
- Sitting too close, initiating hugging, holding the patient or lying next to the patient.

Another warning sign is "special" treatment by a therapist, such as:

- Inviting a patient to lunch, dinner or other social activities.
- Dating.
- Changing any of the office's business practices (for example, scheduling late appointments so no one is around, having sessions away from the office, etc.).
- Confiding in a patient (for example, about the therapist's love life, work problems, etc.).
- Telling a patient that he or she is special, or that the therapist loves him or her.
- Relying on a patient for personal and emotional support.
- Giving or receiving significant gifts.

Signs of inappropriate behavior and misuse of power include:

- Hiring a patient to do work for the therapist, or bartering goods or services to pay for therapy.
- Suggesting or supporting the patient's isolation from social support systems, increasing dependency on the therapist.
- Providing or using alcohol (or drugs) during sessions.
- Any violation of the patient's rights as a consumer (see "Patient Bill of Rights," page 24).

Therapy is meant to be a guided learning experience, during which therapists help patients to find their own answers and feel better about themselves and their lives. A patient should never feel intimidated or threatened by a therapist's behavior.

If you are experiencing any of these warning signs, trust your own feelings. Check on the therapist's behavior with a different therapist, or with any of the agencies in "Where To Start" (see page 10). Depending on what you find out, you may want to find another therapist.

What If It's Me?

If you have been sexually abused or exploited by your therapist, you may be feeling confused. You may feel:

- Guilty and responsible — even though it's the **therapist's** responsibility to keep sexual behavior out of therapy.
- Mixed feelings about the therapist — protectiveness, anger, love, betrayal.
- Isolated and empty.
- Distrustful of others or your own feelings.
- Fearful that no one will believe you or understand what happened, or that someone will find out.
- Confused about dependency, control and power.

You may even have nightmares, obsessive thoughts, depression, or suicidal or homicidal thoughts. You may feel overwhelmed as you try to decide what to do or whom to tell.

It's essential that you face what happened. This may be painful, but it is the first major step in healing and recovering from the experience. You may have positive and negative feelings at the same time, such as starting to feel personal control, being afraid of what may happen in the future, remembering the experience, and feeling relieved that the sexual relationship is over.

Professional Therapy Never Includes Sex

The second step in the healing process is to decide what YOU want to do next. Try to be open-minded about your options.

Remember: **It doesn't matter** if you, the patient, started or wanted the sexual involvement with the therapist. Therapists are responsible for keeping sexual intimacy out of the therapy relationship and are trained to know how to handle a patient's sexual attractions and desires.

Where To Start

You may need to (1) talk to someone who will understand what you're going through, (2) get information on whether the therapist's behavior was illegal and/or unethical, and (3) find out what you can do about it. Three places to get help are:

- **Licensing Boards —** In the Department of Consumer Affairs, three different boards license therapists. They can give general information on appropriate behavior for therapists and your rights for reporting what happened, as well as how to file a complaint (see page 13 for licensing board contact information).
- **Sexual Assault/Crisis Centers —** These centers have staff trained in all types of sexual abuse and exploitation. They can provide general information on appropriate behavior for therapists, crisis services, your rights for reporting what happened, and names of therapists and support groups that may be helpful. Centers are located throughout California. Look in your telephone book under "sexual assault center" or "crisis intervention service."
- **Professional Associations —** Each licensed therapy profession has at least one professional association. Associations can provide general information on appropriate behavior for therapists, your rights for reporting what happened, and how to file a complaint. They can provide names of therapists who may be helpful (see pages 16-17 for association contact information).

What You Can Do

You can deal with your situation in several different ways. Take time to explore all of your rights and options. It may help to decide what your goals are:

- **Reporting the Therapist —** Perhaps you want to prevent the therapist from hurting other patients. You may want to make it known that sexual exploitation is always wrong. If this is your decision, you have several reporting options (see page 12).

  It is important to note that reporting misconduct is time-sensitive. What can be done in response to the report of misconduct usually depends on who the misconduct is reported to and the length of time between the misconduct and when the report was filed.

  Such a time limit is called a “statute of limitations.” As you consider your options, be aware of these time limits.

- **Your Recovery —** You may also want to explore and process what happened between you and the therapist. If you decide to do this, you can look into therapy or support groups (see pages 20–21).

- **Moving On —** You may wish simply to move on past this experience as quickly as possible and get on with your life. Remember — you have the right to decide what is best for you.

Your Reporting Options

If you decide to report a therapist's behavior that you believe is unethical and illegal, there are four different ways to do so. All of these reporting options are affected by time limits, so you should consider reporting misconduct at the earliest appropriate opportunity. You may choose one or more of the options listed below. These options and their time limits are discussed in more detail on the following pages:

- **Administrative Action —** File a complaint with the therapist's licensing board. (See "More About Administrative Action, page 13.)
- **Professional Association Action** — File a complaint with the ethics committee of the therapist's professional association. (See "More About Professional Association Action," page 15.)
- **Civil Action** — File a civil lawsuit. (See "More About Civil Action," page 18.)
- **Criminal Action** — File a complaint with local law enforcement. (See "More About Criminal Action, page 19.)

More About Administrative Action

Three California boards license and regulate therapists:

Board of Behavioral Sciences
1625 N. Market Blvd., Suite S-200
Sacramento, CA 95834
(916) 574-7830
www.bbs.ca.gov
This board licenses and regulates educational psychologists; licensed clinical social workers; registered associate clinical social workers; licensed marriage and family therapists; registered marriage and family therapist interns; licensed professional clinical counselors; and registered professional clinical counselor interns.

Board of Psychology
1625 N. Market Blvd., Suite N-215
Sacramento, CA 95815
(916) 574-7720
www.psychology.ca.gov
This board licenses and regulates psychologists, psychological assistants and registered psychologists.

Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
(916) 263-2389
www.mbc.ca.gov
This board licenses and regulates physicians, including psychiatrists.

The purpose of these licensing boards is to protect the health, safety and welfare of consumers. Licensing boards have the power to discipline therapists by using the administrative law process. Depending on the violation, the board may revoke or suspend a license, and/or place a license on probation with terms and conditions the licensed professional must follow. When a license is revoked, the therapist cannot legally practice.

In many cases, the California Business and Professions Code requires revocation of a therapist's license or registration whenever sexual misconduct is admitted or proven.

It is best to report any case of therapist-patient sexual exploitation as soon as possible, since delays may restrict the disciplinary options available to the board. Time limits require a licensing board to initiate disciplinary action by filing an "accusation" against a licensed professional accused of sexual misconduct:

— within three years from the date the board discovered the alleged sexual misconduct, or

— within 10 years from the date the alleged sexual misconduct occurred.

That means an accusation of sexual misconduct against a therapist can't be filed more than 10 years after the alleged incident. For complaints involving allegations other than sexual misconduct, the licensing board must file an accusation within seven years from the date of the alleged offense.

How the Complaint Process Works

The licensing boards can give you information about the complaint filing process and discuss your situation with you. To file a complaint, you can request a complaint form, write a letter, or start the complaint process online with the appropriate licensing board. With your complaint, be sure to include your name, address, and telephone number; the therapist's name, address, and telephone number; a description of your complaint; copies of any available documentation (for example, letters, bill receipts, canceled checks, or pictures); and names, addresses and telephone numbers of any witnesses.

Each complaint is evaluated and investigated, and you and the therapist will be notified if the board has sufficient evidence to initiate disciplinary action. You and the therapist will be interviewed separately.

Most cases are settled by a *stipulated agreement* — the therapist typically admits to the violation(s) and accepts the disciplinary action, no hearing is held, and the patient does not have to testify. In the event that your case is not settled by a stipulated agreement, a hearing will be held by an administrative law judge, and you will be required to testify. When the judge makes a decision about the case, the board

will then decide whether to accept this decision or to issue its own decision.

It is board policy to use only initials, rather than full names, to identify patients in public disciplinary documents. However, hearings are open to the public, and there is a possibility that confidentiality may be jeopardized during the investigation process or at the hearing itself. If you are concerned about this, discuss it with the licensing board investigator.

The disciplinary process may take about two years from the time a complaint is received to the time a final decision is made. Sometimes the process takes longer. Keep in mind that you cannot receive monetary compensation from the therapist by using this option, but you may affect the therapist's ability to practice and thereby protect other patients from similar misconduct.

More About Professional Association Action

Many therapists join professional associations — organizations that provide education and guidance to members of a profession. Each association has ethics guidelines, and all such guidelines state that sexual involvement with patients is unacceptable and unethical.

If your therapist is a member of a professional association, you may file a formal complaint with the association. After investigating the complaint, the association may recommend disciplinary actions that may include removal of the therapist from its membership. Removing a therapist from the association will let other members know about the person's unethical behavior, **but it will not keep the therapist from practicing**. Only a licensing board or court action can do that. In addition, the action will not result in monetary recovery for you (only a civil action can do that), and will not result in criminal action against the therapist.

Each association has different ways of filing complaints. Call or write the appropriate association for this information. To find out which association, if any, the therapist belongs to, call the therapist's office and request this information; have a friend call the office or therapist for you; or check with the different associations.

Professional Associations

Most professional association ethics committees will typically review only those complaints that include allegations made within one year of the date of the alleged misconduct.

Contact the appropriate association for specifics on reporting professional misconduct, or to get more general information.

Psychiatrist, Physician

American Psychiatric Association
1000 Wilson Blvd. Suite 1825
Arlinghton, VA 22209
(888) 357-7924
www.psych.org

California Medical Association
1201 J Street, Suite 200
Sacramento, CA 95814
(916) 444-5532
www.cmanet.org

California Psychiatric Association
1029 K Street, Suite 28
Sacramento, CA 95814
(916) 442-5196
www.calpsych.org

Licensed Psychologist

American Psychological Association
750 First Street, NE
Washington, DC 20002
(800) 374-2721
www.apa.org

California Psychological Association
1231 I Street, Suite 204
Sacramento, CA 95814
(916) 286-7979
www.cpapsych.org

Licensed Clinical Social Worker

National Association of Social Workers, California Chapter
1016 23rd Street
Sacramento CA 95816
(916) 442-4565
www.naswdc.org

National Association of Social Workers
750 First Street, NE, Suite 700
Washington, DC 20002
(202) 408-8600
www.naswdc.org

California Society for Clinical Social Work
6060 Sunrise Vista Drive, Suite 1300
Citrus Heights, CA 95610
(916) 560-9238
www.clinicalsocialworksociety.org

Professional Associations

Licensed Educational Psychologist

California Association
of Licensed Educational
Psychologists
P.O. Box 387
Aptos, CA 95001
www.calep.com

California Association of
School Psychologists
1020 12th Street, Suite 200
Sacramento, CA 95814
(916) 444-1595
www.casponline.org

Licensed Marriage and Family Therapist

American Association for
Marriage and Family Therapy
112 South Alfred Street
Alexandria, VA 22314-3061
(703) 838-9808
www.aamft.org

American Association for
Marriage and Family Therapy,
California Division
Post Office Box 6907
Santa Barbara, CA 93160
(800) 662-2638
(805) 681-1413
www.aamftca.org

California Association
of Marriage and Family
Therapists
7901 Raytheon Road
San Diego, CA 92111
(858) 292-2638
www.camft.org

Licensed Professional Clinical Counselors

California Association for
Licensed Professional Clinical
Counselors
P.O. Box 280640
Northridge, CA 91328
http://calpcc.org/

Professional Therapy
Never Includes Sex

More About Civil Action

Suing the Therapist or Their Employer

Generally, civil lawsuits are filed to seek money for damages or injuries to a patient. For a sexual misconduct case, a patient may want to sue the therapist for injuries suffered and for the cost of future therapy sessions.

Under California law, you may file a lawsuit against the therapist or the therapist's employer if you believe the employer knew or should have known about the therapist's behavior. If the employer is a local or state public mental health agency for which the therapist works, you must first file a complaint with the agency within six months of the sexual misconduct. Consult with an attorney for specific advice.

If you think you want to file a lawsuit, it is important to consult an attorney as soon as possible, since there are different time limits for filing civil lawsuits. Most civil lawsuits must be filed within one year after the sexual misconduct occurred.

Media Attention

Once a lawsuit is filed, there is the possibility of media coverage, especially if the patient or therapist is well-known. While many cases are settled out of court, some do go to trial, and it can take years before your case is tried.

Patients Don't Always Win

You should be aware that some cases end up being decided in favor of the therapist, rather than the patient.

Finding an Attorney

Take time to choose an attorney to represent you. You may need to interview several. Here are some points to consider:

- Get a list of attorneys from your County Bar Association's referral service. You can also check with your local legal aid society for legal assistance.

- Contact a lawyer referral service certified by the State Bar of California. To find a certified lawyer referral service, look in the telephone book yellow pages at the beginning of the "Attorneys" listings, or visit the State Bar Web site at www.calbar.ca.gov.
- Check with the State Bar of California (www.calbar.ca.gov) to make sure the attorney has a clear license.
- While some attorneys are willing to wait to be paid based on the outcome of the suit (contingency basis), some will not.
- Be sure that the attorney has civil litigation experience in the area of medical and/or psychological malpractice.
- Make sure that you feel comfortable with your attorney and can trust and confide in him or her.

More About Criminal Action

Sexual exploitation of patients by therapists is wrong. The law makes it a crime for a therapist to have sexual contact with a patient. For a first offense with only one victim, an offender would probably be charged with a misdemeanor. For this charge, the penalty may be a sentence of up to one year in county jail, or up to $1,000 in fines, or both. Second and following offenses, or offenses with more than one victim, may be misdemeanors or felonies. The penalty in such felony cases can be up to three years in prison, or up to $10,000 in fines, or both.

This law applies to two situations:

- The therapist has sexual contact with a patient during therapy, or
- The therapist ends therapy primarily to start having sexual contact with the patient (unless the therapist has referred the patient to an independent and objective therapist who has been recommended by a third-party therapist).

To file a criminal complaint against a therapist:

- Contact your local law enforcement agency. Many agencies in larger cities have sexual assault units that handle these complaints.
- Contact your local victim/witness assistance program for help through the legal process. Look in your local telephone book under “District Attorney” or call 1-800-VICTIMS (842-8467).

Once a complaint is filed, it will be investigated by the law enforcement agency, which will give the results of the investigation to the district attorney’s office. The district attorney’s office will decide whether there is enough evidence to file criminal charges.

Time limits, or statutes of limitations, affect this reporting option. If you are considering this option, contact your local law enforcement agency. The agency’s authority to take action may expire as soon as one year from the date the alleged misconduct occurred.

Where to Get Help

Many patients who have been sexually exploited by therapists find it difficult to see another therapist for help and support. However, for most people, the issues that brought them to therapy were never worked on or resolved, and the sexual exploitation created even more issues to handle. If this is your situation, therapy may be an important tool in your healing process.

Before selecting a therapist, interview several until you find one you are comfortable with. Use the “Patient Bill of Rights” as a guide (see page 24). If you are unsure after one session, either consider a different therapist or set up a follow-up session to clarify your concerns. Do not feel pressured to stay with one therapist.

Finding a Therapist

Some ways of finding a therapist are:

- Asking someone you know who has been in therapy, who feels good about the experience and who has changed in ways you consider positive.
- Calling your local sexual assault center or crisis intervention service (in the telephone book yellow pages). These centers can refer you to therapists experienced in dealing with those who have suffered sexual exploitation or abuse.
- Calling professional associations (see pages 16-17) and asking for referrals to therapists who specialize in helping those who have been sexually abused or exploited by therapists.

After getting several names, call the appropriate licensing board (see page 13) or visit their Web site for on-line license verification and disciplinary actions. You can also call the professional association (see pages 16-17) and ask if the therapists are licensed and if any disciplinary actions have been filed against them. Check with your county Superior Court to see if there is a record of any malpractice lawsuits filed against the therapists.

Self-Help Support Groups

There is an informal network of self-help support groups throughout California. While there might not be a group in your area specifically focused on sexual exploitation by therapists, there may be groups dealing with more general kinds of sexual abuse. To find out if there are any groups in your area, call your local sexual assault center or crisis intervention service (listed in the telephone book yellow pages).

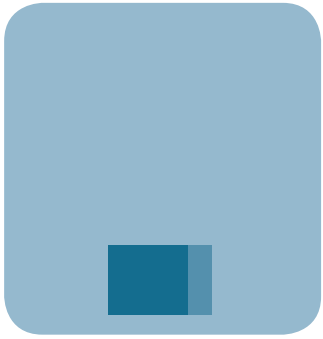
Professional Therapy
Never Includes Sex

Frequently Asked Questions

> Is it normal to feel attracted to my therapist?

Yes. It is normal to feel attracted to someone who is attentive, kind and caring. This is a common reaction toward someone who is helping you. However, all therapists are trained to be aware of this and to maintain a therapy relationship that is beneficial to the patient.

> What if I was the one who brought up having sex?



That doesn't matter. The therapist is the one who is responsible for keeping sexual intimacy out of therapy.

> Does this happen a lot?

A national study revealed that probably fewer than 10 percent of all therapists have had sexual contact with their patients and that 80 percent of the sexually exploiting therapists have exploited more than one patient. If a therapist is sexually exploiting a patient, they have probably done so before and are likely to do so again. In recent years, aggressive prosecution of offending therapists—and passage of laws that facilitate the enforcement work of licensing boards—have helped to significantly reduce the number of such cases reported to the licensing boards.

Why do some therapists sexually exploit their patients?

> There are probably as many excuses as there are therapists who engage in such unprofessional conduct. But no excuse is acceptable for a therapist to abuse the therapeutic relationship and the trust of a patient for the therapist's own sexual gain. All therapists should know that this conduct is unethical and illegal.

Why do I feel scared or confused about reporting my therapist?

Feelings of confusion, protectiveness, shame or guilt are common. In most cases, the therapist is an important person in the patient's life. Get as much information as possible about your options. Keep in mind that you are in control and can choose what to do.

What if the therapist retaliates against me, harasses me or files a lawsuit against me for reporting him or her?

Retaliation against a patient or harassment of a patient is illegal. Contact your local district attorney. If the therapist files a lawsuit against you, you will be required to defend yourself in the lawsuit. However, the law does provide immunity from monetary liability for reporting misconduct to a licensing board.

How can I prevent this from happening again?

1. Acknowledge your right to be free from sexual exploitation.

2. When choosing a therapist, check with the licensing board (see page 13) to see if the therapist is licensed and if the license is under suspension or probation. Check on any complaints filed with a professional association. Review county Superior Court records to see if any malpractice lawsuit judgments are on file against the therapist.

3. Question any action that may seem sexual.

4. Remember that while feelings of attraction are natural, therapy is supposed to be a means to explore and resolve feelings, without having to act them out.

5. Feel free to end a relationship that no longer seems safe.

Professional Therapy Never Includes Sex

Can I file an anonymous complaint with a licensing board?

Anonymous complaints are accepted, but they are almost impossible to investigate without the cooperation of the accuser.

Patient Bill of Rights

Patients have the right to:

- Request and receive information about the therapist's professional capabilities, including licensure, education, training, experience, professional association membership, specialization and limitations.
- Have written information about fees, payment methods, insurance reimbursement, number of sessions, substitutions (in cases of vacation and emergencies), and cancellation policies before beginning therapy.
- Receive respectful treatment that will be helpful to you.
- A safe environment, free from sexual, physical and emotional abuse.
- Ask questions about your therapy.
- Refuse to answer any question or disclose any information you choose not to reveal.
- Request and receive information from the therapist about your progress.
- Know the limits of confidentiality and the circumstances in which a therapist is legally required to disclose information to others.
- Know if there are supervisors, consultants, students, or others with whom your therapist will discuss your case.
- Refuse a particular type of treatment, or end treatment without obligation or harassment.
- Refuse electronic recording (but you may request it if you wish).
- Request and (in most cases) receive a summary of your file, including the diagnosis, your progress, and the type of treatment.
- Report unethical and illegal behavior by a therapist (see "Your Reporting Options," page 12).
- Receive a second opinion at any time about your therapy or therapist's methods.
- Have a copy of your file transferred to any therapist or agency you choose.

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

Board of Behavioral Sciences

CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES BILL ANALYSIS

BILL NUMBER: SB 906 **VERSION:** INTRODUCED JANUARY 17, 2018

AUTHOR: BEALL AND ANDERSON **SPONSOR:** STEINBERG INSTITUTE

RECOMMENDED POSITION: NONE

SUBJECT: MEDI-CAL: MENTAL HEALTH SERVICES: PEER, PARENT, TRANSITION-AGE, AND FAMILY SUPPORT SPECIALIST CERTIFICATION

Overview:

This bill requires the State Department of Health Care Services (DHCS) to establish a peer, parent, transition-age, and family support specialist certification program. It also allows DHCS to amend the state's Medicaid plan to include these providers as a provider type within the Medi-Cal 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)

2) Defines a "Mental Health Rehabilitation Specialist" as someone who has a baccalaureate degree and four years of experience in a mental health setting as a specialist in physical restoration, social adjustment, or vocational adjustment. (California Code of Regulation (CCR) Title 9 §782.35)

3) Defines a "Licensed Mental Health Professional" as a licensed psychologist, physician, licensed clinical social worker, or licensed marriage and family therapist. (9 CCR §782.26)

This Bill:

1) Establishes the Peer, Parent, Transition-Age, and Family Support Specialist Certification Program Act of 2018. (WIC Article 1.4, §§ 14045.10 – 14045.28))

2) Outlines the expected achievements of the peer, parent, transition-age, and family support specialist certification program, including providing increased family support, providing as part of a wraparound continuum of services, and collaborating with others providing care or support. (BPC §14045.12)

3) Defines "peer support specialist services" as culturally competent services that promote engagement, socialization, recovery, self-sufficiency, self-advocacy,

development of natural supports, identification of strengths, and maintenance of skills learned in other support services. The services shall include support, coaching, facilitation, or education to Medi-Cal beneficiaries that is individualized to the beneficiary and is conducted by a certified adult, transition-age youth, family, or parent peer support specialist. (WIC§14045.13(l))

4) By July 1, 2019, requires the State Department of Health Care Services (DHCS) to establish a certification program for adult, parent, transition-age youth, and family peer support specialists. (WIC §14045.14)

5) Requires DHCS to define responsibilities and practice guidelines for each type of peer support specialist using best practice materials, and to determine curriculum and core competencies including, at a minimum, the following (WIC §14045.14):

- Hope, recovery, and wellness
- Advocacy
- The role of consumers and family members
- Psychiatric rehabilitation skills and service delivery, and addiction recovery principals
- Cultural competence training
- Trauma-informed care
- Group facilitation skills
- Self-awareness and self-care
- Co-occurring disorders of mental health and substance use
- Conflict resolution
- Professional boundaries and ethics
- Safety and crisis planning
- Navigation of and referral to other services
- Documenting skills and standards
- Study and test-taking skills

6) Requires DHCS to specify training requirements and continuing education requirements for certification, establish a code of ethics, determine the process for certification renewal and certification revocation, and to determine a process for allowing existing personnel employed in the peer support field to obtain certification. (WIC §14045.14)

7) Requires DHCS to determine clinical supervision requirements for certificate-holders, requiring at a minimum, certificate holders be under the direction of a mental health rehabilitation specialist as defined in §782.35 of Title 9 of the CCR, or a substance use disorder professional. A licensed mental health professional, as defined in §782.26 of Title 9 of the CCR, may also provide supervision. (WIC §14045.14(g)) *(Note: this regulation includes LCSWs and LMFTs in its definition of "licensed mental health professional," but omits LPCCs.)*

8) Provides minimum requirements for adult peer support specialists, transition-age youth peer support specialists, family peer support specialists, and parent peer

support specialists to include the following (WIC §§14045.15, 14045.16, 14045.17, 14045.18):

- Is at least age 18
- Have or had a self-disclosed primary diagnosis of mental illness and/or substance use disorder (adult and transition-age only), or has a family member experiencing one of these (family only), or is a parent to someone experiencing one of these (parent only).
- Has or is receiving mental health or substance use disorder services. (adult and transition-age only)
- Is willing to share his/her experience
- Demonstrates leadership/advocacy skills
- Is strongly dedicated to recovery
- Agrees to follow a code of ethics
- Completes the required curriculum and training
- Passes a certification exam
- Completes any required continuing education, training, and recertification requirements

9) States that this Act does not imply that a certification-holder is qualified or authorized to diagnose an illness, prescribe medication, or provide clinical services. (WIC §14045.19)

10) Requires DHCS to collaborate with the Office of Statewide Health Planning and Development (OSHPD) and to consult with interested stakeholders, the County Behavioral Health Director's Association of California, health plans participating in the Medi-Cal program, the California Behavioral Health Planning Council, and other interested parties, when developing, implementing, and administering this program. This includes holding stakeholder meetings at least bimonthly. (WIC §14045.20)

11) Requires DHCS to amend its Medicaid state plan to include each category of peer support support specialist as a provider type, and to include peer support specialist services as a distinct service type which may be provided to eligible Medi-Cal beneficiaries. (WIC §14045.22)

12) Allows DHCS to use Mental Health Services Act Funds, as well as funds from certain other specified programs, to develop and administer the certification program. (WIC §14045.25)

13) Allows DHCS to establish certification fees. (WIC §14045.26)

14) 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, 2021 (WIC §14045.28)

Comments:

1) 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.

The author notes that peer support programs have emerged as an evidence based practice across the nation, with the U.S. Department of Veterans Affairs and approximately 40 states having a certification process. However, California does not have a certification program or any established scope of practice.

2) Examples of Requirements in Other States.

Several other states recognize certified peer counselors. Staff surveyed a few of these states to determine their requirements.

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.

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.

3) History and Previous Legislation. The Board considered a bill very similar to this one in 2015-2016. SB 614 (Leno) proposed essentially the same program, although some modifications have been made. The Board took a "support if amended" position on SB 614, asking for a clear exclusion of psychotherapy services, a better defined scope of services, and the inclusion of LPCCs as acceptable supervisors. SB 614 was ultimately gut-and-amended to address a different topic.

4) **Scope of Practice and Scope of Practice Exclusions.** This bill appears to outline a scope of practice for peer support specialists, although somewhat indirectly, in WIC §§14045.12, and 14045.13(l) (via a definition of "peer support specialist services."

   One area of concern is with §14045.19, which excludes "providing clinical services" from work that peer support specialists are qualified or authorized to do. The Board may wish to consider recommending the following language to increase clarity:

   "Any services that fall under the scope of practice of the Licensed Marriage and Family Therapist Act (Chapter 13 (commencing with Section 4980) of Division 2 of the Business and Professions Code), the Educational Psychologist Practice Act (Chapter 13.5 (commencing with Section 4989.10) of Division 2 of the Business and Professions Code), the Clinical Social Worker Practice Act (Chapter 14 (commencing with Section 4991) of Division 2 of the Business and Professions Code), and the Licensed Professional Clinical Counselor Act (Chapter 16 (commencing with Section 4999.10) of Division 2 of the Business and Professions Code), which are not performed in an exempt setting as defined in Sections 4980.01, 4996.14, and 4999.22 of the Business and Professions Code, shall only be performed by a licensee or a registrant of the Board of Behavioral Sciences or other appropriately licensed professional, such as a licensed psychologist or board certified psychiatrist."

5) **Inclusion of LPCCs as Supervisors.** WIC §14045.14(g) of the bill permits licensed mental health professionals, as defined in 9 CCR §782.26, to supervise peer support specialists.

   The definition of a "licensed mental health professional" in that regulation section, which has not been updated since 1997, includes licensed psychologists, physicians, LCSWs, and LMFTs. However, it omits LPCCs. Due to this, the Board may wish to consider asking the author to list each acceptable license type for a supervisor in the bill, including LPCCs.

6) **Fingerprinting Not Required for Certification.** This bill does not specify fingerprinting as a requirement to obtain certification as a peer and family support specialist.

7) **Requirements Not Established in Legislation.** This bill requires DHCS to establish the several key components requirements of the peer certification program, including responsibilities and practice guidelines, curriculum, continuing education, training requirements, amount of supervision, renewal and grandparenting for existing personnel, via regulation. Assuming this bill was to pass, it would become effective January 1, 2019, and the certification program must be established by July 1, 2019. Regulations must be established by July 1, 2021. However, the bill leaves discretion to DHCS to implement the program via various instructions until regulations are adopted.

8) **Support and Opposition.**

Support:

- Steinberg Institute (sponsor)

- American Civil Liberties Union of California
- Association of California Healthcare Districts
- Association of Community Human Service Agencies
- Bay Area Community Services
- California Alliance of Child and Family Services
- California Association of Mental Health Peer-Run Organizations California Behavioral Health
- Planning Council
- California Disability Community Action Network California State Association of Counties
- California Youth Empowerment Network
- County Behavioral Health Directors Association of California Disability Rights California
- Massage Garage Pit Crew
- Mental Health America of California
- Mental Health Services Oversight and Accountability Commission Pool of Consumer Champions
- Self-Help and Recovery Exchange
- Steinberg Institute
- The Village Family Services
- United Advocates for Children and Families
- United Advocates for Children and Families Action Alliance Western Center on Law and Poverty
- Several individuals

<u>Oppose:</u>
- None received.

9) History.

2018

03/14/18	From committee: Do pass and re-refer to Com. on APPR. (Ayes 9. Noes 0.) (March 14). Re-referred to Com. on APPR.
02/28/18	Set for hearing March 14.
01/24/18	Referred to Com. on HEALTH.
01/18/18	From printer. May be acted upon on or after February 17.
01/17/18	Introduced. Read first time. 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

SENATE BILL No. 906

Introduced by Senators Beall and Anderson
(Coauthors: Senators Hertzberg and Pan)

January 17, 2018

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 906, as introduced, Beall. Medi-Cal: mental health services: peer, parent, transition-age, 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 ⅔ 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 the act by majority vote.

This bill would require the State Department of Health Care Services to establish, no later than July 1, 2019, a statewide peer, parent, transition-age, and family support specialist certification program, as a part of the state's comprehensive mental health and substance use disorder delivery system and the Medi-Cal program. The bill would include 4 certification categories: adult peer support specialists, transition-age youth 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, establishing a code of ethics, and determining a certification revocation process. The bill would require an applicant for the certification as a peer, parent, transition-age, or family support specialist to meet specified requirements, including successful completion of the curriculum and training requirements.

This bill would require the department to collaborate with OSHPD and interested stakeholders in developing the certification program, and would authorize the department to contract 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 certification program, and would authorize the use of these MHSA funds to serve as the state's share of funding to develop and administer the certification program for the purpose of claiming federal financial participation under the Medicaid Program.

This bill would authorize the department to establish a certification fee schedule and to require remittance of fees as contained in the schedule, for the purpose of supporting the department's activities associated with the ongoing state administration of the certification program. The bill would require the department to utilize the other funding resources made available under the bill before determining the need for the certification fee schedule and requiring the remittance of fees. The bill would declare the intent of the Legislature that the certification fees charged by the department be reasonable and reflect the expenditures directly applicable to the ongoing state administration of the certification program.

99

This bill would require the department to amend the Medicaid state plan to include a certified peer, parent, transition-age, and family support specialist as a provider type for purposes of the Medi-Cal program and to include peer support specialist services as a distinct service type for purposes of the Medi-Cal program. The bill would require Medi-Cal reimbursement for peer support specialist services to be implemented 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 negotiated 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 means of plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action, until regulations are adopted. The bill would require the department to adopt regulations by July 1, 2021, and, commencing July 1, 2019, would require the department to provide semiannual status reports to the Legislature until regulations have been 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:

SECTION 1. Article 1.4 (commencing with Section 14045.10) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 1.4. Peer, Parent, Transition-Age, and Family Support Specialist Certification Program

14045.10. This article shall be known, and may be cited, as the Peer, Parent, Transition-Age, and Family Support Specialist Certification Program Act of 2018.

14045.11. The Legislature finds and declares all of the following:

(a) With the enactment of the Mental Health Services Act in 2004, support to include peer providers identified as consumers,

parents, and family members for the provision of services has been on the rise.

(b) There are over 6,000 peer providers in California who provide individualized support, coaching, facilitation, and education to clients with mental health care needs and substance use disorder, in a variety of settings, yet no statewide scope of practice, standardized curriculum, training standards, supervision standards, or certification protocol is available.

(c) The United States Department of Veterans Affairs and over 30 states utilize standardized curricula and certification protocols for peer support services.

(d) The federal Centers for Medicare and Medicaid Services (CMS) recognizes peer support services as an evidence-based model of care and notes it is an important component in a state's delivery of effective mental health and substance use disorder treatment. The CMS encourages states to offer peer support services as a component of a comprehensive mental health and substance use disorder delivery system, and federal financial participation is available for this purpose.

(e) A substantial number of research studies demonstrate that peer supports improve client functioning, increase client satisfaction, reduce family burden, alleviate depression and other symptoms, reduce hospitalizations and hospital days, increase client activation, and enhance client self-advocacy.

(f) Certification at the state level can incentivize the public mental health system and the Medi-Cal program, including the Drug Medi-Cal program, to increase the number, diversity, and availability of peer providers and peer-driven services.

14045.12. It is the intent of the Legislature that the peer, parent, transition-age, and family support specialist certification program, established under this article, achieve all of the following:

(a) Establish the ongoing provision of peer support services for beneficiaries experiencing mental health care needs, substance use disorder needs, or both by certified peer support specialists.

(b) Provide support, coaching, facilitation, and education to beneficiaries with mental health needs, substance use disorder needs, or both, and to families or significant support persons.

(c) Provide increased family support, building on the strengths of families and helping them achieve desired outcomes.

(d) Provide a part of a wraparound continuum of services, in conjunction with other community mental health services and other substance use disorder services.

(e) Collaborate with others providing care or support to the beneficiary or family.

(f) Assist parents, when applicable, in developing coping mechanisms and problem-solving skills.

(g) Provide an individualized focus on the beneficiary, the family, or both, as needed.

(h) Encourage employment under the peer, parent, transition-age, and family support specialist certification program to reflect the culture, ethnicity, sexual orientation, gender identity, mental health service experiences, and substance use disorder experiences of the people whom they serve.

(i) Promote socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.

14045.13. For purposes of this article, the following definitions shall apply:

(a) "Adult peer support specialist" means a person who is 18 years of age or older and who has self-identified as having lived experience of recovery from mental illness, substance use disorder, or both, and the skills learned in formal trainings to deliver peer support services in a behavioral setting to promote mind-body recovery and resiliency for adults.

(b) "Certification" means, as it pertains to the peer, parent, transition-age, and family support specialist certification program, all federal and state requirements have been satisfied, federal financial participation under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) is available, and all necessary federal approvals have been obtained.

(c) "Certified" means all federal and state requirements have been satisfied by an individual who is seeking designation under this article, including completion of curriculum and training requirements, testing, and agreement to uphold and abide by the code of ethics.

(d) "Certification examination" means the competency testing requirements, as approved by the department, an individual is required to successfully complete as a condition of becoming certified under this article. Each training program approved by the

department may develop a unique competency examination for each category of peer, parent, transition-age, and family support specialist listed in subdivision (b) of Section 14045.14. Each certification examination shall include core curriculum elements.

(e) "Code of ethics" means the professional standards each certified peer, parent, transition-age, and family support specialist listed in subdivision (b) of Section 14045.14 is required to agree to uphold and abide by. These professional standards shall include principles, expected behavior and conduct of the certificate holder in an agreed-upon statement that is required to be provided to the applicant and acknowledged by signing with his or her personal signature prior to being granted certification under this article.

(f) "Core competencies" are the foundational and essential competencies required by each category of peer, parent, transition-age, and family support specialists listed in subdivision (b) of Section 14045.14 who provide peer support services.

(g) "Cultural competence" means a set of congruent behaviors, attitudes, and policies that come together in a system or agency that enables that system or agency to work effectively in cross-cultural situations. A culturally competent system of care acknowledges and incorporates, at all levels, the importance of language and culture, intersecting identities, assessment of cross-cultural relations, knowledge and acceptance of dynamics of cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs to provide services in a culturally competent manner.

(h) "Department" means the State Department of Health Care Services.

(i) "Family peer support specialist" means a person with lived experience as a self-identified family member of an individual experiencing mental illness, substance use disorder, or both, and the skills learned in formal trainings to assist and empower families of individuals experiencing mental illness, substance use disorder, or both. For the purposes of this subdivision, "family member" includes a sibling or kinship caregiver, and their partners.

(j) "Parent" means a person who is parenting or has parented a child or individual experiencing mental illness, substance use disorder, or both, and who can articulate his or her understanding of his or her experience with another parent or caregiver. This

person may be a birth parent, adoptive parent, or family member standing in for an absent parent.

(k) "Parent peer support specialist" means a parent with formal training to assist and empower families parenting a child or individual experiencing mental illness, substance use disorder, or both.

(*l*) "Peer support specialist services" means culturally competent services that promote engagement, socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, identification of strengths, and maintenance of skills learned in other support services. Peer support specialist services shall include, but are not limited to, support, coaching, facilitation, or education to Medi-Cal beneficiaries that is individualized to the beneficiary and is conducted by a certified adult peer support specialist, a certified transition-age youth peer support specialist, a certified family peer support specialist, or a certified parent peer support specialist.

(m) "Recovery" means a process of change through which an individual improves his or her health and wellness, lives a self-directed life, and strives to reach his or her full potential. This process of change recognizes cultural diversity and inclusion, and honors the different routes to resilience and recovery based on the individual and his or her cultural community.

(n) "Transition-age youth peer support specialist" means a person who is 18 years of age or older and who has self-identified as having lived experience of recovery from mental illness, substance use disorder, or both, and the skills learned in formal trainings to deliver peer support services in a behavioral setting to promote mind-body recovery and resiliency for transition-age youth, including adolescents and young adults.

14045.14. No later than July 1, 2019, the department, as the sole state Medicaid agency, shall establish a peer, parent, transition-age, and family support specialist certification program that, at a minimum, shall do all of the following:

(a) Establish a certifying body, either within the department, through contract, or through an interagency agreement, to provide for the certification of peer, parent, transition-age, and family support specialists as described in this article.

(b) Provide for a statewide certification for each of the following categories of peer support specialists, as contained in federal

guidance issued by the Centers for Medicare and Medicaid Services, State Medicaid Director Letter (SMDL) #07-011:

(1) Adult peer support specialists, who may serve individuals across the lifespan.

(2) Transition-age youth peer support specialists.

(3) Family peer support specialists.

(4) Parent peer support specialists.

(c) Define the range of responsibilities and practice guidelines for the categories of peer support specialists listed in subdivision (b), by utilizing best practice materials published by the federal Substance Abuse and Mental Health Services Administration, the federal Department of Veterans Affairs, and related notable experts in the field as a basis for development.

(d) Determine curriculum and core competencies, including curriculum that may be offered in areas of specialization, such as older adults, veterans, family support, forensics, whole health, juvenile justice, youth in foster care, sexual orientation, gender identity, and any other areas of specialization identified by the department. Specialized curriculum shall be determined for each of the categories of peer, parent, transition-age, and family support specialists listed in subdivision (b). Core competencies-based curriculum shall include, at a minimum, all of the following elements:

(1) The concepts of hope, recovery, and wellness.

(2) The role of advocacy.

(3) The role of consumers and family members.

(4) Psychiatric rehabilitation skills and service delivery, and addiction recovery principles, including defined practices.

(5) Cultural competence training.

(6) Trauma-informed care.

(7) Group facilitation skills.

(8) Self-awareness and self-care.

(9) Cooccurring disorders of mental health and substance use.

(10) Conflict resolution.

(11) Professional boundaries and ethics.

(12) Safety and crisis planning.

(13) Navigation of, and referral to, other services.

(14) Documentation skills and standards.

(15) Study and test-taking skills.

(e) Specify training requirements, including core-competencies-based training and specialized training necessary to become certified under this article, allowing for multiple qualified training entities, and requiring training to include people with lived experience as consumers and family members.

(f) Specify required continuing education requirements for certification.

(g) Determine clinical supervision requirements for personnel certified under this article, that shall require, at a minimum, personnel certified pursuant to this article to work under the direction of a mental health rehabilitation specialist, as defined in Section 782.35 of Title 9 of the California Code of Regulations, or substance use disorder professional. A licensed mental health professional, as defined in Section 782.26 of Title 9 of the California Code of Regulations, may also provide supervision.

(h) Establish a code of ethics.

(i) Determine the process for certification renewal.

(j) Determine a process for revocation of certification.

(k) Determine a process for allowing existing personnel employed in the peer support field to obtain certification under this article, at their option.

14045.15. In order to be certified as an adult peer support specialist, an individual shall, at a minimum, satisfy all of the following requirements:

(a) Be at least 18 years of age.

(b) Have or have had a primary diagnosis of mental illness, substance use disorder, or both, which is self-disclosed.

(c) Have received or is receiving mental health services, substance use disorder services, or both.

(d) Be willing to share his or her experience of recovery.

(e) Demonstrate leadership and advocacy skills.

(f) Have a strong dedication to recovery.

(g) Agree to uphold and abide by a code of ethics. A copy of the code of ethics shall be signed by the applicant.

(h) Successful completion of the curriculum and training requirements for an adult peer support specialist.

(i) Pass a certification examination approved by the department for an adult peer support specialist.

(j) Successful completion of any required continuing education, training, and recertification requirements.

14045.16. In order to be certified as a transition-age youth peer support specialist, an individual shall, at a minimum, satisfy all of the following requirements:

(a) Be at least 18 years of age.

(b) Have or have had a primary diagnosis of mental illness, substance use disorder, or both, which is self-disclosed.

(c) Have received or is receiving mental health services, substance use disorder addiction services, or both.

(d) Be willing to share his or her experience of recovery.

(e) Demonstrate leadership and advocacy skills.

(f) Have a strong dedication to recovery.

(g) Agree to uphold and abide by a code of ethics. A copy of the code of ethics shall be signed by the applicant.

(h) Successful completion of the curriculum and training requirements for a transition-age youth peer support specialist.

(i) Pass a certification examination approved by the department for a transition-age youth peer support specialist.

(j) Successful completion of any required continuing education, training, and recertification requirements.

14045.17. In order to be certified as a family peer support specialist, an individual shall, at a minimum, satisfy all of the following requirements:

(a) Be at least 18 years of age.

(b) Be self-identified as a family member of an individual experiencing mental illness, substance use disorder, or both.

(c) Be willing to share his or her experience.

(d) Demonstrate leadership and advocacy skills.

(e) Have a strong dedication to recovery.

(f) Agree to uphold and abide by a code of ethics. A copy of the code of ethics shall be signed by the applicant.

(g) Successful completion of the curriculum and training requirements for a family peer support specialist.

(h) Pass a certification examination approved by the department for a family peer support specialist.

(i) Successful completion of any required continuing education, training, and recertification requirements.

14045.18. In order to be certified as a parent peer support specialist, an individual shall, at a minimum, satisfy all of the following requirements:

(a) Be at least 18 years of age.

(b) Be self-identified as a parent, as defined in Section 14045.13.
(c) Be willing to share his or her experience.
(d) Demonstrate leadership and advocacy skills.
(e) Have a strong dedication to recovery.
(f) Agree to uphold and abide by a code of ethics. A copy of the code of ethics shall be signed by the applicant.
(g) Successful completion of the curriculum and training requirements for a parent peer support specialist.
(h) Pass a certification examination approved by the department for a parent peer support specialist.
(i) Successful completion of any required continuing education, training, and recertification requirements.

14045.19. This article shall not be construed to imply that an individual who is certified pursuant to this article is qualified to, or authorize that individual to, diagnose an illness, prescribe medication, or provide clinical services.

14045.20. The department shall closely collaborate with the Office of Statewide Health Planning and Development (OSHPD) and its associated workforce collaborative, and regularly consult with interested stakeholders, including peer support and family organizations, mental health and substance use disorder services providers and organizations, the County Behavioral Health Directors Association of California, health plans participating in the Medi-Cal managed care program, the California Behavioral Health Planning Council, and other interested parties in developing, implementing, and administering the peer, parent, transition-age, and family support specialist certification program established pursuant to this article. This consultation shall initially include, at a minimum, bimonthly stakeholder meetings, which may also include technical workgroup meetings. The department may seek private funds from a nonprofit organization or foundation for this purpose.

14045.21. The department may contract to obtain technical assistance for the development of the peer, parent, transition-age, and family support specialist certification program, as provided in Section 4061.

14045.22. (a) The department shall amend its Medicaid state plan to do both of the following:
(1) Include each category of peer, parent, transition-age, and family support specialist listed in subdivision (b) of Section

14045.14 certified pursuant to this article as a provider type for purposes of this chapter.

(2) Include peer support specialist services as a distinct service type for purposes of this chapter, which may be provided to eligible Medi-Cal beneficiaries who are enrolled in either a Medi-Cal managed mental health care plan or a Medi-Cal managed care health plan.

(b) The department may seek any federal waivers or other state plan amendments as necessary to implement the certification program provided for under this article.

(c) Medi-Cal reimbursement for peer support specialist services shall be implemented only if and to the extent that federal financial participation under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) is available and all necessary federal approvals have been obtained.

14045.23. To facilitate early intervention for mental health services, community health workers may partner with peer, parent, transition-age, and family support specialists for engagement, outreach, and education.

14045.24. It is not the intent of the Legislature in enacting this article to modify the Medicaid state plan in any manner that would otherwise change or nullify the requirements, billing, or reimbursement of the "other qualified provider" provider type, as currently authorized by the Medicaid state plan.

14045.25. The department may utilize Mental Health Services Act funds under subdivision (d) of Section 5892 and any designated Workforce Education and Training Program resources, including funding, as administered by OSHPD pursuant to Section 5820, to develop and administer the peer, parent, transition-age, and family support specialist certification program. Further, these Mental Health Service Act funds may then serve as the state's share of funding to develop and administer the peer, parent, transition-age, and family support specialist certification program and shall be available for purposes of claiming federal financial participation under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) once all necessary federal approvals have been obtained.

14045.26. The department may establish a certification fee schedule and may require remittance as contained in the certification fee schedule for the purpose of supporting the

department's activities associated with the ongoing state administration of the peer, parent, transition-age, and family support specialist certification program. The department shall utilize all funding resources as made available in Section 14045.25 first, prior to determining the need for the certification fee schedule and requiring the remittance of fees. It is the intent of the Legislature that any certification fees charged by the department be reasonable and reflect the expenditures directly applicable to the ongoing state administration of the peer, parent, transition-age, and family support specialist certification program.

14045.27. For the purposes of implementing this article, the department may enter into exclusive or nonexclusive contracts on a bid or negotiated basis, including contracts for the purpose of obtaining subject matter expertise or other technical assistance. Contracts may be statewide or on a more limited geographic basis.

14045.28. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this article by means of plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action, until the time regulations are adopted. The department shall adopt regulations by July 1, 2021, in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Commencing July 1, 2019, the department shall provide semiannual status reports to the Legislature, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

SEC. 2. The Legislature finds and declares that this act clarifies procedures and terms of the Mental Health Services Act within the meaning of Section 18 of the Mental Health Services Act.

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California Mental Health Planning Council

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PEER CERTIFICATION:

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

[1] *"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…."*

1 *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[2]*"*

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

[2] 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.[3]

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."***[4]

[3] http://www.inspiredatwork.net/uploads/WWT_Peer_Certification_Research_Report_FINAL_6.20.12__1_.pdf

[4] 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*"[5].

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

[5] 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[6].

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.”[7]

[6] http://www.oshpd.ca.gov/HWDD/pdfs/wet/PowerPoint-Peer-Support-Specialist-A-Galvez-S-Kuehn.pdf
[7] 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 respites 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 MHSA 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.

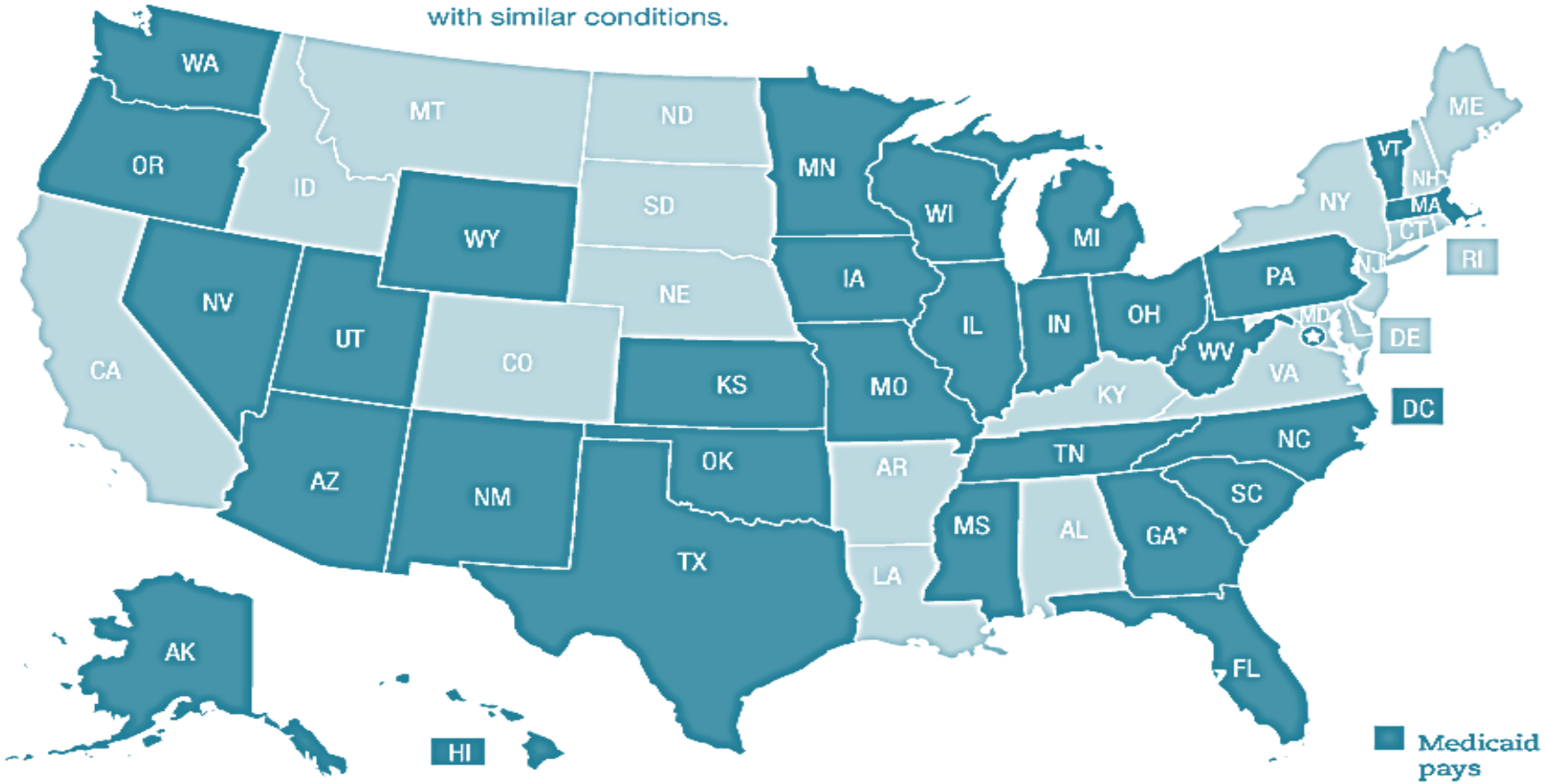
The CMHPC has been following and supporting the efforts of Inspired at Work, California Association of Mental Health Peer Run Organizations (CAMHPRO), United Advocates for Children and Families (UACF), National Alliance on Mental Illness (NAMI) and the former Working Well Together Group to bring this 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,

STATELINE INFOGRAPHIC

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

http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2013/09/11/peers-seen-easing-mental-health-worker-shortage#map

2013

Final Report: Recommendations from the Statewide Summit on Certification of Peer Providers

Working Well Together
Training and Technical Assistance Center

Report prepared for CAMHPRO-PEERS
under Working Well Together
by Inspired at Work
Lucinda Dei Rossi, MPA, CPRP and
Debra Brasher, MS, CPRP

Table of Contents

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.

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.

Board of Behavioral Sciences

CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES BILL ANALYSIS

BILL NUMBER: SB 968 **VERSION:** AMENDED MARCH 12, 2018

AUTHOR: PAN **SPONSORS:**
- CALIFORNIA FACULTY ASSOCIATION
- SEIU

RECOMMENDED POSITION: NONE

SUBJECT: POSTSECONDARY EDUCATION: MENTAL HEALTH COUNSELORS

Summary:

This bill would require specified higher educational entities in California to hire one full-time equivalent mental health counselor per 1,000 students enrolled at each of their campuses.

Existing Law:

1) Establishes the Donahoe Higher Education Act, specifying that public higher education consists of the California Community Colleges, the California State University, and the University of California. (Education Code (EC) §66010)

This Bill:

1) Requires the following educational entities to have one full-time equivalent mental health counselor per 1,000 students enrolled at each respective campus, to the fullest extent consistent with state and federal law (EC §66027.7(a)):

- The Trustees of the California State University;
- The governing board of each community college district.

2) Requests the Regents of the University of California also follow this standard. (EC §66027.7(a))

3) Specifies that this requirement is a minimum requirement, and that additional mental health providers may be hired based on a campus's additional needs. (EC §66027.7(b))

4) Defines a "mental health counselor" as someone who meets both of the following (EC §66027.7(c)):

- Provides individual and group counseling, crisis intervention, emergency services, referrals, program evaluation and research, or outreach and consultation interventions to the campus community, or any combination of these; and

- Is licensed in California by the applicable licensing entity.

5) Requires educational institutions subject to this requirement to report to the legislature every three years on how funding was spent and on the number of mental health counselors employed on each of its campuses. The report shall include the following (EC §66027.7(d)):

- Results from a campus survey and focus groups regarding student needs and challenges regarding their mental health, emotional well-being, sense of belonging, and academic success; and

- Campus data on attempted suicides.

Comment:

1) Author's Intent. The authors office states that the International Association of Counseling Services (IACS) recommends one full-time equivalent mental health counselor for every 1,000 to 1,500 students, and that exceeding this ratio could lead to longer wait lists for services, and decreased support for academic success. They note that while the UC system reports that their ratio falls within this recommended range, it is estimated to be significantly higher for the CSU system. However, it is difficult to know exact ratios because of a lack of reporting and data.

The author believes this bill will address the mental health crisis facing California's public higher education system by helping campus counseling services meet growing student demand, and by providing more data to evaluate the best campus counseling practices.

2) Definition of a "Mental Health Counselor." The Board may wish to discuss whether the bill's definition of a "mental health counselor" is appropriate, including if it would be preferable to specifically state which licensing boards are considered "applicable licensing entities."

3) Consistency with Previous Board Recommendation. In 2014, the Board considered AB 2198 (Levine). That bill proposed requiring licensees of this Board and the Board of Psychology to complete a six-hour training course in suicide assessment, treatment, and management. It would also have required new applicants who began graduate study after January 1, 2016 to take a 15-hour course in this subject area.

While the Board noted that it shared the author's concerns regarding the prevalence of suicide, it did not believe AB 2198 would accomplish its objective. Therefore, the Board took an "oppose unless amended" position on the bill, and proposed the

formation of a task force to discuss the best course of action on three areas of concern:

a. Current coverage of the topic of suicide assessment, treatment, and management in Master's level mental health degree programs, including identifying courses that typically include the topic, aspects of the topic that are already being addressed, and aspects of the topic where improved training is needed.

b. Whether college campus mental health care workers and others who are likely to encounter suicidal individuals are likely to be licensed mental health care professionals, and if not, how to address their training needs; and

c. Lack of resources at the county mental health care level which may be impeding treatment for those who need it.

A copy of the Board's position letter to the Governor, which includes alternative suggested actions, is shown in **Attachment A**.

SB 968 appears to take steps toward addressing one of the Board's identified concerns (item b. above) at the time it considered AB 2198.

Last year, the Board took a "support" position on another bill that took steps toward one of its previously identified concerns (item c. above). AB 1372 (Levine) aims to help ensure that a suicidal patient needing treatment at a crisis stabilization unit is not required to be released in a situation where the crisis stabilization unit's 24 treatment hours are up, but there are no available inpatient beds or outpatient services to help the patient before that time is up. This bill provides the treating crisis stabilization unit with an option, if it so chooses, to have extra time to find the person the care he or she needs before being released. AB 1372 is currently a two-year bill.

4) Support and Opposition.

Support:

- California Faculty Association (Sponsor)
- SEIU (Sponsor)

Opposition:

- None at this time.

5) History.

2018

03/20/18 March 21 set for first hearing canceled at the request of author.
03/12/18 From committee with author's amendments. Read second time and amended. Re-referred to Com. on ED.

03/05/18 From committee with author's amendments. Read second time and amended. Re-referred to Com. on ED.
02/28/18 Set for hearing March 21.
02/08/18 Referred to Com. on ED.
02/01/18 From printer. May be acted upon on or after March 3.
01/31/18 Introduced. Read first time. To Com. on RLS. for assignment. To print.

6) Attachments.

Attachment A: BBS Position Letter to the Governor: AB 2198 (August 20, 2014)

AMENDED IN SENATE MARCH 12, 2018

AMENDED IN SENATE MARCH 5, 2018

SENATE BILL No. 968

Introduced by Senator Pan

January 31, 2018

An act to add Section 66027.7 to the Education Code, relating to postsecondary education.

LEGISLATIVE COUNSEL'S DIGEST

SB 968, as amended, Pan. Postsecondary education: mental health counselors.

Existing law establishes the segments of postsecondary education in this state, including the University of California administered by the Regents of the University of California, the California State University administered by the Trustees of the California State University, the California Community Colleges administered by the Board of Governors of the California Community Colleges, and independent institutions of higher education. Existing provisions of the Ortiz-Pacheco-Poochigian-Vasconcellos Cal Grant Program set forth the requirements for status as a "qualifying institution" whose students are eligible, if as individuals they meet pertinent program requirements, to receive Cal Grant awards. Existing law provides for licensing and regulation of various professions in the healing arts, including physicians and surgeons, psychologists, marriage and family therapists, educational psychologists, clinical social workers, and licensed professional clinical counselors.

This bill would require the Trustees of the California State University, *and* the governing board of each community college district, ~~and the governing body of each independent institution of high education that~~

~~is a qualifying institution,~~ and request the Regents of the University of California, to have one full-time equivalent mental health counselor per 1,000 students enrolled at each of their respective campuses to the fullest extent consistent with state and federal law. The bill would define mental health counselor for purposes of this provision. The bill would require those institutions, on or before January 1, 2020, and every 3 years thereafter, to report to the Legislature how funding was spent and the number of mental health counselors employed on each of its campuses, as specified. The bill would require each campus of those institutions to, at least every 3 years, conduct a campus survey and focus groups to understand student needs and challenges regarding, among other things, their mental health, would require each campus of those institutions to collect data on attempted suicides, as specified, and would require that data, without any personally identifiable information, to be included in the report to the Legislature. To the extent that these provisions would impose new duties on community college districts, it would constitute a state-mandated local program.

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

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

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

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

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

(a) Students face anxiety, depression, and stress as they confront challenges of campus life.

(b) Suicide is the second leading cause of death among college students claiming more than 1,100 lives every year nationally.

(c) One in four students has a diagnosable mental illness and 40 percent of students do not seek mental health services when they need it.

(d) For students of color, these challenges may be even more acute as they face additional stressors, such as discrimination,

immigration status, financial hardship, and being the first of their families to attend college, and students of color are less likely to access needed services.

(e) Among the many benefits of mental health counseling are lower college dropout rates, improved academic performance, and reduced legal liability for campuses.

(f) The California State University system in particular is woefully understaffed with mental health counselors to address the needs of their campuses.

SEC. 2. Section 66027.7 is added to the Education Code, to read:

66027.7. (a) (1) The Trustees of the California State University, *and* the governing board of each community college district, ~~and the governing body of each independent institution of high education that is a "qualifying institution," as defined in Section 69432.7,~~ shall, and the Regents of the University of California are requested to, have one full-time equivalent mental health counselor per 1,000 students enrolled at each of their respective campuses to the fullest extent consistent with state and federal law.

(2) Where possible, mental health counselors hired under paragraph (1) should be full-time.

(b) The number of mental health counselors as computed pursuant to subdivision (a) shall constitute the minimum number of mental health counselors to be hired on a campus based on the campus student population. Additional mental health counselors may be hired in accordance with additional needs identified on a campus.

(c) For purposes of this section, "mental health counselor" means a person who provides individual counseling, group counseling, crisis intervention, emergency services, referrals, program evaluation and research, or provides outreach and consultation interventions to the campus community, or any combination of these, and who is licensed in the State of California by the applicable licensing entity.

(d) (1) On or before January 1, 2020, and every three years thereafter, a postsecondary educational institution subject to this section shall report to the Legislature, consistent with Section 9795 of the Government Code, how funding was spent and the number of mental health counselors employed on each of its campuses.

(2) Each campus of a postsecondary educational institution subject to this section shall, at least every three years, conduct a campus survey and focus groups, including focus groups with students of color, to understand student needs and challenges regarding their mental health and emotional well-being, sense of belonging on campus, and academic success. This data, without any personally identifiable information, shall be included in the report required to be submitted to the Legislature pursuant to paragraph (1).

(3) Each campus of a postsecondary educational institution subject to this section shall collect data on attempted suicides through self-reporting, mental health counselor records, and known hospitalizations. This data, without any personally identifiable information, shall be included in the report required to be submitted to the Legislature pursuant to paragraph (1).

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

O

Board of Behavioral Sciences

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

ATTACHMENT A -

August 20, 2014

Governor Jerry Brown
State Capitol
Sacramento, CA 95814

RE: AB 2198 - Oppose

Dear Governor Brown:

At its May 22, 2014 meeting, the Board of Behavioral Sciences (Board) discussed and took a position of "oppose unless amended" on AB 2198 (Levine) (As Amended April 21, 2014).

The Board shared the author's concerns regarding the need to address deficiencies in suicide assessment, treatment, and management training for professionals who may encounter suicidal individuals. However, it did not believe that the bill, in its current form, would accomplish this objective.

Instead, the Board recommended the bill be amended to form a task force to include members of this Board, its stakeholders, the Board of Psychology, county mental health officials, and university educators. This group should discuss the following areas of concern to determine the best course of action:

1. Current coverage of the topic of suicide assessment, treatment, and management in Master's level mental health degree programs, including identifying courses that typically include the topic, aspects of the topic that are already being addressed, and aspects of the topic where improved training is needed.

2. Whether college campus mental health care workers and others who are likely to encounter suicidal individuals are likely to be licensed mental health care professionals, and if not, how to address their training needs; and

3. Lack of resources at the county mental health care level which may be impeding treatment for those who need it.

This bill was not amended to create such a task force, and therefore the Board is in opposition to this bill, in its current form.

It is the Board's hope that through a future series of stakeholder meetings, a model "Best Practice" training curriculum can be developed for Master's level mental health programs, and effective training for non-licensed workers encountering suicidal individuals can be developed as well.

Please feel free to contact my Legislative Analyst, Rosanne Helms, at (916) 574-7897 if you have any questions.

Board of Behavioral Sciences

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

Sincerely,

Steve Sodergren
Acting Executive Officer

CC: Division of Legislative and Policy Review, Department of Consumer Affairs

Board of Behavioral Sciences

CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES BILL ANALYSIS

BILL NUMBER: AB 1116 **VERSION:** AMENDED SEPTEMBER 8, 2017

AUTHOR: GRAYSON **SPONSOR:**
- CALIFORNIA PROFESSIONAL FIREFIGHTERS
- CALIFORNIA CORRECTIONAL PEACE OFFICERS ASSOCIATION

RECOMMENDED POSITION: NONE

SUBJECT: PEER SUPPORT AND CRISIS REFERRAL SERVICES ACT

Summary: This bill establishes that a communication between an emergency service personnel worker and a peer support team member, crisis hotline staffer, or a crisis referral service staffer is privileged for a noncriminal proceeding.

Existing Law:

1) Establishes that a patient has privilege to refuse to disclose and to prevent another from disclosing a confidential communication between the patient and a psychotherapist under certain circumstances. (Evidence Code (EC) §1014)

2) Defines "confidential communication between patient and psychotherapist" as information, including that obtained by examination of the patient, transmitted between the patient and the psychotherapist in the course of that relationship and in confidence by a means which, so far as the patient is aware, discloses the information to not third persons other than those who further the interest of the patient. It includes the diagnosis made and advice given by the psychotherapist. (EC §1012)

3) Defines a "psychotherapist" as including the following persons (EC §1010):

- A person authorized to practice medicine who practices psychiatry;
- A licensed psychologist;
- A licensed clinical social worker;
- A credentialed school psychologist;
- A licensed marriage and family therapist;

- A registered psychological assistant;
- A marriage and family therapist intern;
- An associate clinical social worker;
- A registered psychologist;
- A psychological intern;
- An MFT trainee;
- A registered nurse listed as a psychiatric-mental health nurse;
- An advanced practice registered nurse certified as a clinical nurse specialist, who participates in expert clinical practice in the specialty of psychiatric-mental health nursing;
- A person rendering mental health treatment or counseling services authorized by §6924 of the Family Code. (This section specifies the professional persons who may provide mental health treatment or counseling to a consenting minor age 12 or older.)
- A licensed professional clinical counselor;
- A clinical counselor intern;
- A clinical counselor trainee.

4) Allows a communication between a patient and a licensed educational psychologist to be privileged to the same extent as a communication with a psychotherapist. (EC §1010.5)

<u>This Bill:</u>

1) Establishes the "Peer Support and Crisis Referral Services Act." (Government Code (GC) §8669 et seq.)

2) Specifies that a communication made by emergency service personnel to a peer support team member is privileged for purposes of a noncriminal proceeding to the same extent, and subject to the same limitations, as a communication between a patient and a psychotherapist described in subdivisions (b), (d), and (e) of Evidence Code Section 1010. (These subsections refer to licensed psychologists, school psychologists, and LMFTs, respectively.) (EC §1029(a))

3) Establishes that communication between an individual employed as emergency service personnel and a person or volunteer staffing a crisis hotline or crisis referral service for emergency service personnel is privileged for purposes of a noncriminal proceeding to the same extent, and subject to the same limitations, as a

communication between a patient and a psychotherapist described in subdivisions (b), (d), and (e) of Evidence Code Section 1010. (EC §1029 (b))

4) Specifies that a communication made by an emergency service personnel to a peer support team member is confidential and shall not be disclosed in a civil or administrative proceeding, and a record kept by the peer support team member related to the provision of peer support services is also confidential, except under the following circumstances (Government Code (GC) §8669.2):

a) The peer support team member must make a referral, or must consult, with another member of the peer support team or appropriate professional associate with the peer support team.

b) Revealing the communication may prevent reasonably certain death, substantial body harm, or commission of a crime.

c) The emergency service personnel agrees in writing that the communication is not confidential.

5) Specifies that emergency personnel who provide peer support services and who have completed a specified training course are not liable for damages, unless there is gross negligence, intentional misconduct, or an action for medical malpractice. (GC §8669.3)

6) Specifies that a communication made by an emergency service personnel to a crisis hotline or crisis referral service is confidential and shall not be disclosed in a civil or administrative proceeding. However, an exemption is provided to prevent reasonably certain death, substantial bodily harm, or commission of a crime. (GC §8669.5)

<u>Definitions</u>

7) Defines “emergency service personnel” as a person who provides emergency response services, including a law enforcement officer, correctional officer, probation officer, juvenile detention officer, firefighter, paramedic, emergency medical technician, dispatcher, emergency response communication employee, or rescue service personnel. (GC §8669.1(d))

8) Defines “peer support services” to include services provided by a peer support team or team member to emergency service personnel affected by a critical incident or accumulation of multiple incidents. They include the following (GC §8669.1(e)):

a) Precrisis education;

b) Critical incident stress defusings and debriefings;

c) On-scene support services;

d) One-on-one support services;

e) Consultation;

f) Referral services;

g) Confidentiality obligations

h) The impact of toxic stress on health and well-being;

i) Grief support

j) Substance abuse identification and approaches; and

k) Active listening skills.

9) Defines a "peer support team" as a local critical incident response team composed of individuals from emergency service professions, emergency medical services, hospital staff, clergy, and educators who have completed a peer support training course developed by the Office of Emergency Services, California Firefighter Joint Apprenticeship Committee, or the Commission on Correctional Peace Officer Standards and Training. (GC §8669.1(f))

10) Defines a "peer support team member" as an individual who is specially trained to provide peer support services as a member of a peer support team. (GC §8669.1(g))

Comments:

1) **Intent.** The author states it is critical to provide first responders and law enforcement officials with an opportunity to address critical incidents of stress through peer support and other means to ensure they receive the help they need. Often, these emergency personnel do not discuss the post-traumatic incidents they experience, due to concern it may result in adverse job action.

   The goal of this bill is to increase the availability of peer support by developing peer support training courses, and to allow peer support communication to be kept confidential.

2) **Previous Board Position.** AB 1116 is a two-year bill, and the Board considered it last year. A previous version of this bill added staffers of a crisis hotline or crisis referral service for emergency service personnel to the definition of "psychotherapists" and granted them the psychotherapist-patient privilege under Article 7 of Chapter 4 of Division 8 of the Evidence Code (which commences with section 1010) for purposes of a noncriminal proceeding. This caused concern among stakeholders, as well as the Policy and Advocacy Committee, about unintended consequences of adding unlicensed individuals to the definition of a "psychotherapist."

   However, the bill was amended and no longer adds crisis hotline or crisis referral service staffers to the definition of a "psychotherapist" under Evidence Code Section 1010. Instead, it protects communication between an individual employed as emergency service personnel and a peer support team member or a person or

volunteer staffing a crisis hotline or crisis referral service for emergency service personnel as privileged for purposes of a noncriminal proceeding to the same extent, and subject to the same limitations, as a communication between a patient and a psychotherapist. However, it does not include them in the definition of a psychotherapist. Due to this amendment, at its May 12, 2017 meeting, the Board took a "support" position on the bill.

3) Support and Opposition.

Support (As of 9/8/17):

- California Correctional Peace Officers Association (co-source)
- California Professional Firefighters (co-source)
- American Red Cross
- Board of Behavioral Sciences
- Peace Officers Research Association of California
- State Coalition of Probation Organizations
- Steinberg Institute
- United EMS Workers

Opposition (As of 9/8/17):

- Department of Finance

4) History

2017

09/11/17	Ordered to inactive file at the request of Senator Atkins.
09/11/17	Read second time. Ordered to third reading.
09/08/17	Read third time and amended. Ordered to second reading.
09/05/17	Read second time. Ordered to third reading.
09/01/17	From committee: Do pass. (Ayes 7. Noes 0.) (September 1).
08/21/17	In committee: Referred to APPR. suspense file.
07/18/17	Read second time and amended. Re-referred to Com. on APPR.
07/17/17	From committee: Amend, and do pass as amended and re-refer to Com. on APPR. with recommendation: To Consent Calendar. (Ayes 7. Noes 0.) (July 11).
07/06/17	From committee: Do pass and re-refer to Com. on JUD. (Ayes 9. Noes 0.) (July 5). Re-referred to Com. on JUD.
06/14/17	Referred to Coms. on HEALTH and JUD.
06/01/17	In Senate. Read first time. To Com. on RLS. for assignment.
05/31/17	Read third time. Passed. Ordered to the Senate. (Ayes 77. Noes 0. Page 1897.)
05/26/17	Read second time. Ordered to third reading.
05/26/17	From committee: Do pass. (Ayes 17. Noes 0.) (May 26).
05/17/17	In committee: Set, first hearing. Referred to APPR. suspense file.
04/24/17	Re-referred to Com. on APPR.

04/20/17	Read second time and amended.
04/19/17	From committee: Amend, and do pass as amended and re-refer to Com. on APPR. (Ayes 11. Noes 0.) (April 18).
04/05/17	From committee: Do pass and re-refer to Com. on JUD. (Ayes 14. Noes 0.) (April 4). Re-referred to Com. on JUD.
03/30/17	Re-referred to Com. on HEALTH.
03/29/17	From committee chair, with author's amendments: Amend, and re-refer to Com. on HEALTH. Read second time and amended.
03/09/17	Referred to Coms. on HEALTH and JUD.
02/19/17	From printer. May be heard in committee March 21.
02/17/17	Read first time. To print.
04/24/17	Re-referred to Com. on APPR.
04/20/17	Read second time and amended.
04/19/17	From committee: Amend, and do pass as amended and re-refer to Com. on APPR. (Ayes 11. Noes 0.) (April 18).
04/05/17	From committee: Do pass and re-refer to Com. on JUD. (Ayes 14. Noes 0.) (April 4). Re-referred to Com. on JUD.
03/30/17	Re-referred to Com. on HEALTH.
03/29/17	From committee chair, with author's amendments: Amend, and re-refer to Com. on HEALTH. Read second time and amended.
03/09/17	Referred to Coms. on HEALTH and JUD.
02/19/17	From printer. May be heard in committee March 21.
02/17/17	Read first time. To print.

AMENDED IN SENATE SEPTEMBER 8, 2017

AMENDED IN SENATE JULY 18, 2017

AMENDED IN ASSEMBLY APRIL 20, 2017

AMENDED IN ASSEMBLY MARCH 29, 2017

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 1116

Introduced by Assembly Member Grayson
~~(Coauthors: Assembly Members Rodriguez and Wood)~~
(Principal coauthors: Assembly Members Bonta, Burke, Cooper, Rodriguez, Rubio, and Wood)

February 17, 2017

An act to add Article 7.5 (commencing with Section 1029) to Chapter 4 of Division 8 of the Evidence Code, and to add Article 21 (commencing with Section 8669) to Chapter 7 of Division 1 of Title 2 of the Government Code, relating to emergency services.

LEGISLATIVE COUNSEL'S DIGEST

AB 1116, as amended, Grayson. Peer Support and Crisis Referral Services Act.

Under existing law, the California Emergency Services Act, the Governor is authorized to proclaim a state of emergency, as defined, under specified circumstances. The California Emergency Services Act also authorizes the governing body of a city, county, city and county, or an official designated by ordinance adopted by that governing body, to proclaim a local emergency, as defined.

This bill would create the Peer Support and Crisis Referral Services Act. The bill would, for purposes of the act, define a "peer support

team" as a local critical incident response team composed of individuals from emergency services professions, emergency medical services, hospital staff, clergy, and educators who have completed a peer support training course developed by the Office of Emergency Services, the California Firefighter Joint Apprenticeship Committee, or the Commission on Correctional Peace Officer Standards and Training, as specified. The bill would provide that a communication made by emergency service personnel to a peer support team member while the emergency service personnel receives peer support services, as defined, is confidential and shall not be disclosed in a civil or administrative proceeding, except as specified. The bill would also provide that, except for an action for medical malpractice, a peer support team or a peer support team member providing peer support services is not liable for damages, as specified, relating to the team's or team member's act, error, or omission in performing peer support services, unless the act, error, or omission constitutes gross negligence or intentional misconduct. The bill would provide that a communication made by emergency service personnel to a crisis hotline or crisis referral service, as defined, is confidential and shall not be disclosed in a civil or administrative proceeding, except as specified.

Existing law provides that a person has a privilege to refuse to disclose, and prevent another from disclosing, a confidential communication with specified persons, except in specified circumstances.

This bill would establish a privilege for a communication between an individual employed as emergency service personnel and a peer support team member or a person or volunteer staffing a crisis hotline or crisis referral service for emergency service personnel for the purposes of a noncriminal proceeding, as specified.

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

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

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

(a) Emergency service personnel frequently respond to traumatic incidents and dangerous circumstances, including, but not limited to, fires, stabbings, gun battles and shootings, domestic violence, terrorist acts, riots, automobile accidents, airplane crashes, and

earthquakes. They are exposed to harmful substances, such as blood, urine, and vomit. They witness grave injuries, death, and grief. They are frequently placed in harm's way, with significant risk of bodily harm or physical assault while performing the duties of their jobs.

(b) The traumatic and unpredictable nature of emergency services results in a high-stress working environment that can take an overwhelming mental, emotional, and physical toll on personnel. Chronic exposure to traumatic events and critical incidents increases the risk for post-traumatic stress and other stress-induced symptoms.

(c) While most emergency service personnel survive the traumas of their jobs, sadly, many experience the impacts of occupational stressors when off duty. The psychological and emotional stress of their professions can have a detrimental impact long after their shift is over.

(d) Such trauma-related injuries can become overwhelming, manifesting in post-traumatic stress, substance abuse, and even, tragically, suicide. The fire service, as an example, is four times more likely to experience a suicide than a "traditional" death in the line of duty in any year.

(e) Similar to military personnel, California's emergency service personnel and first responders face unique and uniquely dangerous risks in their mission to keep the public safe. These professionals rely on each other for survival while placing their lives on the line every day to protect the communities they serve.

(f) The culture of emergency services has often inhibited its personnel from asking for assistance in battling their psychological stress for fear it will cause ridicule, shame, or adverse job action.

(g) California has a responsibility to ensure that its emergency service and public safety agencies are equipped with the tools necessary for assisting emergency service personnel in mitigating the occupational stress that they incur as a result of performing their job duties and protecting the public.

(h) It is, therefore, the intent of the Legislature in enacting this act to enable critically needed, confidential peer support and crisis referral services for California's emergency service personnel.

SEC. 2. Article 7.5 (commencing with Section 1029) is added to Chapter 4 of Division 8 of the Evidence Code, to read:

Article 7.5. Emergency Service Personnel Privilege

1029. (a) A communication between an individual employed as emergency service personnel, as defined in subdivision (d) of Section 8669.1 of the Government Code, and a peer support team member, as defined in subdivision (g) of Section 8669.1 of the Government Code, shall be privileged for purposes of a noncriminal proceeding to the same extent, and subject to the same limitations, as a communication between a patient and a psychotherapist described in subdivisions (b), (d), and (e) of Section 1010.

(b) A communication between an individual employed as emergency service personnel, as defined in subdivision (d) of Section 8669.1 of the Government Code, and a person or volunteer staffing a crisis hotline or crisis referral service for emergency service personnel pursuant to Section 8669.5 of the Government Code, shall be privileged for purposes of a noncriminal proceeding to the same extent, and subject to the same limitations, as a communication between a patient and a psychotherapist described in subdivisions (b), (d), and (e) of Section 1010.

SEC. 3. Article 21 (commencing with Section 8669) is added to Chapter 7 of Division 1 of Title 2 of the Government Code, to read:

Article 21. Peer Support and Crisis Referral Services Act

8669. This article shall be known, and may be cited, as the Peer Support and Crisis Referral Services Act.

8669.1. For purposes of this article, the following terms have the following meanings:

(a) “Crisis referral services” include all public or private organizations that advise employees and volunteers of agencies employing emergency service personnel about consultation and treatment sources for personal problems, including mental health issues, chemical dependency, domestic violence, gambling, financial problems, and other personal crises.

(b) “Critical incident” means an actual or perceived event or situation that involves crisis, disaster, trauma, or emergency.

(c) “Critical incident stress” means the acute or cumulative psychological stress or trauma that emergency service personnel

may experience in providing emergency services in response to a critical incident. The stress or trauma is an unusually strong emotional, cognitive, behavioral, or physical reaction that may interfere with normal functioning, including, but not limited to, one or more of the following:

(1) Physical and emotional illness.

(2) Failure of usual coping mechanisms.

(3) Loss of interest in the job or normal life activities.

(4) Personality changes.

(5) Loss of ability to function.

(6) Psychological disruption of personal life, including his or her relationship with a spouse, child, or friend.

(d) "Emergency service personnel" means an individual who provides emergency response services, including a law enforcement officer, correctional officer, *probation officer, juvenile detention officer,* firefighter, paramedic, emergency medical technician, dispatcher, emergency response communication employee, or rescue service personnel.

(e) "Peer support services" include services provided by a peer support team or a peer support team member to emergency service personnel affected by a critical incident or the accumulation of witnessing multiple incidents. Peer support services assist emergency service personnel affected by a critical incident in coping with critical incident stress or mitigating reactions to critical incident stress. Peer support services include one or more of the following:

(1) Precrisis education.

(2) Critical incident stress defusings.

(3) Critical incident stress debriefings.

(4) On-scene support services.

(5) One-on-one support services.

(6) Consultation.

(7) Referral services.

(8) Confidentiality obligations.

(9) The impact of toxic stress on health and well-being.

(10) Grief support.

(11) Substance abuse identification and approaches.

(12) Active listening skills.

(f) "Peer support team" means a local critical incident response team composed of individuals from emergency services

professions, emergency medical services, hospital staff, clergy, and educators who have completed a peer support training course developed by the Office of Emergency Services, the California Firefighter Joint Apprenticeship Committee, or the Commission on Correctional Peace Officer Standards and Training, as described in Section 8669.4.

(g) "Peer support team member" means an individual who is specially trained to provide peer support services as a member of a peer support team.

8669.2. (a) Except as otherwise provided in this section, a communication made by emergency service personnel to a peer support team member while the emergency service personnel receives peer support services is confidential and shall not be disclosed in a civil or administrative proceeding. A record kept by a peer support team member relating to the provision of peer support services to emergency service personnel by the peer support team or a peer support team member is confidential and is not subject to subpoena, discovery, or introduction into evidence in a civil or administrative proceeding.

(b) A communication or record described in subdivision (a) is not confidential if any of the following circumstances exist:

(1) The peer support team member reasonably must make an appropriate referral of the emergency service personnel to, or consult about the emergency service personnel with, another member of the peer support team or an appropriate professional associated with the peer support team.

(2) Revealing the communication by the emergency service personnel may prevent reasonably certain death, substantial bodily harm, or commission of a crime.

(3) The emergency service personnel or the legal representative of the emergency service personnel expressly agrees in writing that the emergency service personnel communication is not confidential.

(c) If the confidentiality of a communication is removed under paragraph (1) or (2) of subdivision (b), the peer support team member shall notify the emergency service personnel of the removal in writing.

8669.3. (a) Except as otherwise provided in subdivision (b), emergency service personnel who provide peer support services and have completed a training course described in Section 8669.4

shall not be liable for damages, including personal injury, wrongful death, property damage, or other loss related to an act, error, or omission in performing peer support services, unless the act, error, or omission constitutes gross negligence or intentional misconduct.

(b) Subdivision (a) does not apply to an action for medical malpractice.

8669.4. (a) The Office of Emergency Services shall develop a peer support training course that each peer support team member must complete to be eligible for the protections of this article. The course shall include topics on peer support and stress management, including, but not limited to, all of the following:

(1) Precrisis education.

(2) Critical incident stress defusings.

(3) Critical incident stress debriefings.

(4) On-scene support services.

(5) One-on-one support services.

(6) Consultation.

(7) Referral services.

(8) Confidentiality obligations.

(9) The impact of toxic stress on health and well-being.

(10) Grief support.

(11) Substance abuse identification and approaches.

(12) Active listening skills.

(b) (1) Notwithstanding subdivision (a), the Office of Emergency Services shall contract with the California Firefighter Joint Apprenticeship Committee to develop and deliver a fire service-specific peer support training course for a peer support team member who will provide peer support services for firefighters and other fire service emergency response personnel.

(2) This fire service-specific peer support training course shall be developed by the California Firefighter Joint Apprenticeship Committee in consultation with individuals knowledgeable about fire service first responder peer support services. The course shall include topics on peer support and stress management, including, but not limited to, all of the following:

(A) Precrisis education.

(B) Critical incident stress defusings.

(C) Critical incident stress debriefings.

(D) On-scene support services.

(E) One-on-one support services.

(F) Consultation.
(G) Referral services.
(H) Confidentiality obligations.
(I) The impact of toxic stress on health and well-being.
(J) Grief support.
(K) Substance abuse identification and approaches.
(L) Active listening skills.

(3) The contract shall provide for the delivery of training by the California Firefighter Joint Apprenticeship Committee through contracts with state, local, and regional public fire agencies.

(c) (1) Notwithstanding subdivision (a), the Commission on Correctional Peace Officer Standards and Trainings shall develop and deliver a peer support training course for a peer support team member who will be operating in correctional facilities such as the state prison or a county jail.

(2) This peer support training course shall include topics on peer support and stress management, including, but not limited to, all of the following:

(A) Precrisis education.
(B) Critical incident stress defusings.
(C) Critical incident stress debriefings.
(D) On-scene support services.
(E) One-on-one support services.
(F) Consultation.
(G) Referral services.
(H) Confidentiality obligations.
(I) The impact of toxic stress on health and well-being.
(J) Grief support.
(K) Substance abuse identification and approaches.
(L) Active listening skills.

8669.5. (a) Except as otherwise provided in this section, a communication made by emergency service personnel to a crisis hotline or crisis referral service is confidential and shall not be disclosed in a civil or administrative proceeding.

(b) A crisis hotline or crisis referral service may reveal information communicated by emergency service personnel to prevent reasonably certain death, substantial bodily harm, or commission of a crime.

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Board of Behavioral Sciences

CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES BILL ANALYSIS

BILL NUMBER: SB 399 **VERSION:** AMENDED JANUARY 22, 2018

AUTHOR: PORTANTINO **SPONSOR:**
- AUTISM DESERVES EQUAL COVERAGE FOUNDATION
- SPECIAL NEEDS NETWORK
- THE DIR/ FLOORTIME COALITION OF CALIFORNIA

RECOMMENDED POSITION: NONE

SUBJECT: HEALTH CARE COVERAGE: PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM

Summary:

This bill seeks to close some of the loopholes that insurance companies use to deny treatment for behavioral health treatment. It also revises the definitions of a "qualified autism service professional" and a "qualified autism service paraprofessional."

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 by one of the following:

        - A qualified autism service provider;

- A qualified autism service professional under supervision of a qualified autism service provider; or

- A qualified autism service paraprofessional supervised by a qualified autism service provider or qualified autism service professional.

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 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 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 who meets the educational and experience qualifications for 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 or California Early Intervention Services Act.

f) Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.

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 supervised by a qualified autism service provider or qualified autism service professional at a level of clinical supervision that meets professionally recognized standards of practice;

    b) Provides treatment and services according to a treatment plan developed and approved by the qualified autism service provider;

    c) Meets education and training qualifications set forth in Title 17, §54342 of the CCR;

    d) Has adequate education, training, and experience as certified by a qualified autism service provider or an entity or group that employs qualified autism service providers.

    e) Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.

7) Defines vendor service codes and sets requirements for regional centers to classify the following professions (17 CCR §54342):

    a) Associate Behavior Analysts;

    b) Behavior Analysts;

    c) Behavior Management Assistants;

    d) Behavior Management Consultants; and

    e) Behavior Management Programs.

<u>This Bill:</u>

1) Specifies that the behavioral health treatment plan’s intervention plan must include parent or caregiver participation that is individualized to the patient and takes into account the ability of the parent or caregiver to participate. (HSC §1374.73(c)(1)(C)(ii) and IC §10144.51(c)(1)(C))

2) Makes the following changes to the definition of a “qualified autism service professional” (HSC §1374.73(c)(4) and IC §10144.51(c)(4)):

    a) Specifies that they may provide behavioral health treatment, including clinical case management and case supervision, under the direction of a qualified autism service provider, <u>provided that the services are consistent with their experience, training, or education of the professional.</u>

    b) Requires them to meet one of the following criteria:

i. Meet the education and experience requirements to be approved as a vendor by a California 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 regulation (17 CCR §54342), or

ii. Have a bachelor of arts or science degree and one of the following:

- One year of experience in designing or implementing behavioral health treatment under supervision by a qualified autism service provider and 12 semester units from an accredited school in either applied behavior analysis or clinical coursework in behavioral health; or

- Two years of experience in designing or implementing behavioral health treatment supervised by a qualified autism service provider; or

- Be a registered psychological assistant or registered psychologist. However, these professionals may not supervise a qualified autism service paraprofessional until he or she has obtained at least 500 experience hours designing or implementing behavioral health treatment; or

- Be an associate clinical social worker, associate marriage and family therapist, or associate professional clinical counselor. However, these professionals may not supervise a qualified autism service paraprofessional until he or she has obtained at least 500 hours of experience in designing or implementing behavioral health treatment; or

- Be credentialed or certified by an accredited national entity, including but not limited to the Behavior Analyst Certification Board, to provide applied behavior analysis or behavioral health treatment.

c) Have training and experience providing services for pervasive developmental disorder our autism.

d) Has completed a background check with subsequent notifications.

3) Makes the following changes to the definition of a "qualified autism service paraprofessional" (HSC §1374.73(c)(5) and IC §10144.51(c)(5)):

a) Requires them to meet one of the following:

i. The education and training qualifications described in 17 CCR §54342; or

ii. They meet <u>all</u> of the following:

- Have an associate's degree or have completed two years of study from an accredited college with coursework in a related field of study; and

- Have 40 hours of training in the specific form of behavioral health treatment developed by a qualified autism provider, and administered by a qualified autism service provider or autism services professional competent in the form of behavioral health treatment to be practiced by the paraprofessional; and

- Has adequate education, training, and experience, as certified by a qualified autism service provider; or

iii. They are credentialed or certified in applied behavior analysis or behavioral health treatment for paraprofessionals or technicians by an accredited national entity, including but not limited to the Behavior Analyst Certification Board. If the applicant has finished the required training and education necessary for this certification or credential and meets all other requirements, he or she may provide treatment and services for up to 180 days while in the process of obtaining the certification or credential.

b) Requires them to complete a background check with subsequent notification.

4) Specifies that the setting, location, or time of treatment recommended by the qualified autism service provider cannot be used as the only reason to deny or reduce coverage for medically necessary services. Also requires the setting to be consistent with the standard of care for behavioral health treatment. (HSC §1374.73(g)(1), IC §10144.51(g)(1))

5) Specifies that lack of parent or caregiver participation due to hardship shall not be used as a basis for denying or reducing coverage of medically necessary services. (HSC §1374.73(g)(2), IC §10144.51(g)(2))

Comments:

1) Author's Intent. The author's office states that currently, patients with pervasive development disorder or autism (PDD/A) are being denied treatment coverage for prescribed behavioral health treatment, due to loopholes in the law. Some of these loopholes include the requirement for parental participation, location requirements, vendorization requirements, and only offering coverage for one form of behavioral health treatment. This bill seeks to remove these loopholes, and to increase the requirements to qualify as an autism service paraprofessional.

2) Effect on Board Licensees. This bill would broaden the requirements to qualify as an autism service professional. Currently, to qualify, one must meet the same education and experience requirements as a behavioral service provider approved by a regional center to provide services. This bill would leave that as one option to qualify, but would also allow an individual with a registration as an associate marriage and family therapist, associate clinical social worker, or associate

professional clinical counselor to qualify. Under the proposed language, a Board registrant would need to obtain at least 500 hours of experience designing and implementing behavioral health treatment before he or she could supervise a qualified autism service paraprofessional.

3) **Previous Legislation.** AB 1074 (Chapter 385, Statutes of 2017) sought to close several loopholes in law being used to deny coverage for behavioral health treatment, thereby increasing access to care.

   SB 946 (Chapter 650, Statues 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.

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

   SB 1034 (Mitchell, 2016) would have made some adjustments to law to close some of the loopholes insurance companies use to deny behavioral health treatment. The Board took a "support" position on SB 1034 at its May 2016 meeting. However, the bill died in the Assembly Appropriations Committee.

   AB 796 (Chapter 493, Statutes of 2016) deleted the sunset date on the law that requires health care service plans or insurance policies to provide coverage for behavioral health treatment for PDD/A.

4) **Previous Board Position.** At its April 21, 2017 meeting, the Policy and Advocacy Committee recommended the Board consider watching this bill and not taking a position. The bill was a two-year bill at the time of the Board's May 12, 2017 meeting, so the bill was not considered at that time.

Support and Opposition.

Support (As of 1/19/18):

- Autism Deserves Equal Coverage Foundation (co-source)
- DIR/Floortime Coalition of California (co-source)
- Special Needs Network Inc. (co-source)
- Autism Business Association
- Autism Society of California
- California Psychological Association
- Child Development Institute
- Greenhouse Therapy Center
- Newton Center for Affect Regulation
- Professional Child Development Associates

- Special Needs Network, Inc.
- 242 Individuals

Oppose (As of 1/19/18):

- Advanced Behavioral Pathways
- America's Health Insurance Plans
- Association of California Life and Health Insurance Companies
- California Association for Behavior Analysis
- California Association of Health Plans
- California Chamber of Commerce

History

01/30/18	In Assembly. Read first time. Held at Desk.
01/29/18	Read third time. Passed. (Ayes 28. Noes 8.) Ordered to the Assembly.
01/22/18	Read second time and amended. Ordered to third reading.
01/18/18	From committee: Do pass as amended. (Ayes 5. Noes 2. Page 4055.) (January 18).
01/17/18	Set for hearing January 18.
01/16/18	January 16 hearing: Placed on APPR. suspense file.
01/12/18	Set for hearing January 16.
01/10/18	From committee: Do pass and re-refer to Com. on APPR. (Ayes 6. Noes 2.) (January 10). Re-referred to Com. on APPR.
01/03/18	From committee with author's amendments. Read second time and amended. Re-referred to Com. on HEALTH.
12/21/17	Set for hearing January 10.
04/26/17	April 26 set for first hearing canceled at the request of author.
04/17/17	From committee with author's amendments. Read second time and amended. Re-referred to Com. on HEALTH.
04/06/17	Set for hearing April 26.
04/05/17	From committee: Do pass and re-refer to Com. on HEALTH. (Ayes 3. Noes 1. Page 625.) (April 4). Re-referred to Com. on HEALTH.
03/20/17	From committee with author's amendments. Read second time and amended. Re-referred to Com. on HUMAN S.
03/16/17	Set for hearing April 4.
03/14/17	Re-referred to Coms. on HUMAN S. and HEALTH.
03/14/17	Withdrawn from committee.
02/23/17	Referred to Coms. on HEALTH and HUMAN S.
02/16/17	From printer. May be acted upon on or after March 18.
02/15/17	Introduced. Read first time. To Com. on RLS. for assignment. To print.

Attachments

Attachment A: Definitions in 17 CCR §54342 *(Partial: only includes pages with relevant definitions)*

AMENDED IN SENATE JANUARY 22, 2018

AMENDED IN SENATE JANUARY 3, 2018

AMENDED IN SENATE APRIL 17, 2017

AMENDED IN SENATE MARCH 20, 2017

SENATE BILL No. 399

Introduced by Senator Portantino

February 15, 2017

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

SB 399, as amended, Portantino. Health care coverage: pervasive developmental disorder or autism.

Existing law, the Lanterman Developmental Disabilities Services Act, requires the State Department of Developmental Services to contract with regional centers to provide services and supports to individuals with developmental disabilities and their families. Existing law defines developmental disability for these purposes, to include, among other things, autism.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or a health insurance policy to provide coverage for behavioral health treatment for pervasive developmental disorder or autism, and defines "behavioral health treatment" to mean

specified services provided by, among others, a qualified autism service professional or a qualified autism service paraprofessional supervised and employed by a qualified autism service provider. A "qualified autism service provider" is defined as a person that meets certain certification and specialization criteria or a person licensed as a specified healing arts professional who meets certain specialization criteria. For purposes of this provision, existing law defines a "qualified autism service professional" to mean a person who, among other requirements, is a behavioral service provider approved as a vendor by a California regional center to provide services as an associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant, or behavior management program pursuant to specified regulations adopted under the Lanterman Developmental Disabilities Services Act. Existing law also defines a "qualified autism service paraprofessional" to mean an unlicensed and uncertified individual who, among other things, meets the criteria set forth in regulations adopted pursuant to the provisions that require the State Department of Social Services to adopt emergency regulations regarding the use of paraprofessionals in group practice provider behavioral intervention services for developmentally disabled persons living in the community.

This bill, among other things, would expand the definition of "qualified autism service professional" to include behavioral service providers who meet specified educational, professional, and work experience qualifications. The bill, with regard to the definition of "qualified autism service paraprofessional," would also authorize the substitution of specified education, work experience, and training qualifications, or the substitution of specified credentialing or certification, for the requirement to meet the criteria set forth in regulations adopted by the State Department of Social Services, as described above. The bill would also require providers to pass a background check, as specified, in order to meet the definition of a qualified autism service professional or a qualified autism service paraprofessional.

This bill would require ~~that the treatment plan be reviewed, as specified, and would require~~ that the intervention plan include parent or caregiver participation that is individualized to the patient and ~~that~~ takes into account the ability of the parent or caregiver to participate in therapy sessions and other recommended activities. The bill would specify that *the* lack of parent or caregiver participation *shall* not be used to deny or reduce medically necessary services *if a hardship*

95

interferes with parent or caregiver participation and that the setting, location, or time of treatment not be used as ~~a~~ *the only* reason to deny medically necessary services. Because a willful violation of the bill's provisions by a health care service plan would be a crime, it would impose a state-mandated local program.

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

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

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

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

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

~~(a) Autism and other pervasive developmental disorders are complex neurobehavioral disorders that include impairments in social communication and social interaction combined with rigid, repetitive behaviors, interests, and activities.~~

~~(b) Autism covers a large spectrum of symptoms and levels of impairment ranging in severity from somewhat limiting to a severe disability that may require institutional care.~~

~~(c) One in 68 children born today will be diagnosed with autism or another pervasive developmental disorder.~~

~~(d) Research has demonstrated that children diagnosed with autism can often be helped with early administration of behavioral health treatment.~~

~~(e) There are several forms of evidence-based behavioral health treatment, including, but not limited to, applied behavioral analysis.~~

~~(f) Children diagnosed with autism respond differently to behavioral health treatment.~~

~~(g) It is critical that each child diagnosed with autism receives the specific type of evidence-based behavioral health treatment best suited to him or her, as prescribed by his or her physician or developed by a psychologist.~~

~~(h) The Legislature intends that evidence-based behavioral health treatment be covered by health care service plans, pursuant to Section 1374.73 of the Health and Safety Code, and health~~

~~insurance policies, pursuant to Section 10144.51 of the Insurance Code.~~

~~(i) The Legislature intends that health care service plan provider networks include qualified professionals practicing all forms of evidence-based behavioral health.~~

~~SEC. 2.~~

SECTION 1. Section 1374.73 of the Health and Safety Code, as amended by Chapter 385 of the Statutes of 2017, is amended to read:

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

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

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

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

(b) Every health care service plan subject to this section shall maintain an adequate network that includes qualified autism service providers who supervise or employ qualified autism service professionals or paraprofessionals who provide and administer behavioral health treatment. A health care service plan is not

prevented from selectively contracting with providers within these requirements.

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

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

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

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

(i) A qualified autism service provider.

(ii) A qualified autism service professional supervised by the qualified autism service provider.

(iii) A qualified autism service paraprofessional supervised by a qualified autism service provider or qualified autism service professional.

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

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

(ii) Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported. The plan shall include parent or caregiver participation that is individualized to the patient and

that takes into account the ability of the parent or caregiver to participate in therapy sessions and other recommended activities.

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

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

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

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

(3) "Qualified autism service provider" means either of the following:

(A) A person who is certified by a national entity, such as the Behavior Analyst Certification Board, with a certification that is accredited by the National Commission for Certifying Agencies or the American National Standards Institute, 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 who 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) "Qualified autism service professional" means an individual who meets all of the following criteria:

(A) Provides behavioral health treatment, which may include clinical case management and case supervision under the direction and supervision of a qualified autism service provider, provided that the services are consistent with the experience, training, or education of the professional.

(B) Is supervised by a qualified autism service provider.

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

(D) Is a behavioral service provider who meets one of the following criteria:

(i) Meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant, or behavior management program.

(ii) Possesses a bachelor of arts or science degree and meets one of the following qualifications:

(I) One year of experience in designing or implementing behavioral health treatment supervised by a qualified autism service provider and 12 semester units from an accredited institution of higher learning in either applied behavioral analysis or clinical coursework in behavioral health.

(II) Two years of experience in designing or implementing behavioral health treatment supervised by a qualified autism service provider.

(III) The person is a registered psychological assistant or registered psychologist pursuant to Chapter 6.6 (commencing with Section 2900) of Division 2 of the Business and Professions Code. *A registered psychological assistant or registered psychologist may not supervise a qualified autism service paraprofessional until he or she has obtained at least 500 hours of experience in designing or implementing behavioral health treatment.*

(IV) The person is an associate clinical social worker registered with the Board of Behavioral Sciences pursuant to Section 4996.18 of the Business and Professions Code. *An associate clinical social worker may not supervise a qualified autism service paraprofessional until he or she has obtained at least 500 hours of experience in designing or implementing behavioral health treatment.*

(V) The person is a registered associate marriage and family therapist with the Board of Behavioral Sciences pursuant to Section 4980.44 of the Business and Professions Code. *A registered associate marriage and family therapist may not supervise a qualified autism service paraprofessional until he or she has*

obtained at least 500 hours of experience in designing or implementing behavioral health treatment.

(VI) The person is a registered associate professional clinical counselor with the Board of Behavioral Sciences pursuant to Section 4999.42 of the Business and Professions Code. *A registered associate professional clinical counselor may not supervise a qualified autism service paraprofessional until he or she has obtained at least 500 hours of experience in designing or implementing behavioral health treatment.*

(VII) The person is credentialed or certified by a national entity, including, but not limited to, the Behavior Analyst Certification Board that is accredited by the National Commission for Certifying Agencies or the American National Standards Institute to provide applied behavior analysis or behavioral health treatment, which may include case management and case supervision under the direction and supervision of a qualified autism service provider.

(E) Has training and experience in providing services for pervasive developmental disorder or autism.

(F) Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.

(G) Has completed a background check performed by a Department of Justice approved agency, with subsequent notification to his or her employer pursuant to Section 11105.2 of the Penal Code.

(5) "Qualified autism service paraprofessional" means an individual who meets all of the following criteria:

(A) Is supervised by a qualified autism service provider or qualified autism service professional at a level of clinical supervision that meets professionally recognized standards of practice.

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

(C) Meets one of the following:

(i) The education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations.

(ii) All of the following qualifications:

(I) Possesses an associate's degree or has completed two years of study from an accredited college or university with coursework in a related field of study.

(II) Has 40 hours of training in the specific form of behavioral health treatment developed by a qualified autism service provider and administered by a qualified autism service provider or qualified autism service professional competent in the form of behavioral health treatment to be practiced by the paraprofessional.

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

(iii) Is credentialed or certified in applied behavior analysis or behavioral health treatment for paraprofessionals or technicians by a national entity, including, but not limited to, the Behavior Analyst Certification Board or another credentialing or certifying entity that is accredited by the National Commission for Certifying Agencies, or the American National Standards Institute.

~~(iv) Upon~~

However, upon successful completion of the training and education necessary for certification or a credential described in ~~clause (iii)~~ *this clause*, if the applicant is otherwise qualified under this section, the applicant may provide treatment and implement services for up to 180 days while in the process of obtaining the certification or credential.

(D) Has adequate education, training, and experience, as certified by a qualified autism service provider or an entity or group that employs qualified autism service providers.

(E) Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.

(F) Has completed a background check performed by a Department of Justice approved agency, with subsequent notification to his or her employer pursuant to Section 11105.2 of the Penal Code.

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

(1) A specialized health care service plan that does not deliver mental health or behavioral health services to enrollees.

(2) A health care service plan contract in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code).

(e) This section does not limit the obligation to provide services under Section 1374.72.

(f) ~~(1)~~ As provided in Section 1374.72 and in paragraph (1) of subdivision (a), in the provision of benefits required by this section, a health care service plan may utilize case management, network providers, utilization review techniques, prior authorization, copayments, or other cost sharing.

~~(2) If a health care service plan uses utilization review techniques, they shall not be conducted more frequently than every six months and shall be conducted in accordance with good professional practice and the requirements of Section 1363.5.~~

(g) (1) The setting, ~~location~~ *location,* or time of treatment recommended by the qualified autism service provider shall not be used as ~~a~~ *the only* reason to deny or reduce coverage for medically necessary services. *The setting shall be consistent with the standard of care for behavioral health treatment. This subdivision does not require a health care service plan to provide reimbursement for services delivered by school personnel pursuant to an enrollee's individualized educational program for the purpose of accessing educational services, as provided by federal and state law. This subdivision does not require a health care service plan to cover services rendered outside of the plan's service area unless the services are urgently needed services, as described in subdivision (h) of Section 1345, or emergency services, as defined in Section 1317.1, or unless the benefit plan expressly covers out-of-area services.*

(2) ~~The~~ *Parent or caregiver participation is associated with greater improvements in functioning should be encouraged. However, if a hardship interferes with parent or caregiver participation, the* lack of parent or caregiver participation shall not be used as a basis for denying or reducing coverage of medically necessary services.

~~(3) The provision of services under this section, including any limits on the scope or duration of these services, shall be in compliance with all of the following:~~

~~(A) The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343), and all rules, regulations, or guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26).~~

~~(B) The Americans with Disabilities Act (42 U.S.C. Sec. 12101).~~

~~SEC. 3.~~

SEC. 2. Section 10144.51 of the Insurance Code, as amended by Chapter 385 of the Statutes of 2017, is amended to read:

10144.51. (a) (1) Every health insurance policy shall also provide coverage for behavioral health treatment for pervasive developmental disorder or autism no later than July 1, 2012. The coverage shall be provided in the same manner and shall be subject to the same requirements as provided in Section 10144.5.

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

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

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

(b) Pursuant to Article 6 (commencing with Section 2240) of Subchapter 2 of Chapter 5 of Title 10 of the California Code of Regulations, every health insurer subject to this section shall maintain an adequate network that includes qualified autism service providers who supervise or employ qualified autism service professionals or paraprofessionals who provide and administer behavioral health treatment. A health insurer is not prevented from selectively contracting with providers within these requirements.

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

(1) "Behavioral health treatment" means professional services and treatment programs, including applied behavior analysis and ~~other~~ evidence-based behavior intervention programs, that develop

or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism, and that meet all of the following criteria:

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

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

(i) A qualified autism service provider.

(ii) A qualified autism service professional supervised by the qualified autism service provider.

(iii) A qualified autism service paraprofessional supervised by a qualified autism service provider or qualified autism service professional.

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

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

(ii) Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported. The plan shall include parent or caregiver participation that is individualized to the patient and that takes into account the ability of the parent or caregiver to participate in therapy sessions and other recommended activities.

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

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

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

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

(3) "Qualified autism service provider" means either of the following:

(A) A person who is certified by a national entity, such as the Behavior Analyst Certification Board, with a certification that is accredited by the National Commission for Certifying Agencies or the American National Standards Institute, 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 who 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) "Qualified autism service professional" means an individual who meets all of the following criteria:

(A) Provides behavioral health treatment, which may include clinical case management and case supervision under the direction and supervision of a qualified autism service provider, provided that the services are consistent with the experience, training, or education of the professional.

(B) Is supervised by a qualified autism service provider.

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

(D) Is a behavioral service provider who meets one of the following criteria:

(i) Meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an associate behavior analyst, behavior analyst, behavior

management assistant, behavior management consultant, or behavior management program.

(ii) Possesses a bachelor of arts or science degree and meets one of the following qualifications:

(I) One year of experience in designing or implementing behavioral health treatment supervised by a qualified autism service provider and 12 semester units from an accredited institution of higher learning in either applied behavioral analysis or clinical coursework in behavioral health.

(II) Two years of experience in designing or implementing behavioral health treatment supervised by a qualified autism service provider.

(III) The person is a registered psychological assistant or registered psychologist pursuant to Chapter 6.6 (commencing with Section 2900) of Division 2 of the Business and Professions Code. *A registered psychological assistant or registered psychologist may not supervise a qualified autism service paraprofessional until he or she has obtained at least 500 hours of experience in designing or implementing behavioral health treatment.*

(IV) The person is an associate clinical social worker registered with the Board of Behavioral ~~sciences~~ *Sciences* pursuant to Section 4996.18 of the Business and Professions Code. *An associate clinical social worker may not supervise a qualified autism service paraprofessional until he or she has obtained at least 500 hours of experience in designing or implementing behavioral health treatment.*

(V) The person is a registered associate marriage and family therapist with the Board of Behavioral Sciences pursuant to Section 4980.44 of the Business and Professions Code. *A registered associate marriage and family therapist may not supervise a qualified autism service paraprofessional until he or she has obtained at least 500 hours of experience in designing or implementing behavioral health treatment.*

(VI) The person is a registered associate professional clinical counselor with the Board of Behavioral Sciences pursuant to Section 4999.42 of the Business and Professions Code. *A registered associate professional clinical counselor may not supervise a qualified autism service paraprofessional until he or she has obtained at least 500 hours of experience in designing or implementing behavioral health treatment.*

95

(VII) The person is credentialed or certified by a national entity, including, but not limited to, the Behavior Analyst Certification Board that is accredited by the National Commission for Certifying Agencies or the American National Standards Institute to provide applied behavior analysis or behavioral health treatment, which may include case management and case supervision under the direction and supervision of a qualified autism service provider.

(E) Has training and experience in providing services for pervasive developmental disorder or autism.

(F) Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.

(G) Has completed a background check performed by a Department of Justice approved agency, with subsequent notification to his or her employer pursuant to Section 11105.2 of the Penal Code.

(5) "Qualified autism service paraprofessional" means an individual who meets all of the following criteria:

(A) Is supervised by a qualified autism service provider or qualified autism service professional at a level of clinical supervision that meets professionally recognized standards of practice.

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

(C) Meets one of the following:

(i) The education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations.

(ii) All of the following qualifications:

(I) Possesses an associate's degree or has completed two years of study from an accredited college or university with coursework in a related field of study.

(II) Has 40 hours of training in the specific form of behavioral health treatment developed by a qualified autism service provider and administered by a qualified autism service provider or qualified autism service professional competent in the form of behavioral health treatment to be practiced by the paraprofessional.

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

(iii) Is credentialed or certified in applied behavior analysis or behavioral health treatment for paraprofessionals or technicians by a national entity, including, but not limited to, the Behavior Analyst Certification Board or another credentialing or certifying entity that is accredited by the National Commission for Certifying Agencies, or the American National Standards Institute.

~~(iv) Upon~~

However, upon successful completion of the training and education necessary for certification or a credential described in ~~clause (iii)~~ *this clause,* if the applicant is otherwise qualified under this section, the applicant may provide treatment and implement services for up to 180 days while in the process of obtaining the certification or credential.

(D) Has adequate education, training, and experience, as certified by a qualified autism service provider or an entity or group that employs qualified autism service providers.

(E) Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.

(F) Has completed a background check performed by a Department of Justice approved agency, with subsequent notification to his or her employer pursuant to Section 11105.2 of the Penal Code.

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

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

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

(e) This section does not limit the obligation to provide services under Section 10144.5.

(f) ~~(1)~~ As provided in Section 10144.5 and in paragraph (1) of subdivision (a), in the provision of benefits required by this section, a health insurer may utilize case management, network providers, utilization review techniques, prior authorization, copayments, or other cost sharing.

~~(2) If a health insurance policy uses utilization review techniques, they shall not be conducted more frequently than every~~

~~six months and shall be conducted in accordance with good professional practice and the requirements of Section 10123.135.~~

(g) (1) The setting, location, or time of treatment recommended by the qualified autism service provider shall not be used as ~~a~~ *the only* reason to deny or reduce coverage for medically necessary services. *The setting shall be consistent with the standard of care for behavioral health treatment. This subdivision does not require a health insurer to provide reimbursement for services delivered by school personnel pursuant to an enrollee's individualized educational program for the purpose of accessing educational services, as provided by federal and state law. This subdivision does not require a health insurer to cover services rendered outside of the health insurer's service area unless the services are urgently needed services to prevent serious deterioration of a covered person's health resulting from unforeseen illness or injury for which treatment cannot be delayed until the covered person returns to the insurer's service area, or emergency services, as defined in Section 1317.1 of the Health and Safety Code, or unless the benefit plan expressly covers out-of-area services.*

(2) ~~Lack~~ *Parent or caregiver participation is associated with greater improvements in functioning and should be encouraged. However, if a hardship interferes with parent or caregiver participation, the lack* of parent or caregiver participation shall not be used as a basis for denying or reducing coverage of medically necessary services.

~~(3) The provision of services under this section, including any limits on the scope or duration of these services, shall be in compliance with all of the following:~~

~~(A) The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343), and all rules, regulations, or guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26).~~

~~(B) The Americans with Disabilities Act (42 U.S.C. Sec. 12101).~~

~~SEC. 4.~~

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

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

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Board of Behavioral Sciences

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Sacramento, CA 95834
(916) 574-7830, (916) 574-8625 Fax
www.bbs.ca.gov

Memo

To:	Committee Members	**Date:**	April 6, 2018
From:	Rosanne Helms Legislative Analyst	**Telephone:**	(916) 574-7897
Subject:	**Review of Telehealth Regulations**		

Summary

The Board has received feedback that a provision of its telehealth regulations may warrant further discussion.

Background

Prior to 2016, the Board's law offered very little guidance about telehealth, other than providing a definition and some basic requirements for patient consent and confidentiality in Business and Professions Code (BPC) §2290.5.

The lack of guidance was causing increasing confusion among licensees and registrants as telehealth became more prevalent. To address this, the Board proposed its first telehealth regulations. These regulations, which became effective on July 1, 2016, were developed after extensive review and research on the topic, as well as discussion with stakeholders, over several Board and Committee meetings.

The practice of psychotherapy via telehealth continues to evolve, and the Board has received feedback that one particular area of its telehealth regulations is causing confusion and may need further discussion.

Attachment A shows the Board's current telehealth regulations (California Code of Regulations Title 16, §1815.5).

Attachment B shows current statute related to telehealth (BPC §2290.5).

Attachment C is a letter from CAMFT describing their concern with §1815.5(f) and (e) of the current telehealth regulations.

Discussion of Regulation §1815.5(f) and (e)

Regulation §1815.5(e) states that a California licensee or registrant may only provide telehealth to a client in another jurisdiction if he or she meets the requirements to lawfully provide services in that jurisdiction, and if telehealth is allowed by that jurisdiction.

This subsection was added because many Board licensees and registrants are unaware that it is common for jurisdictions to require a license to practice with a patient located there. To avoid opening himself or herself up to liability, therapists need to check to make sure they are following that jurisdiction's laws before practicing there. Otherwise, that jurisdiction could decide to take disciplinary action if there were a violation. If the jurisdiction decided to take such an action for a violation of their law, it would be within their authority to do so (because it occurred in their jurisdiction).

Regulation §1815.5(f) states that failure to comply with any provisions of the Board's telehealth regulations is unprofessional conduct.

CAMFT and other stakeholder have concerns that making it unprofessional conduct if a therapist fails to check to make sure he or she is following the laws of the jurisdiction where the client is located is too rigid and could lead to unintended consequences. For example, it does not necessarily account for a patient who is travelling, a patient who is transitioning to a new therapist, or a patient in crisis. They suggest that the location of 1815.5(e) be moved to <u>after</u> 1815.5(f) so that it functions as guidance, rather than a requirement that one must follow to avoid discipline.

Whether another jurisdiction decides to take disciplinary action based on a complaint they get when a therapist is practicing with a patient in their jurisdiction who is travelling, transitioning, or in crisis is at their discretion, and outside of the authority of this board. However, the Board may wish to discuss whether it should <u>require</u> its licensees to check with the other jurisdiction in which they are practicing, or whether that should simply be suggested as guidance.

Teletherapy Guidelines

A significant amount of guidance has been developed since the Board adopted its initial telehealth regulations:

- **Attachment D** shows guidance on cross-state licensure provided by the Telehealth Resource Center, which provide guidance to individuals who provide or are interested in providing services via telehealth. The Center is funded by a grant from the U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA) Office for the Advancement of Telehealth.

- The Association of Marital and Family Therapy Regulatory Boards released teletherapy guidelines (**Attachment E**) in 2016. In June of 2017, it also released model teletherapy and tele supervision regulations (**Attachment F**).

Recommendation

Conduct an open discussion regarding regulation section 1815.5(e), (f), and any other provisions of §1815.5 that the Committee believes may require amendments.

Attachments

Attachment A: Board Regulations: 16 CCR §1815.5: Standards of Practice for Telehealth

Attachment B: Statute Relating to Telehealth: BPC §2290.5

Attachment C: Letter from CAMFT Dated January 11, 2018

Attachment D: Telehealth Resource Center Website: Cross-State Licensure (www.telehealthresourcecenter.org)

Attachment E: Association of Marital and Family Therapy Regulatory Boards (AMFTRB) Teletherapy Guidelines (September 2016)

Attachment F: AMFTRB Model Teletherapy and Tele supervision Regulation

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Attachment A
Telehealth Regulations
(Effective July 1, 2016)

§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:

(1) Obtain informed consent from the client consistent with Section 2290.5 of the Code.

(2) Inform the client of the potential risks and limitations of receiving treatment via telehealth.

(3) Provide the client with his or her license or registration number and the type of license or registration.

(4) Document reasonable efforts made to ascertain the contact information of relevant resources, including emergency services, in the patient's geographic area.

(d) Each time a licensee or registrant provides services via telehealth, he or she shall do the following:

(1) Verbally obtain from the client and document the client's full name and address of present location, at the beginning of each telehealth session.

(2) Assess whether the client is appropriate for telehealth, including, but not limited to, consideration of the client's psychosocial situation.

(3) 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.

Note: Authority cited: Sections 4980.60 and 4990.20, Business and Professions Code. Reference: Sections 2290.5, 4980, 4989.50, 4996, 4999.30, and 4999.82, Business and Professions Code.

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Attachment B
Telehealth Statute

Business and Professions Code (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 either of the following:

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

(B) A marriage and family therapist intern or trainee functioning pursuant to Section 4980.43.

(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.

CONNECT ENRICH ACHIEVE

California Association of Marriage and Family Therapists
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January 11, 2018

Kim Madsen
Executive Officer
Board of Behavioral Sciences
1625 N. Market Blvd., Suite S-200
Sacramento, CA 95834

RE: 16 CCR § 1815.5: Telehealth

Dear Ms. Madsen:

On behalf of the California Association of Marriage and Family Therapists (CAMFT), we request that the Board of Behavioral Sciences (BBS) put 16 CCR § 1815.5 on their February 22, 2018 agenda for public discussion of possible amendment.

We want to start by thanking the BBS for attempting to tackle the incredibly complicated and difficult topic of California licensed or registered therapists practicing telehealth outside of California. This issue is one that comes up again and again and the BBS's attempt to provide direction is to be commended.

The purpose of this letter, however, is to request that the BBS, along with stakeholders, re-review the subject of telehealth performed with individuals outside of California (sub-section § 1815.5 (e)) and its construction with unprofessional conduct (sub-section § 1815.5(f)). We are concerned that the connection between the two sub-sections, as currently written and placed, could lead to unintended consequences, as well as, additional confusion on this already complicated topic.

During the public comment period in 2014, CAMFT advocated that these sections together did not take into account California patients in other locations temporarily due to vacations or work, nor patients moving out of state but in need of transition. Although CAMFT understands the BBS has no authority over other states' laws, CAMFT would like to see that the regulations allow for some flexibility in determining which out-of-state practices of telehealth would be deemed "unprofessional conduct." The implication of these sub-sections together is that if a therapist does not meet the lawful requirements of the state where the client is located, providing telehealth to the client would inherently be considered unprofessional conduct.

In 2015, in response to the concerns discussed above, the BBS indicated that it would take into account mitigating circumstances if any disciplinary action were to arise, but no standards were released. In 2016, CAMFT requested that official guidelines be developed and published to help practitioners navigate the common patient scenarios, unfortunately none were made available.

As noted above, CAMFT is thankful to the BBS for being a leader in trying to clarify such a complex area of law, as well as empathetic to the difficulties associated in doing so. CAMFT would like to see additional discussion occur on the combination of sub-sections § 1815.5(e) and § 1815.5(f), and the unintended consequences (including sub-par patient care) that could be created with the language as currently written. For example, could sub-section § 1815.5(e) be moved elsewhere and reworded to not only act as a guide, but possibly allow the BBS more flexibility in reviewing any out-of-state complaints against California therapists. This is but one example.

CAMFT would like to hear more from the BBS, and other stakeholders, on how we can improve the law so that we are not only protecting patients, but also providing therapists clear and reasonable legal precedent.

We are hopeful that this topic can appear on the February 2018 Board meeting agenda, even if to simply begin discussions in advance of the April 2018 Board meeting.

Thank you for your time.

Sincerely,

Ann Tran-Lien, JD
Managing Director, Legal Affairs

Cathy Atkins, JD
Deputy Executive Director

cc: Rosanne Helms, Legislative Analyst, Board of Behavioral Sciences
Political Solutions, LLC

ATTACHMENT D

Cross-State Licensure

Table of contents

Licensure authority defines who has the legal responsibility to grant a health professional the permission to practice their profession. Historically, under Article X of the U.S. Constitution, states have the authority to regulate activities that affect the health, safety, and welfare of their citizens including the practice of healing arts within their borders. Laws governing individual health care providers are enacted through state legislative action, with authority to implement the practice acts delegated to the respective state licensing board.

The purpose of licensing health care professionals is to protect the public from incompetent or impaired practitioners. Practicing medicine requires a certificate of licensure from the state in which the practitioner is working and may require licensure in the state where the patient is located. Similar laws cover other practitioners such as nurses, pharmacists, therapists and other professionals dispensing health care services. A practitioner must be licensed, or follow state reciprocity rules, prior to working in a state. In light of telemedicine, licensure requirements can be complicated. Before practicing medicine, the practitioner needs to ensure that his/her activity is legally sanctioned and protected.

State Licensure Requirements

Telehealth makes it possible for providers to connect with patients in other states. When this happens, the originating site (the location of the patient) is considered the "place of service", and therefore the distant site provider must adhere to the licensing rules and regulations of the state in which the patient is located. Each state has their own laws and regulations around licensing which are typically enforced by the state medical board. Most state medical boards enforce strict licensure rules, requiring providers to have a full medical license in the state the patient is physically located in. Therefore, in the case of a telehealth consultation between a provider in California and a patient in Hawaii, for example, the provider must obtain a Hawaii medical license before performing the telemedicine consultation. Under certain circumstances, such as emergencies, an exception may be made to the requirements for state licensure. If all of your patient interactions are within the State in which you are licensed, you maintain your licensure in good standing, and you comply with accepted standards, you are unlikely to have any significant licensure issues. Additional restrictions may apply if you are a physician prescribing medication across state lines. See the section on online prescribing for additional information.

Exceptions

Some state medical boards will issue special licenses or certificates related in some way to telehealth. Other states have laws that don't specifically address telehealth/telemedicine licensing but make allowances for contiguous states or for certain situations where a temporary license might be issued, provided the specific state's licensing conditions are met. To review states' licensure policies visit the Center for Connected Health Policy's policy map tracking tool. However, most laws state that the physician is not allowed to open an office in the State without a license. The most common licensure exceptions are the following:

- Physician-to-physician consultations (not between practitioner and patient)
- Educational purposes
- Residential training
- Border states
- U.S. Military
- Public health services
- Medical emergencies (Good Samaritan) or natural disasters

Potential Solutions to the Cross-State Licensure Barrier

Federal Legislation

State licensing requirements have been identified as a key policy barrier in telehealth. It can be solved at the federal level, and several pieces of federal legislation have been introduced to address this. Some legislation attempts to re-define the "place of service" from the originating site (site of the patient) to the distant site (site of provider delivering care). This would resolve the licensing barrier because a provider would then only need to be licensed in the state in which they are physically located in, as opposed to the state of the patient. However, none of these bills have successfully made it through the legislative process and into law.

Interstate Compact

The cross state licensure issue could also be resolved by forming something similar to the Nurse Licensure Compact (NLC), which allows nurses to have one multistate license, with the ability to practice in both their home state and other states which have signed on to the compact. The Federation of State Medical Boards (FSMB) drafted model language for states to create an Interstate Medical Licensure Compact, which has been adopted by one third of states. Unlike the NLC, this particular Compact creates an expedited medical licensure process with the goal of allowing physicians to become licensed in multiple states more easily, while protecting patient safety. Now that the minimum of seven states that were required to adopt the Compact language has been met, it is expected that the Interstate Commission will soon form, and begin to administer the Compact. See CCHP's policy brief on the Compact for a detailed analysis.

Federal Trade Commission

The Federal Trade Commission has also shown interest in examining whether the restrictions on telehealth providers by state licensing boards are anti-competitive. See the section on the Federal Trade Commission for more information.

Additional Resources

State Telehealth Laws and Medicaid Program Policies

Interstate Medical Licensure Compact

FSMB Interstate Medical Licensure Compact Policy Brief

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ATTACHMENT E

Association of Marital and Family Therapy Regulatory Boards +

Teletherapy Guidelines*

September 2016

AMFTRB
Teletherapy Guidelines

Table of Contents

Overview !

The AMFTRB Teletherapy Committee was created and tasked with developing a set of guidelines for use by Member Boards when regulating the practice of teletherapy by Licensed Marriage and Family Therapists (LMFTs) across the country. The Committee reviewed current AAMFT Codes of Ethics and other professional codes of ethics, state laws, research articles, and telehealth guidelines of many disciplines in creating the following guidelines for Licensed Marriage and Family Therapists.

Key Assumptions of the Teletherapy Committee

The committee agreed upon the following tenets which informed each of the guidelines herein:

I. Public protection must be the overriding principle behind each guideline.

II. Each guideline shall be written with special consideration of those uniquely systemic challenges.

III. All existing minimum standards for face-to-face client interaction are assumed for teletherapy practice.

IV. A teletherapy standard shall not be unnecessarily more restrictive than the respective face-to-face standard for safe practice.

V. Each guideline must be a recommendation for a minimum standard for safe practice *not* a best practice recommendation.

VI. The regulation of teletherapy practice is intertwined with the challenges of portability of LMFT licensure across state lines.

VII. Each guideline shall be written with consideration for the possibility of a national teletherapy credential.

The Process

The AMFTRB Teletherapy Committee members were identified in fall 2015. The committee began with a review of literature and current telehealth practice publications within the field of marriage and family therapy and across professional disciplines. Topical areas for telemental health guidelines were identified, and each committee member was charged with researching the critical elements to be included in the final draft. The committee met and reviewed each of the elements of the guidelines. Please be advised that the committee did not draft specific regulations regarding the appropriateness of telemental health and working with domestic violence victims, completing child custody evaluations, treating cyber addiction, or using technology for supervised sanctions as the research in each of these areas was limited. We also acknowledge that a method by which cultural competency may be measured is needed and encourage Member Boards to advise therapists to seek training in this area.

Committee members identified stakeholders whose input was desired in reviewing the draft guidelines. Comments were requested from marriage and family therapy graduate programs, continuing education resources, and state licensing boards. The committee reviewed and analyzed the comments from stakeholders, consulted the AAMFT Code of Ethics, and Guidelines, and incorporated this information into the final document. The draft guidelines were then submitted to the 2016 AMFTRB delegate assembly for discussion and adoption.

Introduction to Teletherapy Guidelines

Electronic practice in behavioral health has continued to garner momentum. With the creation of Facebook in 2004, the onset of 140 character messages through Twitter in 2006, and the proliferation of video conferencing platforms, therapists and clients have more options available to interact with each other than ever before. Telemental health is experiencing an "evident boom" for many reasons. Social media has significantly contributed to the growth. For example, as of July 2016, Facebook reports over 950 million users, 500 million of whom log in daily. The Pew Research Center (January 2014) reported 87% of American adults use the internet, up from 14% in 1995 (Pew, 2014). The Internet World Stats estimates 3,611 millions of users of the internet (Zephoria, 2016).

The State of Telemental Health in 2016 identifies five reasons for this growth. First, telemental health does not require physical contact with patients; therefore, technology based services are not that different from face-to-face therapy. While this statement overlooks the nuances of providing telemental health, it does support a burgeoning practice of clients receiving services without needing to step foot in a therapist's office. Second, telemental health has been accepted by a large number of payers, more than other telehealth disciplines. As more and more payers cover services provided through electronic practice, it is anticipated that a growing number of therapists will provide care electronically. Third, telemental health may reduce the stigma of those seeking care. One of the unspoken benefits of telemental health is that clients do not need to be seen entering a therapist's office. Therapists are cognizant of the concern clients have for confidentiality when determining where to house their brick-and-mortar practices. With the opportunity to receive telemental health electronically, the stigma of receiving counseling may be lessened. Not only is the potential for the stigma of mental health diminishing, more and more clients may also have an opportunity to receive care through telemental health. Fourth, the prevalence of mental health services and the shortage of mental health counselors is incentivizing stakeholders to look for alternatives to face-to-face care. For psychiatry, the American Medical Association reported that 60 percent of psychiatrists nationwide are at least 55 years old, with about 48 percent considering retiring in the next five years. "According to Mental Health American's latest report on mental health, there is only one mental health provider for every 566 people in the country." Maine has the highest number of mental health providers with a 1:250 ratio and Texas has the fewest (1:1,100). Finally, the patients who have received telemental health services have perceived their care to be effective (Epstein, Becker, & O'Brien, 2016).

Since the early discussions about telemental health, the technological landscape has changed. Cybercounseling (Hughes, 2000), e-counseling, e-therapy (Epstein, Becker, & O'Brien, 2016) and the current term of telemental health services have evolved as the shifting sands of modalities used in electronic practice have altered the modalities therapists use. Early publications about telemental

health services asked questions such as, “Should emails be encrypted?” (Mitchell, 2000), “What fee structures should be established for online services?” (Hughes, 2000), “Can a client decline to use secure systems?”, and “What if a client emergency is received, and there is no identifying information?” (Mitchell, 2000).

Discussions about online therapy have shifted as technologies available for therapy have shifted. Early discussions involved telephonic counseling and emails which evolved into video counseling, avatars, chats, blogs, and more. Social media and social networking sites have also altered the therapy landscape. Although the technologies have changed, the concerns associated with the provision of telemental health services have not. The assurance of confidentiality continues to be a concern (Hertlein, Blumer, & Mihaloliakos, 2014; Derrig-Palumbo & Eversole, 2011), as does boundary management ((Hertlein, Blumer, & Mihaloliakos, 2014; Hertlein et al, 2014), and management of crises (Hertlein, Blumer, & Mihaloliakos, 2014; Perle et al., 2013; Chester & Glass, 2006). Other concerns identified in research include the impact technology has on the therapeutic relationship, liability and licensing issues, and training and education required to provide effective telemental health services (Hertlein, Blumer, & Mihaloliakos, 2014).

As millennials enter the counseling field, the use of technology is anticipated to continue. Reith (2005) noted millennials are more comfortable with technology and have been dubbed the “digital natives”. Digital natives were “born into” a world of technology, more so than previous generations who have been termed “digital immigrants” (Prensky, 2001). Furthermore, Blumer, Hertlein, Allen, & Smith (2012) reported that millennials also feel technology is private and safe. This perception could impact the decisions made in the care and safekeeping of clinical information which fuels the need for technology specific regulations.

The proliferation of counseling-related websites has also impacted the need for technology-related regulations. In September 2008, Haberstroh (2009) identified 4 million websites when searching “online counseling”. In July 2016, a recent search of the same term netted 94 million results. This growth clearly indicates more and more counselors are turning to the internet to provide services of some type. Blumer, Hertlein, Allen, & Smith (2012) noted in their research that therapists used technology to augment treatment and Twist & Hertlein (2015) noted the use of technology for online professional networking.

While research indicates a growing use of technology in professional communications, Maheu & Gordon (2000) discovered that 78% of counselors acknowledged treating clients from other states online. Furthermore, Shaw & Shaw (2004) and Heinlen et al (2003) “found many online clinicians did not regularly follow ethical guidelines in their practices”. In a study of Swedish physicians, Brynold et al (2013) noted that physicians were tweeting in a manner deemed “unprofessional,” and the tweets were considered violations of patient privacy. Nearly 84% of family therapists were noted, in one study, to have communication with clients via email (Hertlein, Blumer & Smith, 2013).

Therapists may be confused about how to ethically and legally provide telemental health services. Haberstroh, Barney, Foster, & Duffey (2013) noted while no state licensing boards prohibit telemental health services, the language is vague. “Less than half of state boards directly allowed the practice of online clinical work through their local state laws or ethical codes…However, the specificity of the guidance provided by licensure boards varied greatly.” States seem to be grappling with the challenges of writing effective and somewhat timeless technology regulations. Therapists must comply with the

relevant licensing laws in the jurisdiction where the therapist is licensed when providing the care and the relevant licensing laws where the client is located when receiving care. Many states will only process complaints from residents of their state. Note, in the United States, the jurisdictional licensure requirement is usually tied to *where the client is physically located* when he or she is receiving the care, *not* where the client lives; however, therapists must ensure they are also compliant with any and all state and federal laws.

While the technologies and opportunities continue to emerge, few graduate programs provide meaningful guidance in how to establish a telemental health practice. Feedback received from graduate programs indicate the majority of programs, if they are addressing telemental health practice at all, are covering telemental health services typically in one class period. Many noted that the lack of clear regulations impacted their willingness to provide more comprehensive education about telemental health practice.

Therapists currently in the field rely on post-graduate training, typically in the form of continuing education workshops and programs, to expand their professional competence. Hertlein, Blumer & Smith (2013) noted that therapists should be trained in providing telemental health services, and yet, at the 2010 AAMFT conference, they note 1 of 220 workshops/posters focused on telemental health. Williams et al (2013) suggested a "framework that includes e-professionalism" be drafted. All of these events support the need for AMFTRB to establish telemental health guidelines.

Definitions

Asynchronous – Communication is not synchronized or occurring simultaneously (Reimers, 2013)

Competency - Marriage and family therapists ensure that they are well trained and competent in the use of all chosen technology-assisted professional services. Careful choices of audio, video, and other options are made in order to optimize quality and security of services and to adhere to standards of best practices for technology-assisted services. Furthermore, such choices of technology are to be suitably advanced and current so as to best serve the professional needs of clients and supervisees. (AAMFT Code of Ethics, 2015)

Electronic communication - Using Web sites, cell phones, e-mail, texting, online social networking, video, or other digital methods and technology to send and receive messages, or to post information so that it can be retrieved by others or used at a later time. (Technology Standards in Social Work Practice, 2016)

Encryption – A mathematical process that converts text, video, or audio streams into a scrambled, unreadable format when transmitted over the internet. (Trepal, Haberstroh, Duffey, & Evans, 2007)

HIPAA compliant – HIPAA, the Health Insurance Portability and Accountability Act, sets the standard for protecting sensitive patient data. Any company that deals with protected health information (PHI) must ensure that all the required physical, network, and process security measures are in place and followed. This includes covered entities (CE), anyone who provides treatment, payment and operations in healthcare, and business associates (BA)**,** anyone with access to patient information and provides

support in treatment, payment or operations. Subcontractors, or business associates of business associates, must also be in compliance. (What is HIPAA Compliance? 2016)

HITECH - Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 addresses the privacy and security concerns associated with the electronic transmission of health information, in part, through several provisions that strengthen the civil and criminal enforcement of the HIPAA rules (HITECH Act Enforcement of Interim Final Rule, 2016)

PHI – Protected Health Information (HIPAA, 2016)

Social media/social networking - Social media are web-based communication tools that enable people to interact with each other by both sharing and consuming information (Webtrends, 2016)

Synchronous – Communication which occurs simultaneously in real time (Reimers, 2013)

Telesupervision - refers to the practice of supervision by a licensed (teletherapy) supervisor through synchronous or asynchronous two-way electronic communication including but not limited to telephone, videoconferencing, email, text, instant messaging, and social media for the purposes of developing trainee marital and family therapists, evaluating supervisee performance, ensuring rigorous legal and ethical standards within the bounds of licensure, and as a means for improving the profession of marital and family therapy.

Teletherapy/Technology-assisted services – refers to the scope of marriage and family therapy practice of diagnosis, evaluation, consultation, intervention and treatment of behavioral, social, interpersonal disorders through synchronous or asynchronous two-way electronic communication including but not limited to telephone, videoconferencing, email, text, instant messaging, and social media.

Verification – Measures to verify both counselor and client identities online (Haberstroh, 2009)

Virtual relationship - A relationship where people are not physically present but communicate using online, texting, or other electronic communication devise (Urban Dictionary, 2016)

Guidelines for the Regulation of Teletherapy Practice

1. Adhering to Laws and Rules in Each Jurisdiction

A. Therapists of one state who are providing marriage and family therapy to clients in another state must comply with the laws and rules of both jurisdictions.
B. Treatment, consultation, and supervision utilizing technology-assisted services will be held to the same standards of appropriate practice as those in traditional (in person) settings.

2. Training/Educational Requirements of Professionals

A. Therapists must be accountable to states of jurisdiction education requirements for teletherapy prior to initiating teletherapy.
B. Therapists may only advertise and perform those services they are licensed and trained to provide. The anonymity of electronic communication makes misrepresentation possible for both therapists and clients. Because of the potential misuse by unqualified individuals, it is essential that information be readily verifiable to ensure client protection.
C. Therapists shall review their discipline's definitions of "competence" prior to initiating teletherapy client care to assure that they maintain recommended technical and clinical competence for the delivery of care in this manner. Therapists shall have completed basic education and training in suicide prevention. While the depth of training and the definition of “basic” are solely at the therapist’s discretion, the therapist’s competency may be evaluated by the state board.
D. Therapists shall assume responsibility to continually assess both their professional and technical competence when providing teletherapy services.
E. Minimum 15 hours initial training. Must demonstrate continued competence in a variety of ways (e.g. encryption of data, HIPAA compliant connections). Areas to be covered in the training must include, but not be limited to:
    a. Appropriateness of Teletherapy
    b. Teletherapy Theory and Practice
    c. Modes of Delivery
    d. Legal/Ethical Issues
    e. Handling Online Emergencies
    f. Best Practices & Informed Consent
F. Minimum of 5 continuing education hours every 5 years is required.

3. Identity Verification of Client

A. Therapists must recognize the obligations, responsibilities, and client rights associated with establishing and maintaining a therapeutic relationship.
B. An appropriate therapeutic relationship has not been established when the identity of the therapist may be unknown to the client or the identity of the client(s) may be unknown to the therapist. An initial face-to-face meeting, which may utilize HIPAA compliant video-conferencing, is highly recommended to verify the identity of the client. If such verification

is not possible, the burden is on the therapist to document appropriate verification of the client.

C. A therapist shall take reasonable steps to verify the location and identify the client(s) at the onset of each session before rendering therapy using teletherapy.
D. Therapists shall develop written procedures for verifying the identity of the recipient, his or her current location, and readiness to proceed at the beginning of each contact. Examples of verification means include the use of code words, phrases or inquiries. (For example, "is this a good time to proceed?").

4. Establishing the Therapist-Client Relationship

A. A therapist who engages in technology-assisted services must provide the client with his/her license number and information on how to contact the board by telephone, electronic communication, or mail, and must adhere to all other rules and regulations in the relevant jurisdiction(s).
B. The relationship is clearly established when informed consent documentation is signed.
C. Therapists must communicate any risks and benefits of the teletherapy services to be offered to the client(s) and document such communication.
D. Screening for client technological capabilities is part of the initial intake processes. (Ex. This type of screening could be accomplished by asking clients to complete a brief questionnaire about their technical and cognitive capacities).
E. Teletherapy services must have accurate and transparent information about the website owner/operator, location, and contact information, including a domain name that accurately reflects the identity.
F. The therapist and/or client shall use connection test tools (e.g., bandwidth test) to test the connection before starting their videoconferencing session to ensure the connection has sufficient quality to support the session.

5. Cultural Competency

A. Therapists shall be aware of and sensitive to clients from different cultures and have basic clinical competency skills providing these services.
B. Therapists shall be aware of the limitations of teletherapy and recognize and respect cultural differences (e.g. when therapist is unable to see the client, non-verbal cues). Therapists shall remain aware of their own potential projections, assumptions, and cultural biases.
C. Therapists shall select and develop appropriate online methods, skills, and techniques that are attuned to their clients' cultural, bicultural, or marginalized experiences in their environments.
D. Client perspectives of therapy and service delivery via technology may differ. In addition, culturally competent therapists shall know the strengths and limitations of current electronic modalities, process and practice models, to provide services that are applicable and relevant to the needs of culturally and geographically diverse clients and members of vulnerable populations.

E. Therapists shall consider cultural differences, including clarity of communications.
F. Sensory deficits, especially visual and auditory, can affect the ability to interact over a videoconference connection. Therapists shall consider the use of technologies that can help with visual or auditory deficit. Techniques should be appropriate for a client who may be cognitively impaired, or find it difficult to adapt to the technology.

6. Informed Consent/Client Choice to Engage in Teletherapy

Availability of Professional to Client

A. The therapist must document the provision of consent in the record prior to the onset of therapy. The consent shall include all information contained in the consent process for in-person care including discussion of the structure and timing of services, record keeping, scheduling, privacy, potential risks, confidentiality, mandatory reporting, and billing.
B. This information shall be specific to the identified service delivery type and include considerations for that particular individual.
C. The information must be provided in language that can be easily understood by the client. This is particularly important when discussing technical issues like encryption or the potential for technical failure.
D. Local, regional and national laws regarding verbal or written consent must be followed. If written consent is required, electronic signatures may be used if they are allowed in the relevant jurisdiction.
E. In addition to the usual and customary protocol of informed consent between therapist and client for face-to-face counseling, the following issues, unique to the use of teletherapy, technology, and/or social media, shall be addressed in the informed consent process:
    a. confidentiality and the limits to confidentiality in electronic communication;
    b. teletherapy training and/or credentials, physical location of practice, and contact information;
    c. licensure qualifications and information on reporting complaints to appropriate licensing bodies;
    d. risks and benefits of engaging in the use of teletherapy, technology, and/or social media;
    e. possibility of technology failure and alternate methods of service delivery;
    f. process by which client information will be documented and stored;
    g. anticipated response time and acceptable ways to contact the therapist;
        i. agreed upon emergency procedures;
        ii. procedures for coordination of care with other professionals;
        iii. conditions under which teletherapy services may be terminated and a referral made to in-person care;
    h. time zone differences;
    i. cultural and/or language differences that may affect delivery of services;
    j. possible denial of insurance benefits;
    k. social media policy;
    l. specific services provided;
    m. pertinent legal rights and limitations governing practice across state lines or international boundaries, when appropriate; and
    n. Information collected and any passive tracking mechanisms utilized.

F. Given that therapists may be offering teletherapy to individuals in different states at any one time, the therapists shall document all relevant state regulations in the respective record(s). The therapist is responsible for knowing the correct informed consent forms for each applicable jurisdiction.
G. Therapists must provide clients clear mechanisms to:

    a. access, supplement, and amend client-provided personal health information;
    b. provide feedback regarding the site and the quality of information and services; and
    c. register complaints, including information regarding filing a complaint with the applicable state licensing board(s).

Working with Children

A. Therapists must determine if a client is a minor and, therefore, in need of parental/guardian consent. Before providing teletherapy services to a minor, therapist must verify the identity of the parent, guardian, or other person consenting to the minor's treatment.
B. In cases where conservatorship, guardianship or parental rights of the client have been modified by the court, therapists shall obtain and review a written copy of the custody agreement or court order before the onset of treatment.

7. Acknowledgement of Limitations of Teletherapy

A. Therapists must: (a) determine that teletherapy is appropriate for clients, considering professional, intellectual, emotional, and physical needs; (b) inform clients of the potential risks and benefits associated with teletherapy; (c) ensure the security of their communication medium; and (d) only commence teletherapy after appropriate education, training, or supervised experience using the relevant technology.
B. Clients must be made aware of the risks and responsibilities associated with teletherapy. Therapists are to advise clients in writing of these risks and of both the therapist's and clients' responsibilities for minimizing such risks.
C. Therapists shall consider the differences between face-to-face and electronic communication (nonverbal and verbal cues) and how these may affect the therapy process. Therapists shall educate clients on how to prevent and address potential misunderstandings arising from the lack of visual cues and voice intonations when communicating electronically.
D. Therapists shall be aware of the limitations of teletherapy and recognize and respect cultural differences (e.g. when therapist is unable to see the client, non-verbal cues). Therapists shall remain aware of their own potential projections, assumptions, and cultural biases.
E. Therapists shall recognize the members of the same family system may have different levels of competence and preference using technology. Therapists shall acknowledge power dynamics when there are differing levels of technological competence within a family system.
F. Before therapists engage in providing teletherapy services, they must conduct an initial assessment to determine the appropriateness of the teletherapy service to be provided for the client(s). Such an assessment may include the examination of the potential risks and benefits to provide teletherapy services for the client's particular needs, the multicultural

and ethical issues that may arise, and a review of the most appropriate medium (e.g., video conference, text, email, etc.) or best options available for the service delivery. It may also include considering whether comparable in-person services are available, and why services delivered via teletherapy are equivalent or preferable to such services. In addition, it is incumbent on the therapist to engage in a continual assessment of the appropriateness of providing teletherapy services throughout the duration of the service delivery.

8. Confidentiality of Communication

A. Therapists utilizing teletherapy must meet or exceed applicable federal and state legal requirements of health information privacy including HIPAA/HiTECH.
B. Therapists shall assess carefully the remote environment in which services will be provided, to determine what impact, if any, there might be to the efficacy, privacy and/or safety of the proposed intervention offered via teletherapy.
C. Therapists must understand and inform their clients of the limits to confidentiality and risks to the possible access or disclosure of confidential data and information that may occur during service delivery, including the risks of access to electronic communications.

9. Professional Boundaries Regarding Virtual Presence

A. Reasonable expectations about contact between sessions must be discussed and verified with the client. At the start of the treatment, the client and therapist shall discuss whether or not the provider will be available for phone or electronic contact between sessions and the conditions under which such contact is appropriate. The therapist shall provide a specific time frame for expected response between session contacts. This must also include a discussion of emergency management between sessions.
B. To facilitate the secure provision of information, therapists must provide in writing the appropriate ways to contact them.
C. Therapists are discouraged from knowingly engaging in a personal virtual relationship with clients (e.g., through social and other media). Therapists shall document any known virtual relationships with clients/associated with clients.
D. Therapists shall discuss and document, and must establish, professional boundaries with clients regarding the appropriate use and/or application of technology and the limitations of its use within the counseling relationship (e.g., lack of confidentiality, circumstances when not appropriate to use).
E. Therapists shall be aware that personal information they disclose through electronic means may be broadly accessible in the public domain and may affect the therapeutic relationship.

10. Social Media and Virtual Presence

A. Therapists shall develop written procedures for the use of social media and other related digital technology with clients. These written procedures, at a minimum, provide appropriate protections against the disclosure of confidential information and identify that personal social media accounts are distinct from any used for professional purposes.

B. In cases where therapists wish to maintain a professional and personal presence for social media use, separate professional and personal web pages and profiles shall be created to clearly distinguish between the two kinds of virtual presence.
C. Therapists must respect the privacy of their clients' presence on social media unless given consent to view such information.
D. Therapists must avoid the use of public social media sources (e.g., tweets, blogs, etc.) to provide confidential information.
E. Therapists shall refrain from referring to clients generally or specifically on social media.
F. Therapists who use social networking sites for both professional and personal purposes are encouraged to review and educate themselves about the potential risks to privacy and confidentiality and consider utilizing all available privacy settings to reduce these risks. They are mindful of the possibility that any electronic communication can have a high risk of public discovery.
G. Therapists who engage in online blogging shall be aware that they are revealing personal information about themselves and shall be aware that clients may read the material. Therapists shall consider the effect of a client's knowledge of their blog information on the professional relationship, and when providing marriage and family therapy, place the client's interests as paramount.

11. Sexual Issues in Teletherapy

A. Treatment and/or consultation utilizing technology-assisted services must be held to the same standards of appropriate practice as those in face to face settings.
B. Therapists must be aware of statutes and regulations of relevant jurisdictions regarding sexual interactions with current or former clients or with known members of the client's family system.

12. Documentation/Record Keeping

A. All direct client-related electronic communications, shall be stored and filed in the client's medical record, consistent with traditional record-keeping policies and procedures.
B. Written policies and procedures must be maintained at the same standard as face-to-face services for documentation, maintenance, and transmission of the records of the services using teletherapy technologies.
C. Services must be accurately documented as remote services and include dates, place of both therapist and client(s) location, duration, and type of service(s) provided.
D. Requests for access to records require written authorization from the client with a clear indication of what types of data and which information is to be released. If therapists are storing the audiovisual data from the sessions, these cannot be released unless the client authorization indicates specifically that this is to be released.
E. Therapists must create policies and procedures for the secure destruction of data and information and the technologies used to create, store, and transmit data and information.
F. Therapists must inform clients on how records are maintained electronically. This includes, but is not limited to, the type of encryption and security assigned to the records, and if/for how long archival storage of transaction records is maintained.

G. Clients must be informed in writing of the limitations and protections offered by the therapist's technology.
H. The therapist must obtain written permission prior recording any/or part of the teletherapy session. The therapist shall request that the client(s) obtain written permission from the therapist prior to recording the teletherapy session.

13. Payment and Billing Procedures

A. Prior to the commencement of initial services, the client shall be informed of any and all financial charges that may arise from the services to be provided. Arrangement for payment shall be completed prior to the commencement of services.
B. All billing and administrative data related to the client must be secured to protect confidentiality. Only relevant information may be released for reimbursement purposes as outlined by HIPAA.
C. Therapist shall document who is present and use appropriate billing codes.
D. Therapist must ensure online payment methods by clients are secure.

14. Emergency Management

A. Each jurisdiction has its own involuntary hospitalization and duty-to-notify laws outlining criteria and detainment conditions. Professionals must know and abide by the rules and laws in the jurisdiction where the therapist is located and where the client is receiving services.
B. At the onset of the delivery of teletherapy services, therapists shall make reasonable effort to identify and learn how to access relevant and appropriate emergency resources in the client's local area, such as emergency response contacts (e.g., emergency telephone numbers, hospital admissions, local referral resources, a support person in the client's life when available and appropriate consent has been authorized).
C. Therapists must have clearly delineated emergency procedures and access to current resources in each of their client's respective locations; simply offering 911 may not be sufficient.
D. If a client recurrently experiences crises/emergencies suggestive that in-person services may be appropriate, therapists shall take reasonable steps to refer a client to a local mental health resource or begin providing in-person services.
E. Therapists shall prepare a plan to address any lack of appropriate resources, particularly those necessary in an emergency, and other relevant factors which may impact the efficacy and safety of said service. Therapists shall make reasonable effort to discuss with and provide all clients with clear written instructions as to what to do in an emergency (e.g., where there is a suicide risk). As part of emergency planning, therapists must be knowledgeable of the laws and rules of the jurisdiction in which the client resides and the differences from those in the therapist's jurisdiction, as well as document all their emergency planning efforts.
F. In the event of a technology breakdown, causing disruption of the session, the therapist must have a backup plan in place. The plan must be communicated to the client prior to

commencement of the treatment and may also be included in the general emergency management protocol.

15. Synchronous vs. Asynchronous Contact with Client(s)

A. Communications may be synchronous with multiple parties communicating in real time (e.g., interactive videoconferencing, telephone) or asynchronous (e.g. email, online bulletin boards, storing and forwarding information). Technologies may augment traditional in-person services (e.g., psychoeducational materials online after an in-person therapy session), or be used as stand-alone services (e.g., therapy provided over videoconferencing). Different technologies may be used in various combinations and for different purposes during the provision of teletherapy services. The same medium may be used for direct and non-direct services. For example, videoconferencing and telephone, email, and text may also be utilized for direct service while telephone, email, and text-may be used for non-direct services (e.g. scheduling). Regardless of the purpose, therapists shall be aware of the potential benefits and limitations in their choices of technologies for particular clients in particular situations.

16. HIPAA Security, Web Maintenance, and Encryption Requirements

A. Videoconferencing applications must have appropriate verification, confidentiality, and security parameters necessary to be properly utilized for this purpose.
B. Video software platforms must not be used when they include social media functions that notify users when anyone in contact list logs on (skype, g-chat).
C. Capability to create a video chat room must be disabled so others cannot enter at will.
D. Personal computers used must have up-to-date antivirus software and a personal firewall installed.
E. All efforts must be taken to make audio and video transmission secure by using point-to-point encryption that meets recognized standards.
F. Videoconferencing software shall not allow multiple concurrent sessions to be opened by a single user.
G. Session logs stored by 3rd party locations must be secure.
H. Therapists must conduct analysis of the risks to their practice setting, telecommunication technologies, and administrative staff, to ensure that client data and information is accessible only to appropriate and authorized individuals.
I. Therapists must encrypt confidential client information for storage or transmission, and utilize such other secure methods as safe hardware and software and robust passwords to protect electronically stored or transmitted data and information.
J. When documenting the security measures utilized, therapists shall clearly address what types of telecommunication technologies are used (e.g., email, telephone, videoconferencing, text), how they are used, whether teletherapy services used are the primary method of contact or augments in-person contact.

17. Archiving/Backup Systems

A. Therapists shall retain copies of all written communications with clients. Examples of written communications include email/text messages, instant messages, and histories of chat based discussions even if they are related to housekeeping issues such as change of contact information or scheduling appointments.
B. PHI and other confidential data must be backed up to or stored on secure data storage location.
C. Therapists must have a plan for the professional retention of records and availability to clients in the event of the therapist's incapacitation or death.

18. Electronic Links

A. Therapists shall regularly ensure that electronic links are working and are professionally appropriate.

19. Testing/Assessment

A. When employing assessment procedures in teletherapy, therapists shall familiarize themselves with the tests' psychometric properties, construction, and norms in accordance with current research. Potential limitations of conclusions and recommendations that can be made from online assessment procedures should be clarified with the client prior to administering online assessments.
B. Therapists shall consider the unique issues that may arise with test instruments and assessment approaches designed for in-person implementation when providing services.
C. Therapists shall maintain the integrity of the application of the testing and assessment process and procedures when using telecommunication technologies. When a test is conducted via teletherapy, therapists shall ensure that the integrity of the psychometric properties of the test or assessment procedure (e.g., reliability and validity) and the conditions of administration indicated in the test manual are preserved when adapted for use with such technologies.
D. Therapists shall be cognizant of the specific issues that may arise with diverse populations when providing teletherapy and make appropriate arrangements to address those concerns (e.g., language or cultural issues; cognitive, physical or sensory skills or impairments; or age may impact assessment). In addition, therapists shall consider the use of a trained assistant (e.g., proctor) to be on premise at the remote location in an effort to help verify the identity of the client(s), provide needed on-site support to administer certain tests or subtests, and protect the security of the testing and/or assessment process.
E. Therapists shall use test norms derived from telecommunication technologies administration if such are available. Therapists shall recognize the potential limitations of all assessment processes conducted via teletherapy, and be ready to address the limitations and potential impact of those procedures.

F. Therapists shall be aware of the potential for unsupervised online testing which may compromise the standardization of administration procedures and take steps to minimize the associated risks. When data are collected online, security should be protected by the provision of usernames and passwords. Therapists shall inform their clients of how test data will be stored (e.g., electronic database that is backed up). Regarding data storage, ideally secure test environments use a three-tier server model consisting of an internet server, a test application server, and a database server. Therapists should confirm with the test publisher that the testing site is secure and that it cannot be entered without authorization.
G. Therapists shall be aware of the limitations of "blind" test interpretation, that is, interpretation of tests in isolation without supporting assessment data and the benefit of observing the test taker. These limitations include not having the opportunity to make clinical observations of the test taker (e.g., test anxiety, distractibility, or potentially limiting factors such as language, disability etc.) or to conduct other assessments that may be required to support the test results (e.g., interview).

20. Telesupervision

A. Therapists must hold supervision to the same standards as all other technology-assisted services. Telesupervision shall be held to the same standards of appropriate practice as those in in-person settings.
B. Before using technology in supervision, supervisors shall be competent in the use of those technologies. Supervisors must take the necessary precautions to protect the confidentiality of all information transmitted through any electronic means and maintain competence.
C. The type of communications used for telesupervision shall be appropriate for the types of services being supervised, clients and supervisee needs. Telesupervision is provided in compliance with the supervision requirements of the relevant jurisdiction(s). Therapists must review state board requirements specifically regarding face-to-face contact with supervisee as well as the need for having direct knowledge of all clients served by his or her supervisee.
D. Supervisors shall: (a) determine that telesupervision is appropriate for supervisees, considering professional, intellectual, emotional, and physical needs; (b) inform supervisees of the potential risks and benefits associated with telesupervision, respectively; (c) ensure the security of their communication medium; and (d) only commence telesupervision after appropriate education, training, or supervised experience using the relevant technology.
E. Supervisees shall be made aware of the risks and responsibilities associated with telesupervision. Supervisors are to advise supervisees in writing of these risks, and of both the supervisor's and supervisees' responsibilities for minimizing such risks.
F. Supervisors must be aware of statutes and regulations of relevant jurisdictions regarding sexual interactions with current or former supervisees.
G. Communications may be synchronous or asynchronous. Technologies may augment traditional in-person supervision, or be used as stand-alone supervision. Supervisors shall be aware of the potential benefits and limitations in their choices of technologies for particular supervisees in particular situations.

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AMFTRB wants to acknowledge and thank the following stakeholders who contributed their responses to the surveys and documents that the Teletherapy Committee has developed. In addition, a special appreciation to the three research assistants who worked with the committee: from Alaska, **Ryan Bergerson**, B.S. and **Lauren Mitchell**, M.S. and from Colorado, **Cody Eden**, B.A.

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Resources !

Alaska Board of Marital & Family Therapy, Professional Licensing, Division of Commerce, Community, and Economic Development, Corporations, Business, & Professional Licensing, Board of Marital and Family Therapy

www.commerce.alaska.gov/web/cbpl/ProfessionalLicensing/BoardofMaritalFamilyTherapy

American Association for Marriage and Family Therapy (AAMFT)

www.aamft.org

American Counseling Association (ACA)

www.counseling.org

Association of Social Work Boards (ASWB)

www.aswb.org

American Psychological Association (APA)

www.apa.org

American Telemedicine Association (ATA)

www.americantelemed.org

Australian Psychological Society (APS)

www.psychology.org.au

Federation of State Medical Boards

www.fsmb.org

International Society for Mental Health Online

www.ismho.org

National Association of Social Workers (NASW)

www.socialworkers.org

National Board for Certified Counselors (NBCC)

www.nbcc.org

Ohio Psychological Association

www.ohpsych.org

Online Therapy Institute

www.Onlinetherapyinstitute.com

Renewed Vision Counseling Services

www.renewedvisioncounseling.com

Texas State Board of Examiners of Marriage and Family Therapists

www.dshs.texas.gov/mft/mft_rules.shtm

TeleMental Health Institute

www.telehealth.org

U.S. Department of Health and Human Services

www.hhs.gov/hipaa/for-professionals/special-topics/mental-health

Zur Institute

www.zurinstitute.com/telehealthresources.html

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Adopted September 13, 2016 by AMFTRB Annual Meeting Delegates.

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ATTACHMENT F

ASSOCIATION OF MARITAL AND FAMILY THERAPY REGULATORY BOARDS
MODEL TELETHERAPY AND TELESUPERVISION REGULATION

The Association of Marital and Family Therapy Boards (the "AMFTRB") has developed this Model TeleTherapy and Telesupervision Regulation (the "Regulation") for use by its member boards in promulgating regulations concerning the practice of teletherapy and telesupervision. It is believed that adoption of a common regulation by AMFTRB's member boards will facilitate the harmonization of the practice of teletherapy and telesupervision across jurisdictions.

The Regulation is based upon the AMFTRB's *Teletherapy Guidelines* dated September 2016 and adopted at the Annual Meeting of Delegates on September 13, 2016. The *Teletherapy Guidelines* may be used as an interpretive document for the Regulation.

First draft February 2017; revised June 2017.

Regulation of Teletherapy and Telesupervision
by
Marital and Family Therapists

I. Scope.

1.1. Any marital and family therapist practicing teletherapy or telesupervision in this state shall comply with all statutes, rules, regulations, ethics decisions and ethics guidelines applicable to the practice of marital and family therapy.

1.2. This regulation supplements the statutes, rules, regulations, ethics decisions and ethics guidelines applicable generally to the practice of marital and family therapy within this state.

II. Definitions

2.1. **Asynchronous** shall mean a communication that does not occur simultaneously in real time.

2.2. **Board** shall mean the regulatory body within this state that has primary regulatory oversight of marital and family therapists.

2.3. **Continuing education unit** or **CEU** shall mean a credit hour of additional education in subject matter related to the practice of teletherapy or telesupervision.

2.4. **Credit hour** shall mean one (1) unit of credit based upon fifty a (50) minute hour.

2.5. **Electronic communication** shall mean the use of Web sites, cell phones, email, texting, online social networking, video, or other digital methods and technology to send and receive messages, or to post information.

2.6. **Encryption** shall mean a mathematical process that converts text, video, or audio streams into a scrambled, unreadable format when transmitted electronically.

2.7. **HIPAA** shall mean the Health Insurance Portability and Accountability Act of 1996.

2.8. **HITECH** shall mean the Health Information Technology for Economic and Clinical Health Act of 2009.

2.9. **PHI** shall mean protected health information.

2.10. **Social media** shall mean a Web-based communication tool that enables people to interact with each other by both sharing and consuming information.

2.11. **Synchronous** shall mean a communication that occurs simultaneously in real time.

2.12. **Telesupervision** shall mean supervision of a trainee marital and family therapist by a licensed marital and family therapist supervisor through asynchronous or synchronous electronic communication.

2.13. **Teletherapy** shall mean the practice of marital and family therapy, including, the diagnosis, evaluation, consultation, intervention and treatment of behavioral, social, interpersonal disorders through asynchronous or synchronous electronic communication

2.14. **Verification** shall mean measures to verify the identity of the client.

2.15. **Virtual relationship** shall mean a relationship in which the marital and family therapist and client are not physically present in the same location.

III. Unauthorized practice of teletherapy or telesupervision prohibited.

A marital and family therapist shall not practice teletherapy or telesupervision in this state if such practice would violate the statutes, rules, regulations, ethics decisions or ethics guidelines applicable to the practice of marital and family therapy in this state or any state in which the marital and family therapist is licensed to practice.

IV. Registration

4.1. **Prior registration required.** Except as set forth in this article, any marital and family therapist practicing teletherapy or telesupervison within this state shall register with the board prior to beginning such practice.

4.2. **Information to be collected upon registration.** The board shall collect the following information at registration:

a. the name, date of birth and office address of the marital and family therapist;
b. contact information for the marital and family therapist;
c. if the marital and family therapist is licensed in this state the license or registration number assigned to the marital and family therapist;
d. if the marital and family therapist is licensed outside this state evidence from each state in which the marital and family therapist is licensed that the license is in good standing and that there are no regulatory actions or other sanctions pending;
e. the educational institution(s) at which the marital and family therapist received training;
f. evidence of specialized training in teletherapy or telesupervison approved by the board;
g. for each biennial registration, evidence of completion of two(2)CEU units in teletherapy or telesupervision in the two (2) year period preceding such registration;
h. the number of years that the marital and family therapist has been in practice;
i. the nature of the marital and family therapist's practice;
j. the approximate number of hours per week the marital and family therapist engages in, or will engage in, teletherapy or telesupervision.

4.3. **Biennial registration.** A marital and family therapist registered to practice teletherapy or telesupervison within this state and who continues such practice shall renew their registration every two (2) years. Such registration must be completed within thirty (30) days after their birthday.

4.4. **Exigent circumstances.** A marital and family therapist shall not be in violation of the registration requirement set forth in this article if the failure to register is the result of exigent circumstances that render such prior registration impractical, provided, that, such marital and family therapist registers with the board as soon as is practical.

4.5. **Transitory practice.** A marital and family therapist shall not be in violation of the registration requirement set forth in this article if such practice is limited to a single patient receiving no more than six (6) therapy sessions in any calendar year.

4.6. **Failure to register.** Any marital and family therapist failing to register as required under this article and who practices teletherapy or telesupervision in this state shall be engaged in the unlawful practice of marital and family therapy and subject to disciplinary proceedings instituted by the board.

4.7. **Registration fee.** The board may impose a fee to process registration.

V. Jurisdiction

5.1. **Consent to jurisdiction.** Any marital and family therapist submitting a registration in accordance with the provisions of this article consents to the jurisdiction of the board.

5.2. **Reporting of complaints and disciplinary proceedings.** The board shall report all complaints, disciplinary proceedings, factual findings, administrative actions and sanctions relating to any marital and family therapist submitting a registration in accordance with the provisions of this article to all states in which the marital and family therapist is licensed.

5.3. **Supplemental reporting.** The board shall update any report submitted in accordance with this article with a supplemental report(s) to ensure the status of all reported complaints, disciplinary proceedings, factual findings, administrative actions and sanctions

remain current and accurate. Such supplemental reporting shall include correcting errors in a previously submitted report, if any.

VI. Teletherapy and telesupervison not authorized in certain instances.

A marital and family therapist shall not perform teletherapy or telesupervison in this state if such therapy or supervision concerns, or is likely to concern, in whole or in part, any of the following:

a. domestic violence;
b. child custody evaluations;
c. treating cyber addiction; and
d. supervised sanctions.

VII. Standard of practice and competency.

7.1. **Standard of appropriate practice.** A marital and family therapist practicing teletherapy or telesupervison in this state shall be held to the same standards of practice as those applicable to therapy and supervision in traditional settings.

7.2. **Competency.** A marital and family therapist shall only deliver teletherapy and telesupervison services in this state in those instances in which the marital and family therapist has technical and clinical competency to render such services.

7.3. **Continued competency.** A marital and family therapist performing teletherapy or telesupervision in this state has an ongoing obligation to assess their technical and clinical competency to render such services.

VIII. Education and continuing education requirements.

8.1. **Initial training.** Prior to being registered to practice teletherapy or telesupervison in this state, a marital and family therapist shall complete a board approved training program.

8.2. **Continuing education.** Each marital and family therapist registered to deliver teletherapy or telesupervision services in this state shall

complete at least two (2)credit hours of board approved CEUs biennially.

IX. Verification of the client.

Before undertaking delivery of teletherapy or telesupervision services in this state a marital and family therapist shall take appropriate steps to verify the identity of the client.

X. Client assessment.

10.1 **Initial assessment.** Prior to providing teletherapy or telesupervision services in this state a marital and family therapist shall conduct an initial assessment of the client to determine if a virtual relationship is appropriate.

10.2 **Ongoing assessment.** A marital and family therapist providing teletherapy or telesupervision services in this state shall throughout the duration of such service delivery engage in a continual assessment of the appropriateness of providing such services to the client.

10.3 Teletherapy or telesupervison services not appropriate in certain circumstances. Teletherpay or telesupervison may not be appropriate if the client:

a. recurrently experiences, or is likely to experience, crises or emergencies;
b. is a suicide risk, or likely to become a suicide risk;
c. is violent, or likely to become violent; or
d. otherwise poses a risk to themselves or to others.

XI. Informed consent.

11.1 **Generally.** Prior to the delivery of teletherapy or telesupervision services in this state, the marital and family therapist providing such services shall obtain the informed consent of the client, which shall include:

a. client confidentiality and the limits to confidentiality in electronic communication;
b. the training and/or credentials of the marital and family therapist;
c. the physical location of and contact information for the marital and family therapist;
d. the marital and family therapist's license number(s) and information on reporting complaints to the board and other appropriate licensing bodies;
e. the specific services to be provided;
f. the risks and benefits of engaging in teletherapy or telesupervision in the clinical setting;
g. the encryption policy;
h. the possibility of technology failure and alternate methods of service delivery;
i. the process by which client information will be documented and stored;
j. time zone differences, if any;
k. cultural or language differences that may affect the delivery of services;
l. the possible denial of insurance benefits;
m. the marital and family therapist's social media policy;
n. the pertinent legal rights and limitations governing practice across state lines or international boundaries, where appropriate;
o. whether delivery of service will be asynchronous or synchronous; and
p. the information collected and any passive tracking mechanisms utilized.

11.2 **Informed consent in the case of a minor.** If the client is a minor, prior to providing teletherapy or telesupervision services in this state the marital and family therapist shall verify the identity of the parent, guardian, or other person consenting to the minor's treatment and obtain the informed consent required in this article.

XII. Emergency procedures, coordination of care and referrals.

Before undertaking the delivery of teletherapy or telesupervision services in this state, the marital and family therapist shall establish with the client:

a. anticipated response time and acceptable ways to contact the marital and family therapist in an emergency;
b. agreed upon emergency procedures;
c. procedures for coordination of care with other professionals; and
d. conditions under which teletherapy or telesupervision services may be terminated and a referral made to in-person care.

XIII. Compliance with privacy laws, documentation and recordkeeping.

A marital and family therapist performing teletherapy or telesupervison services in this state shall:

a. comply with all privacy laws and regulations relating to the transmission and protection of PHI, including HIPPA and HITECH; and
b. comply with all laws and regulations relating to the documentation of services delivered and recordkeeping related thereto.

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Board of Behavioral Sciences

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Memo

To:	Board Members	**Date:**	April 6, 2018
From:	Rosanne Helms Legislative Analyst	**Telephone:**	(916) 574-7897
Subject:	**Legislative Update**		

Board staff is currently pursuing the following legislative proposals:

1. **AB 93 (Medina) Healing Arts: Marriage and Family Therapists: Clinical Social Workers: Professional Clinical Counselors: Required Experience and Supervision**

   This bill proposal represents the work of the Board's Supervision Committee. Its amendments focus on strengthening the qualifications of supervisors, supervisor responsibilities, types of supervision that may be provided, and acceptable work settings for supervisees. The bill also strives to make the Board's supervision requirements more consistent across its licensed professions.

   Status: This bill is in the Senate Appropriations Committee.

2. **AB 2117 (Arambula): Marriage and Family Therapists: Clinical Social Workers: Professional Clinical Counselors**

   The Board is proposing a bill to make some amendments to its licensing process. The bill will make amendments to specify how an expired registration may be renewed, and to supervised experience hours required for long term out-of-state license holders. It also makes some corrections to LCSW law regarding the California law and ethics exam and law and ethics coursework.

   Status: This bill is in the Assembly Appropriations Committee.

3. **SB 1491 (Senate Business, Professions, and Economic Development Committee): Omnibus Legislation**

   This bill proposal, approved by the Board at its November 2, 2017 meeting, makes minor, technical, and non-substantive amendments to add clarity and consistency to current licensing law.

   Status: This bill is awaiting its first hearing (April 23rd) in the Senate Business & Professions Committee.

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Board of Behavioral Sciences

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Memo

To:	Policy and Advocacy Committee Members	**Date:**	April 6, 2018
From:	Christy Berger Regulatory Analyst	**Telephone:**	(916) 574-7817
Subject:	**Rulemaking Update**		

Application Processing Times and Registrant Advertising

This proposal would amend the Board's advertising regulations in line with SB 1478 (Chapter 489, Statutes of 2016) which changes the term "intern" to "associate" effective January 1, 2018, and makes several technical changes. This proposal would also amend the regulation that sets forth minimum and maximum application processing time frames.

This proposal, which was approved by the Board at its meeting in November 2016, has received final approval and took effect March 14, 2018.

Enforcement Process

This proposal would result in updates to the Board's disciplinary process. It would also make updates to the Board's "Uniform Standards Related to Substance Abuse and Disciplinary Guidelines (Revised October 2015)," which are incorporated by reference into the Board's regulations. The proposed changes fall into three general categories:

1. Amendments seeking to strengthen certain penalties that are available to the Board;
2. Amendments seeking to update regulations or the Uniform Standards/Guidelines in response to statutory changes to the Business and Professions Code; and
3. Amendments to clarify language that has been identified as unclear or needing further detail.

The proposal was approved by the Board at its meeting in February 2017, and began the DCA initial review process in September 2017. Upon completion of the DCA review, the proposal will be submitted to OAL for publishing to initiate the 45-day public comment period.

Contact Information; Application Requirements; Incapacitated Supervisors

This proposal would:

- Require all registrants and licensees to provide and maintain a current, confidential telephone number and email address with the Board.

- Codify the Board's current practice of requiring applicants for registration or licensure to provide the Board with a public mailing address, and ask applicants for a confidential telephone number and email address.
- Codify the Board's current practice of requiring applicants to provide documentation that demonstrates compliance with legal mandates, such as official transcripts; to submit a current photograph; and for examination candidates to sign a security agreement.
- Require certain applications and forms to be signed under penalty of perjury.
- Provide standard procedures for cases where a registrant's supervisor dies or is incapacitated before the completed hours of experience have been signed off.

The proposal was approved by the Board at its meeting in March 2017, and began the DCA initial review process in August 2017. Upon completion of the DCA review, the proposal will be submitted to OAL for publishing to initiate the 45-day public comment period.

Examination Rescoring; Application Abandonment; APCC Subsequent Registration Fee

This proposal would amend the Board's examination rescoring provisions to clarify that rescoring pertains only to exams taken via paper and pencil, since all other taken electronically are automatically rescored. This proposal would also make clarifying, non-substantive changes to the Board's application abandonment criteria, and clarify the fee required for subsequent Associate Professional Clinical Counselor registrations. The proposal was approved by the Board at its meeting in November 2017, and began the DCA initial review process in April 2018. Upon completion of the DCA review, the proposal will be submitted to OAL for publishing to initiate the 45-day public comment period.